



California State Board of Pharmacy
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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS

NOTICE OF MEETING and AGENDA Licensing Committee

Date: December 3, 2009
Time: 12:30 p.m. – 3:30 p.m.

Contact: Virginia Herold
(916) 574-7911

Place: Samuel Greenberg Board Meeting Room
(Los Angeles International Airport) – see detailed directions below
1 World Way
Los Angeles, California 90045

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

Opportunities are provided for public comment on each agenda item. A quorum of the board may be present at committee meetings. Board members who are not on the committee may observe, but may not participate as a Committee member or vote.

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

Call to Order

12:30 p.m.

1. Emergency and Disaster Response Planning: Update on the H1N1 Emergency Response Activities in California
2. Impact on Patient Care Caused by Diverse Supply Issues Impacting the Availability of Medication to Hospitals: Presentation by Chad Signorelli, PharmD, Assistant Director of Pharmacy Services, Lompoc Valley Medical Center
3. Request to Modify Title 16 California Code of Regulations Section 1713(d) Regarding the Requirement that Automated Dispensing Machines Be Adjacent to the Secure Pharmacy Area
4. Final Comments on Best Practices for Recalls in Hospitals
5. Presentation of a Drug Distribution Model Proposed by Medco Health Solutions, Using Two Pharmacies, Each with Specialized Functions
6. State of California's Right Care Initiative
7. Update: Psychometric Assessment of the PTCB and ExCPT Pharmacy Technician Exams
8. Discussion of the Reporting and Accounting of Intern Hours for California Pharmacy School Students
9. Impact of State Furloughs on Processing Timelines and Work Flow of the Board
10. Competency Committee Report
11. Job Analysis for the CPJE Initiates in December 2009
12. Public Comment for Items Not on the Agenda*

**(Note: the committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. Government Code Sections 11125 and 11125.7(a))*

Adjournment

3:30 p.m.

More on Next Page

Meeting materials will be available from the board's Web site by November 25, 2009

Directions to the Meeting Location

The address for the meeting is: Samuel Greenberg Board Room: 1 World Way Los Angeles, California 90045.

If driving:

Enter off of Century Boulevard. Follow the signs to the "Arrival" area of LAX from Century Boulevard. Stay in the left lane while entering LAX. To the left will be an off ramp with a sign that will direct you to the Administration Building and parking. At the bottom of the off ramp is a stop sign (the building that the meeting will be held in is directly in front off you). Turn right at the stop sign and go about 50 feet to the parking lot that will then be in front of you after the turn. If the gate is down, push the button and tell the guard that you are there for the meeting in the Board Room. The gate will open and you can park anywhere in the lot except where it is reserved for fleet vehicles (that is only about 4 spaces).

If flying:

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

Date: November 25, 2009

To: Licensing Committee

Subject: Emergency and Disaster Response Planning

For more than one year, health care providers, policy makers and governments worldwide have been dealing with the H1N1 flu worldwide pandemic.

In California, the board has provided assistance. This has included:

- Sharing our subscriber alert system to advise licensees of directives from the California Department of Public Health
- Ensuring the expedited licensing of storage locations for the H1N1 vaccines
- Establishing a specialized list of compounding pharmacies that the Department of Public Health can access if special, compounded formulations of medications are needed.
- Transferring messages from board licensees that need a response or intervention from the Department of Public Health's Emergency Planning and Response Branch, Emergency Preparedness Office

Board staff continue to work closely with the Department of Public Health to assist in ways that will benefit the public.

In order to ensure that the board can act quickly to activate the board's emergency response policy in response to a sudden declared crisis, at the October Board Meeting, the board voted that:

In the event that the board is not able to convene a public meeting on regular notice or pursuant to the emergency meeting provisions of the Open Meetings Act, any three members of the board may convene a meeting by teleconference, by electronic communication (e.g., email), or by other means of communication to exercise the powers delegated to the full board pursuant to Business and Professions Code section 4062.

At this time, there is no additional information to report.

Karen
Abbe/Pharmacy/DCANotes
11/17/2009 09:21 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes
cc Anne Sodergren/Pharmacy/DCANotes@DCANotes, Carolyn
Klein/Pharmacy/DCANotes@DCANotes
bcc
Subject Washington Post: CDC's swine flu toll: 4,000 dead, 22 million
ill

The Washington Post

CDC's swine flu toll: 4,000 dead, 22 million ill

By LAURAN NEERGAARD
The Associated Press
Friday, November 13, 2009 9:15 AM

WASHINGTON -- Estimates of deaths caused by the swine flu have grown to nearly 4,000 since April, roughly quadrupling previous estimates. But that doesn't mean swine flu suddenly has worsened.

Instead, the federal numbers made public Thursday reflect a long-awaited better attempt to quantify the new flu's true toll. Most cases still don't require a doctor's care.

Swine flu has sickened about 22 million Americans since April and killed about 540 children.

And it's still early in the season.

"I am expecting all of these numbers, unfortunately, to continue to rise," said Dr. Anne Schuchat of the Centers for Disease Control and Prevention. "We have a long flu season ahead of us."

Tight supplies of vaccine to combat the illness continue: Not quite 42 million doses are currently available, a few million less than CDC had predicted last week.



Scarlett Adkins, 1, is held by her mother, Kera Adkins, Thursday, Nov. 12, 2009 as she reacts to getting her H1N1 vaccine shot from nurse Rhonda Woolum in Ashland, Ken. The Boyd County Health Department gave the shots out by appointment only. (AP Photo/The Independent, John Flavell) (John Flavell - AP)

A new Associated Press-GfK poll shows nearly 1 in 6 parents has gotten at least some of their children vaccinated against swine flu since inoculations began last month. An additional 14 percent of parents sought vaccine but couldn't find any.

Only about 30 percent of children routinely get flu vaccinations during a normal winter. That even this many have gotten vaccinated against the new flu, which scientists call the 2009 H1N1 strain, despite the shortage suggests CDC's target-the-young message has gotten through.

But three times as many adults have tried and failed to find vaccine for themselves as have succeeded.

And interest among the young adults who also are at high risk is waning fast, found the AP-GfK poll of 1,006 adults nationwide.

Schuchat urged patience in seeking vaccine.

"It's a marathon and not a sprint," she said. "More vaccine is being ordered and delivered and used every day."

Until now, the CDC has conservatively estimated more than 1,000 deaths and "many millions" of new H1N1 infections. The agency was devoting more time to battling the pandemic than to counting it. Earlier figures were based on laboratory-confirmed cases even as doctors largely quit using flu tests months ago - and experts knew that deaths from things like the bacterial pneumonia that often follows flu were being missed.

Thursday's report attempts to calculate the first six months of the new H1N1 strain's spread, from April through mid-October. The CDC said:

- Some 98,000 people have been hospitalized from this new flu or its complications, including 36,000 children, 53,000 adults younger than 65 and 9,000 older adults.

- Deaths could range from a low of 2,500 to as many as 6,100, depending on how the data's analyzed. CDC settled on 3,900 as the best estimate.

- Some 8 million children have become ill, 12 million adults younger than 65 and 2 million older adults.

In a typical winter, seasonal flu strains cause 200,000 U.S. hospitalizations and 36,000 deaths, the vast majority in people over 65. Seasonal influenza doesn't usually start circulating until November. Swine flu began a big climb in September, leading to what CDC called unprecedented high levels of illness so early in a season - and no way to know when the flu will peak.

The estimate of child deaths may seem especially surprising, considering the CDC's conservative count of lab-confirmed pediatric deaths a week ago was 129.

"We don't think things have changed from last week to this week," Schuchat stressed, explaining the importance of looking beyond those lab counts. It's "a better estimate for the big picture of what's out there."

The question now is what effect those estimates will have on a public that largely views swine flu as not that big a threat.

The AP-GfK poll, conducted last weekend, found just 23 percent of responders - and 27 percent of parents - were very likely to keep seeking vaccine.

Stephanie Hannon of Douglas, Mass., decided to get a swine flu vaccine for just one of her three children, the one at extra risk because of asthma. She's concerned that the swine flu vaccine hasn't been studied long enough to justify for her less-at-risk youngsters.

"Only because of my other daughter's condition, I felt like I didn't have a choice," she said. "You never know if you make the right decision."

Swine flu targets young adults, too, yet just 16 percent of 18- to 29-year-olds were very likely to seek vaccine, down from 34 percent in September.

The AP-GfK Poll was conducted Nov. 5-9 by GfK Roper Public Affairs and Media. It involved landline and cell phone interviews with 1,006 adults nationwide and has a margin of sampling error of plus or minus 3.1 percentage points.

AP Polling Director Trevor Tompson contributed to this report.

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

Date: November 24, 2009

To: Licensing Committee

Subject: Impact on Patient Care Caused by Diverse Supply Issues Impacting the Availability of Medication to Hospitals

Several months ago Chad Signorelli, PharmD, Assistant Director of Pharmacy Services, Lompoc Valley Medical Services, contacted the board with concerns the abundance of medications that are unavailable due to various manufacturer supply issues. He initially hoped to discuss this during the board's subcommittee on drug distribution in hospitals, but was unable to attend these meetings.

Dr. Signorelli will provide a presentation to the committee at this meeting.

As examples of his concerns that impact hospital operations and harm patient care:

- Offer for a shortage product, vecuronium, at a 1000% markup (\$16 vs \$170)
- Bicillin L-A 141% price increase (Used for Syphilis)
- Albuterol Inhaler 273% price increase (Used for acute asthma attacks)
- Phenylephrine Inj 3915% price increase (Treatment of hypotension, vascular failure in shock)
- Cefoxitin 208% price increase (Used to prevent infection in Ob/Gyn surgeries)
- Albumin 1112% price increase (Used to maintain cardiac output in shock)

Dr. Signorelli continues:

- The American Society of Health System Pharmacists (ASHP) maintains a list of current shortages. The list includes over 35 items and is but a sampling of the medications that go periodically in and out of supply over the course of the year. Although this in and of itself is a problem that needs to be dealt with, what it creates is arguably even more of a detriment to at least the financial feasibility of facilities that are struggling to break even.

As any economist will tell you (in extensive graphical detail) when the supplies for these medications go down the price should naturally increase. Fortunately for most hospitals, contracts are in place to prevent this, but, unfortunately, as supply from our normal distribution chain reaches zero, the open market of alternate suppliers enters the picture. We are forced to acquire these hard to find, potentially life-saving medications, from distributors that do nothing but selectively stock-pile them. They will use any means necessary (means not available to the rest of us) to obtain this stock before or during the shortage.

- These middle distributors (somewhere between actual wholesalers and the end user) are somehow shifting product from the legitimate wholesaler to themselves and reducing the available contract priced supply for every hospital in the nation.
- During the flu vaccine shortage in 2004 lawsuits were brought by the Kansas and Florida attorneys general against Meds-Stat Pharmaceuticals for price gouging. Meds-Stat was offering to deliver vaccine at 10 times the normal cost (\$900 vs. \$85). The above case garnered national attention but this is the same type of problem we are still dealing with on multitudes of medications.
- These gray market suppliers continue to hound hospitals daily with their stock of short supply medications at greatly inflated prices. The only independent action I can take is to refuse to do business with them. I have instructed my purchaser to not engage in buying any medications from them but yet they continue to stay in business. And continue to stockpile medications that we are in desperate need of.
- I can only ask that this be reviewed and decided if the public health and safety is at risk because of these practices.



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

Date: November 25, 2009

To: Licensing Committee

Subject: Request to Modify Title 16 California Code of Regulations Section 1713(d) Regarding the Requirement that Automated Dispensing Machines Be Adjacent to the Secure Pharmacy Area

At this meeting, the committee will hear a request from Phil Burgess to amend board regulation section 1713(d)(6) regarding the placement of automated medication dispensing machines in pharmacies.

In 2005 and 2006, the board discussed and eventually promulgated a regulation to allow automated dispensing machines in pharmacies to dispense refill medications -- if requested by the patient and approved by the pharmacist. This was a use of emerging technology and several pharmacies had sought the board's authority to install such machines in their pharmacies to provide patients with afterhours access (as well as access during times when the pharmacy was open) to refills. Basically, a patient could pick up refill medication, if approved by the pharmacy, from a vending-like machine using a credit card for payment and not specifically deal with the pharmacy staff. The machine was to be located near -- specifically adjacent -- to the physical area of the pharmacy.

A number of conditions were built into the regulations to provide for assurance patients would not be required to use these machines for refills if they were not supportive. A copy of the final regulation is provided below.

This regulation was promulgated cautiously. Throughout 2006, the board modified and adopted the regulation now in effect as section 1713. In January 2007, the regulation actually took effect.

Here is the adopted regulation (section d) is highlighted:

1713. Receipt and Delivery of Prescriptions and Prescription Medications Must Be To or From Licensed Pharmacy

- (a) Except as otherwise provided in this Division, no licensee shall participate in any arrangement or agreement, whereby prescriptions, or prescription medications, may be left at, picked up from, accepted by, or delivered to any place not licensed as a retail pharmacy.
- (b) A licensee may pick up prescriptions at the office or home of the prescriber or pick up or deliver prescriptions or prescription medications at the office of or a residence designated by the patient or at

the hospital, institution, medical office or clinic at which the patient receives health care services. In addition, the Board may, in its sole discretion, waive application of subdivision (a) for good cause shown.

(c) A patient or the patient's agent may deposit a prescription in a secure container that is at the same address as the licensed pharmacy premises. The pharmacy shall be responsible for the security and confidentiality of the prescriptions deposited in the container.

(d) A pharmacy may use an automated delivery device to deliver previously dispensed prescription medications provided:

(1) Each patient using the device has chosen to use the device and signed a written consent form demonstrating his or her informed consent to do so.

(2) A pharmacist has determined that each patient using the device meets inclusion criteria for use of the device established by the pharmacy prior to delivery of prescription medication to that patient.

(3) The device has a means to identify each patient and only release that patient's prescription medications.

(4) The pharmacy does not use the device to deliver previously dispensed prescription medications to any patient if a pharmacist determines that such patient requires counseling as set forth in section 1707.2(a)(2).

(5) The pharmacy provides an immediate consultation with a pharmacist, either in-person or via telephone, upon the request of a patient.

(6) The device is located adjacent to the secure pharmacy area.

(7) The device is secure from access and removal by unauthorized individuals.

(8) The pharmacy is responsible for the prescription medications stored in the device.

(9) Any incident involving the device where a complaint, delivery error, or omission has occurred shall be reviewed as part of the pharmacy's quality assurance program mandated by Business and Professions Code section 4125.

(10) The pharmacy maintains written policies and procedures pertaining to the device as described in subdivision (e).

(e) Any pharmacy making use of an automated delivery device as permitted by subdivision (d) shall maintain, and on an annual basis review, written policies and procedures providing for:

(1) Maintaining the security of the automated delivery device and the dangerous drugs within the device.

(2) Determining and applying inclusion criteria regarding which medications are appropriate for placement in the device and for which patients, including when consultation is needed.

(3) Ensuring that patients are aware that consultation with a pharmacist is available for any prescription medication, including for those delivered via the automated delivery device.

(4) Describing the assignment of responsibilities to, and training of, pharmacy personnel regarding the maintenance and filing procedures for the automated delivery device.

(5) Orienting participating patients on use of the automated delivery device, notifying patients when expected prescription medications are not available in the device, and ensuring that patient use of the device does not interfere with delivery of prescription medications.

(6) Ensuring the delivery of medications to patients in the event the device is disabled or malfunctions.

(f) Written policies and procedures shall be maintained at least three years beyond the last use of an automated delivery device.

(g) For the purposes of this section only, "previously-dispensed prescription medications" are those prescription medications that do not trigger a non-discretionary duty to consult under section 1707.2(b)(1), because they have been previously dispensed to the patient by the pharmacy in the same dosage form, strength, and with the same written directions.

At this meeting, the committee will be asked to allow the automated dispensing machine to be moved to other areas inside a store, eliminating the requirement in (a)(6) that the device be adjacent to the pharmacy. To make this change would require a full rulemaking by the board.

In 2006 the board carefully crafted the placement of the machine to be very near the pharmacy for a number of reasons – for added security, so that the pharmacy could readily refill it, so that patient could be near the pharmacy, and to ensure it was not placed outside a store.

During the discussions to develop and promulgate the regulations, UCSD proposed initiating a consumer satisfaction survey of how patients felt about use of these machines. While the results of the study were not available in time for adopting the regulation (which took effect in January 2007), UCSD continued the study. The study was completed and in at the January 2008 Board Meeting, the board heard a presentation from researcher Jan Hirsch, PhD, on the satisfaction of patients who use the automated dispensing machines versus regular interaction with pharmacies.

Her paper follows this memorandum.



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Patient request for pharmacist counseling and satisfaction: Automated prescription delivery system versus regular pick-up counter

Jan D. Hirsch^{A1}, Austin Oen^{A2}, Suzie Robertson^{A3}, Nancy Nguyen^{A4}, Charles Daniels^{A5}

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^{A2} Sharp Memorial Hospital, San Diego, CA

^{A3} Clinical Specialist-Product Analyst, Cardinal Health, San Diego, CA

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^{A5} Medical Center, University of California, San Diego

Abstract:

Objectives: To assess the rate of patient-requested pharmacist counseling for refill prescriptions and satisfaction with pick-up process for patients using an automated prescription delivery system (APDS) versus those using a regular pick-up counter and to explore patient willingness to use an APDS as a tool for pharmacist monitoring of medication therapy outcomes.

Methods: In this uncontrolled, cross-sectional, survey study, we assessed use of APDS or the regular counter by 116 patients picking up refill prescriptions at two community pharmacies. The main outcome measures were number of patients requesting pharmacist counseling for refill prescriptions, patient satisfaction with pick-up process, and patient willingness to use an APDS to report medication therapy outcomes.

Results: None of the regular counter users and only two APDS users (3.7%) requested counseling for their refill prescription ($P = 0.126$). Almost all patients agreed that they were able to talk to a pharmacist about their prescription if they wanted to do so (95.1% regular counter and 92.3% APDS; $P = 0.268$). The majority (75%) of patients using APDS indicated that they would be willing to use the system to answer questions or perform simple tests to provide information that the pharmacist could use to improve medication effectiveness or reduce adverse effects.

Conclusion: Very few patients (ADPS or regular counter) asked to speak to a pharmacist about their refill medications, although it appeared that no perceived barriers to pharmacist access existed.

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Most APDS patients were willing to use this new technology to provide information about therapy outcomes to the pharmacist. Further exploration and testing of the APDS as a data collection tool to enhance pharmacist access to therapy outcomes is warranted.

Keywords:

Automation, patient satisfaction, technology, counseling (patient)

The references of this article are secured to subscribers.



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Patient request for pharmacist counseling and satisfaction: Automated prescription delivery system versus regular pick-up counter

Jan D. Hirsch, Austin Oen, Suzie Robertson, Nancy Nguyen, and Charles Daniels

Abstract

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Methods: In this uncontrolled, cross-sectional, survey study, we assessed use of APDS or the regular counter by 116 patients picking up refill prescriptions at two community pharmacies. The main outcome measures were number of patients requesting pharmacist counseling for refill prescriptions, patient satisfaction with pick-up process, and patient willingness to use an APDS to report medication therapy outcomes.

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Conclusion: Very few patients (ADPS or regular counter) asked to speak to a pharmacist about their refill medications, although it appeared that no perceived barriers to pharmacist access existed. Most APDS patients were willing to use this new technology to provide information about therapy outcomes to the pharmacist. Further exploration and testing of the APDS as a data collection tool to enhance pharmacist access to therapy outcomes is warranted.

Keywords: Automation, patient satisfaction, technology, counseling (patient).

J Am Pharm Assoc. 2009;49:73-77.
doi: 10.1331/JAPhA.2009.08037

An automated prescription delivery system (APDS) is a new technology, similar to an automated teller machine (ATM), that can be electronically integrated with a pharmacy's management system, allowing patients to use a password to pay for and pick up their refill prescriptions after the normal pharmacist dispensing and verification process has been completed.¹ The California Board of Pharmacy approved the use of APDS on January 26, 2007, but use on a case-by-case basis via a waiver system has been allowed since October 2004.² Key requirements were that APDS be used for previously dispensed prescriptions only, that the patient provide written consent expressing desire to use APDS, and that the APDS be located adjacent to the secure pharmacy area. In addition, the regulation specified that APDS should not be used if the pharmacist determines that a patient should be counseled on the dispensed medication and that the pharmacy must provide an immediate consultation with a pharmacist (in person or via telephone) if the patient so requests.

Traditionally, pharmacist contact has been facilitated through the prescription pick-up process when a clerk alerts

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Correspondence: Jan D. Hirsch, PhD, Skaggs School of Pharmacy and Pharmaceutical Sciences, University of California, San Diego, 9500 Gilman Dr., Mail Code 0714, La Jolla, CA 92093-0714. Fax: 858-822-6857. E-mail: janhirsch@ucsd.edu

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RESEARCH NOTES

the pharmacist of the need to counsel during the transaction (mandated by law only for new prescriptions in California). Obtaining refill prescriptions at an APDS "kiosk" separate from the regular counter removes patients from this process. At the advent of mail service pharmacy in the late 1980s, similar concerns were raised about changes in direct pharmacist and patient interaction. However, many of these initial concerns have been addressed by mail, fax, or phone service consultations and provision of written patient information.³

Implementing APDS technology has potential benefits and risks. Potential benefits for the patient are convenience, less waiting, and ability to pick up refill prescriptions after regular pharmacy hours. Possible benefits to the pharmacy include enhanced patient flow, less congestion, more pharmacist time for patients at the regular pick-up counter, and possibly reduced clerk labor needs. Possible risks of an APDS include lack of patient-pharmacist contact and, thus, less opportunity for pharmacist consultations and appropriate medication management interventions.⁴ Opponents of APDS have also argued that the system may not be secure or accurate.¹

Because the potential benefits of APDS technology are enticing, widespread adoption of this technology could be rapid and affect pharmacy practice considerably. Evaluating the effect of using APDS on patient-pharmacist interactions is warranted at this early stage of APDS evolution.

Objectives

We sought to assess the rate of patient-requested pharmacist counseling for patients using APDS versus those using a regular pick-up counter to obtain refill prescriptions, to assess the satisfaction of patients using APDS versus those using a regular pick-up counter to obtain refill prescriptions, and to explore patient willingness to use APDS in the future as a tool for pharmacist monitoring of medication therapy outcomes.

Methods

This study was conducted at two community pharmacies, which were under the same corporate ownership, in northern San Diego, CA. These pharmacies were the first in California to use APDS technology. The APDS (ScriptCenter—Asteres; Figure 1) had been in use for at least 12 months at each location prior to the study. The pharmacies were 15 miles apart within an upper-middle-class, primarily English-speaking area. Pharmacy operating characteristics were fairly similar at each site (Table 1). Using APDS did not change the manner in which the refill prescription was ordered by the patient or filled by the pharmacist. The only difference in the process was that completed prescriptions were placed inside the APDS instead of being placed in the traditional holding area for pick-up at the counter. A description of the technical and security features of the APDS used in this study can be found at www.asteres.com. Inclusion criteria were that the patient was receiving a refill prescription either at the regular counter or APDS, was able to read and understand written information, and was 18 years of age or older. Patients picking up their prescription at the APDS had already decided to do so before participating in this study

Table 1. Descriptive characteristics of pharmacy sites and survey respondents by site^a

Characteristic	Site 1	Site 2	P
Operating hours per week			
Pharmacy	82	82	
APDS	119	168	
Average no. prescriptions per day	250	232	
Average refill (%)	60	60	
n	39	77	0.021
No. regular counter (%)	15 (38.5)	47 (61.0)	
No. APDS (%)	24 (61.5)	30 (39.0)	
Gender, no. (%)			0.712
Men	14 (36.0)	25 (32.5)	
Women	25 (64.0)	52 (67.5)	
Age, no. (%) ^b			0.004
18–40 years	8 (22.2)	37 (48.1)	
41–64 years	20 (55.6)	36 (46.8)	
≥65 years	8 (22.2)	4 (5.2)	
Person picking up prescription, no. (%)			0.165
Patient	30 (76.9)	67 (87.0)	
Other for patient	9 (23.1)	10 (13.0)	

Abbreviation used: APDS, automated prescription delivery system.

^aPatients with complete data collected during study time periods.

^bMissing three patients for site 1.



Figure 1. The ScriptCenter, an automated prescription delivery system

Table 2. Characteristics respondents: regular counter versus APDS users (sites combined)

	Regular counter	APDS	<i>P</i>
	No. (%)	No. (%)	
<i>n</i>	62	54	
Gender ^a			0.786
Men	20 (32.8)	19 (35.2)	
Women	41 (67.2)	35 (64.8)	
Age ^b			0.186
18–40 years	20 (32.8)	25 (48.1)	
41–64 years	35 (57.4)	21 (40.4)	
≥65 years	6 (9.8)	6 (11.5)	
Person picking up prescription			0.053
Patient	48 (77.4)	49 (90.7)	
Other for patient	14 (22.6)	5 (9.3)	

Abbreviation used: APDS, automated prescription delivery system.

^aMissing for one regular counter patient.

^bMissing for two APDS and 1 regular counter patient.

and had been trained and received their username via regular pharmacy operations.

This study was approved by the University of California, San Diego, Human Research Protection Program. Data were collected during a 1-week period (February 5–10, 2007), Monday through Friday, 3:00 pm to 7:00 pm, and Saturday, 11:00 am to 2:00 pm. These times were chosen based on historical data indicating that they were the busiest days and times of the week. A student pharmacist, trained in the study data collection requirements, was stationed in the pharmacy area during these times to answer questions. The student was instructed not to reveal the specific objectives or comparative nature of the study. Data collection forms were completed for each patient picking up a refill prescription from the regular counter or APDS during the study period (Appendix 1 in the electronic version of this article, available online at www.japha.org). Questions regarding whether the patient or someone else picked up the prescription, if they requested to speak to a pharmacist, and, if so, the category of information needed (medication, payment related, or other) were self-reported by patients using the APDS and observed and recorded by the pharmacy clerk or attending student pharmacist for patients using the regular counter. All other questions were self-reported. Three questions assessed patient satisfaction with wait time, convenience of the pick-up process, and access to a pharmacist. A 5-point Likert-type scale (strongly agree to strongly disagree), was used to quantify responses as described previously.^{5,6} An additional question for APDS users assessed patient willingness to use the system in the future to answer questions or perform simple tests to provide information that the pharmacist could use to improve medication effectiveness or reduce adverse effects. Patients responded on a 5-point Likert-type scale ranging from very willing to strongly unwilling.

Statistical analyses were performed using SPSS version 15.0 (SPSS, Chicago). Descriptive statistics were calculated for each study variable. Frequency distributions were used to

Table 3. Counseling request and satisfaction: regular counter versus APDS users

	Regular counter	APDS	<i>P</i>
	No. (%)	No. (%)	
Asked to speak to a pharmacist?			0.126
Yes	0 (0.0)	2 (3.7)	
No	62 (100.0)	52 (96.3)	
Was able to talk to pharmacist if wanted ^a			0.268
Strongly agree	31 (50.8)	22 (42.3)	
Agree	27 (44.3)	26 (50.0)	
Not sure	1 (1.6)	2 (3.8)	
Disagree	0 (0.0)	2 (3.8)	
Strongly disagree	2 (3.3)	0 (0.0)	
Waited a long time to pick up prescription ^b			0.188
Strongly agree	1 (1.6)	2 (3.7)	
Agree	5 (8.2)	1 (1.9)	
Not sure	3 (4.9)	0 (0.0)	
Disagree	21 (34.4)	17 (31.5)	
Strongly disagree	31 (50.8)	34 (63.0)	
Overall process to pick up prescription was convenient ^b			0.583
Strongly agree	31 (50.8)	29 (53.7)	
Agree	22 (36.1)	22 (40.7)	
Not sure	2 (3.3)	0 (0.0)	
Disagree	3 (4.9)	2 (3.7)	
Strongly disagree	3 (4.9)	1 (1.9)	
Willing to use APDS to provide information to improve medication management ^c			NA
Very willing	NA	16 (30.8)	
Somewhat willing	NA	23 (44.2)	
Not sure	NA	8 (15.4)	
Unwilling	NA	5 (9.6)	
Strongly unwilling	NA	0 (0.0)	

Abbreviation used: APDS, automated prescription delivery system; NA, not applicable.

^aMissing for two APDS and one regular counter patient.

^bMissing for one regular counter patient.

^cMissing for two APDS patients.

examine patient demographics, to examine counseling rates, and to describe the responses to satisfaction questions. Comparisons among groups were conducted using chi-square analyses. Statistical significance was based on an alpha of 0.05.

Results

A total of 116 respondents returned completed surveys; 39 from site 1 and 77 from site 2 (Table 1). The majority of survey respondents were women and were picking up a prescription for themselves at each site. A larger percentage of respondents at site 1 were 65 years of age or older ($P = 0.004$) and used the APDS as opposed to the regular counter ($P = 0.021$) to pick up their refill prescriptions. Based on historical data for the average number of refill prescriptions dispensed per day at each site and an estimate of 1.5 prescriptions per patient, the 39 respondents at site 1 and 77 respondents at site 2 represented approximately 20% and 39% of the daily number of patients

RESEARCH NOTES

picking up refill prescriptions during the study data collection time brackets, respectively.

When data from the two sites were combined for subsequent analyses due to small sample sizes at each site, the response rate was approximately 29%.

APDS versus regular counter users

No difference was observed in the gender or age distribution of respondents picking up their prescription at an APDS versus regular counter ($P = 0.786$ and $P = 0.186$, respectively) (Table 2). The patient was almost always the person picking up their refill prescription at the APDS (90.7%) compared with the regular counter, where 22.6% of prescriptions were picked up by someone other than the patient ($P = 0.053$).

Counseling requests and satisfaction

Very few patients asked to speak to a pharmacist when receiving their refill prescription (no regular counter users and only two [3.7%] APDS users; $P = 0.126$) (Table 3). One APDS patient had a question about payment and the other had a nonmedication question. Almost all patients agreed that they were able to talk to a pharmacist about their prescription if they wanted to do so (95.1% regular counter and 92.3% APDS; $P = 0.268$). The majority of regular counter and APDS users disagreed that they had waited a long time to pick up their prescription (85.2% regular counter and 94.5% APDS; $P = 0.188$) and agreed that the pick-up process was convenient (86.9% regular counter and 94.4% APDS; $P = 0.583$). The majority (75%) of patients using APDS also indicated that they would be willing to use the system to answer questions or perform simple tests to provide information that the pharmacist could use to improve medication effectiveness or reduce adverse effects.

Discussion

This is the first study, to our knowledge, that has systematically assessed the rate of patient request for pharmacist counseling for patients receiving their refill prescriptions at an APDS versus regular pharmacy counter. No significant difference was observed in the age or gender of patients using APDS or regular counter to pick up refill prescriptions. However, APDS users were more likely to be the patient picking up their own prescription compared with regular counter users. This was not unexpected because APDS requires a personal username and password for use.

Although pharmacist counseling for prescriptions has been generally accepted as an important part of the medication dispensing process and is required by law for new prescriptions in California, the results of this study suggest that counseling is rarely requested by patients for their refill prescriptions. Although only two patients asked to speak to a pharmacist about their refill medication, almost all patients (APDS and regular counter) felt that they were able to speak to a pharmacist if they had wanted to do so. The majority of patients also agreed that their wait time was not long and that the overall prescription pick-up process was convenient at both APDS and the regular counter. This implies that no perceived barriers to pharmacist

access for patients at the regular counter or APDS existed, but instead that patients simply did not feel the need to ask the pharmacist questions about their refill medication. Potential reasons for patients not asking questions about their refill medication include a lower need for information for a continuing medication compared with a new medication, availability of information via other sources (e.g., printed information with prescriptions or via Internet sources), or lack of patient time. A similar study of an ambulatory clinic-based community pharmacy in San Diego found a similar low rate (3%) of counseling for refill prescriptions despite the fact that patients receiving any prescription medications (refill or new) in this pharmacy were routinely asked if they would like to speak to a pharmacist.⁷

Any new prescription delivery technology will elicit controversy, but the possible future benefits should also be considered. It was encouraging that the majority of APDS users indicated that they were willing to use the system to answer questions or perform simple tests to provide information that the pharmacist could use to improve medication effectiveness or reduce adverse effects. Using APDS to collect patient-reported outcomes could fill an information void for the pharmacist. Most community pharmacists today do not have the same degree of access to documented clinical outcomes for patients as a physician or nurse would have in a clinic setting. Expanding the APDS scope to allow patients to answer simple questions about their symptom response or possible adverse effect occurrence or to electronically download laboratory values (e.g., blood glucose history since last visit) could provide pharmacists with outcomes data on an ongoing basis. Future research should investigate opportunities to optimize the use of APDS technology to expand the effectiveness of the pharmacist's role in medication therapy management.

Limitations

The major limitations of this study are that it was conducted on a small convenience sample of patients in only two pharmacies that were among the first to use APDS technology. Patients self-selected to use APDS or the regular counter for their refill pick up; however, this trend would occur in actual practice. Randomization, therefore, would have strengthened the study design but would not have been practical. Our observation period was limited to busy time periods in a single week, and our questionnaire had a very limited number of questions to minimize survey completion time; thus, the scope of our study is limited. Notably, the focus of our study was refill prescriptions because these were the only type of prescriptions delivered via APDS. Therefore, we only measured pharmacist counseling related to refill prescriptions. We did not examine any other patient-pharmacist interactions that occur throughout the course of pharmacy practice (e.g., new prescriptions, over-the-counter medication, disease questions, testing). Our results from two pharmacies cannot be considered representative of the APDS experience in community pharmacies overall but can be used to inform future studies.

Future studies need to include a larger number and wider

variety of pharmacies using APDS technology as its usage expands. Replicating this study at other pharmacy practice sites would provide, at a minimum, a benchmark for interpreting refill consultation rates—at APDS and the regular counter—that does not exist currently. In addition, although counseling for new prescriptions may be a legal requirement, measuring the rate of actual patient acceptance, and thus occurrence, of pharmacist counseling for new prescriptions is also warranted to provide a comparative value for refill counseling rates (APDS or regular counter). Further exploration and testing of APDS as a data collection tool that would give the pharmacist access to therapy outcomes is perhaps the most important next step. APDS technology has the potential to be more than a one-sided delivery mechanism; instead, it could be a new two-way communication system between the patient and the pharmacist for information that was not able to be systematically exchanged in the past. APDS could be used to facilitate the patient-pharmacist interaction to enhance the pharmacist's ability to identify and resolve drug therapy problems and the patient's knowledge of when to speak to a pharmacist (e.g., any new adverse effects).

Conclusion

Very few patients using APDS or the regular counter asked to speak to a pharmacist about their refill medications, although almost all patients believed that they could speak to a pharmacist if they had wanted to do so. Because the majority of patients agreed that their wait time was not long and that the overall prescription pick-up process was convenient, no perceived barriers to pharmacist access appear to exist; patients simply did not perceive the need to ask the pharmacist questions about their refill. Further exploration and testing of APDS as a data collection tool to enhance pharmacist access to ther-

apeutic outcomes is warranted. The effect of APDS technology on pharmacist-patient interactions and data collection in the context of prescription-specific counseling versus the broader, more multifaceted, role of pharmacists providing medication therapy management services would also be useful to explore.

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Appendix 1. Data collection form (APDS version)

1. Your Age: 18-40 41-64 65 and older

2. Your Gender: Male Female

3. Did you pick up your own prescriptions? Yes No

4. Did you request to speak to a Pharmacist? Yes No

5. If requested, why did you request to speak to pharmacist?

- Medication related questions
 Payment or insurance questions
 Other

6. I waited a long time to pick up prescription(s) from the ScriptCenter.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="checkbox"/>				

7. Overall the process to pick up prescription(s) was convenient

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="checkbox"/>				

8. I feel I was able to talk with a pharmacist if I wanted to do so.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="checkbox"/>				

9. In the future, the ScriptCenter may collect information the pharmacist can use to help improve your medication's effectiveness or reduce any side effects you may experience.

Please indicate your willingness to answer questions or perform a simple test to gather this information.

Very Willing	Somewhat Willing	Not Sure	Unwilling	Strongly Unwilling
<input type="checkbox"/>				



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

Date: November 25, 2009

To: Licensing Committee

Subject: Final Comments Sought for Best Practices for Recalls in Hospitals

During the spring of 2008, the board identified 94 hospital pharmacies with recalled heparin still within the facilities, two to three months following the last recall. The board cited and fined the hospital pharmacies and pharmacists-in-charge of these pharmacies. However, because many of these hospitals and PICs have appealed the citations and fines, board members cannot discuss the specific parameters of any of these cases without recusing themselves from voting on the specific case in the future should they be appealed to the Office of Administrative Hearings.

The recall system is not working. Over the last year, the board convened a two-board member task force to work with relevant associations, regulators, hospitals, wholesalers and patient advocates on ways to improve recalls, and other changes needed to provide for improved drug distribution and control within a hospital. Three meetings were held, and at the last meeting in September, a draft Best Practices document was refined. The Best Practices for Hospital Recalls document is one major outcome of these meetings.

At this December Meeting, the Licensing Committee will spend a few minutes while Executive Officer Herold walks the committee through a newly edited version of the Best Practices for Hospital Documents. The revised document is not yet ready to be released in advance of the meeting. A copy of the prior version is available on the board's Web site:
http://www.pharmacy.ca.gov/meetings/agendas/09_sep_hosp_mat.pdf

The last step will be presentation to the board at the January 2010 Board Meeting for adoption and future publication in the board's newsletter.



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

Date: November 25, 2009

To: Licensing Committee

Subject: Proposed Drug Distribution Model

At this meeting a presentation had been planned that needed to be cancelled after the agenda was released. The presentation will be rescheduled to a future Licensing Committee Meeting.



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

Date: November 25, 2009

To: Licensing Committee

Subject: State of California's Right Care Initiative

FOR INFORMATION:

During the late summer the Department of Managed Health Care convened a meeting to describe its development of a Right Care Initiative (RCI), which seeks to improve patient care related to blood pressure, diabetes, and lipid control. Basic information about this project is provided on the attached pages.

In this regard, the Pharmacy Foundation of California led the California Pharmacy Council in providing comments in support of a pharmacist's role in medication therapy management. The board is a member of the California Pharmacy Council.

Also attached is a copy of the California's Pharmacy Council's letter to the Department of Managed Health Care, signed by all members of the council.

Sponsor

California Department of Managed Health Care Director's Office

Contact: Hattie Rees Hanley, MPP, *Health Policy Advisor, Office of the Director, (916) 323-2704*

Warren Barnes, JD, *Counsel to Right Care Initiative*

Technical Expert Group Chair

Stephen Shortell, PhD, MPH, *Professor and Dean, University of California, Berkeley, School of Public Health*

Principal Investigator

Robert Kaplan, PhD, *Professor and Chair, University of California, Los Angeles, Health Services Research*

Diabetes & Heart Disease Work Group Chair

Joseph Scherger, MD, *Medical Director, Quality Improvement and Informatics, Lumetra*

Hospital Acquired Infections Work Group Co-Chairs

Helen Halpin, PhD, *Professor and Director, Center for Health and Public Policy Studies, UC Berkeley School of Public Health*

Arnold Milstein, MD, *Medical Director, Pacific Business Group on Health and National Thought Leader, Mercer*

Funders

Johnson & Johnson, Blue Shield of California Foundation, Novartis, and California Health Care Foundation ("hot spot" identification)

Objective

To measurably improve clinical outcomes through enhancing the practice of evidence-based medicine in a collaborative, expert-based, public-private, multi-year effort, working with the leadership of California health plans and medical groups, National Committee for Quality Assurance, Pacific Business Group on Health, California Quality Collaborative, California Medical Association Foundation, University of California, RAND, University of Southern California, additional clinical quality experts, associated businesses, and the California Department of Managed Health Care.

Focusing on three specific areas where California's clinical quality can clearly be improved, the Right Care Initiative's goal is to reduce morbidity and mortality among the 15 million commercial managed health plan enrollees through the application of scientific evidence and continuous quality improvement engineering methodology. Three trouble spots in need of particular attention, where focus may be directed for significant impact in lives saved and improved, are evident in data from NCQA, the Agency for Health Care Quality and Research, the Commonwealth Foundation, and the Centers for Disease Control:

1. **Cardiovascular disease, with particular emphasis on hypertension.**
2. **Diabetes.**
3. **Hospital acquired infections.**

NCQA estimates that improvement of California's cardiovascular disease and diabetes measures to the national HEDIS 90th percentile could result in 1694 to 2818 lives saved and a \$118 million reduction in avoidable hospital costs yearly. Other results include a reduction of 766,401 avoidable sick days and \$125.56 million in avoidable lost productivity.

2011 GOALS FOR REDUCING THE RAVAGES OF CARDIOVASCULAR DISEASE AND DIABETES:

PERFORM AT THE NATIONAL 90TH PERCENTILE (2009 TARGETS)

- 70% OF HYPERTENSIVE PATIENTS WITH BLOOD PRESSURE CONTROLLED < 140/90 MMHG
- 70% OF PATIENTS WITH CARDIOVASCULAR CONDITIONS WITH LDL-C CONTROLLED < 100 MG/DL
- 52% OF DIABETICS WITH LDL-C CONTROLLED < 100 MG/DL
- 81% OF DIABETICS WITH BLOOD SUGAR HBA1C CONTROLLED < 9

2011 GOALS FOR REDUCING HOSPITAL ACQUIRED INFECTIONS: GETTING TO ZERO

**MEDIAN OF ZERO CENTRAL LINE INFECTIONS AND
SIGNIFICANT REDUCTION OF INFECTIONS DESIGNATED BY THE RIGHT CARE INITIATIVE WORK GROUP**

Heart disease, diabetes, and prevention of hospital acquired infections are increasingly well understood scientifically. They are ripe for collaborative attention to ensure that California patients benefit from evolving best practices. Like the "100,000 Lives" national campaign for reducing medical errors, this project will catalyze the work of experts to facilitate improved outcomes through the application of evidence based medicine in the coordinated, managed care model, thus improving the lives of tens of thousands of California enrollees. Diabetes, hospital acquired infections, and reduction of medical errors were specifically named as priorities in Governor Schwarzenegger's 2007 reform proposal, providing initial inspiration for this continuous quality improvement project.

Initial Implementation Action and Specific Goals

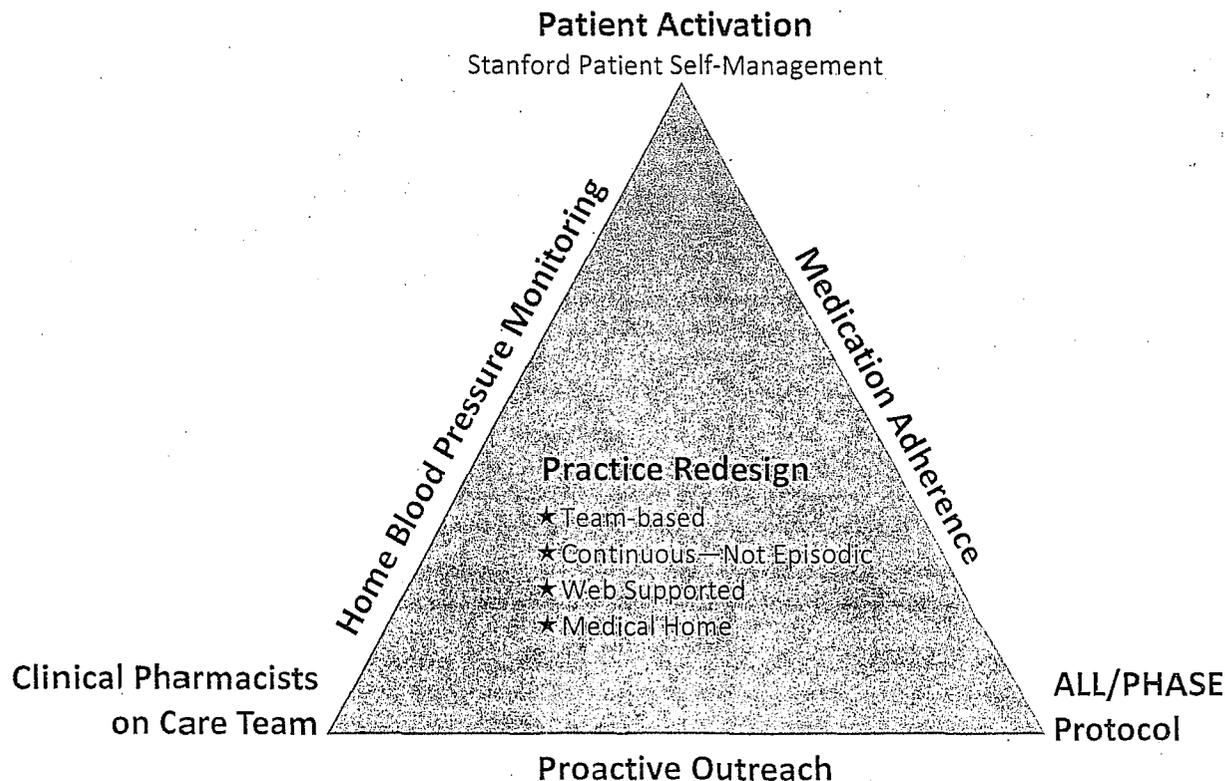
The DMHC launched the Right Care Initiative jointly with NCQA at the first annual clinical quality improvement Leadership Summit in March 2008, which was held on the UCLA campus and sponsored by the Deans of UCLA and UC Berkeley Schools of Public Health. The Summit was geared to obtain participation from the state's leading health plans and medical group medical directors, as well as thought leaders in evidence-based medicine.

Through periodic meetings, research, and collaborative action, the goal of the Right Care Initiative is to reach the 90th percentile in heart and diabetes HEDIS control measures of blood pressure, lipids, and glucose, and to cut the rate of death from hospital acquired infections, by 2011.

Research Questions

- What barriers are preventing improvement, and what are the best strategies for overcoming them?
- What are the best strategies for California to expedite a focused re-engineering effort to refine the implementation of evidence-based medicine to quickly meet these goals that are estimated to save approximately 7000 lives annually?

PROMISING INTERVENTIONS FOR REACHING SAFE CONTROL TARGETS



Right Care Initiative

http://www.hmohelp.ca.gov/healthplans/gen/gen_rci.aspx

California Office of the Patient Advocate, Medical Group Ratings by County and Meeting National Standards of Care

http://opa.ca.gov/report_card/medicalgroupcounty.aspx



CALIFORNIA PHARMACY COUNCIL



August 12, 2009

Lucinda (Cindy) Ehnes
Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Dear Ms. Ehnes,

The California Pharmacy Council consists of the top leadership from California's pharmacy-related academic, professional, regulatory, and advocacy organizations. The Council's membership is listed below, and we collectively applaud your Department for its Right Care Initiative which seeks to "measurably improve clinical outcomes through enhancing the practice of evidence-based medicine in a collaborative, expert-based, public-private, multi-year effort."

As you pursue this effort, we want to make sure you are aware of our support in the event you need assistance leveraging the resources of our state's pharmacists who stand ready to help as medication experts and one of the most accessible members of a patient's health care team.

Given your initiative's focus on diabetes and heart disease, we would also like to make sure you are aware of the pharmacist's ability to play a critical role helping coordinate the care of patients with chronic conditions. Patient access to pharmacist-provided patient care services, such as medication therapy management (MTM), can make a significant difference in health outcomes and a patient's ability to self-manage conditions like diabetes and heart disease.

Across California, pharmacists are already working to reform the system and improve the quality of care and the delivery of services by offering MTM. In Los Angeles, one such MTM program is part of the Diabetes Ten City Challenge (DTCC), a program in the private sector being piloted by the American Pharmacists Association (APhA) Foundation. Thus far, the APhA Foundation's MTM programs have been able to repeatedly reduce health care spending for both the employer and employee in many different practice settings while improving the quality of life for the patient. A similar program is also being conducted in northern California which should soon include participation from CalPERS.

The DTCC is a community-based MTM program that helps patients manage their diabetes by supporting preventive care services from their pharmacists and physicians, who work together with the patient to optimize therapeutic outcomes. The DTCC was modeled after two other highly successful MTM programs, the Asheville Project (established in 1997) and HealthMapsRX (established in 2002 as the Patient-Self Management Program), which focus on patient education by coaching patients on setting goals, using medication properly, and tracking their condition. Data from these programs have shown:

* <http://www.healthmaprx.com/research>

- A \$918 cost savings per employee in total health care costs during the initial year;
- An initial return on investment (ROI) at the beginning of the second year which exceeds a 4:1 ratio;
- A decrease in overall medical costs per patient between \$1,600 to \$3,200 per person per year compared to the baseline for each of the first five years; and
- An average employee approval rating above 95%

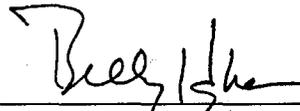
It is because of figures like these that the California Pharmacy Council strongly encourages the inclusion of pharmacist services within the group of interventions that will be promoted to achieve the goals of your Right Care Initiative.

If you would like any additional information about these services, or are in need of assistance designing, implementing, or evaluating MTM programs throughout the state, please do not hesitate to use us as a resource.

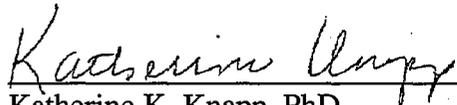
Sincerely,



David Hawkins, PharmD
Dean, CA NorthState College of Pharmacy



W. William Hughes, PhD
Dean, Loma Linda University School of Pharmacy



Katherine K. Knapp, PhD
Dean, Touro University College of Pharmacy



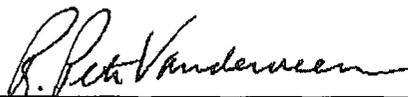
Palmer Taylor, PhD
Dean, UCSD Skaggs School of Pharmacy and
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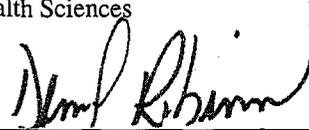
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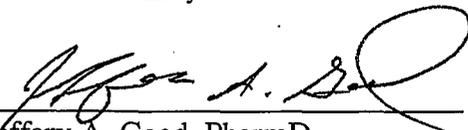
Phillip R. Oppenheimer, PharmD
Dean, Thomas J. Long School of Pharmacy and
Health Sciences



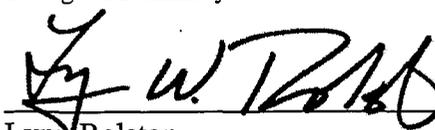
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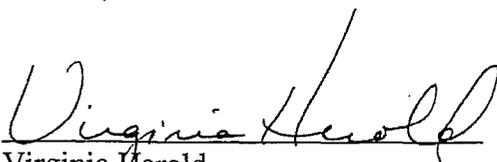
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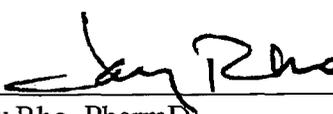
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STATE AND CONSUMERS SERVICES AFFAIRS AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

Date: November 23, 2009

To: Licensing Committee

Subject: Psychometric Assessment of the PTCB and ExCPT Pharmacy Technician Exams.

Background

During the April 2009 Board Meeting, the board voted to direct staff to take the necessary steps to secure a vendor to complete the necessary psychometric assessments of the Pharmacy Technician Certification Board (PTCB) and Exam for the Certification of Pharmacy Technicians (ExCPT). The psychometric assessment of the examination is needed to ensure for compliance with Section 139 of the Business and Professions Code.

The results of the review would ensure that these applicants who qualify for licensure as a pharmacy technician have passed a validated exam.

Board staff has discussed contracting options with the department to determine possible avenues to facilitate this review. We are hopeful that the Office of Professional Examination Services will have staff available to perform these services for the board.



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Date: November 23, 2009

To: Licensing Committee

Subject: Reporting and Accounting of Intern Hours

Under current law, an intern must possess 1,500 hours of intern experience under the supervision of a pharmacist before he or she can be made eligible to take the pharmacist licensure examinations in California.

Additionally, board regulations specify that a minimum of 900 hours of pharmacy experience must be earned under the supervision of a pharmacist in a pharmacy. The remaining 600 hours can be granted for experience under the supervision of a pharmacist substantially related to the practice of pharmacy, but not specifically earned within a pharmacy. California pharmacy students typically earn the 600 "discretionary" hours for school-related experiential training (clinical clerkship).

During the October 2009 Board Meeting, the board discussed the reporting and accounting of intern hours. At that time, staff advised the board of some problems encountered by students and board staff. For students who earn their experience in other states, it is virtually impossible to determine where an intern has gained experience as the board accepts intern hours verified by the state board in the state where the hours were earned. Additionally, the distinction upon whether these hours have been earned in a pharmacy under the supervision of a pharmacist cannot be discerned. Some states have specific requirements for their respective jurisdictions that are not consistent with our requirements. For example, board staff was recently advised that New York will no longer verify intern hours.

Over the last few years, the Licensing Committee has considered proposals to amend the intern hour requirements. The committee has also discussed major changes to intern experience requirements established by the Accreditation Council for Pharmacy Education (ACPE) in the last few years. These new requirements added hours to the educational requirements students need as part of their intern training and are required as a condition for a school to maintain its accreditation status with the ACPE.

Given the changes surrounding the intern hours requirements as well as the disparity in how the board accepts hours from various jurisdictions, staff recommended during the October Board Meeting that the intern hours requirements remain unchanged, but that the method by which staff confirm this information be contingent upon one of the following:

- a candidates PharmD graduation from an ACPE accredited school of pharmacy OR
- licensure status in another state for one year OR
- 1500 hours of experience for foreign educated pharmacist that satisfies all other requirements for licensure.

Based on further review of the statutory requirements detailed in pharmacy law, such a change would require statutory amendment. As such, this change is not possible at this time. The following statement will be placed on the board's web site to respond to questions from students and schools of pharmacy regarding the change.

Recently the Board of Pharmacy considered changes to the application process for pharmacist licensure. This change was in response to the fact that some states no longer verify intern hours to other states.

Please note that the intern hours requirements in California remain unchanged. All applicants for the pharmacist licensure examination must earn 1,500 hours of internship (or have been licensed as a pharmacist in another state for one year.) For states that do not validate or transfer intern hours, applicants must submit proof of their intern experience on board affidavits (form 17A-29) as part of their exam application.

Likewise, the board will continue to require submission of intern hours on board affidavits (form 17A-29) as part of the application process for the exam.

Executive Officer Herold has contacted the deans of each of the California Schools of Pharmacy to notify them of the change.



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Date: November 23, 2009

To: Licensing Committee

Subject: Impact of State Furloughs on Processing Timelines and Work Flow of the Board.

In late June, the Governor issued an Executive Order imposing a third furlough day on each month on most state employees. This order also closes state offices three Fridays each month through June 2010.

The current processing times for pharmacy technician applications is about 90 days and is about 60 – 75 days for all other application types. To allow staff to focus on the most important functions of their jobs, processing applications and issuing licenses, executive staff twice previously authorized a temporary stop in responding to applicants calling on the status of a pending application. This temporary stop allows staff to focus on reducing the backlog of new applications as well as complete a pending file review. A similar stop will begin again in mid December and will last approximately 30 days. (Workload studies show that on average, most board staff spends about 1.5 days each week out of a four-day workweek responding to status inquiries.)

Executive management recently advised staff that pharmacy technician applicants may only submit a status request via e-mail. This method of request allows the board to research and respond to such inquiries more a more efficient manner. (The board receives over 600 telephone status inquiries from pharmacy technician applicants on a monthly basis.)

In an effort to provide applicants with general information, all licensing staff update their voice-mail message to include the date range of applications currently being processed the boards' receptionists are advising callers as well. Executive staff and managers continue to be available to address immediate or urgent applicant concerns from callers.

Following this memo are two charts detailing the number of applications received and licenses issued.

Applications Received	FY 07/08	FY 08/09	*FY 09/10
Pharmacist (exam applications)	2037	2276	738
Pharmacist (initial licensing applications)	1417	1391	730
Intern pharmacist	1818	1983	1198
Pharmacy technician	7609	8978	3906
Pharmacy	428	873	107
Sterile Compounding	74	58	14
Clinics	99	89	30
Hospitals	21	12	0
Nonresident Pharmacy	75	85	17
Licensed Correctional Facility	4	1	0
Hypodermic Needle and Syringes	13	29	6
Nonresident Wholesalers	103	106	36
Wholesalers	51	69	32
Veterinary Food-Animal Drug Retailer	2	3	0
Designated Representatives	464	457	201
Total	14,215	16,410	6876

Licenses Issued	FY 07/08	FY 08/09	*FY 09/10
Pharmacist	1386	1409	879
Intern pharmacist	1654	1820	1115
Pharmacy technician	7118	7096	3025
Pharmacy	427	796	119
Sterile Compounding	76	64	19
Clinics	106	67	21
Hospitals	31	29	14
Nonresident Pharmacy	59	80	15
Licensed Correctional Facility	3	2	1
Hypodermic Needle and Syringes	8	14	10
Nonresident Wholesalers	97	84	43
Wholesalers	59	41	34
Veterinary Food-Animal Drug Retailer	1	4	0
Designated Representatives	417	442	155
Total	11,442	11,948	5450

*Includes data through October 2009.



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Date: November 23, 2009

To: Licensing Committee

Subject: Competency Committee Report and Job Analysis Update

Each Competency Committee workgroup met this fall and focused on examination development and item writing. Additional workgroup meetings are scheduled throughout 2010.

The committee also developed a job survey to be used to complete an occupational analysis with the board's contracted psychometric firm. Pursuant to Business and Professions Code section 139, the board is required to complete an occupational analysis periodically (typically every five years) which serves as the framework for the examination. The information learned from this survey will determine if changes are necessary to the content outline of the CPJE.

We anticipate releasing this survey to a random sample of pharmacists in December 2009. Pharmacists that complete the survey will be awarded 3 hours of continuing education credit.

Following is a copy of the postcard that will be sent to pharmacists requesting their participation.



CALIFORNIA STATE
BOARD OF PHARMACY

We need
your help

**PHARMACISTS
WANTED**

On behalf of the California State Board of Pharmacy, I am requesting your assistance with completing a job analysis survey concerning the duties you perform as a pharmacist. The board's examination committee will develop examination items based on the information collected from the survey responses. Such surveys enable examination items to reflect current technologies, methods, and practices performed, and are required by California law.

You may access the survey at <http://www.goamp.com/CABOPsurvey>. Please submit your responses by **January 3, 2010**. If you have trouble with the survey, contact Jennifer Benavente at Applied Measurement Professionals, Inc. at CABOP@goAMP.com. All information obtained, including your survey responses, will remain confidential. We only use this information for purposes of the study.

You will be credited for 3-hours of continuing education via completion of the final page of the survey. If you have any questions about this survey, please contact Debbie Anderson at (916) 574-7935. Thank you for your cooperation and assistance in this process.

Truly,

Virginia Herold, Executive Officer



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