Agenda Item 2

Consumer Fact Sheet Series

California State Board of Pharmacy
1625 N. Market Blvd, Suite N 219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

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

March 23, 2007

To: Members, Communication & Public Education Committee

Subject: Consumer Fact Sheet Series with UCSF's Center for Consumer Self Care

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Three 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.

An important objective of the fact sheets was to develop new educational materials for issues that emerge in the health care area and for which there is no or little written consumer information available. This would aid the interns who develop the materials and gain the experience of developing consumer informational materials. It also benefits the board, because it gains an invigorated set of public informational materials that are topical and not generally available.

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 in the first year. These fact sheets have been translated by the board into Spanish, Vietnamese and Chinese, and are available on the board's Web site. A list is provided below.

Bill Soller, PhD, of the UCSF Center for Consumer Self Care is overseeing this project. Dr. Soller plans on attending this meeting of the committee to discuss this project.

At the September 2006 committee meeting, Dr. Soller provided four new fact sheets. The committee recommended changes, which were provided to Dr. Soller.

In January the board's new consumer outreach analyst Karen Abbe noted several additional changes that need to be made to the fact sheets. We do not yet have these four fact sheets back for committee review.

In this tab section are the four draft fact sheets.

At this meeting, I would also like to encourage a discussion on where the committee and the Center for Consumer Self Care wishes to go with these fact sheets. Over the last few years, a number of fact sheets have been proposed (see attached list), and nine have been developed. At one point, we had hoped to develop a joint Web site with the UCSF Center for Consumer Self Care to house the fact sheets we intended to develop.

Additionally, I have been approached by two interns at other schools of pharmacy who are interested in developing fact sheets for this project.

The committee is encouraged to consider whether we need to open up the ability to develop these fact sheets to interns at other schools, and if so, how would this work.

Dr. Soller suggested the following fact sheets in a communication with me earlier this week (I have added these to our list).

- Falls - with emphasis on medicines that put you at risk - talk to your pharmacist/read the label
- Consumer reporting of adverse drug events - based on FDA quote
  "Consumers can play an important public health role by reporting to FDA any adverse reactions or other problems with products the Agency regulates. When problems with FDA-regulated products occur, the Agency wants to know about them and has several ways for the public to make reports. Timely reporting by consumers, health professionals, and FDA-regulated companies allows the Agency to take prompt action. FDA evaluates the reports to determine how serious the problem is, and if necessary, may request additional information from the person who filed the report before taking action. "
- Driving when you are taking medicines
- Tips for Parents - read the label (teaspoons and tablespoons, more is not better, ask your pharmacist)
- Allergies to medicines - what to look for, what to do, before purchase, read label/ask your pharmacist, consumer reports to MedWatch current listing on your Web site.

Here are the nine fact sheets that have been developed (and that were recently translated):

- Generic Drugs – High Quality, Low Cost
- Lower Your Drug Costs
- Is Your Medicine in the News?
- Did You Know? Good Oral Health Means Good Overall Health
- Have You Ever Missed a Dose of Medication?
- What's the Deal with Double Dosing? Too Much Acetaminophen, That's What
- Don't Flush Your Medication Down the Toilet!
- Thinking of Herbals?
- Diabetes – Engage Your Health Care Team

Topics Suggested for Consumer Fact Sheet Series

1. Different dosage form of drugs -- the ability for patients to request a specific type of product (liquid or capsule) that would best fit the patients' needs for a given type of medication. Also differences between tablespoons, mLs, cc, teaspoon measures.
2. Falls - with emphasis on medicines that put you at risk - talk to your pharmacist/read the label
3. Consumer reporting of adverse drug events -- based on FDA quote "Consumers can play an important public health role by reporting to FDA any adverse reactions or other problems with products the Agency regulates. When problems with FDA-regulated products occur, the Agency wants to know about them and has several ways for the public to make reports. Timely reporting by consumers, health professionals, and FDA-regulated companies allows the Agency to take prompt action. FDA evaluates the reports to determine how serious the problem is, and if necessary, may request additional information from the person who filed the report before taking action. "
4. Driving when you are taking medicines
5. Rebound headaches and the danger of taking too many OTC pain relievers for headaches
6. Hormone replacement therapy -- what is the current thinking?
7. Pediatric issues
8. Poison control issues
9. Ask for drug product information and labels in your native language if you cannot read English
10. Cough and cold meds and addiction issues (specifically, dextromethorophan)
11. Taking your Medicines Right (four fact sheets)
    - How to Use an Rx Label
    - How to Use an OTC Label
    - How to Use a Dietary Supplement Label
    - How to Use a Food Label
12. Take Only as Directed (three fact sheets)
    - Dangers of Double Dosing
    - Disposal of Out of Date Medicines
    - Tips on How to Take your Medicine Safely
13. Ask your Pharmacist or Doctor
    - Have a question?
    - Ask your Pharmacist for Native Language Materials/Labeling
14. Questions to Ask About your Condition or Medicine:
    - Diabetes: Questions to Ask
    - Cardiovascular Disease: Questions to Ask
    - Asthma: Questions to Ask
    - Depression: Questions to Ask

- Arthritis and Pain: Questions to Ask

15. What Can I do to Prevent Disease?
    - Regular Check Ups
    - Screening
    - What Medicare Offers
16. Childhood Illnesses and Conditions
    - Head Lice
    - Fever Reducers: Questions to Ask
    - Immunizations: Questions to Ask & Schedules
17. Questions to Ask About Your Medicines
    - What Are Drug Interactions?
    - Ask Your Pharmacist: Medicare Part D Prescription Drug Benefit
    - Medication Therapy Management – What Is It?
    - Drinking and Taking Medicines
18. Learn More about your Medicine
    - Credible Sources on the Internet

Medicine Safety

- Heading: Read the Label
  "How to Read an Rx Label"
  "How to Use an OTC Label"
  "How to Use a Dietary Supplement Label"
  "How to Use a Food Label"
- "A Medicine Chest for Traveling"
- "Drug-Drug Interactions"

Health Topics

- "Diabetes and Aspirin"
- "Asthma – Safe Use of Inhalers"
- "Immunizations"
- "Checking Your Blood Pressure"
- "Head Lice – Back to School"

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

CITE SOURCE (INCLUDING PAGE NUMBERS OF REPORTS) FOR FIRST TWO FACTS SHOWN

Ask Your Pharmacist

An aspirin a day?

... maybe...check it out!

LINE UP FIRST AND THIRD LINE TO TAB

FACT: Four out of five U.S. families will be touched by stroke.

FACT: Every 45 seconds, someone has a stroke. Every 3 minutes, someone dies of one.

FACT: Aspirin is approved for prevention of stroke and heart attacks.

SPACE BETWEEN EVERY AND DAY

REMOVE BULLET AND DECREASE INDENT

Should I Be Taking Aspirin Everyday?

- Only your healthcare provider can decide if daily aspirin is right for you. Your ~~health~~ HEALTHCARE provider can:
  - Assess your risk factors.
    - Aspirin may cause bleeding from the stomach or brain. Your ~~health~~ HEALTHCARE provider can assess your possible risk for these side effects.
  - Discuss the benefits of daily aspirin.
  - Recommend the right treatment plan.

REPLACE THIS BULLET WITH A DASH OR ANYTHING OTHER THAN A BULLET

REMOVE BULLET AND DECREASE INDENT

Take an Active Role

- To see if daily aspirin is right for you, schedule a visit with your healthcare provider.
- Ask your pharmacist about aspirin. Did you know?
  - Taking some medicines (e.g., coumadin, warfarin) with aspirin can cause serious bleeding problems.
  - Ibuprofen (Advil) may block aspirin's action on the blood. Aspirin prevents strokes by stopping blood platelets from sticking together.
  - Aspirin ~~does not mix~~ MAY INTERACT IN A DANGEROUS WAY with some herbals.
  - There is more than one type of aspirin product. Talk with your pharmacist about which one is right for you.

REMOVE BULLET ONLY

University of California San Francisco

UCSF School of Pharmacy

STATE

California Board of Pharmacy

~~400 R Street, Suite 4070, Sacramento, CA 95814 (916) 445-5014~~

UCSF Center for Consumer Self Care

3333 California Street, San Francisco, CA 94143-0613

CALIFORNIA STATE BOARD OF PHARMACY

BE AWARE & TAKE CARE
Talk to your pharmacist!

1625 N. MARKET BLVD., SUITE N-219, SACRAMENTO, CA 95834
(916) 574-7900

CITE SOURCES (INCLUDING PAGE NUMBERS) FOR ALL 3 FACTS ON THIS PAGE

Ask Your Pharmacist

Medication Errors

Mistakes happen...Protect your self!

REMOVE SPACE BETWEEN YOUR AND SELF

FACT: Almost 100,00 people die each year because of medication errors.

FACT: It is one of the nation's top health priorities to make our health care system safer.

FACT: Studies show that most medication errors involve the wrong drug or the wrong dose. People who take an active role tend to get better results.

LINE UP "DOSE" WITH OTHER LINES

To lower your risk...

BOLD

1. **Take part in every decision about your health care.**
   - You have the right to question anyone who has a part in your care.
   - Learn more about your condition. Use the Web or a public library.

2. **Do not assume all who have a part in your heath care know everything about you.**
   - Tell your doctor and pharmacist about everything you are taking.
   - Make sure your doctor and pharmacist know about any allergies you may have.

BOLD

3. **Ask for information about your medication that you can understand.**
   - Make sure you can read the prescription that your health provider writes for you.
   - Talk to your pharmacist, so you know ~~about~~ how to take your medicines.
     - When you get your prescription, ask if it is the one your doctor prescribed.
     - Medicine labels can be hard to understand. Ask your pharmacist for help.

USE DASHES OR ANYTHING OTHER THAN BULLETS HERE

BOLD

4. **When in the hospital:**
   - Choose a hospital where many patients have had the SAME procedure YOU ARE HAVING.
   - Ask about the medicines and treatments you're given.
     - Ask your health team to double-check. USE ANYTHING OTHER THAN BULLET HERE
   - When you are discharged...
     - Ask your health provider to explain all the details of the treatment plan you should use at home.
     - Leave the hospital knowing what medicines you are to take, how to take them, and when you're able to return to normal activities.

University of California San Francisco

UCSF

School of Pharmacy

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Uncommon Sense for the Common Cold

FACT: Colds account for more visits to the doctor than any other condition.. REMOVE ONE PERIOD

FACT: Adults average 2 to 4 colds a year. Kids average 6 to 8 colds a year.

FACT: Colds are highly contagious. They spread when droplets of fluid containing cold viruses are transferred by touch.

FACT: The most common cold symptoms are runny nose, congestion, sneezing, scratchy throat, cough.

REMOVE SPACE BETWEEN YOUR AND SELF

Care for your self...

...by caring for others. Share these tips with your family.

1. Avoid close contact with those who have a cold. This is important in the first days of a cold, when they are most likely to be spread.
2. Wash your hands: after touching someone with a cold; after touching something they have touched; after blowing your own nose. Wash your child's toys after play.
3. Keep your fingers away from your nose and eyes. This helps you to avoid infecting yourself with cold viruses you may have picked up.
4. Put a second towel and a second tube of toothpaste in the bathroom, for use by those without a cold to use.
5. Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue away and wash your hands.
6. Avoid contact with those who may be at greater risk if they get a cold. This includes people with asthma or other chronic lung disease.
7. Ask your pharmacist for tips about which medicines to use for your symptoms.
8. Talk to your health provider if:
   - Your cold symptoms are unusually severe;
   - You get high fever, ear pain, or sinus headache;
   - Your cough gets worse while your other symptoms improve; or
   - If you have a flare-up of any chronic lung problem, such as asthma.

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Ask Your Pharmacist

Put the Chill on Myths about Colds and Flu

ON "FACTS" LINES, LINE UP FORMATTING FOR CONSISTENCY

MYTH: Antibiotics can help ~~treat~~ CURE the flu...a myth.

FACT: Antibiotics kill bacteria, not viruses. Viruses cause cold and flu. Antibiotics will not help you get over flu or colds sooner. Overuse can make antibiotics less effective, because bacteria can become resistant to them.

MYTH: Large doses of vitamin C keep you from catching a cold or the flu; vitamin C cures flu and colds...all myths.

FACT: Vitamin C has not been shown scientifically to cure or prevent flu or colds.

MYTH: Feed a fever, starve a cold...both myths.

FACT: Your body needs more fluids if you have the flu or a cold. Drink plenty of fluids (water, juice). Eat enough to satisfy you. Drink hot fluids to help ease cough and sore throat.

MYTH: Herbal remedies are effective treatments for colds...a myth.

FACT: ~~The~~ THERE IS NO scientific support for THE use of herbals to treat or prevent flu and colds ~~is not convincing.~~ PERIOD ← REMOVE EXTRA PERIOD. ~~ALSO, CALLOUT ADJUST "NOT CONVINCING" OR [illegible]~~

MYTH: Chicken soup and spiked drinks are effective treatments for flu or colds...a myth.

FACT: Chicken soup may be delicious, but it's not been shown scientifically that chicken soup can cure the common cold or flu. Spiked drinks (hot toddies, whiskey and lemon, etc.) contain alcohol, which should be avoided when you are sick.

Help in Deciding How to Treat Flu and Colds

FACT: Your pharmacist knows which medicines are best to help relieve each of the symptoms of colds and flu. Ask your pharmacist.

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Agenda Item 3

California Consumer Health Communication Partnership

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

March 22, 2007

To: Members, Communication & Public Education Committee

Subject: Update on the Activities of the California Health Communication Partnership

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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.

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

The last campaign ended in the fall of 2006, and was the second year of the cancer screening campaign, which aimed at educating the public about the need for and importance of breast cancer or prostrate cancer screening. The campaign was titled: "It's Your Life, Do it Today." Outside funding from a private foundation enabled the use of a vendor that specializes in distributing prewritten consumer columns for small and typically weekly newspapers. There were also public service announcements intended for airing on radio. This greatly expands the exposure and reach of the campaign.

A copy of a final report to the donating organization is provided in this tab section.

However, there has not been a meeting of the partnership in months. Bill Soller, PhD, of the Center for Consumer Self Care will attend our April meeting to update us on the status of the partnership.

University of California
San Francisco

School of Pharmacy
Center for Consumer Self Care

Public E

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R. William Soller, Ph.D.
Executive Director
Center for Consumer Self Care
3333 California Street, Suite 420
San Francisco, CA 94143-0613
tel: 415/502-7633
fax: 415/502-0792
email: soller@itsa.ucsf.edu

February 14, 2007

Linda Franciscovich
Managing Director
US Trust Cp., N.A. Secretary
114 W. 47th Street
NY, NY 10036

RE: Oliver and Marie Donaldson Charitable Trust

California Health Communication Partnership's "*Do It Now*" Campaign for Consumer Awareness of Prostate and Cancer Screening (Fall 2006-Winter 2007)

Dear Linda:

On behalf of the California Health Communication Partnership, I would like to thank you for again sponsoring successful national campaigns to raise the awareness of Americans about the need for breast cancer screening and prostate cancer screening. We have just closed the tracking of our national consumer awareness programs, and I would like to share some of the highlights.

The campaigns were included combined radio and newspaper outreach across the United States, with the overarching message "Do It Now." Thematically, we used the concept of partners helping partners, as we did for our 2005 program that was also sponsored by the Oliver and Marie Donaldson Charitable Trust. The 2006-7 radio scripts and newspaper articles are included as Appendix A (English language versions) and Appendix B (Spanish language versions).

We extended our closure date for the current campaigns into February 2007 because of continued pickup by the Hispanic markets for the radio and newspaper public awareness items. As of the closure date for tracking of February 7, 2007:

- The Trust's cumulative national reach was 206,240,092 listeners and readers. This includes outreach figures for both breast and prostate cancer awareness.

- The cumulative equivalent ad rate, had space/time been purchased directly at commercial rates, is $1,240,092. The Trust supported this campaign with a gift of $20,000 to UCSF Center for Consumer Self Care, which administers public education campaigns for the California Health Communication Partnership. This is an approximate 62:1 return on investment for the Trust.

- Market segments specifically addressed in our outreach included English-speaking audiences, as well as Spanish-speaking audiences. In addition, we extended special outreach to African American newspapers.

National Breast and Prostate Cancer Screening Awareness
California Health Communication Partnership

The cumulative outreach figures for these groups are shown in brief below and in more detail in Appendix C.

Tracking Figures for Segmented Target Audiences

Topic	Media	Audience	Cumulative	Equiv.Ad Rate
Breast Cancer	Radio	English	67,185,046	$426,724
		Spanish	25,350,000	$160,972
Prostate Cancer	Radio	English	70,947,046	$450,513
		Spanish	25,390,000	$161,226
Breast Cancer	News	English	6,237,952	$ 11,577
Prostate Cancer	News	English	12,562,784	$ 26,230
		Spanish	851,200	$ 1,777
		African Am.	716,064	$ 1,495
Grand Total	ALL	ALL	209,240,092	$1,240,414

Among the important alliances that we established in these campaigns was an association with the UCSF Comprehensive Cancer Center, through the prostate cancer survivorship story of Stan Rosenfeld, who Chair, Patient Services Advocacy Committee, UCSF Comprehensive Cancer Center (Appendix). We were also fortunate to have Ms. Candis Cohen, Information Officer, Medical Board of California provide a newspaper column update to her survivorship story that she placed in 2006.

In the 2005 campaigns our outreach to the Hispanic and African American audiences was through an English language campaign. While we believe that in both 2005 and 2006 we touched a large number of Hispanics and African Americans in the English language campaigns, we believe that the Spanish language and African American segmentation in 2006-7 was important. The total estimated return on investment for these audiences based on equivalent ad rates for radio and newspapers was about 40:1. Certainly, this is an area we would like to explore further in terms of addressing the needs of the underserved.

In summary, the California Health Communication Partnership believes that it has successfully fielded its 2006-7 national cancer awareness campaigns. We are very grateful to the Oliver and Marie Donaldson Trust for its gift supporting our efforts.

With the success of the 2005 and 2006 national cancer awareness campaigns, we are hopeful that we can return to the Trust for a third national outreach effort later this year.

Best regards,

Bill

R. William Soller, PhD
Executive Director, Center for Consumer Self Care
Professor
University of California, San Francisco School of Pharmacy

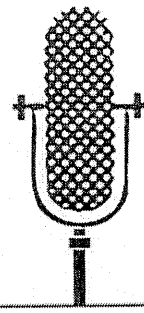
cc: Lorie Rice, MPH – Associate Dean, External Affairs

Attachment A

Radio News Release Scripts and Newspaper Articles
English Language Versions

PF1446

RADIO ROUNDUP
a collection of features, oddities, and helpful tips



NORTH AMERICAN PRECIS SYNDICATE, INC.
350 Fifth Avenue, 65th Fl.
New York, N.Y. 10118-0110

87 WORDS, 30 SECONDS

PROSTATE CANCER SCREENING. DO IT TODAY.

WOMAN: YOU FORGOT?

MAN: HEY...LIKE...IT'S NOT SOMETHING I THINK ABOUT.

WOMAN: WELL, MAYBE YOU SHOULD. IT'S YOUR LIFE...BUT REMEMBER WE'RE A PART OF IT, TOO.

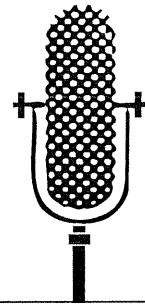
MAN: OKAY...SO...MAYBE TOMORROW.

WOMAN: NO, SURPRISE ME...DO IT TODAY.

IT'S YOUR LIFE. IF YOU'RE OVER FIFTY, ASK YOUR DOCTOR TODAY ABOUT GETTING SCREENED FOR PROSTATE CANCER, ADVISES THE CALIFORNIA HEALTH COMMUNICATION PARTNERSHIP, SUPPORTED BY AN UNRESTRICTED GRANT FROM THE OLIVER AND JENNIE DONALDSON CHARITABLE TRUST. FOR MORE INFORMATION ABOUT SCREENING FOR PROSTATE CANCER, CALL 1--800--4--CANCER.

SS 7/31 1:20

RADIO ROUNDUP
a collection of features, oddities, and helpful tips



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350 Fifth Avenue, 65th Fl.
New York, N.Y. 10118-0110

89 WORDS, 30 SECONDS

BREAST CANCER SCREENING. DO IT TODAY.

WOMAN: THERE'S SO MUCH TO DO...
MAN: YEAH, HARD TO GET EVERYTHING DONE...BUT...
WOMAN: WITH THE HOUSE, MY PARENTS, THE KIDS, I JUST CAN'T FIND...
MAN: HONEY, IT'S YOUR LIFE...REMEMBER...WE'RE A PART OF IT, TOO. DO IT TODAY.

IT'S YOUR LIFE. IF YOU'RE OVER FORTY, ASK YOUR DOCTOR TODAY ABOUT GETTING SCREENED FOR BREAST CANCER, ADVISES THE CALIFORNIA HEALTH COMMUNICATION PARTNERSHIP, SUPPORTED BY AN UNRESTRICTED GRANT FROM THE OLIVER AND JENNIE DONALDSON CHARITABLE TRUST. FOR MORE INFORMATION ABOUT SCREENING FOR BREAST CANCER, CALL 1--800--4--CANCER.

Health Bulletin

A Mammogram Saved My Life

by Candis Cohen
Information Officer, Medical Board of California

(NAPS)—So, it's been two years. I mentioned last year in this column that a mammogram saved my life. Am I grateful! Who would have thought I would need a life-saving mammogram (special X-rays of the breast that can detect cancer)? I lived a healthy life—never smoked, never a drinker, careful with my diet, and had led an active lifestyle. Fortunately, since I turned 40, I had regular screenings for breast cancer. It saved my life.

It's Your Life. *If you're a woman over 40, please get an annual mammogram. If you can't afford one, call the state Department of Health Services at (800) 511-2300.*

At 51, I had a suspicious mammogram, then a needle biopsy, which showed a tiny, aggressive cancer in my breast—so small it was removed by the biopsy itself. I just had to have a little tissue removed, which confirmed it hadn't spread. Because I'd caught it early, I'm cancer-free.

If you're a woman over 40, please get an annual mammogram. If you can't afford one, call the state Department of Health Services at (800) 511-2300. It's Your Life. A message from the California Health Communication Partnership, supported by the Oliver and Jennie Donaldson Charitable Trust.

FACT: A recent study in *The New England Journal of Medicine* found that mammograms contributed to a 24 percent decline in deaths from breast cancer between 1990 and 2000.

Did You Know?

A recent study by the American Cancer Society showed only 6 percent of women getting annual mammograms. A recent study in *The New England Journal of Medicine* found that mammograms contributed to a 24 percent decline in deaths from breast cancer between 1990 and 2000. If you're a woman over 40, please get an annual mammogram. If you can't afford one, call the state Department of Health Services at (800) 511-2300. It's Your Life. A message from the California Communication Partnership, supported by the Oliver and Jennie Donaldson Charitable Trust.

Health Awareness

A PSA Test For Prostate Cancer Saved My Life

by Stan Rosenfeld
Chair, Patient Services Advocacy Committee
University of California, San Francisco

(NAPS)—I was diagnosed with prostate cancer in 1997. I had been getting yearly PSA (prostate specific antigen) tests. Even though I had no symptoms, the PSA test came up positive. This is almost always the case when prostate cancer is caught early enough to be curable. I was treated successfully with surgery and radiation. Without the PSA test my cancer almost assuredly would have gone to an advanced stage, beyond hope of a cure.

If you're a man over 50, ask your doctor about getting screened for prostate cancer. Give support to your partner to get screened. For more information, call 1-800-4-CANCER. It's your life.
Supported by the Oliver and Jennie Donaldson Charitable Trust

Before the PSA test came into use, men were more often coming to their physicians with symptoms, and therefore with advanced prostate cancer. The death rate from prostate cancer has been falling steadily since the advent of the PSA test. For example, one of the Austrian states introduced PSA mass screening, reducing mortality from prostate cancer by 40%.

I truly believe that without the PSA test I would probably not be here, sharing my call to all men over 50 years of age to check with their doctors about getting an annual PSA test. It's Your Life. A message from the California Health Communication Partnership, supported by the Oliver and Jennie Donaldson Charitable Trust. For more information, call 1-800-4-CANCER.

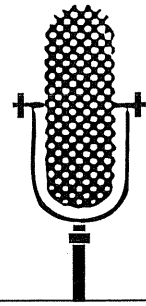
Did You Know?

Prostate and breast cancer are the most common non-skin cancers among U.S. men and women, respectively. Women over 40 should get annual mammograms (an X-ray that can show breast cancer at early stages). If you're a man over 50, ask your doctor about getting screened for prostate cancer. Encourage your partner to get screened. For more information, call 1-800-4-CANCER. It's your life.

Attachment B

Radio News Release Scripts and Newspaper Articles
Spanish Language Versions

RADIO ROUNDUP
a collection of features, oddities, and helpful tips



NORTH AMERICAN PRECIS SYNDICATE, INC.
350 Fifth Avenue, 65th Fl.
New York, N.Y. 10118-0110

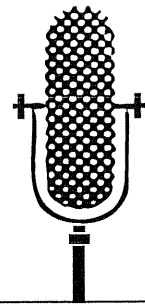
95 WORDS, 30 SECONDS

MONITOREO DE CÁNCER DE PRÓSTATA. HÁGALO HOY.

MUJER: ¿TE OLVIDASTE?
HOMBRE: OIGA...COMO QUE NO ES ALGO EN LO QUE PIENSO.
MUJER: BIEN, QUIZÁS DEBERÍAS. ES TU VIDA...PERO RECUERDA QUE NOSOTROS TAMBIÉN SOMOS PARTE DE ELLA.
HOMBRE: BIEN...ENTONCES...QUIZÁS MAÑANA.
MUJER: NO, SORPRÉNDEME...HAZLO HOY.

ES SU VIDA. SI USTED TIENE MÁS DE 50 AÑOS, PREGUNTA A SU DOCTOR SOBRE EL MONITOREO DE CÁNCER DE PRÓSTATA, ACONSEJA CALIFORNIA HEALTH COMMUNICATION PARTNERSHIP, PATROCINADA POR UNA ILIMITADA DONACIÓN DE OLIVER AND JENNIE DONALDSON CHARITABLE TRUST. PARA MÁS INFORMACIÓN SOBRE MONITOREO DE CÁNCER DE PRÓSTATA, LLAME AL 1—800—4—CANCER.

RADIO ROUNDUP
a collection of features, oddities, and helpful tips



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350 Fifth Avenue, 65th Fl.
New York, N.Y. 10118-0110

89 WORDS, 30 SECONDS

MONITOREO DE CÁNCER DEL SENO. HÁGALO HOY.

MUJER: HAY TANTO QUE HACER...
HOMBRE: SÍ, ES DIFÍCIL LOGRAR HACER TODO, PERO...
MUJER: CON LA CASA, MIS PADRES, LOS NIÑOS, NO ENCUENTRO...
HOMBRE: QUERIDA, ES TU VIDA, RECUERDA...NOSOTROS TAMBIÉN SOMOS PARTE DE ELLA. HAZLO HOY.

ES SU VIDA. SI USTED TIENE MÁS DE 40 AÑOS, PREGUNTA A SU DOCTOR SOBRE EL MONITOREO DE CÁNCER DEL SENO, ACONSEJA CALIFORNIA HEALTH COMMUNICATION PARTNERSHIP, PATROCINADA POR UNA ILIMITADA DONACIÓN DE OLIVER AND JENNIE DONALDSON CHARITABLE TRUST. PARA MÁS INFORMACIÓN SOBRE MONITOREO DE CÁNCER DEL SENO, LLAME AL 1—800—4—CANCER.

EL HISPANO NEWS
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OCT 6 2006

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Boletín de Salud

Un mamograma me salvó la vida

por Candis Cohen
Oficial de Información
Junta Médica de California

(NAPSM)—Sí, ya pasaron dos años. El año pasado mencioné en esta columna que un mamograma me salvo la vida. ¡Estoy agradecida! ¿Quién hubiera pensado que yo iba a necesitar un mamograma para que me salve la vida (rayos X especiales del pecho que pueden detectar cáncer)? Viví una vida sana—nunca fumé, nunca tomé, tuve cuidado con mi dieta y había llevado un estilo de vida activo. Afortunadamente, desde que cumplí 40, había tenido monitoreos regulares de cáncer del seno. Me salvó la vida.

Es Su Vida.
Si usted es mujer que tiene más de 40 años, por favor hágase el mamograma anual. Si usted no lo puede afrontar, llame al Departamento de Servicios de Salud del Estado al (800) 511-2300.

A los 51, tuve un mamograma sospechoso, luego una biopsia, que mostró un cáncer pequeño y agresivo en mi pecho—tan pequeño que fue removido con la biopsia misma. Sólo tuvieron que quitarme un poco de tejido, que confirmó que no se había esparcido. Debido a que se detectó en forma temprana, hoy no tengo cáncer.

Si usted es mujer que tiene más de 40, por favor hágase el mamograma anual. Si usted no lo puede afrontar, llame al Departamento Estatal de Servicios del Estado al (800) 511-2300. Es su vida. Un mensaje de California Health Communication Partnership, patrocinado por Oliver and Jennie Donaldson Charitable Trust.

HECHO: Un estudio reciente en *The New England Journal of Medicine* encontró que los mamogramas contribuyeron en un 24 por ciento a disminuir las muertes por cáncer del seno entre 1990 y 2000.

The Oklahoma Legend
(Tahlequah)
69133
Weekly
(918) 458-0816

Oklahoma Press
Clipping Bureau
3601 N. Lincoln Blvd.,
Okla. City, OK 73105
(405) 524-4421
www.OkPress.com

Una prueba de PSA para el cáncer de próstata me salvó la vida

343R

Por Stan Rosenfeld

Presidente de Comité de Defensa de Servicios de Pacientes, Universidad de California, San Francisco (NAPSM)-Me diagnosticaron con cáncer de próstata en 1997. Me había estado haciendo las pruebas de prostate specific antigen-PSA (antígeno específico de próstata) anualmente. A pesar de que no tenía síntomas, la prueba de PSA resultó positiva. Este es generalmente siempre el caso cuando el cáncer de próstata se detecta lo suficientemente temprano para ser curable. Me trataron exitosamente con cirugía y radiación. Sin la prueba de PSA, mi cáncer hubiera avanzado con mucha seguridad, dejando casi ninguna esperanza de cura.

Antes de que la prueba de PSA comenzara a utilizarse, los hombres iban generalmente al médico con síntomas y por lo tanto con cáncer de próstata avanzado.

La tasa de mortalidad por cáncer de próstata ha disminuido constantemente desde la llegada de la prueba de PSA. Por ejemplo, uno de los estados austríacos introdujo el monitoreo de PSA en masa, reduciendo la mortalidad de cáncer de próstata en un 40 por ciento. Realmente creo que sin la prueba de PSA probablemente yo no estaría aquí, compartiendo mi llamando a todos los hombre de más de 50 años para que chequeen con sus doctores sobre la prueba anual PSA.

Es su vida. Un mensaje de California Health Communication Partnership (Sociedad de Comunidación sobre la Salud de California), patrocinada por Oliver and Jennie Donaldson Charitable Trust. Para mayor información, llame al 1-800-4-CANCER.

Es Su Vida.

Si usted es mujer que tiene más de 40 años, por favor hágase el mamograma anual. Si usted no lo puede afrontar, llame al Departamento de Servicios de Salud del Estado al (800) 511-2300.

Si usted es mujer que tiene más de 40 años, por favor hágase el mamograma anual. Si usted no lo puede afrontar, llame al Departamento de Servicios de Salud del Estado al (800) 511-2300.

LEGAL NOTICE

Attachment C

"*Do It Now*" Campaign for Consumer Awareness of Prostate and Breast Cancer Screening
Sponsored by the Oliver and Marie Donaldson Charitable Trust

California Health Communication Partnership

SUMMARY TRACKING MEASUREMENTS ~ Fall 2006-Winter 2007
(Release Date: 8/16/06; End Date 2-6-07)

"*Do It Now*" Campaign for Consumer Awareness of Prostate and Breast Cancer Screening
Sponsored by the Oliver and Marie Donaldson Charitable Trust
California Health Communication Partnership

SUMMARY TRACKING MEASUREMENTS ~ Fall 2006-Winter 2007
(Release Date: 8/16/06; End Date 2-6-07)

Media	ALL MARKETS						Top 100 MARKETS		TOP MARKETS Radio % (n)		
	Audience Segment	No. of Broadcasts/ Placements	No. States /Stations	No. Stations /Papers	Cumulative Audience	Equivalent Ad Rate $	No. of Broadcasts/ Placements	Cumulative Audience	% in top 50 Mkts	% in 2nd 50 Mkts	% in top 4 Mkts
Prostate Cancer Screening Awareness											
Radio											
r08368	English	593/179	38	na	34,357,046	$218,167	213	14,703,246	21%	15%	45%
r08376	English	300/6	3	na	36,590,000	$232,346	120	8,240,000	40%	0%	100%
r08410	Spanish	90	7	na	25,390,000	$161,226	56	15,820,000	54%	8%	68%
SubTOTAL		**983**	48		**96,337,046**	**$611,739**	389	38,733,246	-	-	-
Newspaper											
69008	English	256	20	na	12,562,784	$26,230	192	ng	39%	39%	97%
69133	Spanish	12	3	na	851,200	$1,777	2	ng	33%	33%	100%
69142	Af.American	24	5	na	716,064	$1,495	16	716,064	33%	33%	100%
SubTOTAL		**292**	28	na	**14,130,048**	**$29,502**	210	-	-	-	-
Breast Cancer Screening Awareness											
Radio											
r08369	English	549/178	38/178	na	31,155,046	$197,834	166	11,623,246	23%	7%	41%
r08375	English	285/105	3	na	36,030,000	$228,790	105	7,680,000	37%	0%	100%
r08411	Spanish	86	7	na	25,350,000	$160,972	52	15,780,000	52%	8%	66%
SubTOTAL		**920**	48	na	**92,535,046**	**$587,596**	323	35,053,246	-	-	-
Newspaper											
68992	English	132	24	na	6,237,952	$11,577	132	ng	48%	21%	94%
SubTOTAL		**132**	24	na	**6,237,952**	**$11,577**	132	ng	48%	21%	94%
TOTAL RADIO		1891	-	na	188,872,092	$1,199,335	712	73,786,492			
TOTAL NEWSP		424	-	na	20,368,000	$41,079	348	-	-	-	-
GRAND TOTAL		**2315**			**209,240,092**	**$1,240414**					

Agenda Item 4

Update Report on The Script

California State Board of Pharmacy
1625 N. Market Blvd, Suite N 219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

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

March 19, 2007

To: Members, Communication & Public Education Committee

Subject: *The Script*

The next issue of *The Script* is planned for publication and distribution in July 2007. The focus of this issue will be application of laws and questions and answers about pharmacy practice asked of the board.

Agenda Item 5

Development of New Consumer Brochures

California State Board of Pharmacy
1625 N. Market Blvd, Suite N 219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

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

March 23, 2007

To: Members, Communication & Public Education Committee

Subject: Development of New Consumer Brochures

Consumer Outreach Analyst Karen Abbe has initiated work on building and revising some of our public education materials.

In draft manuscript form are:

- *Board of Pharmacy Informational Brochures*

  Ms. Abbe has revised two brochures about the board. Drafts of the texts of these brochures are provided following this page – one is an overview of the board, the other is information about filing a complaint with the board.

Currently under development are:

- *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.

- *Informational Fact Sheets for Applicants*
  While the following information is available to applicants who read the pharmacist examination application materials, some applicants do not read this information or retain it.
  - -- Information about applying for the CPJE or a California intern pharmacist license specifically for pharmacists licensed in other states
  - -- Information about how foreign graduate can qualify for a pharmacist license in California

- *Under review for possible development are*:
  - -- The Beers list of medications that should not be provided to elderly patients (although it is no longer know as the Beers list)
  - -- Update of Facts About Older Adults and Medicines (revision)

Resources for Preventing Prescription 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.

Public awareness has been heightened by the recently released SCR 49 Report on Medication Errors

Ms. Abbe is working with me to develop a section 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.

We hope to have this section of the Web site developed by the July or possibly the October Board Meetings, when the new Web site is rolled out.

Healthy Californians Through Quality Pharmacist's Care

(name, logo, etc.)

Who We Are

The California State Board of Pharmacy (board) serves the public as a consumer protection agency. The board is part of the Department of Consumer Affairs, which is in the executive branch of California's government. The Governor is at the top of the executive branch.

The board consists of 13 members, appointed to four-year terms. Members can serve only two consecutive terms. There are seven pharmacists and six public members appointed to the board. The Governor appoints the seven pharmacists, as well as four of the public members. The Senate Rules Committee and the Speaker of the Assembly each appoint one public member. Public members are individuals who are not licensed by the board.

Members of the board appoint the executive officer, who directs board operations and oversees a staff of more than 55 people. The staff includes over 20 pharmacists who inspect licensed premises and investigate suspected violations of pharmacy law. The board is self-funded through licensing fees, and receives no tax money from the General Revenue Fund of California.

How We Protect the Public

The board develops and enforces regulations to protect the public from the misuse and diversion of prescription drugs from pharmacies. The board licenses pharmacists, pharmacist interns, pharmacy technicians, and designated representatives (those involved with wholesaling medicine and medical devices, but who do not hold a pharmacist license).

The board also regulates firms that distribute medicine and medical devices in California. These firms include community pharmacies, hospital pharmacies, clinics, out-of-state pharmacies that fill prescriptions and deliver them to patients in California, and wholesalers who ship medicines into California.

Did You Know?

The board licenses more than 90,000 individuals and firms including:

- Pharmacists
- Intern pharmacists
- Pharmacy technicians
- Foreign educated pharmacists
- Pharmacies
- Non-resident pharmacies
- Wholesaler drug facilities
- Veterinary food animal drug retailers
- Exemptees (non-pharmacists who may operate sites other than pharmacies)
- Out-of-state distributors
- Clinics
- Hypodermic needle and syringe distributors

To become a licensed pharmacist, an individual must graduate from an accredited pharmacy school, pass two examinations, and complete experience in both community and hospital pharmacies. In addition, continuing education is required for a pharmacist to renew his or her license.

What We Do

Under California law, the board's mandate is consumer protection. The board oversees those that compound, dispense, store, ship, or handle prescription drugs and medical devices to patients and practitioners in California. Currently, the board licenses over 100,000 pharmacists, pharmacies, and other individuals and businesses who are involved in these activities. The board sets standards and licenses those who comply with these standards to ensure practitioners and businesses possess necessary skills and follow essential components.

The board ensures that pharmacists provide patients with quality pharmacist care when dispensing prescribed medicine, providing information to protect patients to prevent drug misadventures, and taking responsibility for therapeutic outcomes resulting from their decisions.

Did You Know?

Information regarding license status and official actions taken in connection with a licensee, if known, are disclosed to the public upon request. You can obtain:

- Licensee Name
- License Number
- Name of Licensed Facility Owner (including the corporation name and corporate officers) and the Pharmacist-in-Charge
- Address of Record
- Date the original License was issued
- License Expiration Date
- Current License Status
- Letters of Admonishment
- Citations
- Referrals for formal Disciplinary Action
- Accusation/Petition to Revoke Probation
- Board Decisions
- Temporary Restraining Order
- Automatic Suspension Order
- Summary Suspension Order
- Interim Suspension Order
- Penal Code 23 license restrictions

Where to Find More Information

The board's Web site provides consumer education material, application material for licensing, and information for ensuring compliance with California Pharmacy Law. The Web site also provides information on board meetings and critical forums vital to pharmacy services where

public comments and input are encouraged. Go to www.pharmacy.ca.gov for materials including:

- Consumer Education Material
- Applications and Forms
- Complaint Resolution process
- Publications and Newsletters
- Pharmacy Law and Regulations
- License Verification
- Licensing Requirements and Renewal Information
- Public board and committee meeting dates, agendas, meeting materials and minutes

Consumers and licensees may also call or write to the board:

California State Board of Pharmacy

1625 N. Market Blvd., Suite N-219

Sacramento, CA 95834

(916) 574-7915 (8:00 a.m. - 12:00 p.m.)

(916) 574-7909 (12:30 p.m. - 4:30 p.m.)

Did You Know?

Anyone interested in receiving e-mail alerts about updates to the board's Web site can join the board's e-mail notification list. Go to to www.pharmacy.ca.gov, click on "Information For Consumers", then scroll to "Join our e-mail list." E-mail alerts provide information regarding:

Regulations implemented or released for public comment
Board newsletters when they are published
Agendas for public meetings when released
Questions and answers about new laws
Board actions from board meetings

Do you have a complaint?

(name, logo, etc.)

Complaint Resolution

A primary way the California State Board of Pharmacy (board) protects the public is through the investigation of consumer inquiries and complaints involving the care patients have received. Errors in filling prescriptions or suspected misconduct by a pharmacist may be violations of pharmacy law, and should be reported, whether or not a patient was harmed. The board does not have jurisdiction over drug prices charged by the pharmacy or prescription billing disputes with insurance carriers.

The board advocates and enforces laws that protect the health and safety of patients, and encourages submission of complaints and inquiries from the public. Each complaint is evaluated to determine if the complaint involves a pharmacist, pharmacy, or firm regulated by the board, and whether the complaint involves a violation of California Pharmacy Law.

What is Pharmacist Misconduct?

Examples of misconduct by a pharmacist include (but are not limited to) instances where:

- The pharmacist fails to counsel you about how to take a new prescription medicine (or a prescription with changed instructions) and its possible side effects
- A non-pharmacist counsels you regarding your prescription
- A pharmacist is not present and your prescription is filled by a non-pharmacist
- A pharmacist fails to maintain the confidentiality of your prescription
- A pharmacist appears unable to function safely (due to alcohol or drug abuse)
- The pharmacy is dirty, cluttered, or looks unsanitary
- A pharmacist fails to assist you in obtaining a prescribed drug or device from another pharmacy, when the drug or device is out of stock
- A pharmacist fails to assist you in obtaining a prescribed drug or device from another pharmacy, when the pharmacist refuses to fill the prescription for ethical, moral, or religious reasons

What are Prescription Errors?

Examples of prescription error violations include (but are not limited to) instances where:

- Incorrect information is entered on the label of the prescription container
- A prescription is dispensed with the wrong drug or wrong dosage
- A prescription is refilled without proper authorization from the prescribing physician
- A generic drug is substituted for a brand name drug, without informing the patient of the substitution

- A prescription is filled using drugs whose expiration date has passed

How to File a Complaint

Complaint forms are found at www.pharmacy.ca.gov. The form may be filled out and submitted electronically, or the form can be printed and filled out by hand. The completed form must be sent to the California State Board of Pharmacy, 1625 N. Market Blvd., Suite N-219, Sacramento, CA 95834. An on-line complaint form is also available on the Web site that can be submitted electronically.

What Happens to My Complaint?

The board strives to complete most investigations within 120 days. Routine investigations may take up to 90 days, while more complex cases requiring extensive investigation may take longer.

If the complaint is within the board's jurisdiction, the complaint will be referred to staff for mediation or investigation. If the complaint is not within the board's jurisdiction, it may be closed with no action taken or referred to another agency that may have jurisdiction. A complaint could result in disciplinary action being taken against a licensee ranging from a reprimand, a citation and fine, or revocation of the license with loss of the right to practice or operate a pharmacy.

If you write to the board and request information regarding the outcome of a complaint, the board will respond in writing. The following information may be obtained:

- The date the complaint was received by the board
- A summary of the investigation
- The outcome or type of discipline

Formal disciplinary actions are a matter of public record, as are the names of licensees, their license numbers, their address of record, the date the original license was issued, and the current status (active or inactive) of that license.

Agenda Item 6

Miscellaneous Consumer Issues/Articles in the Media

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

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

Date: March 22, 2007

To: Communication and Public Education Committee

From: Virginia Herold, Executive Officer, Board of Pharmacy

Subject: Miscellaneous Consumer Issues and Articles in the News

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Attached are several articles of consumer interest. During this meeting, the committee can review and discuss these items in the event it wishes to propose action at the next committee meeting.

WSJ.com THE WALL STREET JOURNAL. ONLINE

FORMAT FOR PRINTING sponsored by TOSHIBA Don't copy. Lead.

March 15, 2007

WSJ ONLINE/HARRIS INTERACTIVE HEALTH-CARE POLL

Many Americans Disregard Doctors' Course of Treatment

THE WALL STREET JOURNAL ONLINE
March 15, 2007

DOW JONES REPRINTS

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A quarter of Americans say they have left a drug prescription unfilled because they felt it was unneeded and a fifth have obtained a second opinion because they felt their doctors' recommendations were too aggressive.

In all, 44% of Americans say they or an immediate family member have ignored a doctor's course of treatment or sought a second opinion because they felt the doctor's orders were unnecessary or overly aggressive, according to a Wall Street Journal Online/Harris Interactive health-care poll.

In addition to the 27% who have left a prescription unfilled and 20% who have sought a second opinion, 13% have avoided getting a diagnostic test, 7% have opted against a surgical procedure and 7% have changed doctors because they felt their doctor's recommended treatment was too aggressive. Respondents were presented with several scenarios and were able to select more than one that applied to them or a family member.

Among survey respondents who said they have chosen not to follow a doctor's recommendations, 89% said nothing negative happened as a result. Eleven percent reported some sort of negative effect, such as worsening health conditions and lost time from work.

The survey found 43% of Americans say they are concerned about receiving too many treatments or overly aggressive treatment when they are sick or in need of medical care. In a survey conducted two years ago, 50% said they felt that way.

About 52% of Americans believe doctors overtreat patients because of concerns about malpractice lawsuits, while 41% say doctors do so "to make more money" and 44% say "to meet patients' demands."

Still, Americans seem to believe that undertreatment is a problem, too. When asked how often they believe patients are undertreated, 29% said often and 55% said sometimes.

See full results of the poll:

"Based on what you know or have heard, how often do you think patients who have medical conditions experience problems because of...?"

Base: All adults

		Often/Sometimes (Net)	Often	Sometimes	Rarely/Never (Net)	Rarely	Never
Being **over-treated**, for example, by getting too many treatments or by getting more aggressive treatment than is appropriate	2005	72%	22%	50%	28%	22%	6%
	2007	73	19	54	27	22	5
Being **under-treated**, for example by getting too few treatments or by getting less aggressive treatment than is appropriate	2005	83	31	51	17	13	5
	2007	83	29	55	17	14	3

Note: Percentages may not add up to exactly 100 percent due to rounding.

* * *

"How concerned are you, personally, about receiving too many treatments or overly aggressive treatment when you are sick or in need of medical care?"

Base: All adults

	2005	2007
Very/Somewhat Concerned (Net)	50%	43%
Very concerned	14	10
Somewhat concerned	37	33
Not Very/At All Concerned (Net)	50	57
Not very concerned	36	44
Not at all concerned	14	13

Note: Percentages may not add up to 100 percent due to rounding.

* * *

"Which of the following, if any, have you ever done when your doctor recommended a particular course of treatment for you or an immediate family member? Please select all that apply."

Base: All adults

	2005	2007
Did not fill a prescription that your doctor gave you because you felt it was unnecessary	32%	27%
Got a second opinion from another doctor because you thought your doctor's recommendations were too aggressive	21	20
Did not get a diagnostic test that your doctor recommended because you felt it was unnecessary	16	13
Did not get a surgical procedure that your doctor recommended because you felt it was unnecessary	10	7
Changed doctors because you felt that your doctor's approach was too aggressive	9	7
None of these	48	56

Note: Multiple-response question.

* * *

"What, if anything, happened to your or your family member as a result of choosing not to follow your doctor's recommendations? If you had more than one such experience, please answer for the most recent one. Please select all that apply."

Base: Respondents who chose to forgo recommended treatment

	TOTAL
Experienced a new medical problem or complication	2%
Required hospitalization	2
Lost time from work or school	4
Health got worse	3
Had to go to the emergency room	3
Some other type of problem	3

Nothing negative happened as a result	89

Note: Multiple-response question.

* * *

"Based on what you know or have heard, what do you think are the reasons that doctors sometimes over-treat patients, for example by providing too many treatments or overly aggressive treatments?"

Base: All adults

	2005	2007
Because of concerns about malpractice lawsuits	53%	52%
To make more money	45	41
To meet patients' demands	45	44
To make fast and easy decisions	31	25
Because of misleading information they receive from prescription drug and medical device companies	30	27
Because of a faulty medical diagnosis	27	25
To give patients more reason to hope	16	13
Other	6	7
Don't know	9	16

Note: Multiple-response question.

Methodology:
Harris Interactive conducted this online survey in the U.S., March 5-7, 2007, among a nationwide cross section of 2,673 adults. Figures for age, gender, race/ethnicity, education, income and region were weighted where necessary to align with population proportions. Propensity score weighting was also used to adjust for respondents' propensity to be online. In theory, with probability samples of this size, one can say with 95% certainty that the overall results have a sampling error of +/- 3 percentage points of what they would be if the entire U.S. adult population had been polled with complete accuracy. This online sample is not a probability sample.

About Harris Interactive

Harris Interactive is a world-wide market research and consulting firm, best known for The Harris Poll and its use of the Internet to conduct scientifically accurate market research. For more information, see www.harrisinteractive.com[1]. To become a participant in The Harris Poll Online and join future online surveys, see www.harrispollonline.com[2].

URL for this article:
http://online.wsj.com/article/SB117371341275134217.html

Hyperlinks in this Article:
(1) http://www.harrisinteractive.com
(2) http://www.harrispollonline.com

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Public Ed

Karen Abbe/Pharmacy/DCANotes
03/13/2007 08:17 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject San Diego Union-Tribune: Health illiteracy hampers wellness

The San Diego Union-Tribune.

JANE E. BRODY

Health illiteracy hampers wellness

March 13, 2007

How often have you left a doctor's office wondering just what you were told about your health, or what exactly you were supposed to be doing to relieve or prevent a problem? If you are a typical patient, you remember less than half of what your doctor tries to explain.

National studies have found that "health literacy" is remarkably low, with more than 90 million Americans unable to adequately understand basic health information. The studies show that this obstacle "affects people of all ages, races, income and education levels," Dr. Richard H. Carmona, the U.S. surgeon general, wrote in the August issue of The Journal of General Internal Medicine.

The fallout is anything but trivial. Researchers have found that poor health literacy, which is especially prevalent among the elderly, results in poor adherence to prescription instructions, infrequent use of preventive medical services, increased hospitalizations and visits to the emergency room and worse control of chronic diseases.

The consequences are poorer health and greater medical costs. All because doctors fail to speak to patients in plain English (or Spanish or Chinese or any other language) and fail to make sure that patients understand what they are told and what they are supposed to do and why.

In a study published in the internal medicine journal, conducted among 2,512 elderly men and women living on their own in Memphis and Pittsburgh, those with limited health literacy were nearly twice as likely to die in a five-year period as were those with adequate health literacy. That held true even when age, race, socioeconomic factors, current health conditions, health care access and health-related behaviors were taken into account.

Among the many problems resulting from limited health literacy are misinterpretations of warning labels on prescription drugs. For example, among 251 adults attending a primary care clinic in Shreveport, La., those with low literacy were three times more likely to misunderstand warnings than the more literate.

A main obstacle has been the decreased time patients can spend with their doctors, dictated largely by managed care and other medical reimbursement plans.

A second hurdle is the embarrassment that patients with limited health literacy experience when they do not understand what the doctor has said. And, of course, asking for clarification is seriously impeded by the imbalance in power between the white-coated physician and the paper-wrapped patient. Even when conversations are conducted in the doctor's office with a fully clothed patient, patients are reluctant to ask questions.

More medical schools, residency programs and continuing education programs for practicing physicians need to include training in clinical communication skills.

Dr. Sunil Kripalani of the Emory University School of Medicine in Atlanta and Dr. Barry D. Weiss of the University of Arizona College of Medicine in Tucson suggest these strategies:

Doctors should assess the patient's baseline understanding before providing extensive information:

“Before we go on, could you tell me what you already know about high blood pressure?”

Doctors should use plain language, not medical jargon, vague terms and words that may have different meanings to a lay person. They should say chest pain instead of angina, hamburger instead of red meat.

To encourage patients to ask questions, doctors should ask, “What questions do you have?” rather than, “Do you have any questions?”

Doctors should confirm the patient's understanding by saying, “I always ask my patients to repeat things back to make sure I have explained them clearly.” Or, if a new skill like using an inhaler was taught, the doctor should have the patient demonstrate the action.

Then, as fail-safe measures, the doctor should provide written instructions and educational material for the patient and family to review at home.

Do not wait until doctors become better at communicating. If you want the best medical care, you have to take the initiative. If the doctor says something you do not understand, ask that it be repeated in simpler language. If you are given a new set of instructions, repeat them back to the doctor to confirm your understanding. If you are given a new device to use, demonstrate how you think you are to use it.

Insist that conversations about serious medical matters take place when you are dressed and in the doctor's office. Take notes or take along an advocate who can take notes for you. Better yet, tape-record the conversation to replay it at home for you and your family or another doctor.

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Karen Abbe/Pharmacy/DCANotes
03/06/2007 08:41 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject ASHP: Accidental Poisonings Can Happen During Day-to-Day Routines

American Society of Health-System Pharmacists®

Press Releases and Announcements

Accidental Poisonings Can Happen During Day-to-Day Routines

3/1/2007

With more than 90 percent of poisonings occurring in the home and more than 19 million Americans caring for someone over the age of 75, caregivers and family members of children and seniors play a critical role in prevention of poisonings. The American Society of Health-System Pharmacists (ASHP) recognizes the importance of providing caregivers with poison prevention information during National Poison Prevention Week, March 18-24.

An estimated 44 percent of Americans have an aging parent and a young child for whom they care for. The majority of non-fatal poisonings occur in children younger than six years old and seniors who take multiple medications are at increased risk of accidental poisonings.

"The fact is most accidental poisonings happen among our youngest and oldest populations who are dependant on a caregiver," said Daniel J. Cobaugh, Pharm.D., FAACT, DABAT, director of research for the ASHP Research and Education Foundation. "Accidental poisonings can take many shapes such as when a child thinks medicine is candy or when a senior becomes confused and takes an additional dose of their medicine."

To help prevent poisonings from happening, ASHP has developed practical tips for caregivers of children and seniors.

For caregivers of seniors, ASHP recommends following these six tips:

Keep a list of your medicines. A written record of medications including medication name, dosage, and frequency, is an important tool to have during physician visits and in case of an emergency. It is also important to record any over-the-counter (OTC) medications, vitamins, supplements, or herbal products are being taken. Having a family member or caregiver keep a copy of this list is also invaluable.

Communicate. Stay informed of all medications, including non-prescription medicines and dietary supplements; this will help reduce the chances of an interaction.

Learn about their medicines. Ask the doctor or pharmacist to explain each medication, the food and medicines to be avoided, and possible reactions and side effects. Family members or caregivers should also be given this information.

Use one pharmacy. Many seniors receive prescriptions from more than one doctor, making drug interactions more likely. By using one pharmacy, all of the prescriptions are consolidated and the pharmacist can check for possible interactions between medicines. It is still important, however, to keep in mind that over-the-counter medicines should also be considered, as overdoses could occur this way.

Keep a journal. Make note of all symptoms, especially after taking medicines. Painful or unexpected side effects

such as dizziness, nausea, or drowsiness, may signal a need for adjusting the medication regimen.

Maintain a schedule. Holding to a routine can decrease the chances of missing dosages or taking more than needed. The use of a pillbox may help with this.

For caregivers of children, ASHP recommends following these five tips:

Use original child-resistant containers. Use child-resistant closures on medicines and other products and always keep all medications (both prescription, nonprescription, and dietary supplements) in their original child-resistant containers.

Always call medicine "medicine". Avoid calling medicine "candy" in order to get the child to take the medicine.
Check your medicines periodically for expiration dates. If a medication is not dated, consider it expired six months after purchase.

Avoid putting medicines in open trash containers. This is especially important in the kitchen or bathroom because many adult medications can be deadly to small children.

Keep medications secure. Keep all medicines, including OTC's, herbals, vitmins, and supplements, out of reach of children, or in a locked cabinet.

"The good news is that healthcare professionals and caregivers can work together to create a solution," said Cobaugh. "By being active participants in their healthcare, family members and caregivers can be informed on the best ways to prevent an accidental poisoning."

Caregivers and family members should post the poison control center number (800.222.1222) visibly in the home, Cobaugh said. "Many poison control centers are staffed by pharmacists, whose training makes them uniquely qualified to advise caregivers in the event of an emergency."

Medication tips and information on using medicine safely can be found on ASHP's consumer Web site, www.SafeMedication.com.

For more than 60 years, ASHP has helped pharmacists who practice in hospitals and health systems improve medication use and enhance patient safety. The Society's 30,000 members include pharmacists and pharmacy technicians who practice in inpatient, outpatient, home-care, and long-term-care settings, as well as pharmacy students. For more information about the wide array of ASHP activities and the many ways in which pharmacists help people make the best use of medicines, visit ASHP's Web site, www.ashp.org , or its consumer Web site, www.SafeMedication.com .

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Med ERRORS

Karen Abbe/Pharmacy/DCANotes
03/07/2007 11:20 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject Washington Post: Risk of Errors In Medication Said to Rise With Surgery

washingtonpost.com

Risk of Errors In Medication Said to Rise With Surgery

By Rob Stein
Washington Post Staff Writer
Tuesday, March 6, 2007; A08

Patients going under the knife face a significant risk of becoming the victim of a medical error involving medication, according to a report being released today.

The report, the largest examination of medication errors before, during and after surgery, found that operations are among the riskiest times for mistakes involving drugs.

The report was prepared by U.S. Pharmacopeia, a private group that sets standards for the drug industry. It has been gathering reports from hospitals nationwide about medication mistakes.

Its latest report is based on data voluntarily supplied by more than 400 hospitals about medication errors from 1998 to 2005 that occurred during outpatient surgery, in preparation for surgery, in the operating room and in recovery.

A total of 11,239 errors were reported, including giving the wrong drug or the wrong dose, or giving it at the wrong time.

Five percent of the mistakes caused harm, making surgery one of the most dangerous times for medication mistakes.

Mistakes during the operation itself were the most likely to result in harm.

In most cases the harm was temporary, but four deaths resulted from the errors. The mistakes were most dangerous to children, and the most common involved antibiotics and painkillers.

In addition to encouraging hospitals to take steps to reduce errors, the findings intend to alert patients and their families to be vigilant to protect themselves.

"We hope this will impact practice and make the whole system safe by bringing awareness to the topic," said Rodney Hicks, who helped prepare the report.

Kaiser Daily Health Policy Report

Tuesday, March 13, 2007

Prescription Drugs

Generic Medications Often More Expensive Than Expected

The *Wall Street Journal* on Tuesday examined how the prices of generic medications "can vary wildly and may not be nearly as cheap as expected." Patients with prescription drug coverage in most cases pay the lowest copayments for generic medications when they reach the market, but those without coverage are subject to different, and in some cases high, prices charged by pharmacies. According to the *Journal*, at a "time when policymakers are searching for ways to cut health care costs, generic drugs are often viewed as one of the most straightforward solutions," but generic versions of a "number of other notable drugs that came off patent recently" have "failed to deliver big savings in many cases." Jim Yocum -- executive vice president of DestinationRx, a pharmacy data and software company -- said, "We're not seeing that sharp a drop-off" in prices among generic medications that have reached the market in recent years, adding, "We're just not seeing it."

Zocor

For example, although the price that health insurers pay for simvastatin -- the generic version of the anticholesterol medication Zocor, which lost patent protection in June 2006 -- has "dropped dramatically," the "price that pharmacies charge patients who pay cash remains high in many locations, with wide variations by vendor." Walgreens.com had charged $129.99 for 30 tablets of the 20-milligram dose of simvastatin, compared with $149.99 for Zocor. In late February, after a call from a reporter, walgreens.com reduced the price of simvastatin to $89.99. A walgreens.com spokesperson said that the company previously had the price of simvastatin under review. CVS.com had charged $108.99 for the same dose of simvastatin, compared with $154.99 for Zocor. Last week, after a call from a reporter, CVS.com announced plans to reduce the price of simvastatin to $79.99 as part of an "ongoing price analysis." Drugstore.com had charged $125 for the same dose of simvastatin, compared with $135.99 for Zocor. On Friday, after a call from a reporter, drugstore.com reduced the price of simvastatin to $27.99, a move that the company attributed to part of a regular review. A Rite Aid spokesperson last week said that the company charges $131.99 for the same dose of simvastatin, compared with $178.99 for Zocor. On Monday, the spokesperson said that the prices were inaccurate but did not provide revised prices (Rubenstein, *Wall Street Journal*, 3/13).

help make sure each set was complete before it was shipped to a surgeon, and to determine which parts or instruments were used or missing when the kits returned to Biomet.

Moreover, the U.S. Food and Drug Administration (FDA) is investigating how the use of a unique device identification (UDI) system, such as one making use of RFID technology, might improve patient safety by tracking medical devices in the supply chain (see FDA Reviews Comments on Device-ID System).

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Public

Karen Abbe/Pharmacy/DCANotes
03/19/2007 10:58 AM

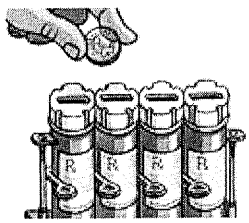
To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject LA Times: Soothing the pain of prescription drugs' cost

Los Angeles Times latimes.com

Soothing the pain of prescription drugs' cost

Many people are unaware of money-saving options, and doctors often don't think to discuss it. So ask.

By Genevieve Bookwalter, Special to The Times
March 19, 2007



Theresamary JOHNSON is supposed to take nine prescriptions each day – 10 on Thursdays – for lung disease, high blood pressure, osteoporosis, heart disease, rheumatoid arthritis and lupus.

Sometimes she does. Sometimes, she can't afford to.

"I busted my buns to see I wasn't in poverty in my old age, and I feel like I'm getting dragged right into it," the 70-year-old Rio Linda, Calif., resident says.

Like Johnson, many Americans have trouble paying for prescription drugs. But as legislators, employers, insurance and drug companies wrestle with the issue, patient advocates say consumers could be doing more to lower their own drug costs.

In 2001, 12.7% of working-age adults with private insurance and chronic health conditions reported that they had skipped refills because of the cost; by 2003, that number had risen to 15.2%, according to the Center for Studying Health System Change.

Last year, more than 10% of the 39 million people enrolled in Medicare's prescription drug plan paid out-of-pocket for drugs that potentially cost hundreds of dollars, according to the Kaiser Family Foundation.

For people without health insurance, the burden of prescription drugs is entirely their own. The Census Bureau reported last year that 46.6 million people, or 15.9% of those living in the United States, are without health insurance. An additional 16 million are underinsured and often spend more than 10% of their incomes on medical care, according to a 2005 survey by the Commonwealth Fund, a private foundation dedicated to improving healthcare practice and policy.

Republican and Democratic lawmakers in Congress are backing legislation to legalize drug imports from Canada and other industrialized countries, where they're often cheaper, but such efforts are opposed by the Food and Drug Administration and the pharmaceutical lobby.

Meanwhile, the House has approved a bill that would allow the federal government to bargain over prescription drug prices for seniors and others covered by Medicare's drug plan. Although under

consideration in the Senate, President Bush has vowed to veto it, supporting a reliance on private enterprise instead.

As prescription drug sales rise – up 8.3% last year to $274.9 billion, according to a survey released this month by IMS Health – consumer advocates say patients need to start speaking up. With research, compromise and aggressive questions, many patients can reduce the amount of money they spend on prescription drugs.

When medicine bills get too high, "it is up to the patient to make the physician and pharmacist aware," said Dr. Derjung Mimi Tarn, an assistant professor of family medicine at UCLA's David Geffen School of Medicine.

Tarn illustrated that point in November with a study published in the American Journal of Managed Care. Her survey found that only a third of doctors discussed cost, insurance, supply, refills or money-saving generic drugs with patients when writing prescriptions. Only 2% of patients asked those questions, the study showed.

"Physicians aren't always aware of patient costs," Tarn said, "and patients are often intimidated or embarrassed to talk about cost issues with their physician."

Nor are patients taking advantage of other easily available, cost-saving measures.

Health plans, for example, regularly offer mail-order prescription drugs, with a three-month supply often rivaling the cost of a one-month supply at a brick-and-mortar pharmacy. Consumers who used these mail-order plans are expected to save as much as $85 billion through 2016, according to a study by the Lewin Group prepared for the Pharmaceutical Care Management Assn., which represents these discount pharmacies. But if all qualifying maintenance drugs were ordered through these pharmacies, the savings could double, the study showed.

And millions of patients qualify for programs that could provide them with free drugs – but are unaware of such assistance. Through the Partnership for Prescription Assistance, pharmaceutical companies and healthcare providers give free or low-cost drugs to the uninsured who make less than $41,300 for a family of four.

Since 2005, more than 3.5 million people have signed up for the program, said Ken Johnson, senior vice president of Pharmaceutical Research and Manufacturers of America, an advocacy group for pharmaceutical research and biotechnology companies. But according to the Partnership, more than 29 million might have qualified.

"The real burden is on people who have multiple chronic illnesses who are taking lots of medications," said Arthur Levin, director of the Center for Medical Consumers in New York, a nonprofit patient advocacy group. "They're running up thousands of dollars in drugs costs."

Johnson is covered by a prescription drug plan offered by Medicare, a federal insurance program for those older than 65 and others with disabilities. Her co-pays – or her share of the prescription costs – can run between $6 and $28 a month for each drug, and sometimes more, she said.

She must also cope with the "doughnut hole" in the Medicare prescription program. This quirk cuts off federal coverage for prescription drugs once a patient buys more than an allotted amount of medication in one year, which in 2007 is $2,400. Johnson must spend $3,850 out-of-pocket before coverage kicks back in. With 10 prescriptions, she – like many seniors – anticipates falling into that hole very quickly this year. Last year, the doughnut hole affected about 4 million of the 39 million subscribers to Medicare's drug plan, according to the Kaiser Family Foundation, a nonprofit research group focused on medical issues.

As a result, Johnson said, "you experiment." Some months she stretches out her drug supply by taking less than her prescribed daily dose. Other months, she'll go days without taking a medication, restarting

only when her disease symptoms become unbearable.

It was patients like Johnson who Tarn said inspired her to study the communication between doctors and their charges. As Tarn worked through her residency in family medicine, desperate measures like Johnson's "really made me wonder what we could do better to help our patients, and made me wonder whether better communication could make a difference," she said.

She, along with patient advocacy groups, pharmaceutical and insurance companies have developed strategies to help cut prescription drug costs. But as Tarn's and other numbers show, many struggling patients might not know about them.

For starters, talk to your doctor. Ask what the cost is of any new prescription and if a cheaper alternative is available.

"Doctors are really bad at identifying patients who have problems with cost," Tarn said. But when asked, physicians can often help patients find a less expensive drug with the same benefits. This applies to both insured and uninsured patients; many drug insurance plans offer cheaper co-pays for generic or older brand-name medications.

Make sure you really need all your medications.

Premera Blue Cross of Washington encourages subscribers to carry a brown bag to their doctors' offices holding all vitamins, drugs and other supplements. Go through the contents with your doctor to make sure each one is necessary. A voluntary survey of 11,000 Premera participants showed that 44% received dosage changes and 36% were advised to stop taking at least one existing medication after discussing the drugs with their doctors.

Consider generic drugs. Under federal law, generics must work in the same way and carry the same benefits and risks as their brand-name counterparts. But they often cost significantly less.

Because makers of generic drugs don't have to recoup money spent on creating a drug from scratch, they don't charge as much for the final product.

Although the creator of a drug can usually hold a patent – and thus a monopoly – on a product for 17 years, generic versions are available after the patent expires. The popular antidepressant Zoloft, for example, costs $88.19 for a 30-day supply of 100-milligram tablets on drugstore.com. Its generic equivalent, Sertraline HCl, runs $68.99 for a month's supply at the same strength.

Comparison shop. Prices often vary dramatically by store.

"In a lot of cases, there can be some pretty significant differences between what one pharmacy charges and another," said Ken Johnson, senior vice president of Pharmaceutical Research and Manufacturers of America, an advocacy group for pharmaceutical research and biotechnology companies. For example, Diovan, a popular brand-name blood pressure medication, sells for $90.99 at Walgreens.com for a month's supply of 320-milligram pills.

The same prescription at drugstore.com, which works with Rite Aid pharmacies, costs $83.18. Always make sure an online site requires a prescription, has a pharmacist you can ask questions and is licensed by the state board of pharmacy where it is located. For a list of state boards, visit www.nabp.info.

Split pills. Ask your doctor if your medication can safely be cut in half. If so, a prescription for a double-dose pill might not cost much more than for a single dosage.

At drugstore.com, for example, a month's supply of 160-milligram Diovan pills costs $63.66; customers can buy pills twice as strong for $83.18 per month. For those with insurance, the difference can be an entire co-pay. In 2005, UnitedHealthcare, the nation's second-largest health insurer, issued pill splitters to

subscribers to help them cut drugs and costs. Not all drugs can be split, though, so always check with your physician beforehand.

Make sure a new prescription works for you and doesn't carry harmful side effects before buying a large supply.

Many pharmacies will fill a week's supply if asked when you drop off a new prescription. This trial run will give you a chance to assess the drug's efficacy and potential problems before spending money on something that might not work.

Learn if your insurance plan supports a mail-order pharmacy. If so, you can often order a three-month supply of maintenance drugs at the same co-pay as what one month would cost at the neighborhood drug store.

If you don't have insurance, check out a Patient Assistance Program or drug discount card.

PhRMA will link uninsured patients who earn up to 200% of the federal poverty line – or $41,300 for a family of four – with free or nearly free prescription drugs, Ken Johnson said. The group's website, www.phrma+.org, links patients with a clearinghouse to 475 assistance programs providing 2,500 medications. Since 2005, drug companies have given away $5 billion worth of prescriptions.

If you are uninsured but make too much money to qualify for the assistance programs, ask if your drugstore accepts a discount card. Insured customers won't qualify.

But qualifying uninsured patients can save 25% to 40% on 300 brand name drugs with cards like Together Rx Access, a consortium of 10 pharmaceutical companies that offer medication for diabetes, high blood pressure and depression, among other things. Talk to your pharmacist to see what cards are accepted at your pharmacy and cover your drugs.

Check if your pharmacy offers generic drugs at a flat reduced rate. Both Wal-Mart and Target pharmacies sell hundreds of generic drugs for $4 each for a 30-day supply. Drugs to treat allergies, Parkinson's disease and arthritis are among those included.

Comparison shop before crossing the border.

Although drugs in Mexico and Canada seem cheaper than those in the U.S., consider how much you will spend in travel costs or shipping, and how much you could save by using a discount plan at home. According to the FDA, the savings often are not as high as they might seem.

Karen Abbe/Pharmacy/DCANotes
02/21/2007 02:02 PM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject press release from Office of National Drug Control Policy: FEDERAL GOVERNMENT ISSUES NEW GUIDELINES FOR PROPER DISPOSAL OF PRESCRIPTION DRUGS

FOR IMMEDIATE RELEASE:
Tuesday, February 20, 2007

CONTACT: Jennifer de Vallance, ONDCP
(202) 395–6648 / (202) 368–8422

FEDERAL GOVERNMENT ISSUES NEW GUIDELINES FOR PROPER DISPOSAL OF PRESCRIPTION DRUGS: WHAT EVERY AMERICAN CAN DO TO PREVENT MISUSE OF PRESCRIPTION DRUGS

(Washington, DC)—In the face of rising trends in prescription drug abuse, the Federal government today issued new guidelines for the proper disposal of unused, unneeded, or expired prescription drugs. The White House Office of National Drug Control Policy (ONDCP), the Department of Health and Human Services (HHS), and the Environmental Protection Agency (EPA) jointly released the new guidelines, which are designed to reduce the diversion of prescription drugs, while also protecting the environment.

The new Federal prescription drug disposal guidelines urge Americans to:

- Take unused, unneeded, or expired prescription drugs out of their original containers
- Mix the prescription drugs with an undesirable substance, like used coffee grounds or kitty litter, and put them in impermeable, non-descript containers, such as empty cans or sealable bags, further ensuring that the drugs are not diverted or accidentally ingested by children or pets
- Throw these containers in the trash
- Flush prescription drugs down the toilet only if the accompanying patient information specifically instructs it is safe to do so
- Return unused, unneeded, or expired prescription drugs to pharmaceutical take-back locations that allow the public to bring unused drugs to a central location for safe disposal

Abuse of prescription drugs to get high has become increasingly prevalent among teens and young adults. Past year abuse of prescription pain killers abuse now ranks second—only behind marijuana—as the Nation's most prevalent illegal drug problem. While overall youth drug use is down by 23 percent since 2001, approximately 6.4 million Americans report non-medical use of prescription drugs. New abusers of prescription drugs have caught up with the number of new users of marijuana. Much of this abuse appears to be fueled by the relative ease of access to prescription drugs. Approximately 60 percent of people who abuse prescription pain killers indicate that they got their prescription drugs from a friend or relative for free.

John Walters, Director of National Drug Control Policy, said, "Millions of Americans benefit from the tremendous scientific achievements represented by modern pharmaceutical products. But, when abused, some prescription drugs can be as addictive and dangerous as illegal street drugs. The new prescription drug disposal guidelines will help us stop and prevent prescription drug abuse, and the harm it can cause.

Health and Human Services Secretary Michael Leavitt said, "Health care providers, pharmacists, and family should be alert to the potential for prescription drug misuse, abuse, and dependence. In addition to supporting the new prescription drug disposal guidelines, they should address prescription drug misuse

honestly and directly with their patients or loved ones when they suspect it. People in need should be encouraged to seek help for drug problems and if needed, enter treatment."

The new Federal guidelines are a balance between public health concerns and potential environmental concerns.

While EPA continues to research the effects of pharmaceuticals in water sources, one thing is clear: improper drug disposal is a prescription for environmental and societal concern," said EPA Administrator Stephen L. Johnson. "Following these new guidelines will protect our Nation's waterways and keep pharmaceuticals out of the hands of potential abusers."

The new Federal prescription drug disposal guidelines go into effect immediately. As part of the National Drug Control Strategy, the Bush Administration has set a goal of reducing prescription drug abuse by 15 percent over three years. In addition to promoting awareness of the risks involved with using prescription drugs for non-medical purposes as well as they need for adults to strictly control access to pharmaceuticals within their homes, the Administration supports the implementation of Prescription Drug Monitoring Programs at the State level. Currently, 33 States have such programs in place.

For more information, please visit www.whitehousedrugpolicy.gov.

Proper Disposal of Prescription Drugs

Office of National Drug Control Policy February 2007

Federal Guidelines:

- Take unused, unneeded, or expired prescription drugs out of their original containers and throw them in the trash.

- Mixing prescription drugs with an undesirable substance, like used coffee grounds or kitty litter, and putting them in impermeable, non-descript containers, such as empty cans or sealable bags, will further ensure the drugs are not diverted.

- Flush prescription drugs down the toilet *only* if the label specifically instructs doing so.

- Take advantage of community pharmaceutical take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Some communities have pharmaceutical take-back programs or community solid-waste programs that allow the public to bring unused drugs to a central location for proper disposal. Where these exist, they are a good way to dispose of unused pharmeceuticals.

Office of National Drug Control Policy
750 17th St. NW, Washington, D.C. 20503
p (202) 395-6618 f (202) 395-6730

Public Ed

Karen Abbe/Pharmacy/DCANotes
02/21/2007 01:20 PM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject Sacramento Bee: EPA unveils drug disposal guidelines

The Web Site of The Sacramento Bee

EPA unveils drug disposal guidelines

-- The Associated Press
Published 11:01 am PST Wednesday, February 21, 2007

WASHINGTON (AP) Here's a safety tip from your government: Trash those unwanted prescription drugs with kitty litter or coffee grounds to keep them from falling into the wrong hands - and mouths.

New federal prescription drug disposal guidelines recommend mixing unused, unneeded or expired drugs with undesirable substances - like cat litter or coffee grounds - and tossing them in the trash in nondescript containers. Doing so should curb prescription drug abuse and protect lakes and streams from contamination, the White House and government health and environment officials said.

"Following these new guidelines will protect our nation's waterways and keep pharmaceuticals out of the hands of potential abusers," Environmental Protection Agency administrator Stephen L. Johnson said Wednesday.

Drugs should be flushed down the toilet only if the label says it's safe to do so, according to the guidelines. Some pharmacies also collect drugs for safe disposal.

The government warned that abuse of prescription drugs is increasingly common among teens and young adults. Often those drugs are taken from the medicine cabinets of relatives or friends.

While flushing drugs down the toilet can stem that sort of abuse, it also can create environmental problems.

Recent U.S. Geological Survey studies have shown that a wide range of pharmaceuticals and other compounds survive wastewater treatment and later are discharged into lakes, streams and other bodies of water across North America. The USGS research found antidepressants and their byproducts, for example, are being released into the environment at concentrations that may affect aquatic life.

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Drug Prices

Kaiser Daily Health Policy Report

Wednesday, March 07, 2007

Prescription Drugs

Prescription Drug Prices for U.S. Residents Ages 50 and Older Increased at About Twice Inflation Rate, AARP Study Finds

Manufacturers' prices for the 193 prescription drugs most commonly used by U.S. residents ages 50 and older increased at about twice the rate of inflation in 2006, according to an annual report released on Tuesday by AARP, *Cox/Atlanta Journal-Constitution* reports. AARP found that manufacturers' drug prices on average increased by 6.2%, while the Consumer Price Index increased by 3.2%. According to the report, average drug prices since the end of 1999 have increased by nearly 54%, while overall inflation increased by 20% (Lipman, *Cox/Atlanta Journal-Constitution*, 3/7). The report found that the insomnia pill Ambien, manufactured by Sanofi-Aventis, had the highest price increase, up 30% in 2006. Prices for the respiratory drugs Combivent and Atrovent, both manufactured by Boehringer Ingelheim, had the next highest rates of growth, up 18% and 17%, respectively, in 2006, according to the report (*Reuters*, 3/6). David Sloane, senior managing director for government relations and advocacy at AARP, said, "Over time, escalating drug prices will make Medicare drug plans unaffordable for older Americans. One way to address high drug prices is to take full advantage of Medicare's bargaining power and allow Medicare to negotiate lower drug prices" (*Cox/Atlanta Journal-Constitution*, 3/7). He added, "We need to send a loud and clear message to the pharmaceutical industry that Americans cannot afford to continue to pay the highest prices for prescription drugs in the world" (*Reuters*, 3/6).

Industry Response

The pharmaceutical industry called AARP's report "inaccurate and misleading," citing data from CMS and the Bureau of Labor Statistics that show increases in prescription drug spending slowed for the sixth year in a row and retail drug prices increased by 1.5% in 2006. Ken Johnson, vice president of the Pharmaceutical Research and Manufacturers of America, said, "Expert data strongly suggest that AARP's numbers simply do not reflect the true amounts paid by seniors for their medicines. And they do not reflect the clear downward trend in prescription drug price growth" (*Cox/Atlanta Journal-Constitution*, 3/7).

The study is available online. Note: You must have Adobe Acrobat Reader to view the report.

PublicEd

Karen Abbe/Pharmacy/DCANotes
03/08/2007 11:05 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject Associated Press: Drug Imports Battle Heats Up Again

Drug Imports Battle Heats Up Again

The Associated Press
By MATTHEW PERRONE
March 07, 2007

The pharmaceutical lobby pushed back Wednesday against a renewed effort in Congress to pass a law enabling U.S. consumers to buy cheaper prescription drugs from Canada and other countries.

The legislation, supported by Democrats and Republicans, would allow individuals and pharmacies to order drugs from 19 countries. Supporters of the bills point out that Canadians pay about 60 percent less for their medication than Americans, according to a study by the Canadian government.

But the president of the pharmaceutical industry's lobbying group says there are 'better, safer alternatives,' to get affordable drugs to patients.

Billy Tauzin, who formerly chaired a House committee that regulated drug makers and now heads the Pharmaceutical Research and Manufacturers of America, told lawmakers so-called reimportation would expose consumers to counterfeit drugs and force industry to cut back on research and development spending. Tauzin, whose group represents companies such as Pfizer Inc. and Merck & Co., pointed out that the recently launched Medicare prescription drug benefit has greatly increased access to affordable drugs.

Senate Commerce Committee Chairman Daniel Inouye pressed representatives of the medical and legal professions on whether they believe it is fair that Americans pay the highest prices in the world for medications, many of which are produced in the U.S. and affordable at lower prices abroad. Inouye, a Hawaii Democrat, said he plans to move forward with a vote on the measure.

The push to legalize drug imports is not new. Similar legislation has been proposed in Congress since the 1990s without ever passing into law. A 2004 study by the Congressional Budget Office concluded that allowing importation of drugs from foreign countries would reduce total drug spending by about 1 percent over 10 years.

Nevertheless, the issue enjoys widespread support among senior citizen voters. The AARP, which supports the measure, released figures ahead of Wednesday's hearing indicating prices of several key brand name drugs rose at about twice the rate of inflation in 2006.

According to analysts, its unclear how much impact drug reimportation would have on drug company profits. Shares of Pfizer Inc. rose 25 cents Wednesday to $25.44 in mid day trading on the New York Stock Exchange. Merck rose 12 cents to $44.41, also on the NYSE.

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Karen Abbe/Pharmacy/DCANotes
03/12/2007 02:19 PM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject Washington Post: Internet Offers Many Ways to Avoid Harmful Drug Mixtures

washingtonpost.com

Internet Offers Many Ways to Avoid Harmful Drug Mixtures

Tuesday, February 27, 2007; HE05

To protect against unintended drug interactions, make sure your doctors and pharmacists know "about every drug you are taking, including nonprescription drugs and any dietary supplements such as vitamins, minerals and herbals," the Food and Drug Administration Web site advises.

But that doesn't let you off the hook.

Ultimately, patients bear the onus for keeping tabs of what they take. "It is just vital that patients keep a list of the medications they're taking," said Kasey Thompson, director of patient safety at the American Society of Health-System Pharmacists.

Armed with that list, patients can call their doctor or pharmacist to ask whether it's safe to add a product. They can also do their own homework and -- as a first step -- check online for potential drug interactions. But because the alerts listed may be incomplete or not specific to your needs, it's smart to check that information with your doctor or pharmacist. Here are some free (with the exception of one site, as noted) online resources that may be useful:

Medication Information

American Pharmacists Association , drug information site, http://www.pharmacist.com/drug_information.cfm

American Society of Health-System Pharmacists , which offers tips and advice for using medications safely and effectively, http://www.safemedication.com

As You Age: A Guide to Aging, Medicines and Alcohol , U.S. Department of Health and Human Services, http://www.asyouage.samhsa.gov/media/asyouage/asyouagebrochure01.pdf

Consumer Reports Guides to Prescription, OTC and Natural Medicines , http://www.consumerreports.org/mg/a-z-drug-index/A.htm and http://www.consumerreports.org/mg/natural-medicine/index.htm (Note: Some pages on the Consumer Reports site require a paid subscription.)

Drug Interactions: What you should know , FDA,

http://www.fda.gov/cder/consumerinfo/druginte3.pdf

Drugs@FDA , a database offering detailed information about all drugs approved by the FDA, http://www.accessdata.fda.gov/scripts/cder/drugsatfda

Be an Active Member of Your Health Care Team , an FDA presentation, http://www.fda.gov/cder/consumerinfo/Be-An-Active-Member-2005.pdf

My Medicines , a form for listing your medications and supplements, http://www.fda.gov/cder/consumerinfo/mymeds.pdf

Herb and Drug Interactions , Mayo Clinic, http://www.mayoclinic.com/health/herbal-supplements/SA00039

Your Medicine: Play It Safe , Agency for Healthcare Research and Quality, http://www.ahrq.gov/consumer/safemeds/safemeds.htm

Drug Interaction Checkers

About.com List , http://www.thyroid.about.com/library/drugs/blinteractionchecker.htm

Caremark , http://www.caremark.com; click on Drug Interactions under the heading Health Resources

Discovery Health , http://www.health.discovery.com; search for "drug interaction"

Drugs.com , http://www.drugs.com/drug_interactions.html

Drugstore.com , http://www.drugstore.com/pharmacy/drugchecker

Eckerd , http://www.eckerd.com; click on Pharmacy, then select Drug Interaction Tool

Express Scripts , http://www.drugdigest.org; click on Check Interactions

Medscape , http://www.medscape.com; search for "drug interaction checker"

University of Maryland Medical Center , http://www.umm.edu/adam/drug_checker.htm

Walgreens , http://www.walgreens.com/help/hy_cdi.jsp (Requires free site registration.)

Wal-Mart , http://www.walmart.com/pharmacy; click on Learn About Drug Interactions under heading Health & Drug Information

-- January W. Payne

Karen Abbe/Pharmacy/DCANotes
03/15/2007 08:12 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject Sacramento Bee: Medicine that talks

The Web Site of The Sacramento Bee

Medicine that talks

By LEE BOWMAN -- Scripps Howard News Service
Published 12:35 pm PDT Wednesday, March 14, 2007

Time to take your pill.

You know it is because your cell phone or other hand-held electronic device just issued you a reminder in a text or voice message. Or maybe an alarm set on the cap of your medicine bottle chirped, re-setting for the next dose as you replace the cap.

A while later, as the pill makes its way through the digestive system and dissolves, a tiny radio chip attached to it emits a weak signal that's recorded by a pager-sized sensor on your belt, documenting that the medicinal mission was accomplished.

The device may go on sending a wireless signal to your doctor or nurse, and may even update your Web-based electronic medical record.

If this all seems a bit of futuristic excess to ensure drug compliance, rest assured that all these technologies already exist and most are commercially available.

And the nagging may be needed. Studies indicate that only half to perhaps as few as a third of seniors take prescriptions as they're supposed to all the time.

The solution may be as simple as the "Beep N Tell" medication reminder cap that plays a voice recording from the patient or a caregiver that can go off as many as 24 times a day; or as complex as Medsignals, which features both the alerts and automatically passes on data to a computer database.

Some of the innovations require more active participation. At a recent conference on "mobile persuasion" techniques held at Stanford University, a company called myFoodPhone Nutrition presented its service designed for camera phones.

Users take a picture of their plate at each meal and build an online food journal. A team of nutrition coaches and advisers analyzes the meals weekly and provides online counseling about what might be changed.

Downloading what you're eating is one thing, but one of the big sticking points for tracking drug intake is the still-garbled world of electronic medical records. Industries are still wrangling over standard formats for medical information, but a bigger problem is being able to ensure that all the health care a person receives is logged in, and that everyone who should be able to access the information can do so, but no one else.

Health insurers and a host of private services are establishing personal health record sites with password protection and other safeguards, and surveys show most patients like the idea of being able to access their personal health records.

But polls also show they're anxious about who else might peek, and there are thorny intergenerational issues about whether adult children caring for elderly parents should have full access, or parents of adolescents.

Still, there's evidence that a little tattling about what you're taking can help.

For instance, in Wyoming, an information management system called RiteTrack is used to follow how supplies of nicotine gum or lozenges are dispensed for each client in the Wyoming Quit Tobacco Program.

People in the program get vouchers to help pay for the drugs but must also enroll in a telephone counseling program. The counselors use data about the quantity of gum and lozenges the smoker's been getting to help guide them in kicking the habit. Studies have shown that tele-counseling can double a person's chances of quitting over using self-help material alone; and nicotine replacement therapies double the odds yet again.

As far as tattletale pills go, they're the next generation of pills and devices that are already used by doctors to take various images of our innards.

Kodak filed a patent on the radio-frequency technology last month, but company officials didn't outline any timetable for bringing out a commercial product.

On the Net: http://www.nia.nih.gov

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Public Ed

Karen Abbe/Pharmacy/DCANotes
01/16/2007 08:09 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject USA Today: FDA to sweep unapproved drugs off the market

Page 8D

FDA to sweep unapproved drugs off the market

Unknown whether 2% are safe, effective

By Rita Rubin
USA TODAY

ROCKVILLE, Md. – A Food and Drug Administration official told representatives of 65 companies that sell unapproved drugs Tuesday that the agency plans to step up efforts to remove such products from the market.

"We do intend to accelerate removal of unapproved drugs this year," Deborah Autor, director of the FDA's Office of Compliance, said at a day-long workshop about the routes that manufacturers of unapproved drugs can take to get the agency's blessing and avoid expulsion from the market.

In September, a USA TODAY cover story reported that many doctors, patients and pharmacists were unaware that some medications on the market – nearly 2% of prescription drugs, according to the FDA – have never been scrutinized by the agency.

The story spurred Sen. Chuck Grassley, R-Iowa, to write a letter to FDA Commissioner Andrew von Eschenbach asking for more information about how unapproved drugs end up on the market.

The medications are sold as prescription and over-the-counter products for a range of ailments, including colds and coughs, hot flashes and pain. But consumers cannot be sure whether such medications are effective, let alone safe, Autor says.

Companies that market unapproved drugs, many of which have been sold for years, argue that their products have stood the test of time. But, said Robert Temple, director of the FDA's Office of Medical Policy, "the fact that there's long-term use really doesn't tell you anything."

Temple cited the case of anticholinergic sedatives, which had been used for years to treat irritable bowel syndrome. Eventually, the drugs were tested for that condition in large clinical trials, Temple said, and "every one of them failed completely."

When one audience member asked why the FDA doesn't just ban all unapproved drugs, Autor said the agency instead is taking a "concerted and concentrated approach." She said, "We are constantly evaluating potential targets."

One priority is getting unapproved versions of approved drugs off the market, Autor said.

URL/Mutual Pharmaceuticals of Philadelphia waited nearly a year for the FDA to remove unapproved quinine products from the market before launching Qualaquin, its approved version of the drug, in July. Qualaquin is prescribed for malaria, but the unapproved versions were marketed for leg cramps and other uses as well as malaria.

URL filed court motions in August against seven makers of unapproved quinine sulfate products, and all but one agreed to stop selling them by mid-November. Finally, the FDA announced last month that, because of safety concerns, it had ordered all unapproved quinine products off the market. Since 1969, the FDA said, unapproved quinine products had been linked to 93 deaths.

FDA NEWS

THE FOOD AND DRUG ADMINISTRATION / AN AGENCY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Ed

EMBARGOED UNTIL 1:00 p.m. EST

FOR IMMEDIATE RELEASE
January 11, 2007
P07-03

Media Inquiries: 301-827-6242
Susan.Cruzan@fda.hhs.gov
Sandy.Walsh@fda.hhs.gov
Kristen.Neese@fda.hhs.gov
Consumer Inquiries: 888-INFO-FDA

FDA Proposes New Measures to Strengthen Drug Safety Under PDUFA Reauthorized User Fee Program

Proposed Recommendations Would Also Enhance Drug Development, Boost Reviews of TV Drug Commercials

The Food and Drug Administration (FDA) today proposed recommendations to Congress for the next reauthorization of the Prescription Drug User Fee program which, if adopted, would significantly broaden and upgrade the agency's drug safety program, increase resources for review of television drug advertising, and facilitate more efficient development of safe and effective new medications for the American public. To achieve these public health benefits, the agency proposes to recommend, as part of the reauthorization of the program, that annual user fee collections be increased to $392.8 million, an $87.4 million increase over the current base line.

The user fee program, which was first authorized by the Prescription Drug Use Fee Act (PDUFA) in November 1992, adds industry's funds to the agency's appropriations to help FDA's human drug review program achieve demanding performance goals. Over the years, the PDUFA programs, which have to be reauthorized by Congress every five years, have enabled the agency to dramatically reduce its review times for drugs and biological medications while increasing scientific consultations, clarifying issues involving drug development, and increasing oversight of postmarket safety.

"The proposed recommendations would support significant improvements in FDA's ability to monitor and respond to emerging drug safety issues, as well as continuing FDA's commitment to scientific improvements to and streamlining the drug approval process," said HHS Secretary Mike Leavitt. "I commend FDA for the important progress they have made and look forward to working with Congress to ensure action on these proposals."

"In the last 14 years, three consecutive user fee programs -- PDUFA I, II and III -- have brought enormous public health gains to our and, indeed, the world's consumers, by helping FDA make increasingly complex medications available to patients faster than was ever possible before without sacrificing quality," said Andrew C. von Eschenbach, M.D., Commissioner of Food and Drugs. "Our proposed recommendations for PDUFA IV aim to top these accomplishments by achieving, above all, an impressive expansion and modernization of our drug safety system, and adding resources to enhance information technology initiatives."

To develop the proposal, FDA held a public meeting and other consultations with stakeholders, including organizations representing health care professionals, consumers, patient advocates,

and regulated industry. These stakeholders urged the FDA to seek additional appropriated funds to strengthen its ongoing drug safety program. In addition, consumer groups favored the adoption of user fees to increase FDA's capacity for review of direct-to-consumer TV ads.

Based on these consultations and an analysis of its commitments and anticipated means, FDA proposes to recommend using the $87.4 million user fee increase for significant program enhancements. PDUFA IV is the mechanism for placing the drug review process on a sound financial footing. The following are the key components of the proposal:

Program enhancements: $37.9 million
The biggest recommended increase, of $29.3 million, would provide a major boost for FDA activities to ensure the safety of medications after they are on the market. The increased funds would be available for FDA drug safety activities for marketed medications throughout as long as they remain on the market and would increase FDA's drug safety capacity for surveillance including hiring an additional 82 employees to perform postmarket safety work. To that end, FDA also recommends elimination of a statutory provision under which PDUFA fees may be used to assess safety issues only during the first three years after the product's approval. The agency would also use the added resources to adopt new scientific approaches and improve the utility of existing tools for the detection and prevention of adverse events, for example obtaining access to the best available databases to better analyze drug safety signals.

Other enhancement proposals call for:
*$4.6 million in new user fees and 20 employees to help expand FDA's implementation of guidance for FDA's reviewers (Good Review Management Principles) and develop guidelines for industry on clinical trial designs and other topics; and
*additional $4 million to improve the information technology activities for human drug review by moving the agency and industry towards an all-electronic environment.

In addition, the FDA proposes to recommend creating a separate new user fee program to collect new fees from companies that seek FDA advisory reviews of their direct-to-consumer television advertisements. FDA anticipates that these fees will be $6.2 million in the first year and support 27 additional staff to carry out this review function.

Financial baseline: $49.4 million

Since the user fees collected have not kept up with the increasing costs of the program, FDA proposes to request several increases in user fees to stabilize PDUFA IV's financial base line, to be divided as follows:
*$17.7 million to adjust the base amount for inflation and support increases in salaries and benefits;
*$11.7 to ensure that the fees cover a share of increased rents and the costs of the agency's move to the new White Oak facility in Silver Spring, Md.;
*$20 million in additional fees to cover significant increases in FDA's drug review workload that were incurred but not compensated for under PDUFA III, and are expected to continue.

FDA's PDUFA proposals will be presented to the public at a public meeting on February 16, 2007. After all public comments are evaluated and any appropriate changes made, final proposals will be submitted to Congress. PDUFA reauthorization would go into effect only after enacted by Congress and signed by the President.

For more information, The Federal Register Notice is available at
http://www.accessdata.fda.gov/scripts/oc/ohrms/advdisplay.cfm

FDA's PDUFA proposals will be presented to the public at a public meeting on February 16, 2007. After all public comments are evaluated and any appropriate changes made, final proposals will be submitted to Congress.

To submit electronic comments on the documents, visit http://www.accessdata.fda.gov/scripts/oc/dockets/comments/commentdocket.cfm?AGENCY=FDA. Written comments may be sent to: Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD, 20852. Comments must be received by Feb. 23, 2007 and should include the docket number 2007N-0005.

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ATTENTION TV BROADCASTERS: Please use open caption for the hearing impaired.

FDA On The Internet: www.fda.gov

Karen Abbe/Pharmacy/DCANotes
03/15/2007 10:13 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject USA Today: College drug use, binge drinking rise Prescription abuse, pot use both way up

College drug use, binge drinking rise Prescription abuse, pot use both way up

By Donna Leinwand, USA TODAY

Nearly half of America's 5.4 million full-time college students abuse drugs or drink alcohol on binges at least once a month, according to a new study that portrays substance and alcohol abuse as an increasingly urgent problem on campuses across the nation.

Alcohol remains the favored substance of abuse on college campuses by far, but the abuse of prescription drugs and marijuana has increased dramatically since the mid-1990s, according to the study released today by the National Center on Addiction and Substance Abuse (CASA) at Columbia University.

CASA, which called on educators to move more aggressively to counter intensifying drug and alcohol use among students, first studied students' drug and alcohol habits in 1993. Today's report – the center's second on the subject – involved a survey of 2,000 student and 400 administrators as well as analyses of six national studies.

The center found that "the situation on America's campuses has deteriorated" since 1993, CASA President Joseph Califano says.

'HIGHER' EDUCATION?

The percentage of college students saying they took potentially dangerous drugs during the previous year is up:

Any illicit drug
- 1993: 30.6
- 2005: 36.6

Marijuana
- 1993: 27.9
- 2005: 33.3

Hallucinogens
- 1993: 6.0
- 2005: 5.0

Inhalants
- 1993: 3.8
- 2005: 1.8

Cocaine
- 1993: 2.7

• 2005: 5.7

Heroin
• 1993: 0.1
• 2005: 0.3

Source: The National Center on Addiction and Substance Abuse at Columbia University

AUDIO: Califano: Time to get the 'high' out of higher education

The study found that college students have higher rates of alcohol or drug addiction than the general public: 22.9% of students meet the medical definition for alcohol or drug abuse or dependence – a compulsive use of a substance despite negative consequences – compared with 8.5% of all people 12 and older.

White students are more likely to use drugs and alcohol than minority students, and students at historically black colleges have much lower rates of substance abuse than other students, the study found.

School administrators have not done enough to curtail drug and alcohol abuse on campus, Califano says. In CASA's survey of administrators, two-thirds said responsibility for stopping drug abuse rests with students.

"It's not on the radar screen of college presidents. This is not a priority," Califano says. "We believe they have an obligation to protect the health and safety of their students."

Donald Harward, president emeritus of Bates College in Maine, says drinking and drug abuse are a symptom of students' disengagement from academic and civil life on campus. "I think a lot of presidents are aware of (increasing alcohol and drug problems among students), and they are struggling to come to grips with it."

Nearly half the students surveyed by CASA said they drank or used drugs to relax, reduce stress or forget about problems. Other findings:

Students who said they had abused painkillers such as Percocet, Vicodin and OxyContin during the past month rose from fewer than 1% of students in 1993 to 3.1% in 2005, a reflection of how the rising number and availability of prescription drugs has increased abuse.

The percentage of students who reported smoking marijuana heavily – at least 20 days during the past month – more than doubled, from 1.9% in 1993 to 4% in 2005.

The percentage of students who reported using illegal drugs other than marijuana, such as cocaine and heroin, in the past month jumped from 5.4% in 1993 to 8.2% in 2005.

Overall, the percentage of students who reported drinking alcohol at least occasionally was about the same: 68% in 2005, compared with 70% in 1993. Those who said they engaged in binge drinking – defined as having five drinks for male students and four drinks for female students at one "drinking occasion" during the previous two weeks – held steady at 40%.

However, the percentage of students who reported binge drinking three or more times during the previous two weeks increased from 19.7% in 1993 to 22.8% in 2001, the study found. In 2005, 83% of campus arrests involved alcohol, the study found.

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Agenda Item 7

Update on the Board Public Outreach Activities

California State Board of Pharmacy
1625 N. Market Blvd, Suite N 219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

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

March 22, 2007

To: Members, Communication & Public Education Committee

Subject: Update on the Board's Public Outreach Activities

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

- Executive Officer Herold provided information about the Board of Pharmacy as a speaker at the CPhA's House of Delegates during their annual meeting on February 15, 2007.
- The board staffed an information booth for two days at CPhA's annual meeting Outlook.
- Board Member Hiura provided information about pharmacy law to pharmacists at a Korean pharmacist association meeting.
- Supervising Inspector Nurse provided a PowerPoint presentation on California's Electronic Pedigree requirements to the Generic Pharmaceutical Manufacturers Association annual meeting in Phoenix on March 1.
- Supervising Inspector Ratcliff provided information about pharmacy law and the board to 80 UCSF students on March 6, 2007.
- Former Board Member John Jones provided a law update to Western University students on March 15.

Future:

- Analyst Karen Abbe and Inspector Wong will staff an information booth at the 2007 Consumer Protection Day forum in San Diego on March 24.
- Supervising Inspector Dennis Ming will provide an update on pharmacy law review to staff of Anaheim Memorial Hospital on April 6.
- Board Member Goldenberg will provide information about pharmacy law to the Diablo Valley Pharmacists Association Meeting in April.
- Board Member Schell will present FAQs about licensing issues to the San Diego Pharmacists Association on April 26.
- Debbie Anderson will provide information about pharmacist licensure application and examination to Loma Linda graduating students on May 7.
- Board Members Goldenberg and Conroy will provide information about pharmacy law to the UOP graduating class on May 17.
- Supervising Inspector Ratcliff will speak to Sutter Hospital pharmacists about pharmacy law on May 18.
- Supervising Inspector Nurse will provide information about California's electronic pedigree requirements for prescription medicine at the NABP Annual Meeting on May 19.

Agenda Item 8

SCR 49 Report: Medication Errors Report

California State Board of Pharmacy
1625 N. Market Blvd, Suite N 219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

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

March 20, 2007

To: Members, Communication & Public Education Committee

Subject: Review and Discussion of the SCR 49 Medication Errors Report

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On March 6, the Medication Errors Panel, brought together by SCR 49, released its report on "Prescription for Improving Patient Safety: Addressing Medication Errors." A copy of this report follows, as does the executive summary and an article from *The Sacramento Bee*.

This meeting will be the first opportunity for the board to review this report. I believe that over the coming months, the board will continue to closely review and work with the findings of this report.

There are 12 recommendations in this report:

A. Communication Improvements, with an emphasis on improving the quality and accuracy of communications between prescribers, pharmacists and patients.

1. Improve the legibility of handwritten prescriptions and establish a deadline for prescribers and pharmacies to use electronic prescribing.
2. Require that the intended use of the medication be included on all prescriptions and require that the intended use of the medication be included on the medication label unless disapproved by the prescriber or patient.
3. Improve access to and awareness of language translation services by pharmacists at community pharmacies and encourage consumers to seek out pharmacists who speak their language and understand their cultural needs.
4. Promote development and use of medication packaging, dispensing systems, prescription container labels and written supplemental materials that effectively communicate to consumers accurate, easy-to-understand information about the risks and benefits of their medication, and how and where to obtain medication consultation from a pharmacist.

B. Consumer Education to increase consumer awareness regarding the proper use – and dangers of misuse – of prescription and over-the-counter medications.

5. Identify and disseminate information about best practices and effective methods for educating consumers about their role in reducing medication errors.
6. Establish an ongoing public education campaign to prevent medication errors, targeting outpatients and persons in community settings.

7. Develop and implement strategies to increase the involvement of public and private sector entities in educating consumers about improving medication safety and effectiveness.

C. Pharmacy Standards and Incentives, with a focus on information and mediation consultations given by pharmacists to their patients as a means of educating consumers about drug safety.

8. Help ensure quality and consistency of medication consultation provided by pharmacists within and among pharmacies.
9. Establish standards for Medication Therapy Management programs and create incentives for their implementation and ongoing use by pharmacists and other healthcare providers.

D. Training and Education for healthcare providers on various medication safety practices

10. Create training requirements for pharmacists and other healthcare professionals that address medication safety practices and related programs, including medication consultation and medication therapy management programs.

E. Research, with a focus on obtaining information about the incidence, nature and frequency of medication errors in the community setting.

11. Establish and support efforts to collect data regarding the nature and prevalence of medication errors and prevention methods for reducing errors, especially focused on persons at high risk for medication errors and in community, ambulatory and outpatient settings.

F. Other: relating to the obstacles that pharmacists face in providing drug consultation to patients, encompassing a variety of factors such as manpower shortages and lack of payment systems to cover the time and expense associated with these tasks. Before additional duties can be imposed upon pharmacists in outpatient settings, these issues must be addressed:

12. Convene a panel of stakeholders to identify and propose specific actions and strategies to overcome barriers to qualified pharmacists being recognized and paid as health care providers.

Karen Abbe/Pharmacy/DCANotes
03/07/2007 08:26 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc
bcc
Subject Statement from Health and Human Services Secretary Kim Belshé Regarding Efforts to Reduce Medical Errors

Office of the Governor

ARNOLD SCHWARZENEGGER
THE PEOPLE'S GOVERNOR

PRESS RELEASE

03/06/2007 GAAS:181:07 FOR IMMEDIATE RELEASE

Statement from Health and Human Services Secretary Kim Belshé Regarding Efforts to Reduce Medical Errors

California Secretary of Health & Human Services Kim Belshé said Tuesday that the report titled "Prescription for Improving Patient Safety: Addressing Medication Errors" outlining potential costs of medication errors underscores the need for reducing medication errors as called for in the Governor's Health Care Reform proposal, as well as broader changes the Governor proposes to reduce all medical errors and promote patient safety.

"No one should suffer from errors in the improper prescribing, dispensing or use of medication, or suffer from unnecessary health care-acquired infections," Belshé said. "For this reason, Governor Schwarzenegger's reform proposal calls for dramatic change to prevent not only medication errors, but medical errors as well."

The Governor's Health Care Proposal includes a wide range of changes to improve patient safety and prevent harm by reducing adverse medical events:

<!--[if !supportLists]-->· <!--[endif]-->requires that all prescriptions be transmitted electronically from doctor to pharmacist by 2010 to prevent errors caused by illegible handwriting;

<!--[if !supportLists]-->· <!--[endif]-->calls upon California hospitals and health care facilities to implement critical safety measures related to infection control, surgical errors, and adverse drug events by 2008;

<!--[if !supportLists]-->· <!--[endif]-->enacts new health care safety and reporting

requirements; and,

<!--[if !supportLists]-->· <!--[endif]-->establishes an Office of Patient Safety within the Department of Public Health.

Last year, the Governor signed legislation to prevent and reduce medical errors through improved reporting and targeted efforts to reduce health care acquired infections. The Governor also signed two executive orders, one setting a goal to achieve 100 percent electronic health data exchange in the next decade; and a second to eliminate obstacles to telemedicine in rural areas.

Secretary Belshé said a 10 percent reduction in medical errors has the potential to reduce health care costs by an estimated $450 million per year.

Prescription for Improving Patient Safety: Addressing Medication Errors

An Executive Summary of the The Medication Errors Panel Report

Pursuant to California Senate Concurrent Resolution 49 (2005)

About the Medication Errors Panel:

Recognizing the significant and growing public health concern of medication errors, in 2005 Senator Jackie Speier authored Senate Concurrent Resolution (SCR) 49, sponsored by the California Pharmacists Association. This resolution, adopted September 14, 2005, called for the creation of an expert panel to study the causes of medication errors in the outpatient setting and to recommend changes to the healthcare system that would reduce errors associated with prescription and over-the-counter medication use.

The Medication Errors Panel, assembled in 2006, consisted of two Senators, two Assembly members and 13 persons representing academia, consumer advocacy groups, health professions (medicine, nursing, public health and pharmacy), health plans, the pharmaceutical industry, and community pharmacies. Throughout 2006, Panel members gave a tremendous effort to this study and met at the state capitol 12 times to hear and discuss testimony from 32 invited speakers who included many widely respected state and national leaders in the fields of pharmacy practice, medicine, medical technology, healthcare regulation, academia, and the pharmaceutical industry.

The following is the Executive Summary of the Panel's report complete with its consensus recommendations.

The Problem of Medication Errors

A medication error is any preventable event occurring in the medication-use process, including prescribing[1], transcribing, dispensing, using and monitoring, that results in inappropriate medication use or patient harm. These errors and their consequences present a significant public health threat to Californians.

While most consumers and healthcare providers do not often associate poor health outcomes with adverse drug events – frequently the result of medication errors – the human and financial costs of the problem are staggering.

The most recent estimate of costs associated with drug-related morbidity and mortality in the US exceeds $177 billion per year.[2] Amazingly, this amount is significantly greater than the amount actually spent on prescription drugs during the same year. In terms of patient harm, the Institute of Medicine projects that at least 1.5 million Americans are sickened, injured or killed each year by medication errors.[3] Extrapolating these figures to California suggests that on an annual basis, the problem costs our state $17.7 billion and causes harm to 150,000 Californians.

Perhaps the most concerning aspect of these errors is that the tremendous human and financial costs are not the result of some serious disease, but rather, well-intentioned attempts to treat or prevent illness.

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Testimony provided to the Panel indicated that efforts to address errors are best targeted not at a particular group of individual "wrong doers," but rather at faulty systems, processes, and conditions that either lead people to make mistakes or fail to prevent them. Consequently the Panel took a "systems approach" for studying the problem and developing its recommendations.

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2) **The education of the consumer** regarding the purpose of the treatment, the effective use of the medication, and the monitoring of signs and symptoms that may indicate efficacy or toxicity.
3) **Healthcare provider payments and incentives** which can directly or indirectly influence providers to pursue behaviors designed to reduce medication errors.
4) **Healthcare provider training and licensure** which could foster a better understanding among providers about the seriousness of medication errors and the behaviors to adopt that will reduce them.

The three key stakeholder groups which the Panel believes will be critical in affecting the necessary changes to these processes are:

1) **Consumers and consumer oriented organizations** such as the California Department of Consumer Affairs; advocacy organizations (e.g. AARP, American Heart Association); community-based organizations; and private and public foundations.
2) **Healthcare providers and related organizations** such as academic institutions, professional societies and advocacy groups, and provider licensing/oversight Boards.
3) **Healthcare purchasers, payers, regulators and related organizations** such as the State of California, its Department of Health Services and the Medi-Cal program; private purchasers of health care such as employers; commercial insurance companies which administer health benefits for both public and private sector purchasers; the California Departments of Insurance and Managed Health Care which regulate these insurance companies; pharmacy benefit managers which focus specifically on the administration of pharmacy benefits; and of course, the Legislature and Administration of the State of California which possess the potential to influence and/or establish accountability for these groups.

Based on the analysis of these four key processes and three key stakeholder groups, the Panel developed 11 consensus recommendations within five subject areas, and a twelfth recommendation to further consider and address issues that went beyond the scope of the Panel's purpose.

Recommendations

A. **Communication Improvements,** with an emphasis on improving the quality and accuracy of communications between prescribers, pharmacists and patients. Specific recommendations are:

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   5) *Identify and disseminate information about best practices and effective methods for educating consumers about their role in reducing medication errors.*
   6) *Establish an on-going public education campaign to prevent medication errors,*

targeting outpatients and persons in community settings.

7) *Develop and implement strategies to increase the involvement of public and private sector entities in educating consumers about improving medication safety and effectiveness.*

C. **Pharmacy Standards and Incentives,** with a focus on information and medication consultations given by pharmacists to their patients as a means of educating consumers about drug safety. Specific recommendations are:

8) *Help ensure quality and consistency of medication consultation provided by pharmacists within and among pharmacies.*

9) *Establish standards for Medication Therapy Management (MTM) programs and create incentives for their implementation and ongoing use by pharmacists and other healthcare providers.*

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10) *Create training requirements for pharmacists and other healthcare professionals that address medication safety practices and related programs, including medication consultation and medication therapy management programs.*

E. **Research,** with a focus on obtaining information about the incidence, nature, and frequency of medication errors in the community setting. The specific recommendation is:

11) *Establish and support efforts to collect data regarding the nature and prevalence of medication errors and prevention methods for reducing errors, especially focused on persons at high risk for medication errors and on community, ambulatory and outpatient settings.*

In addition to these five subject areas, the Panel identified a sixth that needs to be addressed but which it determined was beyond its scope. This issue relates to the many obstacles that pharmacists face in providing drug consultation to their patients which encompasses a variety of factors such as manpower shortages and the lack of payment systems to cover the time and expense associated with these tasks. Before additional duties can be imposed on pharmacists practicing in outpatient settings, the Panel recognizes that these issues must be addressed. Therefore the Panel put forth a twelfth recommendation:

12) *Convene a panel of stakeholders to identify and propose specific actions and strategies to overcome barriers to qualified pharmacists being recognized and paid as healthcare providers.*

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End Notes and References

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[2] Ernst FR, Grizzle AJ. Drug-related morbidity and mortality: updating the cost-of-illness model. J Am Pharm Assoc 2001;41:192-9.

[3] Institute of Medicine (IOM). (2007). *Preventing medication errors: Quality chasm series.* P. Aspden, J. Wolcott, J. L. Bootman, & L. R. Cronenwett (Eds.). Washington, DC: The National Academies Press.

MEDICATION ERRORS PANEL MEMBERS

Senate Appointees

Senator Jackie Speier, Chair

Senator Sam Aanestad

Dorothy (De) Calvert, RN
Kaiser Permanente Medical Group (representing California Nurses Association*)

Robert Friis, PhD
Professor and Chair, Health Sciences Department, California State University Long Beach (representing a public health organization*)

John Gallapaga
(representing AARP*)

Gil Preston, JD
Watson Pharmaceuticals (representing Generic Pharmaceutical Association*)

Susan Ravnan, Pharm.D., FCSHP
Associate Professor, University of the Pacific, Thomas J. Long School of Pharmacy and Health Sciences (representing CA Society of Health System Pharmacists*)

Lorie Rice, M.P.H.
Associate Dean, School of Pharmacy, University of California San Francisco (representing Consumer Healthcare Products Association*)

Debbie Veale, R.Ph
Director, Managed Care, CVS/pharmacy (representing California Retailers Association*)

Assembly Appointees

Assemblymember Wilma Chan

Assemblymember Greg Aghazarian

Brian Alldredge, Pharm.D.
Professor, Department of Clinical Pharmacy, University of California, San Francisco (representing pharmacy school faculty*)

Ramon Castellblanch, PhD
Assistant Professor, Health Education Department, San Francisco State University (representing a consumer organization*)

Carey Cotterell, R.Ph.
Pharmacy Quality & Patient Safety Leader, Kaiser Permanente Medical Care Program (representing California Association of Health Plans*)

Merrill Jacobs
Deputy Vice President, State Government Affairs, Pharmaceutical Research and Manufacturers of America*

Carlo Michelotti, R.Ph.
CEO (retired), California Pharmacists Association*

Gurbinder Sadana, MD, FCCP
Director of Critical Care Services, Pomona Valley Hospital Medical Center (representing California Medical Association*)

Panel Staff

Sandra K. Bauer
Arthur Bauer & Associates, Inc.

Ronald Spingarn
Office of Senator Jackie Speier

Michael J. Negrete, Pharm.D.
Pharmacy Foundation of California

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Prescription for Improving Patient Safety: Addressing Medication Errors

A report from
The Medication Errors Panel
Pursuant to California Senate Concurrent Resolution 49 (2005)

March 2007

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SECTION I: REPORT OF THE PANEL

Background & Overview

The Problem of Medication Errors

For the purpose of its work, the SCR 49 Panel defined a medication error as "any preventable event occurring in the medication-use process, including prescribing[1], transcribing, dispensing, using and monitoring, which results in inappropriate medication use or patient harm."

Errors involving prescription and over-the-counter medications represent an enormous public health problem. When an error occurs, the best possible outcome is for a medication to simply not elicit an adverse result. Even under this best-case scenario, medication errors have a significant negative impact on the US healthcare system, contributing to increasing costs for consumers, employers and other persons who pay for health care. Even worse than the financial cost is the harm to consumers' health and well-being caused by medication errors, which can range from mild to life-threatening and even death.

The scope and severity of medication errors and the related consequences have been documented by many health researchers. For the year 2000, experts estimated the overall cost of drug-related morbidity and mortality to be in excess of $177.4 billion.[2] That amount greatly exceeds the $120.8 billion spent on prescription drugs during that year.[3] In terms of patient harm from medication errors, the Institute of Medicine (IOM) estimates that at least 1.5 million Americans are sickened, injured or killed each year by medication errors.[4] Extrapolating these figures to California suggests that on an annual basis, the problem costs our state $17.7 billion dollars and causes harm to 150,000 Californians.

Perhaps the most disturbing aspect of medication errors is that these tremendous human and financial costs are not the result of some serious disease, but rather well-intentioned efforts to treat or prevent illness.

The Importance of Addressing Errors in Community Settings

When imagining places where medication is dispensed and taken or "administered," many people think of hospitals or other health care facilities. But, in fact, the vast majority of medications are taken by out-patients in "community settings," including homes, schools, offices, independent living facilities, and children or adult day care centers. Last year, over 5,000 licensed "community" pharmacies in California filled about 400 million prescriptions for community dwelling individuals.

In community settings a person often has a prescription written by his or her health care provider, usually a doctor, and has it filled at a community pharmacy, often a neighborhood drug-store, supermarket or other retail outlet. After a consumer receives medication from a community pharmacy, they or their caregiver is largely left on their own to take/administer the medication and monitor for signs and symptoms of efficacy or toxicity.

Compounding the problem of medication errors in community settings are the increasing numbers of consumers that buy and use over-the-counter medicines, herbals or other alternative treatments. While many consumers believe the "all-natural" or non-prescription status of these therapies suggests inherent safety, these products do have the potential to cause adverse effects and interact with prescription medications or each other.

In spite of incredible potential for medication errors to occur in the community setting, much of the attention paid to the problem thus far has focused on hospital and other institutional settings. In fact, there are already many state and national efforts underway aimed at reducing errors in these settings. This, coupled with evidence regarding the magnitude of the problem outside of institutional settings, led the Panel to focus on making recommendations about medication errors that occur in the community.

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U.S. and California Medication Error Data

There is no organization responsible for maintaining comprehensive data about medication errors in the United States or California. Several national organizations collect information related to medication errors, but their data is not comprehensive and has many limitations – it may focus on health care professionals, not consumers or on health care facilities, not community settings – or organizations may mix data about medication errors with other data – for example, data about "medical" errors or "adverse drug events." Also, organizations often define "medication error" differently, creating challenges with combining or comparing data.

Finding medication error data specific to California is even more challenging. One could extrapolate from data at the State's Board of Pharmacy and Medical Board, although neither body is charged with actively monitoring medication errors or collecting comprehensive error data. They simply document and respond, as appropriate, to complaints made by health care professionals or consumers about medication errors and other issues related to their areas of oversight.

California-specific research studies identified by the Panel did not include information about community-settings, only hospitals and residential care settings. National organizations, including the federal Food and Drug Administration (FDA) and the nonprofit Institute for Safe Medication Practices (ISMP), contacted by the Medication Errors Panel staff were unable to report medication error data specific to California.

Types of Medication Errors

In the community setting, there are three general types of medication errors that can occur: those related to the prescribing process; those that occur when the medication is dispensed at the pharmacy; and those related to the consumer's use of the medication.

Prescribing Errors

The first step in obtaining a prescription medication occurs when a consumer visits a physician, or other health care professional with prescribing authority, and receives a prescription.

In order to avoid selecting a drug that could be inappropriate or harmful to a patient, it is important for the prescriber to have access to the patient's complete health information record at the time the patient is being seen. The patient information should include all medicines the patient is taking, lab test results, other physicians the patient has seen, and any past hospitalizations or drug allergies.

The Panel heard testimony that prescribers in California often do not have ready access to vital patient information at the time that a prescription is written. This is largely due to continued reliance on paper-based documentation systems which lend themselves to having important patient information be missing, inaccessible, illegible and inaccurate – all of which can contribute to prescribing errors.

While the Panel identified drug and dose selection as a place where errors can occur, it decided to focus its analysis and recommendations on areas of the medication-use system that occur *after* the point where such decisions are made. From a prescribing standpoint, this includes practices related to the transcription and transmission of prescription information which may contribute to patients not receiving the intended medication or dose. More information on these types of errors is included in the next section of this report.

Dispensing Errors

Dispensing errors occur when a patient is given a medication other than the one intended by the prescriber. These types of errors are often the result of sound/alike or look/alike drugs, according to testimony provided by Patricia Harris, Executive Officer of the California Board of Pharmacy. Ms. Harris noted that an increasingly reported mistake is the dispensing of the "right drug" to the "wrong person," often the result of similar names shared by several members of a family, many of whom may speak limited English.

To help address errors such as these, the California Board of Pharmacy created a requirement in 2002 for every pharmacy to adopt a quality assurance program. Such programs require pharmacies to document and identify the cause of any errors that occur, and develop systems and workflow processes designed to prevent the same type of error from occurring in the future.

The Panel heard testimony regarding other types of dispensing errors from Michael Cohen, RPh, ScD, founder and director of the Institute for Safe Medication Practices (ISMP). His data is based on voluntary reports of errors received by the ISMP from health practitioners and consumers nationally over many years. A summary of all the major medication error causes identified by

ISMP is listed in Table 1. Causes of dispensing errors include confusing drug names, labels, and/or packaging (look/sound alike problems); environmental, staffing, or workflow issues (poor lighting, excessive noise, workload, interruptions); lack of quality control or independent verification systems; missing patient information (allergies, age, weight, pregnancy); and missing drug information (outdated references, inadequate computer screening).

In relation to the last two causes, it is pertinent to note a California regulation which requires pharmacies to maintain records on all patients who have prescriptions filled at their pharmacy for at least one year. These records must include "patient allergies, idiosyncrasies, current medications and relevant prior medications including nonprescription medications and relevant devices, or medical conditions which are communicated by the patient or the patient's agent".[5] For the purposes of creating as complete a record as possible in one location, the Board of Pharmacy recommends that consumers use only one pharmacy when feasible.

By reviewing patient records, a dispensing pharmacist can determine whether a new medication the patient is being prescribed is appropriate and compatible (not contraindicated or in conflict with) with other medications the patient is already taking. Reviewing patient records in this way is called Drug Utilization Review (DUR) and is a very important safety feature.

Administration/Medication Use Errors

A key characteristic of the community setting that contributes to medication errors is that medications are administered by patients or other persons who are not health care professionals trained to do so. This is in sharp contrast to inpatient hospital settings where prescribers write orders for medications on patients' medical charts and drugs are subsequently administered by health care professionals. In hospitals, patients are often passive, and rely on others for their treatment. In community settings the opposite is true, and medication use is almost completely dependent upon consumer knowledge and motivation which can often be lacking. In fact, it has been estimated that people who are prescribed self-administered medications typically take less than half the prescribed doses.[6]

Many consumers simply do not understand what medications they are taking, their importance, their contraindications, or proper usage. In addition, consumers may not be asked by their health care professionals what non-prescription medications or supplements they are taking and may not know the importance of volunteering this information to avoid problems such as therapeutic duplications or interactions.

Because the majority of medication errors in community settings are made by consumers, it is clear that real progress will require significant efforts to improve consumers' knowledge, skills and motivation to use their medications correctly. Health care professionals and others involved with prescribing, dispensing, administering and monitoring medication use in community settings can all help achieve these goals.

TABLE 1: Institute of Safe Medication Practices' Major Causes of Medication Errors

- **Critical patient information is missing** (allergies, age, weight, pregnancy, etc.)
- **Critical drug information is missing** (outdated references, inadequate computer screening, etc.)
- **Miscommunication of drug order** (illegible, incomplete, misheard, etc.)
- **Drug name, label, packaging problem** (look/sound alike, faulty drug identification)
- **Drug storage or delivery problem**
- **Drug delivery device problem** (poor device design, IV administration of oral syringe contents, etc.)
- **Environmental, staffing, workflow** (lighting, noise, workload, interruptions, etc.)
- **Lack of staff education**
- **Patient education problem** (Lack on patient consultation, non-compliance)
- **Lack of quality control or independent check systems in pharmacy**
- **Physician knowledge is lacking** (when a drug comes to market that replaces an existing one or several ones, i.e., a combination drug may mean that a person takes it once a week instead of daily)

[5] California Code of Regulations, Title 16, Section 1707.1

[6] Haynes RB, Yao X, Degani A, Kripalani S, Garg AX, McDonald HP. Interventions for enhancing medication adherence. Cochrane Database Syst Rev 2005;(4):CD000011.

Working Towards Patient Safety: A Systems Approach

Several experts who testified to the Panel cited multiple reports indicating that efforts to address errors are best targeted not at a particular group of individual "wrong doers," but rather at faulty systems, processes, and conditions that either lead people to make mistakes or fail to prevent them. The Panel consequently agreed to take a "systems approach" for studying the problem and developing its recommendations.

As a result, the Panel spent considerable time examining each part of the medication-use process – prescribing, dispensing, using (administering/self-administering) and monitoring – and the inter-relationships of each component. The Panel determined the medication-use system to be quite complex involving a multitude of stakeholders. A detailed explanation of the entire system is beyond the scope of this report, but through its work, the Panel identified four key processes and three key stakeholder groups which served as the focus of its recommendations.

Key Medication Use Processes

Prescription, Transcription and Transmission Processes

Once a prescriber decides what medication and dose to prescribe, he or she must find a way to communicate that information to the pharmacy where the patient will have their prescription filled. It is through this communication where a significant proportion of prescription errors occur.

Often, prescribing information is communicated via handwritten prescriptions which employ the use of Latin abbreviations that can sometimes be confusing. These prescriptions can be illegibly written and may be submitted to pharmacies via fax which can further contribute to legibility problems. The most frequent problems of this sort are related to medication names (particularly for drugs that have "look-alike" names such as those in Table 2), and medication strengths.

Table 2: Look-alike/Sound-alike Drug Name Examples

Seroquel 200mg	Serzone 200 mg
Aciphex	Aricept
Hydroxyzine	Hydralazine
Zyprexa 10mg	Zyrtec 10mg
Quinine 324mg	Quinidine 324mg

Alternatively, the prescription can be communicated to a pharmacy verbally over the telephone but this mode of communication is not without its own challenges, such as the confusion of "sound alike" drugs (see examples in Table 2). These problems can be exacerbated through the use of non-professional medical office staff who may not be familiar with drug names and medical terminology. It should also be noted that whenever a person other than the prescriber is used to communicate prescription information over the telephone, they are almost always reading information that was written by another individual, which of course is subject to the same legibility issues as hard-copy prescriptions.

Electronic or "e-prescribing" is, most broadly, the transmission of prescription information from a prescriber to a pharmacy using computer technology. While recent efforts have been made by some prescribers and pharmacies to adopt e-prescribing, medical offices has been slow to do so, predominantly because of high-costs and a lack of incentives for providers to change their practices. Compounding the situation is the fact that state and federal e-prescribing standards have not been set or are inconsistent or conflicting.

Even when medical offices have the technology to facilitate e-prescribing, most do not fully employ it. Rather, they simply use their electronic record systems to send computer generated prescriptions via fax.

While some persons may consider the transmission of a prescription from a computer to a fax machine as "e-prescribing," others believe that transmitting a static image, picture or facsimile is of limited value to helping ensure information accuracy, quality control or data analysis. The benefit is maximized from e-prescribing only when prescriptions are transmitted in a manner so that a recipient may use and analyze the information without having to manually copy or enter the data received.

The end goal with e-prescribing should be full system connectivity between pharmacies and medical offices to allow for *two-way* communication. Such connectivity could better leverage pharmacy data and has the potential to notify prescribers of possible medication-related problems before they occur.

Another problematic aspect of the prescribing process is that it frequently does not engage the consumer to an appropriate degree. All too often patients leave the prescriber's office without having the adequate medication-related information effectively communicated to them. Of particular concern are the consumers who present to the pharmacy without knowing the most basic information such as the name of the medication or what it is for. Without this minimal knowledge, there is very little consumers can do on their own to identify errors – even the most obvious ones such as receiving the wrong medication.

Consumer Education Processes

At the center of the medication-use process is the consumer. In the community setting, successful medication use is heavily dependent upon consumer knowledge and motivation which can often be lacking. When a person is not well-informed and motivated to manage their therapy, they cannot be expected to take their medication correctly or be an active partner in screening for signs and symptoms of medication efficacy or toxicity. There are a variety of complex reasons why many consumers allow themselves to be passive participants in the medication use process but the most significant is that consumers are largely unaware of, or do not accept the personal risks associated with medication use.

In addition to the consumer education challenges that pertain to the prescribing process, the Panel identified other aspects of the medication use process that could be modified to provide patients with better information and tools to reduce medication errors.

Pharmacist Consultation

While pharmacists are widely known for their dispensing activities, they can also play an important role educating consumers to ensure that the patient or their caregiver knows what the medicine is for, how to take it correctly, and what signs/symptoms should be monitored to assess for efficacy and toxicity.

State regulation requires pharmacists to provide a verbal medication consultation to the patient or the patient's agent each time a new medication is dispensed, or whenever an existing medication therapy is dispensed with a change in dosage form, strength or instructions for use.[7] This consultation is to include "directions for use and storage and the importance of compliance with the directions." Also included should be a "discussion of the precautions and relevant warnings, including common severe side or adverse effects or interactions that may be encountered."

In spite of these requirements, the Panel received testimony suggesting considerable variability in the quality of these consultations as well as the consistency to which they are offered by pharmacy staff and utilized by consumers. The reasons for this are not well defined but there appear to be contributing factors from both the pharmacist end (lack of time and incentives) and the consumer end (lack of awareness regarding availability and perceived value).

While there is not a lot of data about the effectiveness of this dispensing-related counseling, it is reasonable to assume that the significant number of consumer-related medication errors could be positively influenced by greater efforts in this arena, particularly with at risk populations including seniors and minority patients.

Prescription Labels and Labeling

The information that consumers need to know about their medication is often complex and may include unfamiliar language or concepts. Expecting a consumer to retain all the pertinent knowledge from a brief verbal encounter may not be reasonable in many instances. For this reason, it is important that consumers also receive written information regarding their prescription.

Often-times however, even this information can be forgotten and lost, and in those instances, the consumer may be left with nothing more than the prescription packaging and label to guide them. Testimony provided to the Panel identified many limitations related to the prescription label as an effective communication tool. These included the limited size of a prescription label (approximately 2 x 3 inches) which, due to established pharmacy systems, processes, and drug container variability would be functionally and financially difficult for the pharmacy industry to change.

Further complicating matters is the fact that there is already a significant amount of information required by California law to be printed on the label.[8] The most recent label requirement went into effect on January 1, 2006 and was created to help consumers identify erroneously filled prescriptions by mandating that pharmacies include the physical description of the dispensed medication, including its color, shape, and

[7] California Code of Regulations, Title 16, Section 1707.2

[8] California Business and Professions Code 4076

any identification code that appears on the tablets or capsules.

While this requirement is obviously directed at reducing errors, one might question the utility of some of the other label requirements which include the date of issue, the name of the pharmacy, the address of the pharmacy, the prescription number or other means of identifying the prescription, the name of the patient, the name of the prescriber, the name of the medication, the name of the medication's manufacturer, the strength of the drug, the quantity dispensed, the expiration date of the drug, and of course the directions for use. Given the limited space available, are all of these elements the most valuable pieces of information for the patient?

Regarding the directions of use, even when individuals are able to read and repeat back the directions, they may still not understand how to take the medication. This is particularly a problem for individuals with limited health literacy (the ability to read, understand and act on health information). A recent study by Davis, Wolf and others showed that even though 70.7% of patients with low literacy could correctly read and repeat the instructions, "Take two tablets by mouth twice daily," only 34.7% could accurately demonstrate the actual number of pills to be taken daily.[9] In this study the researchers found that it was common for consumers to make mistakes when dosing medicine for themselves, their elderly parents, and their children.

Tailoring and Targeting Consumer Education Efforts

To maximize the impact of consumer education activities, efforts will need to be tailored and targeted to individuals who are likely to achieve the greatest benefit. While the Panel did not come to consensus on the most important subset of consumers that are at "high risk" for medication errors, it did acknowledge that there are a variety of factors which may increase an individual's risk for experiencing a medication error.

In addition to 1) low health literacy, these can include; 2) limited English proficiency; 3) cultural incongruence with healthcare providers; 4) physical, cognitive and/or other impairments that make understanding and/or complying with medication instructions difficult; 5) age at either end of the age spectrum (the variability of a medication's response, metabolism and dose increases in children and seniors); 6) multiple medications; 7) multiple prescribers; 8) non-prescription medication use (including herbals, dietary supplements alcohol and tobacco); and 9) medication procurement from more than one pharmacy including mail-order. These factors must be taken into consideration in the development of any consumer education efforts.

Provider Payment/Incentive Processes

Incentives that directly or indirectly influence the behavior of prescribers and pharmacists are a key aspect of the medication use system. Testimony provided to the Panel indicated that prescriber incentives are frequently not aligned to promote spending time educating patients about medication use, or to closely follow patient compliance and medication monitoring parameters.

A fairly recent collaboration between healthcare purchasers, payers and medical groups provides incentives byway of "pay-for-performance" and shows promise for realigning prescriber incentives to reward behavior that results in positive outcomes. However, it is clear that there is still room for improvement in this area, particularly as it relates to safe and effective medication use.

Similarly, pharmacy incentives appear to do little to encourage pharmacist activity in areas related to patient education and the promotion of safe and effective medication use. Since pharmacies generally only receive compensation when a product is dispensed, financial pressures may, in fact, be driving pharmacy processes and personnel to minimize any activities not directly related to product distribution. Ironically, the structure of this financial model may possibly create disincentives for pharmacists to identify and prevent prescriptions with prescribing errors from leaving the pharmacy.

Fortunately, testimony provided to the Panel suggests that the healthcare system may be in the very early stages of what could be a paradigm shift. It appears that increasing numbers of healthcare purchasers and payers are beginning to understand that there is more to consider when it comes to medication than the simple cost of distribution, and the speed and convenience by which it can be put into the hands of consumers. There is a growing recognition that no matter how cheaply a drug can be purchased, the cost is too great if it does not elicit the desired effect, or worse, causes patient harm.

In response to this growing recognition, more and more healthcare purchasers and payers are developing

[9] Davis TC, Wolf MS, Bass PF 3rd, Thompson JA, Tilson HH, Neuberger M, et al. Literacy and misunderstanding prescription drug labels. Ann Intern Med. 2006;146:887-94.

specialized initiatives focused around improving medication use, particularly in target populations where safe, appropriate and effective medication use is critical. These "medication therapy management programs" have been developed for people with particular conditions such as diabetes[10], individuals who have multiple chronic conditions and/or take multiple medications, and those whose medication costs exceed a certain threshold.

Perhaps the most prominent example of this early trend is the requirement placed in the Medicare Modernization Act for sponsors of the Medicare Part D drug benefit to have in place a medication therapy management program designed to promote optimal therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions.

While medication therapy management programs may hold significant promise for reducing medication errors, many issues will need to be resolved before the full potential of such programs can be known and realized. As with any new healthcare initiative, there is uncertainty regarding how the quality and financial returns-on-investment can be maximized by adjusting program variables such as:

- The types of services that are provided (e.g. patient education, medication compliance packaging and comprehensive medication reviews);
- The patient populations that are targeted (e.g. those with a particular condition, medication, cost, or combination thereof);
- The types of providers who deliver various services (e.g. physicians, nurses and pharmacists);
- Service delivery models (e.g. face-to-face, telephone or mail); and
- Payment and documentation methodologies.

Until there is more information and standardization around issues such as these, the spread of medication therapy management programs will likely be slower than perhaps it should. Nonetheless, the fact that innovative purchasers and payers of healthcare are developing novel models to incentivize physicians, nurses, and/or pharmacists to pursue behaviors that will decrease medication errors is a positive step in the right direction.

Healthcare Provider Training and Licensure Processes

Obviously, simply aligning incentives to encourage safe medication practices among healthcare providers is not enough. Providers must also be cognizant of the seriousness of medication errors, know the behaviors to adopt that will reduce errors, and possess the knowledge and skills to effectively execute those behaviors.

Healthcare providers undergo extensive training to become licensed practitioners. Subsequent to licensure, providers must continue training to maintain their licenses. The vast majority of this training is clinical in nature. Most providers receive little education on subjects such as healthcare administration, error prevention, patient communication, and effective, systematic approaches to medication therapy management.

While testimony provided to the Panel indicates that some formal education on topics related to medication errors may be included in provider training programs, the very size of the medication errors problem suggests that the current amount may not be enough. More education in these areas would likely promote greater awareness among providers about what they can do to protect consumers. Informed providers can also be powerful advocates of change in a variety of healthcare settings.

Key Stakeholder Groups

In addition to the four key processes, the Panel identified three key stakeholder groups believed to play critical roles in the development and implementation of initiatives designed to address medication errors.

Consumer-Oriented Organizations

Since the consumer is at the center of the medication use process, it is imperative that all relevant consumer organizations be solicited to join the effort to prevent medication errors. These organizations can play critical roles in educating consumers about medication errors and advocating for healthcare policy and practice changes that have the potential to reduce errors. These groups may be government-related (e.g. the California Department of Consumer Affairs), private foundations, member-benefit organizations (e.g. AARP), or public-benefit organizations.

[10] Information was presented to the Panel on APhA Foundation's Asheville Project. Details can be found at www.aphafoundation.org/programs/Asheville_Project

Healthcare Provider Groups and Related Entities

Healthcare providers such as physicians, nurses and pharmacists are on the front lines of healthcare. In many respects, the burden of reducing medication errors will fall largely on their shoulders. A problem of this scope and size, however, cannot be solved by any single group of individuals, or even by a single sector of the healthcare system acting alone.

Any appreciable reduction in medication errors will require that the entities which support, direct, or influence provider behavior also be actively engaged in addressing this problem. These entities include the academic institutions and professional societies that train providers; the associations that advocate for them; the individuals that mange them; the companies that employ them; and the oversight boards that license and regulate them.

Healthcare Purchasers, Payers and Related Entities

The group that has perhaps greatest opportunity to influence the healthcare system consists of the entities that actually purchase and administer healthcare benefits – and to some extent, those which regulate and oversee the activities of these groups. Many of these entities have the power to decide which healthcare-related behaviors and outcomes are truly of value, and they can create payment structures, non-financial incentives and/or requirements to drive processes and behaviors that seek to deliver those results.

Stakeholders in this group include: the State of California which uses taxpayer monies to purchase, and through its Department of Health Services, administer healthcare benefits through programs such as Medi-Cal; private purchasers of health care such as employers which purchase healthcare for a majority of Californians under 65; commercial insurance companies which administer health benefits for both public and private sector purchasers; the California Departments of Insurance and Managed Health Care which regulate these insurance companies; pharmacy benefit managers which focus specifically on the administration of pharmacy benefits; and, of course, the Legislature and Administration of the State of California which possess the potential to influence and/or establish accountability for these groups.

Conclusion

Based upon the information provided to the Panel, and the identification of these key processes and stakeholders, the Panel developed 12 consensus recommendations in the following subject areas:

- **Communication Improvements** with an emphasis on improving the quality and accuracy of communications between prescribers, pharmacists and patients;
- **Consumer Education** to increase consumer awareness regarding the proper use, and dangers of misuse, of prescription and over-the-counter medications;
- **Provider Standards and Incentives** with a focus on information and medication consultations given by pharmacists to their patients as a means of educating consumers about drug safety;
- **Training and Education for Healthcare Providers** on various medication safety practices;
- **Research** with a focus on obtaining information about the incidence, nature and frequency of medication errors in the community setting.
- **Other Topics to be Addressed** which were determined to be beyond the scope of the Panel but which the Panel recognizes must be addressed hand-in-hand with other practice enhancement efforts in order to assure success in the current and future marketplace and workforce environments.

The recommendations are provided in their entirety in the next section of the report.

SECTION II: RECOMMENDATIONS

A. Communication Improvements

Background:

Improving the quality of communication among prescribers, pharmacists and patients is critical to the success of any effort aimed at decreasing medication errors. The existing process for communication among health professionals and their patients leaves much room for improvement, according to testimony received by the Panel. Indeed, California health practitioners have been slow in their adoption of computer-based patient records and electronic prescribing.

Currently, pharmacist-patient consultation is often compromised by the pharmacist's lack of knowledge of the prescriber's treatment objectives, including such basic information as the condition being treated. Confirming prescriber intent with the patient at the time of dispensing is an additional means of confirming that the medication treatment is understood and properly implemented.

In addition, prescribers' lack of writing legibility has long compromised pharmacists in their efforts to correctly dispense the desired drug product and provide accurate instructions for use. Addressing these two problems of communication between prescribers and pharmacists has been shown to substantially decrease medication errors.

In regard to communication between consumers and their health care providers, an important step would be to adopt techniques that bridge the language and cultural diversity of the patient population in California. This would provide the prescriber and pharmacist with the means to confirm that the medication treatment is understood and will be properly implemented.

Another important improvement in communication between health care providers and their patients would result from improved readability of drug labels and user-friendly packaging.

Goal 1: Improve prescriber-pharmacist communication quality and accuracy regarding prescriptions.

Recommendation 1

Improve legibility of handwritten prescriptions, and establish a deadline for prescribers and pharmacies (allowing for some exceptions) to use electronic prescribing.

Methods

1.1 Require each prescription to be legibly hand written or printed, computer generated or typed, and by 2010 that all prescriptions be computer generated or typed.

The California Board of Pharmacy and the California Medical Board shall review and seek modification of statutory and regulatory requirements as needed to implement adoption of computerized prescriber order entry (CPOE) systems and secure 2-way electronic communication between prescribers and pharmacies, with consideration for identified exceptions to the requirement.

1.2 Require the California Medical Board to collect and disseminate information in order to educate and assist physicians about the benefits of and ways to adopt electronic prescribing systems and supporting CPOE and secure 2-way transmission to pharmacies. Coordinate these efforts with related activities undertaken by the State. For example, Executive Order S-12-06 was issued by Governor Schwarzenegger on July 24, 2006 regarding efforts planned to make reforms regarding healthcare, especially regarding health information technology.

1.3 Require the California Medical Board to adopt regulations by January 1, 2008 that require

prescribers using electronic prescription systems to provide patients with a written "receipt" of the information that has been transmitted electronically to a pharmacy. The document should include at least the patient's name, the dosage and drug prescribed and the name of the pharmacy where the electronic prescription was sent, and should indicate that the receipt cannot be used as a duplicate order for the same prescription.

Goal 2: Improve prescriber-pharmacist and pharmacist-consumer communications to enhance understanding of the intended use of prescribed medication.

Recommendation 2

Require that the intended use of the medication be included on all prescriptions and require that the intended use of medication be included on medication label/labeling unless disapproved by the prescriber or the patient.

Methods

2.1. Require the California Board of Pharmacy and the California Medical Board to pursue necessary statutory and/or regulatory changes to require that by January 1, 2008 these entities coordinate efforts to develop plans to require prescribers to include the diagnosis, medical condition, symptoms or other indicators of the intended use of the medication on each prescription written, allowing for some exemptions.

2.2. Require the California Board of Pharmacy to pursue necessary statutory and/or regulation changes to require that the intended use of any prescribed medication be included on the medication label, unless the prescriber or consumer disapproves, and consumer disapproval is documented by the pharmacist.

Recommendation 3

Improve access to and awareness of language translation services by pharmacists at community pharmacies and encourage consumers to seek out pharmacists who speak their language and understand their cultural needs.

Methods

3.1 The California Board of Pharmacy, Department of Health Services and/or the Department of Consumer Affairs should develop and implement methods, when possible in coordination with other state entities, that are designed to reduce barriers for pharmacists at community pharmacies to access and utilize language translation services. These entities should report their respective related activities planned and undertaken annually on their respective websites and to the Assembly and Senate health committees, beginning January 1, 2008. They should, but not be limited to distributing information to pharmacies about the pharmacies' obligations to provide language translation services and resources for pharmacies to do so via the telephone.

Messages related to this method and goal should be included in the public awareness campaign (Recommendation #6) to inform consumers about their right to use language translation services and availability of these services at community pharmacies and other health care providers.

Recommendation 4

Promote development and use of medication packaging, dispensing systems, prescription container labels and written supplemental materials that effectively communicate to consumers accurate, easy-to-understand information about the risks and benefits of their medication, and how and where to obtain a medication consultation from a pharmacist.

Methods

4.1 Require the California Board of Pharmacy to examine the existing requirements for prescription container labels, prescription containers, and supplementary consumer information, and to consider revising these requirements to encompass required, supplemental consumer information and California Board of Pharmacy contact information.

Require these finding be issued by January 1, 2009 and distributed to the Senate and Assembly Health committees, posted on the California Board of Pharmacy's website and that public notice be made by issuance of a press release.

4.2 Encourage prescription drug plans, health care service plans, and health insurance companies to develop strategies to provide incentives for pharmacies and drug manufacturers to package medications in a manner that increases medication compliance, safety and efficacy.

4.3 Require the California Board of Pharmacy to adopt regulations mandating all pharmacies, including non-resident pharmacies, provide written materials with all dispensed prescriptions that inform consumers of their right to receive a medication consultation from a pharmacist with any new or changed prescriptions. These regulations should include enforcement provisions and the California Board of Pharmacy should make enforcement a priority.

B. Consumer Education

Background:

There is a great need to increase consumer awareness of the proper use, and dangers of misuse, of prescription and over-the counter-medications. Consumers often do not appreciate the potency and risks involved in the use of drugs that are widely advertised and promoted on television, radio and print media.

The California Board of Pharmacy is in an excellent position to spearhead an educational effort directed toward the public concerning drug safety issues. In recent years, the Board has been recognized nationally for its consumer protection efforts. A Board program that capitalizes on their proven expertise in consumer safety and which takes into account health literacy and culturally appropriate communication could be very effective in alerting consumers to potential medication errors, and in motivating them to adhere to their drug treatment instructions. A commitment by the State of California to capitalize on this proven expertise will go far to aid consumers in understanding their role in recognizing potential medication errors and preventing injury from those that do occur.

Goal 3: Improve consumer awareness and knowledge about the risks of medication errors and about steps they can take to reduce their risk of medication errors.

Recommendation 5

Identify and disseminate information about best practices and effective methods for educating consumers about their role in reducing medication errors.

Methods

5.1 Propose legislation allocating funds to and requiring the California Board of Pharmacy to:

a) Identify effective methods for educating consumers about ways to prevent and report medication errors. Include methods that are culturally and linguistically appropriate, especially addressing the needs of persons at high-risk for medication errors.

b) Develop guidelines and/or related regulations to define ways for effectively educating consumers to prevent medication errors. Include both verbal and written education strategies.

c) Disseminate information about the methods and guidelines/standards to specific relevant public and private sector entities, including mail-order (non-residential pharmacies) and pharmacies that dispense prescriptions to outpatients.

d) Improve public access to California Board of Pharmacy services (e.g., telephone, mail, and internet).

Recommendation 6

Establish an on-going public education campaign to prevent medication errors, targeting outpatients and persons in community settings.

Methods

6.1 Pass legislation allocating funds to and requiring the Department of Consumer Affairs and/or the California Board of Pharmacy to oversee development and implementation of a public education campaign to reduce medication errors. Public and/or private funds may be pursued.

The campaign shall be based on principles of public health practice and shall use methods that have been shown effective in educating consumers. The methods shall be culturally and linguistically appropriate and shall be developed in collaboration with other state entities.

The campaign shall develop messages that educate consumers about their medication use, risks, rights and responsibilities and shall include a consumer's right to basic consultation from a pharmacist with each new or changed prescription.

6.2 Require the California Board of Pharmacy and/or the Department of Consumer Affairs to collaborate with appropriate state entities and stakeholder groups, including but not limited to health plans, retail pharmacists, and consumer advocates representing persons at high risk for medication errors to:

a) Develop an evidence-based "safe medication use curriculum" that is designed to be used for educating consumers, and promote its availability to intermediaries, such as health care service plans, colleges, high schools, health insurers, Medi-Cal providers, and healthcare providers throughout the state who can educate consumers.

b) Post the curriculum on the websites of the relevant state departments and promote its availability through issuance of a press release and other public notice activities;

c) Develop and disseminate suggested strategies, possibly unique to each intermediary, to encourage consumers to attend presentations based on the curriculum.

d) Create a web-based interactive version of the curriculum that will be posted on websites of designated state entities and require those entities to promote the availability of the curriculum via no or low cost methods, such as press releases, faxes and email.

e) Coordinate this activity with the efforts to educate health care professionals about medication errors and prevention issues in Goal 5, Recommendation 10.

6.3 Recommend that the California Medical Board and the California Board of Pharmacy encourage physicians and other prescribers to post notice in their offices informing consumers of their right to know, and the benefits of understanding the name of any medication prescribed and the indication(s) and instructions for use, in addition to their right to consult with a pharmacist.

Recommendation 7

Develop and implement strategies to increase the involvement of public and private sector entities in educating consumers about improving medication safety and effectiveness.

Methods

7.1 Require the California Board of Pharmacy and/or the Department of Consumer Affairs to collaborate with a cross-section of public and private sector entities, including prescription drug plans, health care service plans, health insurers, and/or mail-order pharmacies, to support and/or undertake efforts to educate consumers about safe medication use. Use legislative and regulatory means to ensure a joint effort is made by all agencies that regulate these entities to collaborate in these efforts.

C. Provider Standards and Incentives

Background:

The drug consultation given by a pharmacist to their patient, or the patient's agent, can be a powerful means for educating consumers about drug safety. However, current law regarding pharmacists' consultation contains only the minimal requirements that were established in the early 1990s. In light of the substantial changes the State's health care system has undergone since that time, a re-examination of the pharmacist's consultation requirement is in order.

The Panel recommends that the Board of Pharmacy establish new pharmacist consultation standards that would provide greater benefit and protections to the public. Consistency should be a key component of the new standards, and they should take into account the economic and workforce conditions that impact the ability of pharmacists to provide this essential service.

Medication therapy management programs (MTM) provide another important tool in avoiding medication errors. The purpose of these programs is to evaluate whether prescribed medications are yielding desired results and, if not, to recommend or implement adjustments to therapies to maximize outcomes. To properly protect consumers, MTM programs should meet minimum standards for provider qualifications and program design.

Goal 4: Improve the quality and availability of pharmacist-patient medication consultation.

Recommendation 8

Help ensure quality and consistency of medication consultation provided by pharmacists within and among pharmacies.

Methods

8.1 Require the California Board of Pharmacy to review and, as needed, revise current regulations regarding patient consultation to focus on what would actually be useful to patients to help maximize their therapeutic outcomes and take their medications safely and effectively.

The California Board of Pharmacy shall invite stakeholders, including consumer representatives, to collaborate to develop minimal standards for required consultation. These deliberations should consider factors that reflect the current conditions of the business and healthcare environments, various types of pharmacy practices and practice settings (e.g. community, mail-order, extended care), and the "learning environment" available in those settings for providing consultation. The standards should be applied equally to all providers or entities dispensing medications to California consumers, including non-resident pharmacies.

Nothing in consideration of these standards shall preclude pharmacists from being paid for services that exceed these minimal standards.

These standards should address, at a minimum:

a) Encouraging or providing incentives to pharmacists for providing patient medication consultation with prescription renewals, when appropriate.

b) Re-examining the circumstances involved with patients' refusal of consultation, and what type of documentation is required, if any, for patients who refuse consultation. The Panel strongly emphasized that the following factors be considered as part of the re-examination process: (1) prohibiting any pharmacy employee from asking a patient or patient's agent if he/she wants pharmacist prescription consultation (i.e. no "screening" questions) and (2) requiring that the patient communicate the refusal of consultation directly to a pharmacist.

Recommendation 9

Establish standards for medication therapy management (MTM) programs and create incentives for their implementation and ongoing use by pharmacists and other healthcare providers

Methods

9.1 Require the California Board of Pharmacy to identify best practices and to develop evidence-based standards of care for MTM programs, and to disseminate these to known MTM providers, the Department of Health Services, Department of Managed Health Care, Department of Insurance, the Managed Risk Medical Insurance Board, CalPERS, California Medical Board, and to applicable professional and healthcare associations (e.g. California Medical Association, California Pharmacists Association, California Association of Health Plans).

9.2 Require the Department of Health Services, Department of Managed Health Care, Department of Insurance, Managed Risk Medical Insurance Board, California Medical Board, Board of Registered Nursing, Board of Pharmacy, and appropriate private sector entities to develop and implement strategies to incentivize payers, pharmacists and other healthcare providers to implement and routinely use MTM standards of care. These public entities shall report their respective related activities to the Assembly and Senate Health Committees, and to notify the public by posting descriptions of their activities and/or any findings on their websites and notifying the public and media by issuing one or more press releases.

9.3 Consistent with the standards developed in this recommendation, require the Department of Managed Health Care, the Department of Health Services and the Department of Insurance to allow health plans, health insurers, and Pharmacy Benefit Managers flexibility in methods of implementing MTM programs, including via face-to-face interaction, call center advice lines, and secure e-mail communication.

9.4 Encourage state-funded programs (e.g., Medi-Cal and CalPERS) to establish financial and other incentives for healthcare providers and patients improving drug therapy compliance, including cases of over-use (including therapeutic duplication) and under-use of prescription medication.

D. Healthcare Provider Training and Education

Background:

Good communication skills are essential in the current health care environment, and are a key tool in reducing medication errors. Pharmacists and other health care professionals must take into account their patients' language skills and cultural characteristics in order to effectively convey essential information to them. There is therefore a need to educate prescribers and pharmacists concerning improved ways to help their patients understand the proper use of medications, the importance of complying with their treatment regimen, and the need to report any problems to their prescriber or pharmacist.

Considering the ever increasing numbers of patients who have conditions that can be managed with therapies that are frequently long-term and involve the use of multiple medications, healthcare providers are also likely to benefit from more training and education around the intricacies of medication therapy management (MTM). While much of this information is already an integral component of pharmacist training, many of the skills needed to apply it are distinct from a pharmacist's traditional dispensing role. Consequently some pharmacists may have a need to obtain other types of training as well.

Goal 5: Improve education and training of pharmacists and other health care professionals about medication errors and prevention methods.

Recommendation 10

Create training requirements for pharmacists and other healthcare professionals that address medication safety practices and related programs, including medication consultation and medication therapy management programs.

Methods

10.1 Require that the licensing boards for relevant health care professionals (e.g., pharmacists, physicians, nurses, dentists and optometrists) establish specific requirements for training/education about medication safety practices (e.g., medication error reduction strategies, patient medication consultation, and medication therapy management methods) as part of licensure, certification, and/or continuing education requirements. Further, require these boards to report their findings and plans for improving their requirements in this regard to the appropriate cabinet-level position, the Assembly and Senate Health Committees, and the public through posting of the report on their websites and issuing one or more press releases.

10.2 Encourage the colleges, universities, and schools that provide degree programs for health care professionals (e.g., pharmacists, physicians, nurses, dentists, optometrists, pharmacy technicians) to establish and maintain specific curricular requirements about medication safety practices (e.g., medication error reduction strategies, patient medication consultation, medication therapy management methods).

10.3 Encourage employers of healthcare providers, as well as the healthcare professional associations (e.g., the California Medical Association, California Pharmacists Association, California Society of Health System Pharmacists, and California Nurses Association), to establish and maintain ongoing training and educational activities for their respective constituencies about medication safety practices (e.g., medication error reduction strategies, patient medication consultation, medication therapy management methods).

10.4 Require that the licensing boards of relevant healthcare professions (e.g. pharmacists, physicians, nurses, dentists and optometrists) evaluate the effectiveness of their respective licensing requirements (e.g. board examinations) in determining a licentiate's ability to communicate medication-related information and instructions to consumers in a manner that reduces the risk of medication errors related to patient misunderstanding. Further, require these boards to report their findings and plans for improving their requirements in this regard to the appropriate cabinet-level position, the Assembly and Senate Health Committees, and the public through posting of the report on their websites and issuing one or more press releases.

E. Research about Prevalence & Occurrence of Medication Errors

Background:

Obtaining information about the incidence, nature and frequency of medication errors in the community setting is challenging. Most research on medication errors has been conducted in hospitals, even though the drugs administered in inpatient settings represent a very small proportion of medications dispensed. Indeed, there is comparatively little academic research available regarding medication errors occurring in the community setting. While it appears that this situation is beginning to improve, a greater emphasis on research related to medication errors in the community setting is definitely warranted.

Goal 6: Increase evidence-based information about the nature and prevalence of medication errors available to policy-makers, pharmacists, consumers, and other interested parties.

Recommendation 11

Establish and support efforts to collect data regarding the nature and prevalence of medication errors and prevention methods for reducing errors, especially focused on persons at high risk for medication errors and on community, ambulatory and outpatient settings.

Methods

11.1 Require by legislation, regulation, joint legislative resolution, and/or issuance of a Governor's Executive Order that the California Board of Pharmacy establish an agreement with a private sector organization, such as the Institute of Safe Medication Practices (ISMP), to establish a pilot project to collect and analyze data about the nature and prevalence of medication errors at California community-based pharmacies.

Require that the cost of this project to the State be negligible.

Require the California Board of Pharmacy to share data about medication errors reported to it with the entity responsible for implementing this recommendation and that the Board collaborate with the entity responsible for implementing this recommendation to promote the project to consumers, pharmacies and providers. The project should ensure that:

a) Prescribers, pharmacists and consumers may voluntarily and confidentially report errors to the ISMP or other responsible entity.

b) The entity responsible for implementing this recommendation report annually to the California Board of Pharmacy, the California Medical Board and the Senate and Assembly health committees, and that these reports indicate if an error occurred either under the auspices of a health care facility or in a community setting (i.e., retail pharmacy or private residence) and the severity of the error (i.e., if it resulted, contributed or may have been associated with death, hospitalization or serious injury).

c) The information collected and reported by this project should not be used in any legal proceedings against prescribers and/or pharmacists.

d) The project be designed to minimize conflict with existing systems that are used to collect data from pharmacies as part of their current California Board of Pharmacy Quality program.

e) Efforts to inform consumers about this project include information handed out at pharmacies, on medication information sheets, and with related public education campaigns.

f) The California Board of Pharmacy and the Medical Board post the reports produced by this project on their respective websites.

g) Persons reporting errors to the entity responsible for implementing this recommendation be informed of their right to also report errors to the California Board of Pharmacy and the benefits of doing so.

F. Other Topics to be Addressed

Background:

The many obstacles that pharmacists face in providing drug consultation to their patients as required by law are exacerbated by the lack of a payment system that would compensate them for the time and expense associated with performing these mandated tasks. Before additional duties can be imposed on pharmacists practicing in the outpatient setting, changes to the health care financing/ reimbursement system must occur. This issue was beyond the charge of the Panel, but it was recognized to be an issue that must be addressed hand-in-hand with other practice enhancement efforts in order to assure success in the current and future marketplace and workforce environments.

Goal 7: Develop strategies designed to increase incentives for pharmacists to offer and provide medication consulting and medication therapy management services to consumers.

Recommendation 12

Convene a panel of stakeholders to identify and propose specific actions and strategies to overcome barriers to qualified pharmacists being recognized and paid as healthcare providers.

Methods

12.1 The Legislature should convene a panel of stakeholders representing California pharmacists, healthcare providers, consumer groups, payers, health plans and other perspectives to hold a series of public meetings and issue recommendations addressing the reimbursement of pharmacists for non-dispensing services.

Reimbursement for medication consultation should be based on standards of care (see recommendations and discussion under Goal 4). If such standards have not been adopted at the time that the panel is convened, then the panel should make recommendations to the California Board of Pharmacy about development of the standards.

In considering recommendations for reimbursing pharmacists for patient medication consultations, the panel should weigh factors based on patient-specific information, including, but not limited to time spent providing the consultation or complexity of the consultation (the number of medications taken by the consumer, the consumer's compliance challenges, language, literacy or translation needs, or patient diagnosis). Additionally, the panel should take into account the most current thinking on this subject from relevant regional or national entities such as the US Centers for Medicare and Medicaid Services, Quality Improvement Organizations, and pertinent payer and provider organizations.

SECTION III: APPENDICES

Appendix A: Panel Meeting Dates and Speakers

The Medication Errors Panel held 12 meetings in Sacramento, the first on May 5 and the last on November 16, 2006. Presentations were made to the panel by persons listed below on the dates indicated.

May 5

- Senator Jackie Speier, Panel Chair and Author of SCR 49
- Senator Sam Aanestad, Panel Member
- Lynn Rolston, CEO of CA Pharmacists Association
- Robert MacLaughlin, Aging and Long Term Care, Senate Health Subcommittee
- John Gilman, Assembly Health Committee
- Dawn Adler, Office of Assemblymember Betty Karnette
- Sang-ick Chang, M.D., San Mateo County Medical Center
- Michael J. Negrete, Pharm.D., Pharmacy Foundation of CA

May 19

- Eleanor M. Vogt, R.Ph., Ph.D., Health Sciences Clinical Professor and 2004 – 2005 Presidential Chair, UC San Francisco School of Pharmacy
- Patricia Harris, Executive Director, Board of Pharmacy
- John Gallapaga, SmartRx for Seniors
- Lisa Chan, Office of Assemblymember Wilma Chan

June 2

- Michael Cohen, R.Ph., MS, FASHP, founder of the Institute for Safe Medication Practices (ISMP)
- Patricia Harris, Executive Director, CA Board of Pharmacy
- Dave Thornton, Executive Director, CA Medical Board
- Dr. William Soller, PhD, Executive Director, Center for Consumer Self-Care, University of CA, San Francisco

June 16

- Bill G. Felkey, Professor, Pharmacy Care System, Auburn University, Alabama
- David Murphy, SureScripts
- Pam Bernadella, RPh, Manager, Pharmacy Professional Services, Target Corporation, Minnesota

June 30

- Victoria Bermudez, RN, CA Nurses Association
- Lori Hack, Interim CEO, CA Regional Health Information Organization
- Sharon Youmans, Pharm.D, MPH, Professor of Clinical Pharmacy, University of CA, San Francisco

August 11

- Dr. Robert E. Lee, Jr., Eli Lilly, and U.S. Food and Drug Administration Trademark Focus Group Member
- Tom Williams, CEO, Integrated Healthcare Association
- David Murphy, SureScripts and Get Connected CA
- Carmella Gutierrez, Lumetra
- Peter Boumenot, Lumetra, Electronic Health Records Implementation Consultant

August 25

- Paul Tang, MD, Vice President, Chief Medical Information Officer, Palo Alto Medical Foundation, Sutter Health

- Susan L. Ravnan, Pharm. D., Associate Professor, University of The Pacific Thomas J. Long School of Pharmacy and Health Sciences; CA Society of Health System Pharmacists representative

September 15

- Robert Friis, PhD, California State University Long Beach, Department of Health Sciences Chair, and American Public Health Association Southern California Chapter President
- Gurbinder Sadana, MD, FCCP - Director of Critical Care Services, Pomona Valley Hospital Medical Center; California Medical Association representative

September 29

- Panel committees begin work of drafting recommendations for final report

October 13

- J. Kevin Gorospe, Pharm. D., Chief, Medi-Cal Pharmacy Policy Unit
- Loriann De Martini, Pharm.D., Chief Pharmaceutical Consultant, Licensing and Certification Division, Department of Health Services

November 2

- Senator Jackie Speier, Panel Chair, met with the Panel to discuss major issues, and Panel's progress on developing final recommendations

November 16

- Final meeting of the Panel to discuss recommendations

Appendix B: Prior Legislative Efforts to Address Medication Safety

The following legislation relevant to the objectives of the Panel has been enacted:

- SB 1339 (Figueroa) became law in 2000 and requires pharmacies to establish quality assurance programs to reduce frequency of medication errors. Every pharmacy is required to have a system of tracking and assessing errors so that the proper steps can be taken to reduce the chance of a reoccurrence. It exempts any documents generated by the program from legal discovery proceedings.

- SB 1875 (Speier), 2000, requires hospitals and surgical centers to develop medication error reduction plans and submit the plans to the Department of Health Services. In order for a health facility or clinic to obtain a license it must complete a plan to eliminate or substantially reduce medication error by 2005.

- SB 292 (Speier) 2003, requires labels on pill bottles to include a written description of the drug that was prescribed, including its color, shape, and any identification code appearing on the tablets or capsules. (This bill initially sought to have a color image of the pill or tablet printed on the bottle label.)

- SB 151 (Burton), 2004, requires that tamper-resistant security forms be used for nearly all *written* prescriptions for controlled substances (Schedules II-V). This pre-printed and numbered form must contain at least ten security features and replaces the Schedule II triplicate prescription forms. Pharmacies must report Schedule III prescriptions to the CURES program.

There were six bills before the legislature during the 2005-2006 session that had objectives relevant to medication safety. They were the following:

- AB 71 (Chan) would have established the Office of the California Drug Safety Watch to administer a database of information about the safety and effectiveness of highly advertised prescription drugs. The database was to include reports of adverse drug reactions (ADRs) which would have been accessible to health professionals and the public. This bill is inactive.

- AB 657 (Karnette) would have required that the purpose or indication of a medication be listed on the prescription label if a prescriber had written it on the prescription. This bill is inactive.

- SB 1301 and SB 380 were both introduced by Senate Elaine Alquist in 2005. SB1301 was chaptered September 29, 2006 and requires acute care facilities to report ADRs to the Department of Health Services within five days of the occurrence. SB 380 originally contained a mandatory reporting requirement to the federal Food and Drug Administration for all serious ADRs, but was amended to address a non-related issue.

- SB 329 (Cedillo) 2005, would have established the California Prescription Drug Safety and Effectiveness Commission within the California Health and Human Services Agency. The Commission would request assistance from a unit of the University of California and be a repository of information about prescription drug safety and effectiveness. In February 2006, this bill was returned to Secretary of Senate pursuant to Joint Rule 56.

- AB 72 (Frommer) 2005, would have established the Patient Safety and Drug Review Transparency Act in order to ensure that information regarding clinical trials of prescription drugs is available to the public, physicians, and researchers. On January 31, 2006, this bill died on the inactive file.

Agenda Item 9

Update of the Committee's Strategic Plan 2007-08

California State Board of Pharmacy
1625 N. Market Blvd, Suite N 219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

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

March 19, 2007

To: Members, Communication & Public Education Committee

Subject: Update of the Committee's 2007-08 Strategic Plan

Last July, the board finalized its strategic plan for 2006-2011. However, each year in the spring, the board revises its plan to keep it current. It is time to start this review.

At this meeting, the Communication & Public Education Committee will have the opportunity to revise its strategic plan, if warranted.

At the April Board Meeting, the board will review any modifications to the strategic plan recommended by each committee for development of the 2007-08 strategic plan (completing the annual updating process).

The last activity update of the Communication & Public Education Committee's strategic plan follows this page.

COMMUNICATION AND PUBLIC EDUCATION COMMITTEE

Goal 4: Provide relevant information to consumers and licensees.

Outcome: Improved consumer awareness and licensee knowledge.

Objective 4.1	Develop a minimum of 10 communication venues to the public by June 30, 2011.
Measure:	Number of communication venues developed to the public
Tasks:	1. Assess the effectiveness of the board's educational materials and outreach: survey consumers to identify whether board-produced materials are valued and what new materials are desired. *Sept. 2006:* *Committee begins review of consumer outreach* *Dec. 2006:* *Staff conducts assessment of the board's consumer outreach written materials. Material is identified for revision and update, future development, or evaluation for continued need.* *Jan. 2007:* *Drafts of board informational brochure and complaint process brochures are updated; brochures will undergo review.* 2. Restructure the board's Web site to make it more user friendly. *July 2006:* *Web site modified to contain lists of disciplinary actions finalized each quarter and permit online access to public documents regarding board disciplinary actions taken against a licensee.* 3. Work with the California Health Communication Partnership on integrated public information campaigns on health-care topics. *Sept. 2006:* *Committee continues collaboration with the partnership whose fall campaign is screening for prostate and breast cancer. Plans underway to work to promote generic drugs in the future.* 4. Continue collaboration with UCSF's Center for Consumer Self Care for pharmacist interns to develop consumer fact sheets on health topics. *Sept. 2006:* *Nine previously developed fact sheets are sent to a translation service to develop Spanish, Chinese, and Vietnamese versions of these materials. Four new fact sheets developed and undergoing review by the board.* 5. Develop a Notice to Consumers to comply with requirements of AB 2583 (Nation, Chapter 487, Statutes of 2006) on patients' rights to secure legitimately prescribed medication from pharmacies. *Sept. 2006:* *Governor signs AB 2583* *Oct. 2006:* *Committee advances draft regulation text for comment at the October Board Meeting. Board votes to create a second Notice to Consumers poster vs. adding additional language to current poster.* *Jan. 2007:* *Committee refines language to be advanced to the board. Board reviews, modifies, and sets for regulation notice the proposed language for a second Notice to Consumers poster.*

6. Evaluate the practice of pill splitting

Objective 4.2	Develop 10 communication venues to licensees by June 30, 2011.
Measure:	Number of communication venues developed to licensees
Tasks:	1. Publish The Script two times annually. *Sept. 2006:* *The Script published and mailed to pharmacies and wholesalers.* *Jan. 2007:* *The Script published and mailed to pharmacies and wholesalers.* 2. Develop board-sponsored continuing education programs in pharmacy law and coordinate presentation at local and annual professional association meetings throughout California. *1st Qtr 2006:* *Board supervising inspectors present five CE programs on pharmacy law and the Board of Pharmacy to pharmacist associations statewide.* *Sept. 2006:* *Supervising Inspector Ming provides information on pharmacy law to 80 pharmacists and pharmacy technicians at a San Mateo Pharmacist Association.* *Supervising Inspector Ratcliff provides information on pharmacy law to the Sacramento Valley Society of Health System Pharmacists.* *Oct. 2006:* *Interim Executive Officer Herold presents Legislation and Regulation update at CSHP's Annual Seminar. Board also staffs information booth for licensees.* *Nov. 2006:* *Board Member Goldenberg speaks at the California Association of Health Facilities Convention in Palm Springs.* *Supervising Inspector Ming provides information on pharmacy law to UCSD students.* *Jan. 2007:* *Supervising Inspector Ming provides information on pharmacy law to the Indian Pharmacist Association.* 3. Maintain important and timely licensee information on Web site. *1st Qtr 2006:* *Added 50-year pharmacist recognition pages as a special feature.* *Updated license totals.* *Added enforcement actions for effective dates between April 1 and June 30, 2005.* *Changed definitions on license lookup to clarify license status.* *Posted board and committee meeting agendas and materials.* *Sent out subscriber alert notifications to the board's e-mail notification list, including two drug recalls.* *2nd Qtr 2006:* *Unveiled new Web site of the board, and created new Web links.* *Revised and added new fax and contact information to speed communication with appropriate enforcement and licensing staff.* *Updated listing of 50 year pharmacists.* *Added frequently asked questions on emerging contraception.* *Updated listing of enforcement actions taken.* *Reviewed and updated board member biographies.* *Made corrections to the board's online lawbook.* *Added all agendas, meeting packets and minutes for board and committee meetings.* *Sent out nine subscriber alerts for important information added to the board's Web site.*

Objective 4.3	Participate in 12 forums, conferences and public education events annually
Measure:	Number of forums participated
Tasks:	1. Participate in forums, conferences and educational fairs. *Sept. 2006:* *Supervising Inspector Nurse provides presentation on California's e-pedigree requirements at Logi-Pharma's Annual Convention in Austin TX.* *Oct. 2006:* *Board hosts the three-day NABP Districts 7 & 8 Meeting. Topics include the FDA's pedigree requirements, the DEA's pseudoephedrine requirements, divergent intern requirements from state to state, and development of ethics programs for health professionals.* *Supervising Inspector Nurse provides presentations to national EPCglobal Convention (a standards setting organization) in Los Angeles on California's e-pedigree requirements for prescription drugs.* *Board staffs information booth at San Mateo Senior Fest where 600 people attend.* *Dec. 2006:* *Inspector Barnard and Public and Licensee Education Analyst Abbe staff information booth at the Sacramento AARP-sponsored Ask A Pharmacist event.* *Jan. 2007:* *Supervising Inspector Nurse provides presentation on California's e-pedigree requirements at Secure Pharma 2007, the supply chain security conference in Philadelphia.*

Agenda Item 10

Creation of the New Board Web Site

California State Board of Pharmacy
1625 N. Market Blvd, Suite N 219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

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

March 19, 2007

To: Members, Communication & Public Education Committee

Subject: New Web Page Design for State Agencies

In July 2006, the board completed its redesign of the board's Web page to conform to the parameters established by the Governor's Office. This completed a process started about a year before to redesign our Web page so it looked like those of other state agencies.

Well -- we recently received notice that it is time to redesign our Web page again to conform to the new look for state agency Web pages. The deadline for conversion to the new format is November 2007.

According to the department: "This redesign is part of an effort to expand and refresh California's online presence, and to help visitors find the information they need as quickly as possible. Some notable changes include a new look-and-feel, the reorganization of the navigation and structure of the homepage, the Google search engine, and a statewide brand."

Staff has begun work on the new format, and I believe we will meet the November deadline. This time we will be at the leading edge of the conversion, instead of being among the last to convert to the new format.

Following this page are some materials on the subject.

OFFICE OF THE STATE CHIEF INFORMATION OFFICER
J. Clark Kelso
Chief Information Officer

January 22, 2007

To: Agency Secretaries
Agency Undersecretaries
Agency Information Officers
Department Directors
Chief Information Officers
Webmasters

Subject: California Portal

I am pleased to announce that the redesign of the California Portal (www.ca.gov) has been completed and was released today, January 22nd. The redesign is part of an effort to expand and refresh California's on-line presence, and to help visitors find the information they need as quickly as possible. Some notable changes include a new look-and-feel, the reorganization of the navigation and structure of the home page, the Google search engine, and a statewide brand.

Agencies, departments, commissions and boards within the State Executive Branch are requested to comply with the new design by November 2007. To help departments make this transition, tools, templates, and other resources are available in an on-line Webmaster's Toolbox at www.eservices.ca.gov. Some of the required elements follow:

- Logo and Banner – A new logo and banner have been established that use less space and facilitate co-branding. The header helps signify to users that they are on an official State site, and is a required element for every State web site.

- Tabs – For the State web sites, the primary navigation will transition to tabs, versus left hand sub-navigation. A variety of color combinations are available.

- Footer – The footer should appear at the bottom of all State pages. The footer contains links to the policies of www.ca.gov, contact information, and other information.

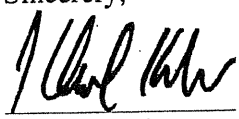
The redesign was based on feedback from citizens, businesses, and State departments that the portal was not meeting their needs. This was confirmed through a usability study and search engine review conducted in the summer of 2006. As a result, the organization of the information has been improved and content has been updated. To provide more relevant search results, California's search engine is powered by industry-leading Google. Additionally, we made extensive changes to ensure that the site is accessible to people with disabilities.

3200 Fifth Avenue • Sacramento, California 95817 • (916) 739-7302 • (916) 739-7072 facsimile

I am very excited about the work that has been done to make it easier and more convenient for citizens, businesses, and visitors to do business with the State of California. This redesign has been a significant undertaking, and it represents the work of many cross-departmental committees, workgroups, and user groups over the last year. This first step puts California in an easier position to implement future improvements and features.

If you have any questions, please contact the eServices Office at info@eservices.ca.gov or visit www.eservices.ca.gov.

Sincerely,



J. Clark Kelso
Chief Information Officer
State of California

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3/22/2007

Schwarzenegger highlights California's importance on the national stage at *Exporting California* Luncheon

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California's Gang Problem

Deputy Chief of Staff Ross LaJeunesse discusses what Governor Schwarzenegger is doing to tackle California's gang problem. Learn more...

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Schwarzenegger Speaks at Exporting California Luncheon

3/22/2007 - The Governor addressed the *Exporting California: California's Influence in 2008 and Beyond* Luncheon and highlighted California's importance on the national stage. Read More »

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Maria Shriver
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MORE NEWS

Schwarzenegger Discusses Ways to Fight Gang Related Crimes

3/21 - Governor Schwarzenegger met with local Fresno officials to discuss ways to fight gang related crimes and then took questions from the media. The Governor is advocating for strong

ISSUE SPOTLIGHT

The Governor's Office hosted a live, interactive video Web discussion on California's prison crisis and Governor Schwarzenegger's proposed reforms to reduce overcrowding.

Internet

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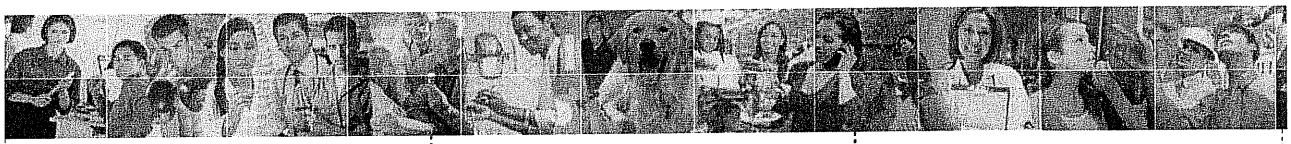

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- To Verify a License
- The Consumer Connection Newsletter
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More

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- To Renew My License Online
- Search for a Board or Bureau by Profession
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