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

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

NOTICE OF MEETING and AGENDA
Communication and Public Education Committee

Contact Person: Virginia Herold
(916) 574-7911

Time: 10 a.m. – 12 noon
Date: January 17, 2006
Place: Holiday Inn Capitol Plaza
300 J Street, Sacramento, CA 95814

This committee meeting is open to the public and is held in a barrier-free facility in accordance with the Americans with Disabilities Act. Any person with a disability who requires a disability-related modification or accommodation in order to participate in the public meeting may make a request for such modification or accommodation by contacting Candy Place at (916) 574-7912, at least five working days before the meeting. Candy Place can also provide further information prior to the meeting and can be contacted at the telephone number and address set forth above. This notice is posted at *www.pharmacy.ca.gov*.

Opportunities are provided for public comment on each agenda item.

MEETING AGENDA

A. Call to Order — 10 a.m.

B. Consumer Fact Sheet Series with UCSF's Center for Consumer Self Care

C. Update on the Activities of the California Health Communication Partnerships

D. Joint Public Outreach with the Department of Health Services Office of AIDS to Increase Awareness of Access to Syringes in Pharmacies without a Prescription

E. Update Report of *The Script*

F. Update Report of *Health Notes*

G. Need for New Consumer Brochures

H. Miscellaneous Consumer Issues/Articles in the Media

I. Update on the Board's Public Outreach Activities

J. Adjournment

12 noon

Meeting materials will be on the board's Web site by January 13, 2006

Agenda Item B

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

State of California

Department of Consumer Affairs

Memorandum

To: **Communication and Public Education Committee** **Date: October 7, 2005**

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

Subject: **Development of Fact Sheet Series for Consumers**

Since July 2004, the board has been working with the Center for Consumer Self Care at the University of California San Francisco to integrate pharmacy students into public outreach activities. The project selected was to develop a consumer fact sheet series by student interns.

By January 2005, the program had been initiated. By July 2005, four fact sheets were developed, and a fifth was undergoing work by the board. The first fact sheets prepared:

- Generic Drugs – High Quality, Low Cost
- Lower Your Drug Costs
- Antibiotics – A National Treasure
- Is Your Medicine in the News?

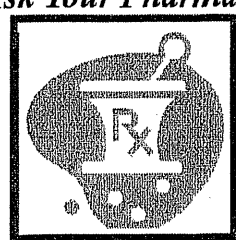
The fact sheets contain general information on the topic, but then contain questions consumers can discuss with their pharmacists on making wise decisions in the subject area.

In mid-2005, Dr. Soller had 11 students who agreed to develop at least three fact sheets each over the coming year. At the July 2005 Board Meeting, the board agreed to cosponsor a joint web site with the Center for Consumer Self Care to house the approximately 35 fact sheets what would be developed over the year,

In October, the Communication and Public Education Committee received three fact sheets that have not been reviewed by the department (these are not enclosed):

- Lower Your Drug Costs (revision to earlier fact sheet)
- Have You Ever Missed a Dose of Medication?
- Don't Flush Your Medication Down the Toilet!

The committee initially determined that it would evaluate the project after one year. As such, this review should take place at this meeting.



Generic Drugs

...real medicines at high quality, low cost

What Is a Generic Drug?

A drug patent gives a drug company the sole right to sell a new drug. The company sells its new drug under its own brand name. By law, other companies cannot sell this drug until the term of the patent is over. When the patent term ends, other drug companies may then sell that drug, but not under the same brand name. These types of drugs are called generics, or generic drugs.

The generic drug has the same active ingredient as the brand name drug; but it may not look like the brand name drug. The generic drug usually has its own shape or color. This does not affect how it works. For example, CIPRO is the brand name drug containing the active ingredient, ciprofloxacin. The generic version is also sold as "ciprofloxacin."

They are the same as brand name drugs...

When used as directed, a generic drug is the same as a brand name drug:

- It has the same use.
- It is as safe.
- It works the same way in the body.
- It is taken the same way.
- It has the same quality.

...But they may cost less!

Generic drugs cost less than brand name drugs. The U.S. Food and Drug Administration (FDA) says, if people use generic drugs, they may save up to 15% in drug costs.

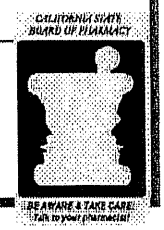
Their quality is ensured by FDA

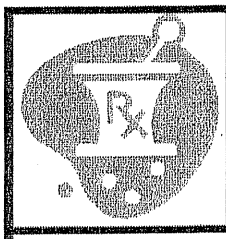
- Each generic drug is tested. It must enter the bloodstream at the same rate and extent as the brand name drug.
- Generic drugs must also be tested to show they are stable.
- A generic drug must have the same active drug ingredient and the same strength and quality as the brand name drug.
- FDA inspects the factories of generic drug companies.
- FDA decides whether generic drugs are safe and high quality before they are sold in the USA.

Ask Your Pharmacist!

University of California San Francisco
UCSF
School of Pharmacy

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





Lower Your Drug Costs

To Help You Keep On taking Your Medicines

It makes sense. Take your medicine just as your doctor says and for as long as your doctor says. But ...

Drug costs are high. Everyone knows this, but it is especially hard on those of us living on fixed incomes, such as Seniors.

A recent study found that 25% of Seniors reduced or stopped their medicines if they use up their yearly drug benefit 2 ½ to 6 months before the end of the year.

Here are some hints on how to cut your drug costs.

1. **Ask your pharmacist for help.** Your pharmacist can work with your doctor to safely cut your drug costs.

2. **With your pharmacist, get the answers to these questions.**
   - Can I get my medicine in generic form?
   - Is there another less costly older drug in the same class that can be used as safely for my condition?
   - Does my doctor have free samples that I can take?
   - Does my pharmacy offer mail order, so I can get a lower cost 90-day supply of my medicine?
   - Does my pharmacy offer a discount plan for Seniors?
   - Does the drug manufacturer offer discounts or coupons on my medicine?
   - Will my doctor prescribe a higher dosage, so I can use a pill cutter to cut the pill in half?
   - Do I really need the medicine? Do NOT decide this by yourself. Check with your doctor and pharmacist.

University of California
San Francisco
UCSF
School of Pharmacy

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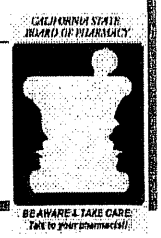
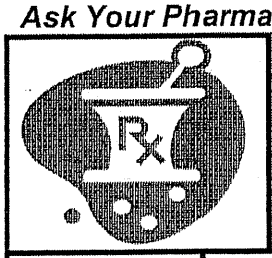


Ask Your Pharmacist



Antibiotics
A National Treasure

FACT:	If medicines called antibiotics are not used properly or used when they are not needed, bacteria can mutate and develop resistance to the antibiotics. Then these medicines may no longer help us when we need them.
FACT:	This is a big problem, and is a major public health threat within hospitals and communities – wherever antibiotics are used.
FACT:	Antibiotics only work against infections caused by bacteria, not infections caused by viruses.
FACT:	Colds or flu (or influenza), are examples of illnesses caused by viruses. Strep throat is an example of an illness caused by bacteria.

In which illness	are antibiotics needed?
Cold	**No**
Flu	**No**
Chest cold (in otherwise healthy children or adults)	**No**
Sore throat (except strep throat)	**No**
Bronchitis (in otherwise healthy children and adults)	**No**
Runny nose (with clear discharge) *	**No**
Fluid in Middle Ear (otitis media with effusion)	**No**

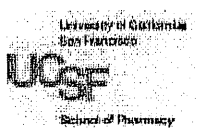
(From the Center for Disease Control)

** Discharge from a runny nose due to colds or flu will often turn from a clear/neutral color to yellowish as the cold is clearing up. If a greenish or yellowish discharge from your nose persists, contact your health care provider.*

If in doubt, contact your health care provider about whether or not your condition warrants antibiotics.

What Can You Do to Help Check Antibiotic Resistance?

- ✓ Don't insist on an antibiotic when your health care provider says one is not right for your condition. Ask for remedies to relieve your symptoms.
- ✓ Don't take an antibiotic for a simple viral infection such as a cold, a cough, or the flu.
- ✓ Take medicine exactly as your health care provider tells you. If he or she prescribes an antibiotic, take it until it is gone, even if you are feeling better.
- ✓ Don't take leftover antibiotics, and don't take antibiotics prescribed for someone else. These antibiotics may not be right for your current condition. Taking the wrong medicine could delay getting the right medicine and may allow bacteria to grow.



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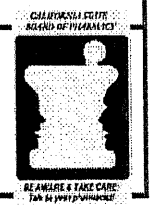

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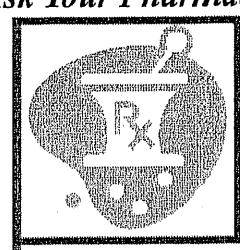

Is Your Medicine In the News?

It's not unusual for the media to pick up on a possible safety problem with a popular medicine. After all, nothing is more precious than our health. So, consumers are always interested to hear or read news about their medicines.

It is not a surprise that a new safety problem may arise with a medicine. When a drug is approved by the Food and Drug Administration, not all is known about its safety. This is because the drug has not been studied in a large enough population to identify rare side effects. When drugs are newly approved, only side effects found in about 1% or more of patients are known.

A Common Sense Approach

Here are some steps to take to help make the right decision about your medicines:

1. **Don't panic.** Usually a safety debate about a popular drug relates to reports of rare effects.
2. **Contact your doctor or pharmacist** — personally, by telephone, or by e-mail.
3. **Have a list of things to ask your doctor or pharmacist.** If you can, send a copy of your questions before your visit.
4. **Tell your doctor or pharmacist exactly how you take your medicines.** Be sure to say if you are not following directions, taking more than you should, forgetting dosages etc.
5. **Ask the following questions.**
   - Do you think the benefits of my taking this medicine outweigh the risks?

More questions to ask:

- What risks might I face in taking this medicine?
- Are there alternative medicines to the one I am taking?
- Are there alternatives to some of my medicines, such as lifestyle changes? Should I try these? What do I need to do to be successful with non-drug alternatives?
- If I have to continue to take this medicine, what side effects should I look out for, and when should I call you about them?
- In summary, would you review the best course of action for me? (Take notes, if you need to.)
- Can we set up an appointment in 1-3 months to review what we've decided and see how I am doing?

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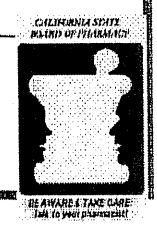


Agenda Item C

Activities of the California Health Communication Partnerships

State of California

Department of Consumer Affairs

Memorandum

To: **Communication and Public Education Committee** **Date: January 11, 2006**

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

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

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

The function of the group is to develop or disseminate integrated public information campaigns on priority health topics identified by the partnership members. Other active members of the group are the Medical Board of California, the Food and Drug Administration, CPhA and California Retailers Association. There have been two conference call meetings of this group since the October Communication and Public Education Committee.

The third project of this group was an education campaign about early detection tests for cancer (breast cancer and prostate cancer). This project aired in September and October 2005. This project was funded by a grant from a private foundation, which enabled use of a firm (the North American Precis Syndicate) that specializes in dissemination of public service announcements and prewritten articles to a diversity of media outlets nationwide. The board used the same firm for similar dissemination services in the late 1990s.

This cancer screening campaign was among the most successful campaigns ever released by this distribution firm in terms of the number of messages published and aired. The North American Precis Syndicate will provide the partnership a certificate and award for achieving record outreach.

The next campaign of the partnership is on generics, and the California Retailers Association and board staff will be working with Dr. Soller on behalf of the partnership to promote the use of generics. The current plan is to follow a program along the lines of "Generics Makes Sense [Cents,$]," a campaign to raise awareness among consumers about cost-savings of generic medicines.

Other items proposed for future campaigns:

- Talk to Your Pharmacist Campaign "Say Yes" [to Consultation]"
  Dr. Soller will seek input on ideas, materials and other information that might help define a campaign strategy.
- "It's Your Life II" – Fall 2007 Breast and Prostate Cancer Awareness Campaign
- Antibiotic Resistance – Poster/brochure outreach to hospital waiting rooms
- New Prescribing Information – related to new initiative by FDA to provide easier to read/use format for Rx labeling. Dr. Soller is gathering information from the FDA on this.

Agenda Item D

Public Awareness Campaign Access of Needles and Syringes in Pharmacies (Implementation of SB 1159)

State of California

Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee Members

Date: January 13, 2006

From: Virginia Herold

Subject: UCSD Study on Legalizing Nonprescription Syringe Sales

At the October 2005 Board Meeting, the board agreed to assist in a study being conducted by the Department of Health Services' Office of AIDS and UCSD to evaluate Senate Bill 1159 (Vasconcellos, Chapter 608, Statutes of 2004) that allows local health jurisdictions to authorize nonprescription syringe sales by pharmacies to prevent HIV and Hepatitis.

A collaborative plan has been developed by the researchers and is provided in this packet. Many of the components are informational, aimed at educating others about the provisions of the new law.

Tom Stopka of the Office of AIDS will attend this committee meeting to provide an overview of the project and outreach effort.

I am providing the following documents regarding this project:

- Collaborative Plan
- SB 1159 Survey Results (PowerPoint slides)
- SB 1159 Pharmacy Access to Over the Counter Syringes in California (PowerPoint slides)

Senate Bill 1159 – Pharmacy Access to Syringes

California DHS Office of AIDS and The California State Board of Pharmacy

Collaborative Plan

During 2006 the California Department of Health Services Office of AIDS (DHS/OA) would like to collaborate with the California State Board of Pharmacy, Pharmacist Associations, Schools of Pharmacy and other interested organizations in order to increase awareness of Senate Bill 1159 (SB 1159) and pharmacy sales of sterile syringes in an effort to decrease transmission of blood-borne diseases such as HIV and hepatitis. To this end, DHS/OA proposes the following activities for consideration:

- SB 1159 Presentations to the California Pharmacists Association via statewide and regional conferences and meetings;
- Presentations on pharmacy access to syringes for Continuing Education Units (CEU) to pharmacists in various venues across California;
- Collaboration with California Schools of Pharmacy to develop HIV prevention curricula that includes a focus on syringe access and pharmacy access to syringes. The goal would be to integrate this curricula into existing study plans for students who will become future pharmacists in the state.
- Trainings for current pharmacists to become SB 1159 peer educators who will educate fellow pharmacists across the state on the legislation and the role of pharmacists as public health agents who can contribute to HIV prevention efforts;
- On-line CEU Courses in-order to educate pharmacists on SB 1159;
- Presentations at future Board of Pharmacy Inspectors Meetings to educate inspectors on SB 1159;
- Presentations and trainings with the California Retailers Association (i.e. chain pharmacy association) in order to increase their knowledge and understanding of policies and protocols related to SB 1159;
- Periodic articles on SB 1159 progress in *Scripts* – the publication of the California State Board of Pharmacy;
- Creation of a co-signed letter from DHS/OA, the State Board of Pharmacy and California Schools of Pharmacy highlighting collaborative efforts, providing recommendations for pharmacists and local health jurisdictions, and delineating future collaborative endeavors related to SB 1159;

- Consideration of collaboration with the Association of American Council of Pharmacies;

- Creation of standardized continuing education presentations and courses that can be presented by various experts on SB 1159 in a variety of venues across California;

- Increased collaboration with AIDS Drug Assistance Programs (ADAP) pharmacies across California;

- Add links and presentations to the SB 1159, DHS/OA and State Board of Pharmacy (www.pharmacy.ca.gov) websites to enhance knowledge and awareness of SB 1159.

SB 1159 / DPDP: LHJ Survey Results

Thomas J. Stopka[1], MHS, Richard Garfein[2], PhD, Alessandra Ross[1], MPH

1. DHS Office of AIDS
2. UC San Diego

CCLHO Meeting
Squaw Valley, CA
October 26, 2005

SB 1159 LHJ Survey: June-August, 2005

- Administered by OA and UCSD
- Pilot survey of LHJs to learn about the status of SB 1159 and DPDPs across the state.
- Survey forwarded to 61 LHJs through CCLHO, CCLAD, CHEAC
- Email and telephone follow-up
- Surveys obtained from 57 (93%) of LHJs

Survey Respondents

- County Health Officers
- HIV/AIDS Prevention Coordinators
- Public Health Nurses
- Deputy Health Officers
- Health Executives

Local DPDP Coalitions

- 25% of the LHJs reported that they had formed a coalition
- Generally, coalitions were formed in LHJs that approved or are in the process of approving
- Coalitions→PH staff, HIV prevention staff, waste management, pharmacists, pharm. assoc., etc.
- Discussions with law enforcement taking place in some LHJs

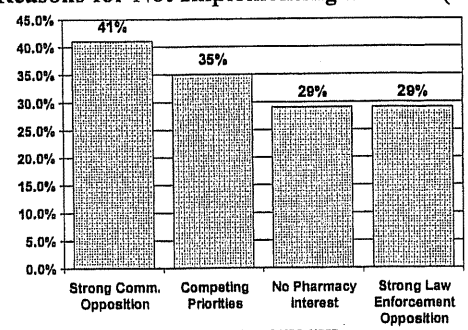
Status of SB 1159 approval among LHJs in California – August 2005

Status	Number of LHJs
Approved	9
In process of approving	9
Plan to adopt	17
Approval process on hold	2
No plans to approve	18
Status Unknown	2

DPDP Lead

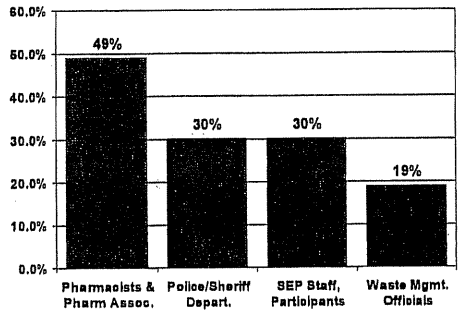
- Health Officers (23%)
- Local HIV/AIDS Prevention Coordinators (23%)
- Local Offices of AIDS (11%)

Reasons for Not Implementing a DPDP (n=18)



Source: CA DHS Office of AIDS, UCSD

Provision of Education on SB 1159 (n=37)

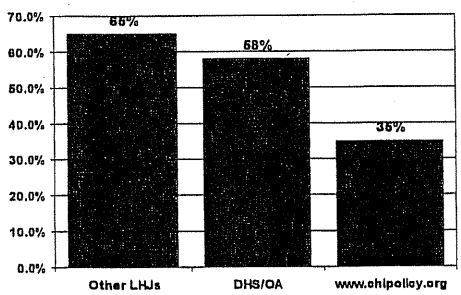


Source: CA DHS Office of AIDS, UCSD

Number and Percentage of Registered Pharmacies – August 2005

LHJ	# of Reg. Pharmacies	% of Pharms. Registered	Total Pharms. in LHJ
Alameda	41	30%	137
Contra Costa	32	22%	145
Marin	12	35%	34
S.F.	35	40%	88
Yolo	10	78%	13
Yuba	3	43%	7
Total	**133**	**31.4%**	**424**

Received SB 1159 Technical Assistance From… (n=26)



Source: CA DHS Office of AIDS, UCSD

Independent vs. Chain-Wide Participation by County

County	Walgreens	RiteAid	Safeway	Longs
Alameda	Chain-wide	Chain-wide		
Contra Costa	Independently	Independently	Independently	
Marin	Chain-wide			Chain-wide
Yolo		Chain-wide		Chain-wide
Yuba	Independently			Independently
San Francisco	Chain-wide	Chain-wide	Chain-wide	

Dissemination of Information

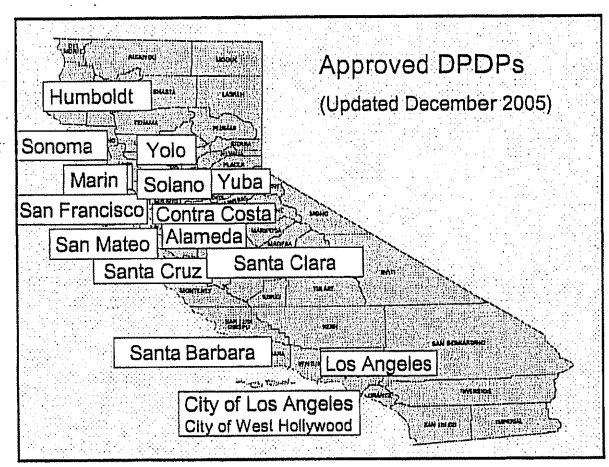
- 2/3 of pharmacies offer oral counseling and pamphlets
- Majority of educational materials being used by pharmacies are produced by LHDs

Addressing Syringe Discard Costs in LHJs

- Surcharge added to syringe sales
- Integrated into existing waste management system (SB 1362, Figueroa?)
- Subsidy from local health department

LHJ Syringe Discard Plans/Activities

- 16% provide pre-addressed sharps boxes for discard of syringes through mail
- 30% have sharps containers returned to the pharmacy
- 50% provide sharps containers that can be discarded at other designated locations
- 30% provide drop box for containerized syringes
- 16% provide drop box for uncontainerized syringes



Anecdotal Reports

- Small number of IDU customers/pharmacy
- Modest increase in syringe sale and syringe disposal, with most pharmacies reporting between 2-10 customers weekly.
- Some pharmacies require log signature
- Some pharmacies permit purchase of more than 10 syringes per visit
- No negative experiences reported
- We want to make sure that things go well initially; we have not done a lot of outreach to users thus far

SB 1159 Advisory Panel Suggestions

- Social marking
- Community collaboratives with other players
- Standard health education materials could be developed
- Outreach to physicians
- List of participating pharmacies
- Participating pharmacy logo/sign (statewide logo)

SB 1159 Advisory Panel: Suggestions for Pharmacy Work

- Provide DPDP orientation to pharmacies
- Keep in touch with pharmacies that have not opted-in
- Inform pharmacies on evaluation plans & methods
- Have pharmacies play a more active role in the paperwork
- Engage pharmacists in peer education
- Set a price for syringes

Concerns/Interests

- LHDs understaffed to provide proper supervision; creating implementation advisory board
- Police want to be able to distinguish "legal" from "illegal" syringes.
- Referrals from SEPs to pharmacies

OA present and future activities

- Evaluation activities
  - Evaluation advisory panel
  - NIDA grant submitted
  - Other research proposals
- Implementation support
  - Connecting people with resources
  - CHI website at chipolicy.org
  - www.syringeaccess.com
  - Supporting local health department participation

AB 547 (Berg)

- Modifies AB 136 and SEP approval process
  - Simplifies the procedure for SEP authorization
  - SEPs certified annually w/o declaration of emergency
  - Health Officer must submit a year-end report
- DHS Role
  - Local SEP authorization done in consultation with DHS
  - SEP Report guidance
  - Coordinate with LHJs and SEPs
  - Statewide technical assistance initiative

Suggestions for Future LHJ Surveys

- Questions
- Topics
- What would you like to know?
- What will be key to learn?
- Methods
- Timing:
  - Semi-annual
  - Season

AB 547 (Berg)

- Health Officers required to present an annual report detailing the status of local SEPs, infection rates, relevant risk behaviors
  - Board of Supervisors meeting
  - City Council meeting
- Stakeholders afforded ample opportunity to comment
  - Law enforcement
  - Administrators of alcohol and drug treatment programs
  - other stakeholders

AB 547 (Berg)

- CCLHO Suggestions?
  - Report topics
  - Variables of interest (e.g., clients, services, prev. mats.)
  - Timing
  - Electronic vs. paper template
  - Aggregate report back

For More Information Contact:

Alessandra Ross, MPH (Implementation)
CA DHS Office of AIDS
phone: (916) 449-5796
email: aross@dhs.ca.gov

Or

Tom Stopka, MHS (Research and Evaluation)
CA DHS Office of AIDS
phone: (916) 449-5828
email: tstopka@dhs.ca.gov

SB 1159: Pharmacy Access to Over-the-Counter Syringes in California

Alessandra Ross, MPH and Tom Stopka, MHS

Marina del Rey, CA
October 19, 2005

Background

- HIV/AIDS
  - 20% of cumulative AIDS cases attributed to injection drug use in California
  - 1,000+ injection related infections annually
- Hepatitis C Virus (HCV)
  - 600,000 hepatitis C (HCV) infections in CA
  - 60% attributed to injection
  - 5,000 new HCV infections annually

The Impact of Pharmacy Access to Syringes…

Syringe Sharing

- Increased use of pharmacies as a syringe source is associated with a decline in syringe sharing
  - Pouget et al.. (2005). *JAIDS. 2005;39(4):471-477.*
- HIV infection rates among IDUs were twice as high in cities that required Rx (n=36) for syringe purchase as compared to cities that did not (n=60).
  - Holmberg, SD. (1996). *Am J Public Health* 86:642-654.

Syringe Disposal

- Promoting safe syringe disposal goes "hand in hand" with Expanded Syringe Access (ESAP) in NYS.
  - Klein, SJ et al., (2002). *J Am Pharm Assoc.* 42(Supplement 2): S105-S107.
- Needle sightings among sanitation workers decreased post ESAP (Expanded Syringe Access Program-NY) implementation
  - Lawitts, S. (2002). *J Am Pharm Assoc.* 42(Supplement 2): S92-S93.
- S.F. Safe Needle Disposal Program (SFNDP) effective
  - Drda, B. (2002). *J Am Pharm Assoc.* 42(Supplement 2): S115-S116.

Needle-stick Injuries

- Accidental needle-sticks decreased among law enforcement officers by 66% post pharmacy access legislation in Connecticut.
  - Grossclose SL et al. (1995). Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting Drug Users and Police Officers - Connecticut, 1992-93. *JAIDS* 10:73-81
- Frequency of needle-stick injuries among sanitation workers stable/decrease post ESAP.
  - Lawitts, S. (2002). *J Am Pharm Assoc.* 42(Supplement 2): S92-S93.
- Needle stick injuries to garbage collectors declined after implementation of SFNDP
  - Drda, B. (2002). *J Am Pharm Assoc.* 42(Supplement 2): S115-S116.

Cost-Effectiveness

- Treatment of chronic liver disease related to HCV costs approximately $20,000 per person per year
- Liver transplant costs approximately $300,000.
- Average lifetime cost for treating a person with AIDS is estimated to be $195,000.
- Reducing the number of injection drug use-related HIV/AIDS and HCV cases can reduce the economic burden on county-funded care and treatment programs

SB 1159 (Vasconcellos)

- Signed by Governor on September 20, 2004
- Allows for establishment of a Disease Prevention Demonstration Project (DPDP) in counties that authorize it
- Sunsets in 2010
- Opt-in oriented: counties and cities can opt-in, pharmacies can opt-in

What the bill says

SB 1159 permits individuals to:

- Purchase up to 10 syringes without a Rx if they are at least 18 years of age (DPDP)
- Legally possess up to 10 syringes if acquired from an authorized source (DPDP)
- Carry syringes "containerized for safe disposal" and these syringes cannot be considered as illegal drug paraphernalia (anywhere in the state, no sunset)

LHJs that authorize are required to:

- Maintain a list of registered pharmacies
- Make written information available to pharmacies to be shared with customers:
  - Drug treatment
  - HIV and HCV counseling & testing, treatment
  - How to safely dispose of syringes

Pharmacies who participate are required to:

- Register with the county
- Store syringes behind the counter
- Provide for disposal through either:
  - On-site syringe disposal program
  - Furnishing or selling mail-back sharps containers, or
  - Furnishing or selling personal sharps containers

State Office of AIDS must:

- Convene an evaluation advisory panel
- Seek funding for evaluation
- Conduct research to monitor effects on:
  - Rates of disease infection
  - Needlestick injuries
  - Drug crime or other crime
  - Safe or unsafe syringe discard
  - Rates of injection
  - Syringe sharing practices

Understanding the bill

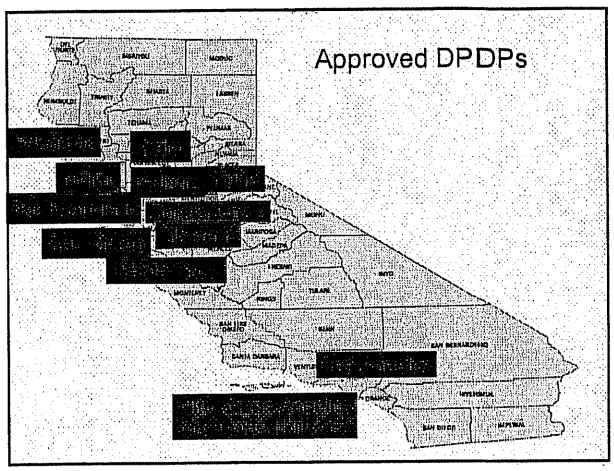
The law says…

- Individuals anywhere in the state now can carry syringes "containerized for safe disposal" and these syringes cannot be considered as illegal drug paraphernalia.
- There is no limit on the number of syringes that may be carried.

The law says…

- Individuals in county with a DPDP can purchase up to 10 syringes without a Rx if they are at least 18 years of age, and
- Legally possess up to 10 syringes if acquired from an authorized source.

Adventures in Implementation



In process

- Santa Barbara
- Fresno
- Sonoma
- Orange
- Shasta
- Sacramento
- Solano
- Ventura
- Santa Clara
- Stanislaus
- San Luis Obisbo
- Humboldt
- Sutter
- Long Beach

Commonalities

- Full plan must be in place
- Health Department in the lead
- Working in coalition
- Approval linked to disposal
- Different levels of persuasion necessary, different levels of preparedness for persuasion and comfort with the role

Partners in Implementation

"In any city or county that authorizes non-prescription sale, Walgreens intends to encourage all of our pharmacies to participate…I expect that most…of our outlets will cooperate with local health departments to implement the life-saving strategies authorized by SB1159."

--Phil Burgess, Walgreen's

Lessons from the field

- Outreach to pharmacists
- Social marketing
- Stress "demonstration project"
- Partnership with diabeties associations
- User-friendly disposal
  - Syringe discard kiosks

- Fitpacks
- Work with ADAP pharmacies
- Downloadable brochures
- Collaborate with needle exchange

SB 1362 (Figueroa)

- Provides that local governments may use waste collection fees to fund creation of, or expansion of programs to collect home generated sharps waste.
- Benefits all syringe users, especially diabetics
- Environmental health specialists, health officers and local waste haulers should discuss with city or county officials.

OA present and future activities

- Evaluation activities
- Implementation support
  - Connecting people with resources
  - CHI website at chipolicy.org
  - Supporting local health department participation

For More Information Contact:

Alessandra Ross, MPH (Implementation)
CA DHS Office of AIDS
phone: (916) 449-5796
email: aross@dhs.ca.gov

Or

Tom Stopka, MHS (Research and Evaluation)
CA DHS Office of AIDS
phone: (916) 449-5828
email: tstopka@dhs.ca.gov

Agenda Item E

Report on The Script

State of California

Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee

Date: January 10, 2006

From: Virginia Herold

Subject: Update on *The Script*

The next issue of the board's newsletter, *The Script,* has been written and reviewed, and is currently being printed. This issue will focus on new pharmacy laws enacted in 2005.

President Goldenberg's column is directed to pharmacist interns, encouraging them to become involved in board activities. Copies will be mailed to pharmacies, pharmacist interns and wholesalers.

The next issue of the newsletter will be developed for publication in July 2006.

The California Pharmacy Foundation mailed the October issue of *The Script* to all California pharmacists in December.

The board is initiating work on the next issue, likely a July 2006 issue.

Agenda Item F

Report on Health Notes

State of California | Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee

Date: January 10, 2006

From: Virginia Herold

Subject: Update on *Health Notes*

There has been no work on the two pending issues of *Health Notes* since the October committee meeting.

The information provided below for the October meeting is still applicable.

Health Notes is a monograph, produced by the board, that contains up-to-date drug therapy guidelines for a specific subject area. Because the board produces *Health Notes*, it conveys what the board believes is current drug treatment in a particular area. Pharmacists can earn continuing education credit by completing a test published at the back of the monograph. Thus the board provides information and actually is sponsoring CE in an area of importance to the board. Seven issues have been produced since 1996. Regrettably, no issues have been published in the last two years due to lack of staff resources to commit to this project.

Under development are two issues:
1. Pain Management Issue
2. Pharmacy Emergency Response to Patients in a Declared Disaster Area

Neither publication is yet ready for publication, but articles for both have been written.

The articles for pain management have been written and edited; however, referral back to the authors for confirmation remains to be completed. Likely publication date may be late spring or summer 2006.

According to RoseAnn Jankowski, PharmD., most of the articles for emergency response have been written. These articles will still need to be edited by technical experts and by the board. Again, the likely publication date may be late spring or summer 2006.

Once all articles have been written, edited and confirmed for these issues, funding for publication costs will be sought from outside sources.

Agenda Item G

Need for New Consumer Materials

State of California | Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee **Date: January 13, 2006**

From: Board of Pharmacy – Virginia Herold

Subject: Need for New Consumer Brochures

1. Consumer Materials

   Under development by board staff are new consumer brochures and fact sheets. I had hoped to have these materials available to share at this meeting, but the board's move into its new location has delayed the completion of these items.
   - Consumer information about the importance of Black Box warnings on medication and what this means
   - The Beers list of medications that should not be provided to elderly patients
   - Update of Facts About Older Adults and Medicines (revision)

2. Information about the Bird Flu

   The board has expressed an interest in developing information for patients and pharmacists on the bird flu. There is now a government Web site for information about the bird flu: www.pandemicflu.gov. I am enclosing material downloaded from the Web site. I will work with the board's Web person to establish a link.

3. Improving Use of Prescription Medications: A National Action Plan

   "Patient non-adherence in prescription medication use is a major barrier to fully realizing the benefits of medical and pharmaceutical advancements, and non-adherence is attributed to 22% of hospitalizations each year. A wide range of factors has been attributed to non-adherence, some of which present critical opportunities for healthcare providers to intervene, such a s through better communication and follow-up for patients with limited hath literacy and language barriers."

   Just before the October Board Meeting, Patricia Harris and I attended a briefing for the release of a study titled: "Improving Use of Prescription Medications: A National Action Plan." Funded by The California Endowment, this report consisted in part of a literature review of studies showing the importance of medication compliance and the impact on patient health when patients are noncompliant.

A copy of the executive summary is attached. I will provide copies of the actual report to those members who are interested. I will also bring a copy to the committee meeting.

The study concludes: "Patients will not be able to benefit fully from medical research and pharmaceutical developments until their use of prescription medications is greatly improved." There are elements they identify for (1) data and measurement, (2) practices for healthcare providers, and (3) stakeholder engagement.

The committee may wish to discuss whether this is an area it seeks to explore more fully in 2006.

4. Center for Health Improvement Report: "Opportunities for Improving the California Pharmacist-Patient Consultation Process"

   The board was a sponsor of a recent survey on the mandated pharmacist to patient consultation process and its effects on Californians aged 65 and over.

   The study is now complete and the findings were released in November to a group of stakeholders involved in health policy. Board President Goldenberg, Vice President Powers, Patricia Harris and myself attended this meeting.

   The report is now done and will be shared with the board at the February Board Meeting. A draft copy of the manuscript is provided for your information in advance of the receipt of the final report.

State of California | Department of Consumer Affairs

Memorandum

To: **Communication and Public Education Committee** **Date: January 13, 2006**

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

Subject: **Need for New Consumer Brochures**

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PandemicFlu.gov

Get Informed. Be Prepared.

The official U.S. government Web site for information on pandemic flu and avian influenza. Information is organized by topic on the left sidebar.

Pandemic Flu Home

General Information

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Monitoring Outbreaks

Health & Safety

Vaccines & Medications

Bird & Animal Issues

Global Activities

Travel

Research Activities

What Can Be Done Now

Federal Government | State & Local Governments | Individuals & Families | Business | Schools | He

New Information & Activities

$100 Million for State and Local Pandemic Preparation
Jan. 12 — Pandemic preparedness grants are awarded to states, territories, and the District of Columbia. More >>

Rhode Island State Summit
Jan. 13 — Meeting in Providence, state and local officials, along with HHS Secretary Leavitt, hold the fifth state planning summit More >>

Planning for Faith-Based and Community Organizations
Jan. 12 — HHS Secretary Leavitt releases a pandemic planning checklis for faith-based and community organizations Press release >>
Checklist for Faith-Based and Community Organizations >>

West Virginia State Summit
Jan. 12 — Governor Joe Manchin and other state officials host a conference of local and state officials and private sector partners, with HHS Secretary Leavitt speaking on pandemic planning. More >>

Vermont State Summit
Jan. 12 — The third state planning summit, hosted by Governor Jim Douglas, is held in Burlington. More >>

Planning Guide for Individuals and Families
Jan. 6 — Secretary Leavitt Releases Guide to Help Individuals and Families Get Informed and Be Prepared For a Pandemic. Press release >>
Guide for Individuals & Families >>

Arizona State Summit
Jan. 6 — HHS Secretary Leavitt and Governor Janet Napolitano hosted the Arizona State Pandemic Planning Summit, inviting a wide range of community and business leaders from across the state. More >>

Agriculture Secretary applauds Avian Flu funding

Dec. 30 — U.S. Agriculture Secretary Mike Johanns commended President Bush for signing and Congress for approving $91.4 million in funding to enhance USDA's efforts to prevent and prepare for avian influenza. More >>

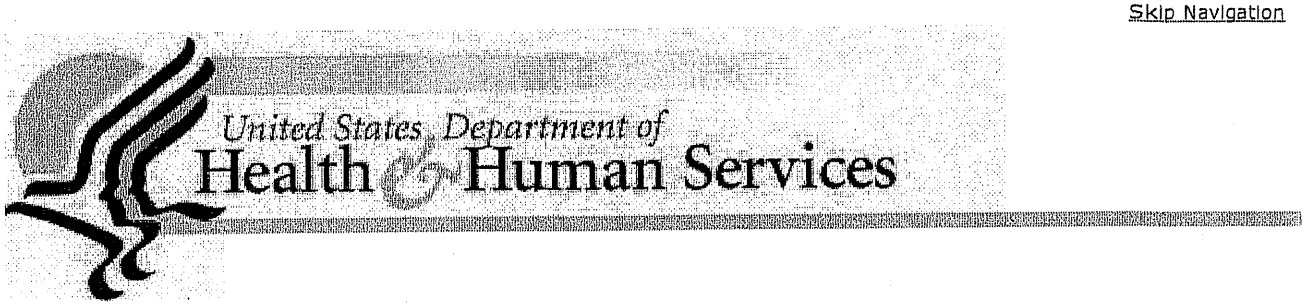
Pandemic planning for business
Dec. 14 — HHS Secretary Leavitt released a pandemic planning checkli for business and industry. Checklists for other sectors of society are being developed. More >>

First State Planning Summit held
Dec. 14 — HHS Secretary Leavitt held the first state summit in Minnesota. More than 250 representatives from public and private organizations discussed state and national preparations for potential pandemic. More >>

Exercise to evaluate federal preparedness
Dec. 10 — White House held a Pandemic Flu "Table top exercise" to tes responses to a possible pandemic. More >>

Agricultural Workers at Increased Risk
Nov. 25 — Study finds that workers who routinely come into contact with pigs have an increased risk of infection with flu viruses that infect pigs, including avian and human viruses. More >>

This is an official U.S. Government Web site sponsored by the U.S. Department of Health & Huma



News Release

FOR IMMEDIATE RELEASE
Thursday, Jan. 12, 2006

HHS Press Office
(202) 690-6343

New Checklist Helps Faith-Based and Community Organizations Prepare for an Influenza Pandemic

HHS Secretary Mike Leavitt today announced the release of the "Faith-Based and Community Organizations Pandemic Influenza Checklist." This tool provides guidance for religious organizations, social service agencies that are faith-based and community organizations to plan for the impact of a pandemic on their organization and mission.

"The collaboration of faith-based and community organizations with public health agencies will be important in protecting the public if and when a pandemic occurs," Secretary Leavitt said. "These organizations provide vital support services and can help build awareness of the pandemic influenza threat. By working together now, we'll be better equipped to serve communities in the future."

The new checklist identifies steps faith-based and community organizations can take to prepare for a pandemic and could be helpful in other types of emergencies. The checklist was developed by the Centers for Disease Control and Prevention (CDC), and preparedness suggestions include:

- Determine the potential impact of a pandemic on usual activities and how it might alter the delivery of services;
- Consider the organization's role in stopping rumors, misinformation, fear and anxiety;
- Advise staff, members and communities they serve to follow information provided by public health authorities;
- Evaluate access to mental health and social services during a pandemic;
- Identify persons with special needs served by the organization such as the elderly, disabled and people with limited English language skills, ensure their needs are included in the response plan; and
- Evaluate the organization's usual activities and services including rites and religious practices if applicable to identify those that could facilitate virus spread from person to person; set policies to modify those activities to prevent the spread of pandemic influenza.

Secretary Leavitt released the guide at Pandemic Planning Summits in Vermont and West Virginia with state officials and community leaders today. These summits are the latest in a series of forums that will be convened in each state over the next few months.

The release of this new tool builds on the Administration's overall planning to increase pandemic preparedness. President Bush has outlined a coordinated government strategy that includes the establishment of the new International Partnership on Avian and Pandemic Influenza, stockpiling of vaccines and antiviral medications, expansion of early-warning systems domestically and abroad and new funding and initiatives for local and state level preparedness.

In December, Secretary Leavitt met with senior officials from all 50 states and launched a series of preparedness summits to be held in every state over the next several months with the goal of enhancing state and local preparedness. In addition to today's checklist, Secretary Leavitt has issued preparedness checklists for individuals and families, businesses, and state and local health departments to aid their pandemic preparedness efforts.

A copy of the "Faith-Based and Community Organizations Pandemic Influenza Preparedness Checklist," other checklists and pandemic planning information is available online at www.pandemicflu.gov.

###

Note: All HHS press releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*.

Last revised: January 12, 2006

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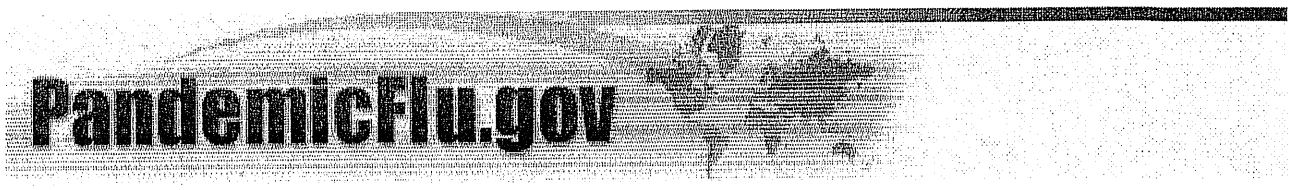

Get Informed. Be Prepared.

The official U.S. government Web site for information on pandemic flu and avian influenza. Information is organized by topic on the left sidebar.

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Global Activities

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Research Activities

What Can Be Done Now

Federal Government | State & Local Governments | Individuals & Families | Business | Schools | He

Please note that documents in PDF format require Adobe's Acrobat Reader

On January 12, 2006, Secretary Leavitt released a planning checklist for faith-based and community organizations at Pandemic Planning Summits in Vermont and West Virginia with state officials and community leaders.

The new checklist identifies specific steps faith-based and community organizations can take now to prepare for a pandemic. Developed by the Centers for Disease Control and Prevention, the checklist suggests these actions:

- Determine the potential impact of a pandemic on usual activities and ho of services;
- Consider the organization's role in stopping rumors, misinformation, fea
- Advise staff, members and communities they serve to follow information authorities;
- Evaluate access to mental health and social services during a pandemic;
- Identify persons with special needs served by the organization such as t limited English speakers and ensure their needs are included in the resp
- Evaluate the organization's usual activities and services including rites a applicable to identify those that may facilitate virus spread from person modify these activities to prevent the spread of pandemic influenza.

This is an official U.S. Government Web site sponsored by the U.S. Department of Health & Huma

Welcome to the CDC Flu site.
Skip directly to the search box, site navigation, or content.

- CDC Home
- About CDC
- Press Room
- A-Z Index
- Contact Us

Department of Health and Human Services
Centers for Disease Control and Prevention

CDC en Español

Search: GO

Pandemic Influenza

Influenza (flu)

Avian Flu

Pandemic Flu

- Highlights
- Key Facts
- Preparedness
- Checklists
- Q & A
- References & Resources
- Info for Specific Audiences
  - Agricultu
  - Business
  - Health Professi
  - Governm
  - Travelers

Seasonal Flu

Information for Health Professionals

Pandemic Influenza Toolkit

- A compilation of resources and information provided to clinicians for their use in discussing Pandemic influenza with patients and providing care in case of spread of this agent to the United States.

Overview

- Flu Pandemics (historical)
  Timeline for human flu pandemics.
- Frequently Asked Questions about Pandemic influenza.

Quarantine Information

- Quarantine Executive Order Information
  Questions and Answers on the Executive Order Adding Potentially Pandemic Influenza Viruses to the List of Quarantinable Diseases

Professional Guidance

- Pandemic Influenza Surveillance (712 KB/ 19 pages)
  Pandemic influenza surveillance includes surveillance for influenza viruses (virologic surveillance) and surveillance for influenza-associated illness and deaths (disease surveillance).
- Laboratory Diagnostics (281 KB/ 30 pages)
  Diagnostic testing for pandemic influenza virus may involve a range of laboratory assays, including rapid antigen tests, reversetranscription polymerase chain reaction (RT-PCR), virus isolation, and immunofluorescence antibody (IFA) assays (see Box 1 and Appendix 1).
- Healthcare Planning (184 KB/ 30 pages)
  An influenza pandemic will place a huge burden on the U.S. healthcare system. Published estimates based on extrapolation of the 1957 and 1968 pandemics suggest that there could be 839,000 to 9,625,000 hospitalizations, 18–42 million outpatient visits, and 20–47 million additional illnesses, depending on the attack rate of infection during the pandemic.
- Clinical Guidelines (303 KB/ 35 pages)
  Healthcare providers play an essential role in the detection of an initial case of novel or pandemic influenza in a community. If implemented early, identification and isolation of cases may help slow the spread of influenza within a community.
- Community Disease Control and Prevention (208 KB/ 36 pages)
  The initial response to the emergence of a novel influenza subtype that spreads between people should focus on containing the virus at

- E-mail this page

its source, if feasible, and preventing a pandemic.

- Public Health Communications (163 KB/ 21 pages)
  Strategic communications activities based on scientifically derived risk communications principles are an integral part of a comprehensive public health response before, during, and after an influenza pandemic.

- Workforce Support: Psychosocial Considerations and Information Needs (179 KB/ 14 pages)
  The response to an influenza pandemic will pose substantial physical, personal, social, and emotional challenges to healthcare providers, public health officials, and other emergency responders and essential service workers.

Infection Control

- Infection Control (173 KB/ 22 pages)
  The primary strategies for preventing pandemic influenza are the same as those for seasonal influenza: vaccination, early detection and treatment with antiviral medications (as discussed elsewhere in this plan), and the use of infection control measures to prevent transmission during patient care.

Vaccine Information

- Vaccine Distribution and Use (138 KB/ 12 pages)
  The initial response to an influenza pandemic will include medical care, community containment and personal protective measures, and targeted use of antiviral drugs.

Treatment Information

- Anti-Viral Drug Distribution and Use (276 KB/ 19 pages)
  Drugs with activity against influenza viruses ("antivirals") include the adamantanes amantadine and rimantadine and the neuraminidase inhibitors oseltamivir and zanamivir (see Table 1 and Appendix).

Prevention & Health Education

- Cover your cough content
  Stop the Spread of Germs that Make You and Others Sick! (posters, flyers, etc.)

- Handwashing content
  By frequently washing your hands you wash away germs that you have picked up from other people, or from contaminated surfaces, or from animals and animal waste. (posters, flyers, etc.)

Travel Advice

- Managing Travel-Related Risk of Disease Transmission (152 KB/ 17 pages)
  The 2003 pandemic of severe acute respiratory syndrome (SARS) demonstrated how quickly human respiratory viruses can spread, especially in a world of modern air travel (Appendix 1).

Preparedness Tools

- FluAid
  Designed to help state & local public health officials plan, prepare, & practice for the next flu pandemic.

- FluSurge
  A spreadsheet-based model that provides hospital administrators & public health officials with estimates of the surge in demand for hospital-based services during the next flu pandemic.

- Crisis and Emergency Risk Communication Course (CERC) (696 KB/57 pages)
  This is a fast-paced course that gives participants essential knowledge and tools to navigate the harsh realities of communicating to the public, media, partners and stakeholders during an intense public health emergency, including terrorism.

Other Resources and References

- Influenza Pandemic Preparedness

Emerging Infectious Diseases 2003 Dec;9(12):1645-1648.
In the list of potential bioterrorist agents, influenza would be classified as a category C agent (1). While previous influenza pandemics were naturally occurring events, an influenza pandemic could be started with an intentional release of a deliberately altered influenza strain.

- CDC - Influenza (Flu) Avian Flu References
- CDC Clinical Information Service:
  1-800-CDC INFO Contact Center or coca@cdc.gov
- Flyer: About CDC Clinical Information Services
- Clinician Feedback Form

Page last modified January 12, 2006

Safer Healthier People
Centers for Disease Control and Prevention, 1600 Clifton Rd, Atlanta, GA 30333, U.S.A
Tel: (404) 639-3311 / Public Inquiries: (404) 639-3534 / (800) 311-3435

PandemicFlu.gov

Frequently Asked Questions About Pandemic Influenza

1. **What is an influenza pandemic?**

   A pandemic is a global disease outbreak. An influenza pandemic occurs when a new influenza A virus emerges for which there is little or no immunity in the human population, begins to cause serious illness and then spreads easily person-to-person worldwide.

2. **How do pandemic viruses occur?**

   New influenza viruses emerge as a result of a process called antigenic shift, which causes a sudden and major change in influenza A viruses. These changes occur when proteins on the surface of the virus combine in new ways as a result of mutation or exchange of genetic material between multiple influenza viruses. If such changes result in a new influenza A virus subtype that can infect humans and spread easily from person to person, an influenza pandemic can occur.

3. **Is a pandemic imminent?**

   Many scientists believe it is a matter of time until the next influenza pandemic occurs. However, the timing and severity of the next pandemic cannot be predicted. Influenza pandemics occurred three times in the past century — in 1918-19, 1957-58, and 1968-69.

4. **Why is there concern about the H5N1 avian influenza outbreak in Asia and other countries?**

   Although it is unpredictable when the next pandemic will occur and what strain may cause it, the continued and expanded spread of a highly pathogenic—and now endemic—avian H5N1 virus across eastern Asia and other countries represents a significant threat.

   Avian H5N1 influenza infection in humans was first recognized in 1997 when this virus infected 18 people in Hong Kong, causing 6 deaths. Concern has increased in recent years as avian H5N1 infections have killed large numbers of poultry flocks and other birds in Asia and Europe. Since 2003, more than 100 human H5N1 cases have been reported in Thailand, Vietnam, Cambodia, Indonesia, China, and Turkey, and more than half have died.

   The H5N1 virus has raised concerns about a potential human pandemic because:

   - The H5N1 virus is widespread in poultry in many countries in Asia and has spread to Europe;
   - The virus has been transmitted from birds to mammals and in some limited circumstances to humans;

- Wild birds and domestic ducks have been infected without showing symptoms and become carriers of viral infection to other domestic poultry species;
- There a few cases of human-to-human transmission have been reported; and
- Genetic studies confirm that H5N1 influenza viruses, like other influenza viruses, are continuing to evolve.

5. **Is influenza A (H5N1) virus the only avian influenza virus of concern regarding a pandemic?**

Although H5N1 probably poses the greatest current pandemic threat, other avian influenza A subtypes also have infected people in recent years. For example, in 1999, H9N2 infections were identified in Hong Kong; in 2002; and 2003, H7N7 infections occurred in the Netherlands and H7N3 infections occurred in Canada. These viruses also have the potential to give rise to the next pandemic.

6. **Will H5N1 cause the next influenza pandemic?**

Scientists cannot predict whether an avian influenza (H5N1) virus will cause a pandemic. That is why we are focusing on comprehensive public health efforts — increasing surveillance monitoring for outbreaks, international cooperation, antiviral and vaccine stockpiles and building more robust capacity for vaccine production — that will help protect us no matter what pandemic strain emerges or where.

7. **Why won□t the annual flu vaccine protect people against pandemic influenza?**

Influenza vaccines are designed to protect against a specific virus, so a pandemic vaccine cannot be produced until a new pandemic influenza virus emerges and is identified. Even after a pandemic influenza virus has been identified, it could take at least 6 months to develop, test and produce vaccine.

8. **How much time does it take to develop and produce an influenza vaccine?**

The influenza vaccine production process is long and complicated. Traditional influenza vaccine production for the U.S. relies on long-standing technology based on chicken eggs. This production technology is labor-intensive and takes 9 months from start to finish.

The flu vaccine production process is further complicated by the fact that influenza virus strains continually evolve. Thus, seasonal flu vaccines must be modified each year to match the strains of the virus that are known to be in circulation among humans around the world. As a result of this constant viral evolution, seasonal influenza vaccines cannot be stockpiled year to year.

The appearance of an influenza pandemic virus would likely be unaffected by currently available flu vaccines. Researchers are making and testing possible H5N1 vaccines now.

Large amounts of vaccine cannot be made before knowing exactly which virus will cause the pandemic. It could then take up to 6 months before a vaccine is available and in only limited amounts at first. Research is underway to make vaccines more quickly.

9. **How many influenza vaccine manufacturers have production facilities in the United States?**

Currently, Sanofi Pasteur and Medimmune have influenza vaccine production facilities in the United States, although only Sanofi Pasteur□s entire production process is based in this country.

HHS has made the establishment and expansion of U.S.-based manufacturing facilities for influenza vaccine a key component of its strategy to improve the security of the influenza vaccine supply.

10. **How will vaccine be distributed if a pandemic breaks out?**

Most likely, the federal government will work with manufacturers, distributors and states and the states will develop distribution plans at the local level. States are developing and improving plans to distribute a vaccine rapidly. These plans build on experience gained from other emergencies.

In addition, influenza vaccine makers already have systems in place to distribute vaccine. Tens of millions of doses of seasonal influenza vaccine are shipped every year, and during past shortages, vaccine makers have responded to urgent situations.

Fairness in vaccine distribution and use during a pandemic is important. Protecting people at high risk and protecting essential day-to-day services are also important considerations.

11. **What age groups are most likely to be affected during an influenza pandemic?**

Although scientists cannot predict the specific consequences of an influenza pandemic, it is likely that many age groups would be seriously affected. Factors to consider include the following:

- Few if any people would have immunity to the virus
- The virus could spread rapidly.
- An influenza pandemic could temporarily disrupt activities important to overall public health, the economy, and essential community services.

12. **What is the difference between a vaccine and an antiviral?**

Vaccines are usually given as a preventive measure. Currently available viral vaccines are usually made from either killed virus or weakened versions of the live virus or pieces of the virus that stimulate an immune response to the virus. When immunized, the body is then poised to fight or prevent infection more effectively.

Antivirals are drugs that may be given to help prevent viral infections or to treat people who have been infected by a virus. When given to treat people who have been infected, antiviral medications may help limit the impact of some symptoms and reduce the potential for serious

complications, especially for people who are in high risk groups.

13. **How would antivirals be used?**

Antivirals may help prevent infection in people at risk and lessen the impact of symptoms in those infected with influenza. It is unlikely that they would substantially modify the course or effectively contain the spread of an influenza pandemic.

A number of antiviral medications (antivirals) are approved by the U.S. Food and Drug Administration to treat and sometimes prevent flu. At this time, Tamiflu® and Relenza® are the most likely antivirals to be used in a pandemic. There are efforts to find new drugs and to increase the supply of antivirals. If everyone follows the recommended uses of antivirals there will be more available for those who need it most.

14. **What other strategies will help protect Americans?**

In the event of a pandemic, certain public health measures may be important to help contain or limit the spread of infection as effectively as possible. The following actions could include:

- Treating sick and exposed people with antivirals,
- Isolating sick people in hospitals, homes, or other facilities,
- Identifying and quarantining exposed people,
- Closing schools and workplaces as needed,
- Canceling public events, and
- Restricting travel.

In addition, people should protect themselves by:

- Getting seasonal flu shots,
- Washing hands frequently with soap and water,
- Staying away from people who are sick, and
- Staying home if sick.

15. **How many people would die in a pandemic?**

The consequences of an influenza pandemic are difficult to predict. Pandemics occurred three times in the past century. The most recent (1968) was the mildest and killed about 34,000 people in the United States. The most severe influenza pandemic in the past century occurred in1918 and killed about 500,000 Americans and up to 40 million people worldwide.

16. **Could terrorists spread the avian influenza viruses to create a worldwide pandemic?**

Experts believe it highly unlikely that a pandemic influenza virus could be created by terrorists. Developing a pandemic influenza virus would require extraordinary scientific skill as well as sophisticated scientific equipment and other resources.

17. **What is the Government doing now to prepare for a pandemic flu outbreak?**

Federal, State, and local health agencies are making plans to prepare for, respond to, and contain an outbreak of pandemic flu. HHS activities to prepare for a pandemic flu include:

- Supporting Federal, State, and local health agencies□ efforts to prepare for and respond to a pandemic flu outbreak;
- Working with the World Health Organization (WHO) and other nations to help detect and contain outbreaks;
- Developing a national stockpile of antiviral drugs to help treat and control the spread of disease;
- Supporting the manufacture and testing of possible vaccines, including finding more reliable and quicker ways to make large quantities of vaccines; and
- Working with other Federal agencies to prepare and to encourage communities, businesses, and organizations to plan for a pandemic influenza outbreak.

18. **How many state and local governments are prepared for a pandemic outbreak?**

Funding from CDC's Public Health Preparedness Cooperative Agreements has allowed state and local health agencies to enhance the capacity of their public health systems to respond to public health threats, including pandemic influenza.

All states have emergency plans for responding to an influenza pandemic. All states have reviewed their public health legal authorities pertaining to isolation and quarantine. States are in various phases of updating regulations and legislation after reviewing their current authorities. CDC's Public Health Law program is cataloging all state quarantine authorities.

As part of planning for smallpox, all states have developed plans for mass immunization. In the past 12 months, all states conducted exercises to test components of their smallpox plans and 46 conducted exercises related to components of their pandemic influenza plan. Exercises such as these allow states and communities to identify weaknesses and take corrective action.

19. **How would pandemic flu affect communities and businesses?**

If an influenza pandemic occurs, many people could become sick at the same time and would be unable to go to work. Many would stay at home to care for sick family members. Schools and businesses might close to try to prevent disease spread. Large group gatherings might be canceled. Public transportation might be scarce. These are examples of challenges that local communities, schools, civic organizations, and businesses will have to work together on to plan for a pandemic response.

Last revised: January 12, 2006

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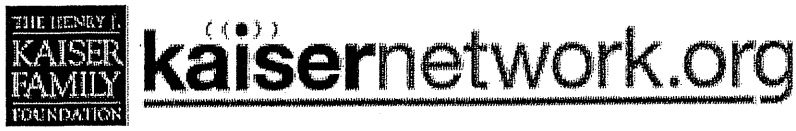

Kaiser Daily Health Policy Report

Thursday, January 12, 2006

Prescription Drugs

Pandemic Flu Could Cause Breakdown of Drug-Supply Chain

The *Wall Street Journal* on Thursday examined how the drug-supply chain is "almost certain to break" in the event of a flu pandemic, which could cause the closing of drug factories and truck routes and lead to shortages of important medicines -- "quite apart from any shortages of medicine to treat the flu itself." The "very rules of capitalism that make the U.S. an ultra-efficient marketplace also make it exceptionally vulnerable in a pandemic," the *Journal* reports. For example, many drugs are manufactured outside of the U.S. because of lower costs, while warehouses in the U.S. are generally kept nearly empty for efficiency reasons. In addition, the federal government does not intervene as a guaranteed buyer of vaccines -- meaning that such products are not attractive for drug companies -- and antitrust rules prevent private companies from collaborating their efforts to hasten new drug development. Many large hospitals stock only 30-day supplies of drugs because of costs and waste associated with stockpiling more, as well as drug manufacturing delays. According to the *Journal,* a supply-chain breakdown could cause the economy to "go into a tailspin" in the event of a pandemic flu, since "at the first sign of panic, all supplies disappear from shelves." To assist states and hospitals in bolstering medical preparedness, the federal government allocated $5 billion in grants over three years, but the money has been used toward priorities other than surge capacity at hospitals as well.

Comments

Michael Osterholm, director of the Center for Infectious Disease Research and Policy at the University of Minnesota, said, "Most if not all of the medical products or protective-device companies in this country are operating almost at full capacity." He added, "That's the reality of today's economy -- just-in-time delivery with no surge capacity." Indiana-based emergency physician Michael Bishop said, "You can't plan for a surge capacity in an emergency room of 500 or 1,000 patients from the 20 you see in a day. Nobody could afford to do that. You can't have 10 doctors and 100 nurses sitting around waiting for something to happen" (Wysocki/Lueck, *Wall Street Journal,* 1/12).

NQF
NATIONAL QUALITY FORUM

THE CALIFORNIA ENDOWMENT

Invitational Luncheon Briefing
"Improving Use of Prescription Medications - A National Action Plan"

Monday, October 24, 2005
12:00 p.m. - 2:00 p.m.

The California Endowment
101 Second Street
San Francisco, CA

DRAFT AGENDA

12:00	**Registration and lunch**
12:30	**Opening comments** Robyn Y. Nishimi, PhD, Chief Operating Officer, National Quality Forum Ignatius Bau, JD, Program Officer, The California Endowment
12:40	**Project overview and summary of recommendations** Helen W. Wu, MSc, Program Director, National Quality Forum
1:00	**Panelist commentary** Alicia Fernandez, MD, Assistant Clinical Professor of Medicine, San Francisco General Hospital Linda Neuhauser, DrPH, Clinical Professor, Community Health and Human Development, University of California-Berkeley School of Public Health Diane Stewart, MBA, Senior Manager, Pacific Business Group on Health Eleanor Vogt, RPh, PhD, Presidential Scholar and Visiting Professor, UCSF School of Pharmacy Carl Volpe, PhD, Vice President, Strategic Health Partnerships, Wellpoint Health Networks, Inc.
1:40	**Audience Q&A and general discussion**
2:00	**Adjourn**

NATIONAL QUALITY FORUM

Improving Use of Prescription Medications: A National Action Plan

Executive Summary

One of the enduring challenges in healthcare today, for both providers and patients, is ensuring that patients follow treatment recommendations once they leave the care setting. Patient non-adherence is a longstanding problem across the healthcare enterprise and is one that raises serious issues for patient health, public health, and healthcare quality. With respect to the use of prescription medications, poor patient adherence—which may occur as a result of cost, side effects, misunderstandings, or other reasons—is especially problematic, given the potential of pharmaceuticals to improve health. In fact, prescription medication non-adherence is a major barrier to fully realizing the benefits of modern medical research and advancements in pharmaceuticals.

Myriad intentional and unintentional factors have been attributed to causing non-adherence, and it can be challenging for healthcare providers to change the motivations of patients who deliberately, or intentionally, choose not to follow recommended treatment regimes. Unintentional causes of poor adherence—such as inadequate provider-patient communication and patient confusion over basic directions—are key leverage points, however, and should be a high priority for improvement.

Given the significant impact of prescription medication adherence on patient safety, equity, effectiveness, efficiency, and other domains of quality, the National Quality Forum (NQF) initiated a project in March 2004 to address the need for a coordinated, national action plan to improve consumer use of prescription medications. The project was not designed to identify specific consensus standards per se; instead, it was an exploratory effort to evaluate the major issues and promising

practices or measures for their potential future use as voluntary consensus standards, with a special emphasis on populations at high risk for unintentional non-adherence, such as persons with limited health literacy, including those with limited English proficiency (LEP).

The project consisted of three major components: a comprehensive evidence review, the development of a framework to define a strategy for the action plan, and the convening of a multistakeholder invitational workshop. The review of the state of the evidence yielded approximately 3,000 relevant articles, underscoring the need for a coordinated effort to evaluate the existing body of work in order to identify priorities for improvement. A framework to outline major issues and define an overall strategy for the action plan was developed based on the input of a small focus group and workshop participants. The invitational workshop was held in October 2004 in Washington, DC, convening a diverse group of experts in quality, performance measurement, prescription medication safety, adherence, health literacy, and minority healthcare quality. The proceedings of this workshop are described in this report, which presents a national action plan for broadly improving consumer use of prescription medications in the United States.

Recommendations

Patients will not be able to benefit fully from medical research and pharmaceutical developments until their use of prescription medications is greatly improved. The coordinated efforts of a broad group of stakeholders, including NQF Members, are critical for enacting the healthcare system reforms that are needed to begin to address the issues involved in medication non-adherence. The solution should begin with the standardization of a set of performance measures that addresses adherence; the standardization of a set of practices that can be used by healthcare providers; and multistakeholder engagement and action to improve adherence. Three major recommendations are offered to create a national action plan for improving consumer use of prescription medications, as follows:

- **Data and measurement.** Identify and implement a standardized set of measures that uses existing data to measure provider performance, drawing on the wealth of information available from pharmacies, pharmacy benefits management organizations, state Medicaid agencies, and other available sources. Promote the sharing of those data with pharmacists, physicians, and other prescribers in order to facilitate the evaluation and improvement of patient adherence.
- **Practices for healthcare providers.** Evaluate and identify a set of practices for improving medication use adherence that healthcare providers at the individual and organization levels can use and that addresses medication use over the continuum of care. The set should include practices that apply to all patients, as well as those that address the additional needs of populations that face challenges in understanding healthcare information, such as those with LEP, limited literacy, and/or cognitive impairments, as well as other vulnerable or high-risk populations. Goals for improvement in a set of provider-focused practices should include facilitating care coordination; improving written information and verbal communication; routinely assessing patient adherence; providing tools patients can use to take charge of their own care; and addressing poor adherence resulting from cost/access issues.
- **Stakeholder engagement.** Engage a broad array of stakeholders, including consumers, pharmacies, provider organizations, purchasers, policymakers, pharmaceutical manufacturers, and information technology vendors, in developing and implementing strategies to improve adherence. Establish a case for each respective stakeholder that emphasizes how improving medication adherence meets its established needs and interests. Implement system-level changes through a combination of policy and purchasing strategies that will support and facilitate action by all involved stakeholders to improve medication adherence.

Center for Health Improvement
Policy Brief Manuscript Draft 12-05-05

Opportunities for Improving the California Pharmacist-Patient Consultation Process

Older Californians at Risk

This Center for Healthcare Improvement (CHI) issue brief summarizes the findings of a two-year study to examine the mandated pharmacist-patient consultation process and its effects on Californians aged 65 years and older. This is a timely issue, given the recent addition of prescription drugs to the federal Medicare program and anticipated expansion in particpation of the benefit. By May 16, 2006, 4.3 million California seniors must make a critical decision about their drug coverage[1]. The study's focus on seniors is also important since persons aged 65 and older are prescribed twice as many medications as persons under 65[2]. Approximately 90% of older persons take at least one prescription drug, and among them, nearly half use five or more different drugs[3]. Older adults have more chronic diseases and multiple conditions, thus the consultation is more relevant and complex. Finally, persons 65 and older constitute a more vulnerable population[4].

Recent attention by the Institute of Medicine has significantly raised the visibility of medical errors overall. Problems related to prescriptions drugs comprise one source for such errors. For example, in an analysis of adverse drug events (ADEs) occurring in a population of older adults in an ambulatory setting, 27.6% of the documented ADEs were deemed preventable[5]. Findings from this CHI study identified two key areas for improving the consultation: 1) pharmacist time and compensation, and 2) pharmacist-patient communication, as well as pharmacist-physician communication.

California-Mandated Consult: (pullout text box)

A pharmacist shall provide oral consultation...whenever the prescription drug has not previously been dispensed to a patient; or whenever a prescription drug not previously dispensed to a patient in the same dosage form, strength or with the same written instructions is dispensed by the pharmacy. California Regulation 1707.2.b.1[6]

Federal and State Mandate

Enacted just prior to the federal mandate[7], California's Board of Pharmacy (Board) enacted regulations in August of 1990 that required the pharmacist-patient consultation. The regulation was enacted to ensure that necessary dialogue occurs between patients and medication experts to promote safe and effective medication use. Previously, the only study to examine the effectiveness of the counseling regulations was conducted in the early 1990s[8],[9].

Methodology for Examining the Regulation

The CHI study consisted of five components: 1) review of literature; 2) review of Board inspection and complaint data; 3) statewide survey of pharmacists; 4) focus groups of pharmacists, physicians and patients; and, 5) policy roundtable convening. The written survey of pharmacists involved sampling 3,000 of the roughly 5,000 California-licensed community pharmacies. A 32.4% response rate was achieved. The independent/chain pharmacy ratio was 45.4% to 54.6%, generally reflecting the state distribution. Kaiser Permanente Foundation pharmacies were also included in the study. CHI focus groups and the policy roundtable provided further qualitative information.

Survey Findings About the California Regulation

The regulation describes two required components for every consultation:

- Directions for use and storage and the importance of compliance with directions; and,

- Precautions and relevant warnings, including common severe side or adverse effects or interactions that may be encountered.

In addition, the regulation specifies optional components where deemed warranted by the pharmacist.

Figure I: Survey Findings

Provide directions for use and storage of the medication (**Required**)	93.1%
Discuss precautions and relevant warnings, including common severe side or adverse effects or interactions that may be encountered (**Required**)	86.9%
Describe the importance of compliance with the medication directions (**Required**)	81.1%
Verify the name and description of the medication (Optional)	88.1%
Discuss any precautions for preparation and administration of the medication by the patient, including self-monitoring drug therapy (Optional)	81.8%
Discuss serious potential interactions with known nonprescription medications (Optional)	59.6%
Discuss therapeutic contraindications (Optional)	59.0%
Discuss action to be taken in the event of a missed dose (Optional)	39.1%

Respondents were asked how often these events occurred during an average consultation for patients 65+: the scale was "rarely ever", "occasionally", "sometimes", "often" and "always". Figures above reflect the sum of the responses for "often" and "always".

Pharmacist Time & Compensation

The findings from the survey, focus groups and policy roundtable all identified time and compensation as critical barriers to maximizing the pharmacist-patient consultation.

- 56.8% of the survey respondents indicated that the pharmacist's lack of time was a significant barrier.
- 42.3% indicated that insufficient compensation specific to the consultation was a significant barrier.

The issue of time and compensation as barriers to the consultation are consistent with findings from studies in both New York and Massachusetts[10,11]. Specifically, formulary issues and staffing were identified as time and compensation barriers.

Formulary Problems

Pharmacists in the focus groups discussed time-consuming activities that have no clinical bearing on the consult, specifically, spending time dealing with prior authorization issues. For example, pharmacists submit a prescription for insurance approval, are then notified of the need for prior authorization, and then have to contact the prescribing physician. Physicians also noted that the prior authorization process was unwieldy and time-consuming for them and their staff.

Further, as formularies have become more complex, some pharmacists now rely on electronic devices to submit information for prescription approval. One focus group participant described that his pharmacy is charged $.13 per transmittal, and that if the prescription is rejected as not covered by the formulary, his pharmacy still bears the transmittal charges.

Pharmacy Technician Staffing Ratio

Staffing ratios were identified as an important factor that affects time. In particular, participants described how the pharmacist-pharmacy technician staffing ratio that is regulated by the California Board of Pharmacy adversely impacts small, independent pharmacies that might only have one pharmacist on duty. Some pharmacists advocated for less stringent ratios, as is the case in other states, so that technicians could alleviate the pharmacist from non-clinical duties (insurance follow-up, dispensing, administrative duties, etc.). For pharmacies with one pharmacist on duty, one pharmacy technician is allowed. For each additional pharmacist, two additional technicians are allowed (two total pharmacists, three total technicians; three total pharmacists, five total technicians; etc.).

Time & Compensation Recommendations

- **Consider eliminating the pharmacist-pharmacy technician staffing ratio.** Currently, the pharmacist-technician ratio limits small, independent pharmacies from maximizing technician assistance. Other states have less stringent or no ratios regulating the staffing of pharmacy technicians. The National Association of Boards of Pharmacy surveyed pharmacists and found that "having more technicians available to assist with dispensing duties would increase pharmacist time for patient counseling."[12]
- **Examine current California regulations that might discourage the use of technology.**
  Stakeholders at the policy roundtable expressed interest in examining current policies and regulations that affect technology use in California. Participants noted that the promotion of technology did not have to come at the expense of pharmacists, but that technology can assist pharmacists by freeing them from administrative and other activities that do not fully take advantage of their clinical training.

- **Create financial incentives based on pharmacists' performance.**
  As is occurring with hospitals and physicians, financial incentives awarded to pharmacists can encourage continued quality improvement. Performance measures could include patient satisfaction, dispensing efficiency, and additional services such as medication compliance monitoring, disease management counseling, medication profile review among others.

Technology Innovations (box)

Both small independent and large chain pharmacies are beginning to use robotic machines to conduct dispensing functions. In addition to the added quality assurance benefit to using robots behind the counter, the machines free pharmacist time toward clinical duties. Komoto Pharmacy, an independent community pharmacy in Delano, utilizes a dispensing machine, filling approximately 35% of the total

prescription volume. Owner Brian Komoto, Pharm.D., noted, "the new technology has improved the accuracy of filling prescriptions and given our pharmacists more time to spend with patients"[13].

Communication Process

Survey, focus group and policy roundtable findings also identified communication as critical barrier to the consultation. A distinct gap exists in communication between pharmacists, consumers and physicians.

Pharmacist-Patient Communication

Communication issues in the pharmacist-patient relationship revolve around patient education. There is a need to educate patients about the changing pharmacy profession and the value pharmacists provide in the healthcare system [14].

California pharmacists spoke of the need to educate consumers about the process of navigating formulary issues, including communicating back to the physician, time needed to obtain prior authorization and coordination with changing formularies. One pharmacist noted that as the "last man on the totem pole", all of the consumer's frustrations came to him.

Patients also need to understand the importance of the clinical information that pharmacists can provide, and that patient participation in the consultation is critical. Nearly a quarter of the survey respondents rated the "patient's refusal to participate" as a significant barrier.

Survey results also revealed that older patients waived the consultation 50% of the time "sometimes", "often" or "always". Patients in the focus group mentioned that sometimes they felt embarrassed when the pharmacist "makes the long journey from behind the counter, around the corner to talk to me". Others indicated that "waiting in line with others waiting behind me" only added to the uncomfortable feeling.

Figure 2: Practice Setting Affects Waived Consultations (Box)

Practice setting	Older persons waive the consult "sometimes", "often" or "always"
Independent	43.8%
Small chain	46.6%
Grocery chain	53.2%
Mass merchandise	58.0%
Total Average	50.0%

Older Californians who fill prescriptions at large chain pharmacies are more likely to waive the consultation than those who frequent independent pharmacies. Roundtable stakeholders felt that patients who frequent independent pharmacies have a stronger relationship with their community pharmacist.

Pharmacist-Physician Communication

Survey results reveal that nearly a third of the respondents spend between 10-25% of their time communicating with physicians. Focus group results indicated that this communication is inefficient at best: sending and receiving faxes, calling and leaving messages. Both pharmacists and physicians described frustration at communication with each other and shared the opinion that improvement was necessary in order to better deliver care. It was also apparent during the physician focus groups that some physicians were not aware of the clinical training that pharmacists undertake in order to receive their advanced degree.

Communications Recommendations

- **Develop an integrated, common message around the patient's right to a consult.**

  While multiple groups (e.g., state agencies, patient advocacy groups, pharmacist associations) have been working to improve patient education, the delivery is often through "pilot" projects limited to specific cities. A concerted statewide campaign, involving numerous stakeholders and multiple delivery

methods, may improve education to both patients and physicians about the "patient's right" to a consultation and its clinical value.

- **Examine methods to improve communication between pharmacists and clinicians.**

  Outreach among stakeholders is vital to improving communication. Policy roundtable participants, particularly the California Medical Association and the California Pharmacists Association, spoke of the need for continued forums in order to work on communication issues and develop strategies to improve. Pharmacy and medical school curriculum can be improved to promote better communication and team efforts for delivering care.

- **Promote technology to reduce inefficiencies.**

  As health information technology continues to grow in California, ePrescribing can reduce the communication inefficiencies between pharmacists and physicians. Adoption of ePrescribing may simplify formulary complexities, as the physician should be notified whether the medication is covered by the patient's insurance.

- **Explore a process of patient follow-up that shares the results among the care team.**

  Currently certain pharmacies and physician offices use follow-up phone calls to patients regarding use and potential prescription side effects. Within a quality initiative, the sharing of the results between pharmacists and physicians, can improve communication among the three parties. Further, this will promote coordinated care and improve compliance.

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[2] Stagnitti, M. (2003, July). Statistical Brief #21: Trends in Outpatient Prescription Drug Utilization and Expenditures: 1997:2000. Rockville, MD: Agency for Healthcare Research and Quality.

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[4] American Society of Consultant Pharmacists. (2002, March). *Seniors at Risk: Designing the System to Protect America's Most Vulnerable Citizens from Medication-Related Problems.* Alexandria, VA: Author.

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[12] McRae, T. (2003, March). Pharmacy Technicians in California: Snapshot of an Emerging Profession. UCSF Center for the Health Professions.

[13] Brian Komoto, Pharm D. (November 27 2005.) Email communication.

[14] Barnes, J., Riedlinger, J., McCloskey, W., Montagne, M. (1996, October)

Agenda Item H

Miscellaneous Consumer Issues/Articles in the Media

State of California

Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee

Date: January 12, 2006

From: Virginia Herold

Subject: Miscellaneous Consumer Issues and Articles in the News

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

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

Pill regimens test patients
By Kim Painter
USA TODAY
January 9, 2006

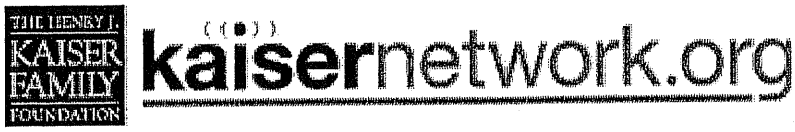
When Judith Feinberg speaks to groups of medical professionals, she often asks a question: How many have ever failed to finish a one-week prescription for antibiotics? "Invariably, almost every hand in the room goes up," she says. Now, she says, imagine you must take handfuls of pills two or three or more times a day. And you have to take them forever. Oh, and if you miss a few pills a month, you might get very sick or even die. Feinberg, a researcher at the University of Cincinnati College of Medicine, is describing how important it is for people with HIV to take their medications. To control the virus, patients need to take at least 95% of their prescribed pills, something 31% of patients recently surveyed by Feinberg didn't do. But the problem goes way beyond HIV. Increasingly, doctors are asking people with chronic and life-threatening illnesses — such as high blood pressure, diabetes and severe psychiatric disorders — to stay for years on often complex drug regimens. Even treatments for some cancers now come in the form of pills that must be taken for months or years. Unfortunately, people are not very good at taking pills over long periods, even when their lives are at stake. Adherent," says Ann Partridge of Dana-Farber Cancer Institute in Boston. "But it turns out that human nature is human nature." In a 2003 study, she found 23% of women prescribed Tamoxifen to prevent recurrence of breast cancer missed at least one of every five doses, enough to raise their risk. Just 50% stayed on the therapy for four years. The World Health Organization estimates just 50% of people with chronic diseases in developed countries correctly follow medical regimens. The reasons aren't always clear but can include side effects, inconvenience, costs and doubts about a medicine's effectiveness.... SKIPPING PILLS? TELL YOUR DOCTOR If you are having problems sticking to a pill-taking routine, you are not alone: Your difficulty is a common one and won't shock your doctor. In fact, your doctor needs to know so he or she can help you do better. Experts say patient-to-doctor communication can help clear up many of the problems that get in the way of completing long-term treatments. So when you talk with your doctor, try to figure out what's causing the problem. That may suggest a solution. For example, if you hesitate to take a drug because it makes you sleepy, you might be able to take it in the evening instead of the morning. Or your doctor might be able to assure you that the sleepiness is temporary or offer a lower dose. Likewise, if you think the medication is unneeded, you and your doctor should talk about why it was prescribed. Other people can help too: If you often forget to take pills or order refills, a pharmacist can suggest solutions. And a family member or friend can be enlisted to help you devise pill-taking routines that work for you.

When Teenagers Abuse Prescription Drugs, the Fault May Be the Doctor's
By HOWARD MARKEL, M.D.
NY Times - Essay
December 27, 2005

Every Thursday evening, I counsel a group of teenagers with serious substance abuse problems. None of the youngsters elected to see me. Typically, they were caught using drugs, or worse, by their parents or a police officer and were then referred to my clinic. To be sure, all the usual intoxicants - alcohol, marijuana, amphetamines, LSD and cocaine - are involved. But a new type of addiction has crept into the mix, controlled prescription drugs, including potent opiate painkillers, tranquilizers and stimulants used to treat attention deficit disorders. This is hardly unique to my clinic. Several studies report that since 1992, the number of 12- to 17 -year-olds abusing controlled prescription drugs has tripled. In fact, dabbling with some of the pharmaceutical industry's finest psychoactive compounds constitutes the fastest growing type of drug abuse in the United States, outpacing marijuana abuse by a factor of two. One of my patients, Mary, illustrates this trend all too well. A voracious reader and a talented musician in her high school orchestra, Mary at 16 is also a "garbage head," meaning that she will ingest anything she thinks will give her a high. So where does this physically robust teenager obtain her pills? Weeks earlier, she had a tonsillectomy, a minor though uncomfortable procedure by any standards. The surgeon wrote a prescription for 80 tablets. Mary spent the next week in a narcotized and medically sanctioned bliss, until her mother confiscated the last 20 tablets. At medical conferences, I hear colleagues fault parents who abuse and obtain these controlled substances but leave them easily accessible in their unlocked medicine chests where teenagers can help themselves. Other experts fault the Internet, where almost anyone can obtain controlled prescription drugs from offshore pharmacies with a few clicks on a home computer. ?None of these targets come close to the real root of the problem. Many doctors are too quick to write prescriptions for these powerful drugs. The National Center for Addiction and Substance Abuse recently reported that 43.3 percent of all American doctors did not even ask patients about prescription drug abuse when taking histories; 33 percent did not regularly call or obtain records from a patient's previous doctor or from other physicians before writing such prescriptions; 47.1 percent said their patients pressured them into prescribing these drugs; and only 39.1 percent had had any training in recognizing prescription drug abuse and addiction. Yet from 1992 to 2002, prescriptions written for controlled substances increased more than 150 percent, three times the increase in prescriptions for all other drugs. The morning after hearing about Mary's Oxycontin holiday, I called her surgeon and asked him whether he had read her medical chart detailing an extensive history of substance abuse. "Why did you prescribe this narcotic bazooka when a BB gun of a painkiller such as acetaminophen might have done the trick?" I asked. Sheepishly, the surgeon replied, "Well, I guess I wasn't thinking." No one in pain - physical or psychic - should suffer. But the fact remains that we doctors still do the bulk of prescribing of the substances. The search for root causes of the epidemic with controlled substance abuse has to include doctors as active participants. A big part of the solution depends on reserving prescriptions for those who need, rather than desire, them.

http://www.nytimes.com/2005/12/27/health/27essa.html

Public Ed



Kaiser Daily Health Policy Report

Wednesday, November 02, 2005

Prescription Drugs

Wholesale Prices of Brand-Name Prescription Drugs Rose at Double Inflation Rate, Generic Drug Prices Did Not Rise in Past Year, AARP Says

Wholesale prices for brand-name prescription drugs increased at twice the inflation rate for the one-year period that ended on June 30, according to a report released on Wednesday by AARP, *USA Today* reports. For the report, AARP tracked wholesale prices charged by pharmaceutical companies for the 200 brand-name prescription drugs most commonly used by U.S. residents ages 50 and older, as well as prices for the 75 most commonly used generic medications (Appleby, *USA Today*, 11/2). Wholesale prices for brand-name prescription drugs increased by about 6.1% for the year, compared with an inflation rate of 3%, the report found. In addition, the report found that wholesale prices for generic medications increased by about 0.9% for the year (Freking, *AP/Hartford Courant*, 11/2). According to the report, the brand-name prescription drugs with the highest rates of increase in wholesale price for the year included the emphysema medication Atrovent and the insomnia treatment Ambien. The wholesale price for a one-day supply of Atrovent increased by more than 18% for the year, from $2.12 to $2.51, and the wholesale price for a one-day supply of Ambien increased by more than 14%, from $2.19 to $2.50, the report found (*USA Today,* 11/2). The report also found that prescription drug costs for the average U.S. resident age 50 or older who took three prescription drugs increased by $97 (Heldt Powell, *Boston Herald*, 11/2).

Reaction

A statement released by the Pharmaceutical Research and Manufacturers of America criticized the AARP report. According to PhRMA, the report should have examined retail prices, rather than wholesale prices, and did not account for discounts provided to large prescription drug purchasers. PhRMA also said that the consumer price index indicated a 4.2% medical inflation increase and an average prescription drug price increase of 3.4% between July 2004 and July 2005. In addition, according to some analysts, the report does not indicate most U.S. residents have health insurance that covers some or all of their prescription drug costs. Joe Antos, a health policy analyst at the American Enterprise Institute, said, "What they've been trying to measure, even if they were successful at measuring that, really hasn't had a lot of relevance to many people in this country." However, Consumers Union spokesperson Steven Findlay said that the report highlights important trends over time. John Rother, policy director for AARP, added, "We're putting a spotlight on what manufacturers are charging, which is by far the most significant part of the price equation" (*USA Today,* 11/2).

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

public ed

New Washington, D.C., Prescription Drug Price Law To Take Effect Next Week

A Washington, D.C., law that aims to regulate prescription drug costs by allowing residents to file lawsuits against drug companies over their pricing will take effect next week despite lawsuits challenging the regulation, the Washington Examiner reports. The legislation, sponsored by D.C. Council member David Catania, would allow residents to file suit against a drug company if a judge determines the drug's cost to be excessive, which is defined in the law as more than 30% of the drug's price in Germany, Australia, Canada or the United Kingdom. Companies found to charge excessive prices could be fined or forced to lower their prices (Neibauer, Washington Examiner, 12/12). Mayor Anthony Williams signed the measure into law on Oct. 3 after the council approved it in September (Kaiser Daily Health Policy Report, 11/1). The Pharmaceutical Research and Manufacturers of America filed a lawsuit in U.S. District Court alleging the law will decrease drug supplies, limit development of new drugs and lead to excessive lawsuits. The Biotechnology Industry Organization filed a similar suit, and the cases have been consolidated. The D.C. government responded to the suits by filing a motion arguing that PhRMA has no basis to sue. A ruling is expected this month. Meanwhile, Catania said he is not aware of any individuals or groups who plan to immediately file suits against drug companies under the new law (Washington Examiner, 12/12).

http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=34311

Lawmakers Working on Provision That Would Protect Vaccine Makers Against Lawsuits

Some Senate Republicans hope to add "sweeping language" that would provide flu vaccine manufacturers with liability protections to the "must-pass" fiscal year 2006 defense appropriations bill (HR 2863), a move that has "sparked outrage from Democrats and consumer advocates," USA Today reports. Lawmakers on Wednesday continued to discuss the details of the liability protection provision, which Senate Majority Leader Bill Frist (R-Tenn.) supports. One version of the provision would allow patients injured by flu vaccines to file lawsuits against manufacturers only in cases in which they could prove misconduct. According to Amy Call, a spokesperson for Frist, the Senate could vote on the provision as early as Friday (Stone, USA Today, 12/15). According to the Christian Science Monitor, consumer and open-government groups have "succeeded in slowing the progress" of a bill (S 1873) introduced by Sen. Richard Burr (R-N.C.) to establish a Biomedical Advanced Research and Development Agency that included similar liability protections.

http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=34339

Health Insurers Push Pill Splitting: As a Way to Save Money on Drugs
Tara Parker-Pope
Wall Street Journal
November 22, 2005

A new cost-cutting push by one of the nation's largest insurance companies is encouraging patients to engage in a controversial tactic: cutting their drug bills by cutting their pills in half.

UnitedHealth Group's is now offering patients a chance to lower their copayments by buying a pill for twice the dose they need and cutting it in half. The program is voluntary and gives patients the opportunity to save as much as $300 annually in copayment costs per prescription. The move is being closely watched by the insurance industry, and experts say that if it is successful, other insurers likely will begin to offer pill-splitting options to their customers as well.

One concern is whether insurers will eventually make pill splitting mandatory, forcing patients to essentially become their own pharmacist. Drug makers have long raised concerns about the health risks of splitting pills incorrectly, or attempting it with inappropriate drugs. But a slew of research demonstrates that for many medications, pill-splitting is entirely safe when done correctly.

Because of a quirk in the way drugs are made and priced, many pills cost the same regardless of the dosage. For instance, drugstore.com sells a one-month supply of the cholesterol drug Lipitor in 20-milligram pills for $99. It also sells a month's worth of 40-milligram pills for about $99. One reason drug makers price drugs this way is to encourage patients to take the most effective dose without having to pay significantly more money than a lower dose. So a patient with a 20-milligram Lipitor prescription could buy a month of the higher-dose pills, cut them in half, and get two months' worth of Lipitor for the same price.

The practice of pill splitting to save money has long been used by uninsured patients who have to pay for drugs out of their own pocket. And some insurance firms like Kaiser Permanente, provide information and pill-splitting devices to customers whose plans don't include drug coverage. The U.S. Department of Veterans Affairs has also pushed the practice. But the pill-splitting plan by UnitedHealth marks the first time a major insurance firm has encouraged the practice as a way for customers who already have prescription-drug coverage to lower copayment costs.

Although pill splitting conjures up images of kitchen knives and cutting boards, numerous plastic devices have been developed to make the job easier and more precise. The devices range in price from about $3 for a simple drug-store version to $25 for one specially designed to easily split Viagra. UnitedHealth gives its patients a free splitter that looks a little like a small stapler. Open it and set the pill inside. Close it and a blade inside the device swipes through the pill.

The easiest pills to split are relatively flat, round and scored with a line down the center. Odd shaped pills like diamond-shaped Viagra can be trickier, which is why specialty pill-splitters have gained popularity. In addition, splitters only work if a pill comes in double your needed dose -- they can't be used to cut a pill into thirds.

The drug industry, which stands to lose billions if the practice is widely adopted, has long criticized pill splitting as unsafe, saying that patients may not get the exact dose if they start cutting pills in half.

And some pills -- like extended release tablets or the migraine drug Imitrex -- won't work at all if they're cut in half. Capsules with powder or gel in them also can't be split. And the simple splitters might be too difficult to use for patients with vision problems, severe arthritis or dementia. In addition, since some elderly patients are burdened with several prescriptions, some experts worry that pill splitting will end up being a disincentive to comply with a doctor's prescription regimen, because it will involve splitting hundreds of pills each month.

But some recent studies have debunked the safety concerns about splitting pills. Most recently, the American Journal of Cardiology in June examined voluntary pill-splitting of cholesterol drugs among nearly 4,000 patients seen by doctors at six Veterans Affairs centers in Florida. There were no differences in patient compliance, side effects or improvement among pill splitters and non-pill splitters. The pill-splitting push saved the VA more than $46 million in 2003, according to the journal report.

UnitedHealth customers who split pills will cut their copayment costs in half, saving $12 to $25 per prescription, depending on the drug. For the insurance industry, pill-splitting has the potential of saving billions annually.

The company says the plan has built-in safety measures. For instance, patients can split pills and save on copayments only with permission from a doctor. That way doctors can make sure that patients with dementia or other health problems that could interfere with accurate pill splitting don't take part.

To prevent patients from splitting the wrong types of pills, only certain categories of drugs qualify, including cholesterol drugs, blood pressure drugs known as ACE inhibitors and Angiotensin Receptor Blockers, anti-depressants such as Zoloft and the anti-viral drug Valtrex. A company spokesman said the plan only includes drugs that have been shown in published studies or other research to be safe to split.

UnitedHealth says the program was "extremely popular" when it was studied as a pilot test program among patients in Wisconsin, which is why the firm decided to launch it nationally.

Half of a pill "is as safe as any normal pharmaceutical," says spokesman Mark Lindsay. "The clinical evidence clearly shows that under a doctor's supervision you can do this and have the same clinical effect and save consumers and employers a lot of money."

http://online.wsj.com/article/SB113261907027203602.html?mod=health_hs_pharmaceuticals_biotech

CBS NEWS

BACK PRINT

A Prescription For Price Relief

ASHBY, Minn., Nov. 21, 2005

(CBS) Sharon Martinson was as concerned as anyone about prescription drugs. After all, she's a professional care giver.

But **CBS News correspondent Lee Cowan** reports that now that Martinson is 62 and her health has begun to fail, pushing pills became personal.

Her prescriptions came to $800 a month, which she simply couldn't afford.

"I so much as went to the doctor and said 'Is there any thing, any one of these that I can get off of?' and he said 'no,'" Martinson says.

Then, she heard about this tiny pharmacy in the middle of a Minnesota cornfield, where a young pharmacist was offering the same drugs that cost her $800 — for just $200.

His name is Jim Witt. Don't let his quiet demeanor fool you — he's almost single handedly taking on the pharmaceutical industry.

"If my cost for a bottle of pills is, ya know, a dollar," says pharmacist Jim Witt. "Why should I charge $25 for that?"

There's no gimmick. Instead of charging what the drug companies suggest for their generic drugs, he charges about what he pays.

Imagine — drugs near cost.

Witt points to one medicine which costs about $15, as opposed to what a drug company suggests he should charge — $198.

Witt's goal: to try to keep his prices between 35 and 40 percent less than the so-called discount pharmacies.

"Every little helps now days," says customer Harold Larson.

But Witt admits it's a risk. By not charging the mark up on generic drugs, it comes out of Witt's pocket at the end of the day.

"I could be charging more but I wouldn't feel right about it," Witt says.

It started out as just a little home town hospitality, but it's catching on. His corner drug store — the only one in this town of about 500 — is now getting inquiries from all over the country.

He hopes the volume may one day make up for whatever losses he's taking — proof he says that good business doesn't necessarily mean bad medicine.

For Sharon Martinson, it was nothing short of a miracle.

"I was just blessed," Martinson says. "I was just blessed."

A David in a sea of Goliaths, dispensing relief in more ways than one.

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Drug Costs Are Target of Long Beach Hospital Pharmacist, Melinda Klein scours studies and patrols the halls in an effort to ensure smart spending.

Denise Gellene
LA Times
January 3, 2006

When Sepracor Inc. wanted Long Beach Memorial Medical Center to use more of its asthma medicine, the company went to see Melinda Klein. Three published studies touted the benefits of Xopenex for asthma patients requiring emergency care. But Klein, a Memorial pharmacist, thought the medicine looked no better than an inexpensive generic drug. Klein recommended keeping Xopenex off the hospital's list of preferred medicines, or formulary. A hospital committee of doctors, nurses and pharmacists voted to follow her advice, despite objections from some local allergists. With drug costs threatening to consume more of their budgets, hospitals are turning to experts like Klein. At Memorial, she oversees a team of pharmacists who pore over clinical studies to penetrate drug-company hype. Although Klein does not have the final say on which medicines make it onto the hospital's list of preferred drugs, her opinion carries weight. "The pharmacy has a lot of power," said Sara Owen, a Sepracor sales representative who had sought Klein's endorsement of Xopenex. When Klein, a graduate of USC's School of Pharmacy, started at Memorial in 1982, her focus was getting prescriptions filled quickly and accurately. After she became director of inpatient pharmacy five years ago, Klein's attention was increasingly drawn to the bottom line...Memorial says Klein's efforts have saved the hospital money while giving patients access to appropriate drugs. But some doctors say the drive to control costs may prevent some patients from receiving drugs that may be better for them....From a tiny office in the hospital's basement, Klein monitors an annual budget of more than $13 million. Charts tracking drug expenditures cover a bulletin board. Each day she receives spending reports on the 25 costliest drugs used at the hospital. Five expensive medicines can't be administered without her OK....Klein is careful to keep herself from coming under the influence of drug companies. She won't accept pens, notepads or other gifts. Klein strives to limit the industry's sway with the medical staff. ...In May, Memorial barred sales reps from providing free meals to doctors and nurses on hospital grounds. Klein pressed for the ban, modeled on prohibitions at Veterans Administration hospitals. The policy also prevents sales reps from promoting products to physicians that aren't on Memorial's formulary. The prohibition doesn't apply off campus. Before calling on doctors and nurses — a practice called detailing — sales reps must fill out a form in Klein's office stating the purpose of the meeting. Klein regularly patrols the hospital to make sure sales reps haven't strayed off limits into staff lounges or patient wards. Three years ago, she removed a sales rep whom she'd found in surgical garb on a restricted patient floor....

http://www.latimes.com/business/la-fi-drugcosts3jan03,1,401383.story?coll=la-headlines-business

http://www.bizjournals.com/industries/health_care/pharmaceuticals/2005/12/05/albuquerque_focus4.html

Published

Personalized medicine could be antidote to soaring care costs
Daniel S. Levine
San Francisco Business Times
December 5, 2005

Here's a little secret of the pharmaceutical industry: Lots of the drugs they sell don't work on a large portion of the people who use them. All right, so it's not so little and it's not so secret. Antidepressants fail in 20 percent to 50 percent of patients who use them. Cholesterol-reducing statins fail in 30 percent to 70 percent of patients who use them. And beta2 agonist drugs fail in 40 percent to 70 percent of all patients who use them. Treating patients with drugs that don't work is not only bad medicine, it is a waste of money in a health-care system struggling to rein in costs. Some see personalized medicine as the answer to this problem. Through the unraveling of the human genome and the pairing of diagnostics and therapeutics, doctors are gaining the ability to genetically determine whether a given drug will work on a particular patient. Genentech's breast cancer drug Herceptin is the classic example of this. Before a patient is given the drug, a test is used to see if the patient overexpresses the HER2 gene. About one in four breast-cancer patients overexpress the HER2 gene and for them the drug is effective. The Washington, D.C.-based Personalized Medicine Coalition, a year-old education and public policy advocacy group, wants to make sure this so-called age of personalized medicine arrives. Ed Abrahams, executive director of the coalition who was in the Bay Area for a dinner meant to draw new members to the group, said it's not the scientific, but the political, regulatory and economic barriers that need to be overcome for personalized medicine to succeed. First, there is the political reality that two-thirds of Americans fear that their genetic information can be used against them by insurance providers and employers. There is legislation in Congress that would prohibit genetic discrimination, and Abrahams said it is important to pass such protections. In the regulatory arena, the question is whether regulators will provide incentives for drug developers to link diagnostics and therapeutics. Developing a test that eliminates the 50 percent of patients that won't benefit from a drug also promises to eliminate 50 percent of its sales. Will drug makers get extended patent protection for developing drugs that are safer and more effective? No less significant is the question of how payers will reimburse people for personalized medicine. Though Centers for Medicare & Medicaid Services Administrator Mark McClellan is seen as supportive of personalized medicine, the industry may face a tough sell to justify higher prices for drugs that are paired with diagnostics, even though they promise to deliver overall economic benefits in the long run. ...But there are also ethical questions personalized medicine will likely raise that may not be front and center in the discussion. What will happen when a doctor has a patient where a diagnostic indicates the drug for his disease will not work for him and it is the only drug available? Will the patient insist on getting a useless drug? Will the doctor prescribe it assuming that even though it probably wouldn't work, it's better than nothing? Will a payer refuse to cover the cost of the drug if a diagnostic test says the drug is not right for the patient and will it be right to do so? These questions will need to be addressed, too.

http://www.bizjournals.com/industries/health_care/pharmaceuticals/2005/12/05/sanfrancisco_newscolumn5.html

Davis Enterprise 1/12/06

WHO urges calm over avian flu

ANKARA, Turkey (AP) — The World Health Organization tried to allay fears today of a massive bird flu outbreak in Turkey, telling people not to panic but urging them to avoid contact with sick or dead poultry.

Preliminary tests in the last week indicate that 15 people in Turkey have been infected with the deadly H5N1 strain — the largest number of cases in a single week since late 2003, when the virus began sweeping Asia. Three children have died, but only two of those cases were confirmed to have tested positive for bird flu.

"The worst situation is a panic situation. There is no reason to panic," Dr. Marc Danzon, WHO regional director for Europe, told reporters at a joint press conference with Turkish Health Minister Recep Akdag. Danzon said health officials were doing "everything that is known to maintain and manage this difficult situation."

Meanwhile, in Rome, the U.N. agriculture agency warned today that the Turkish outbreak could spread to neighboring countries.

"The virus may be spreading despite the control measures already taken," said Juan Lubroth, senior animal health officer at the U.N. Food and Agriculture Organization.

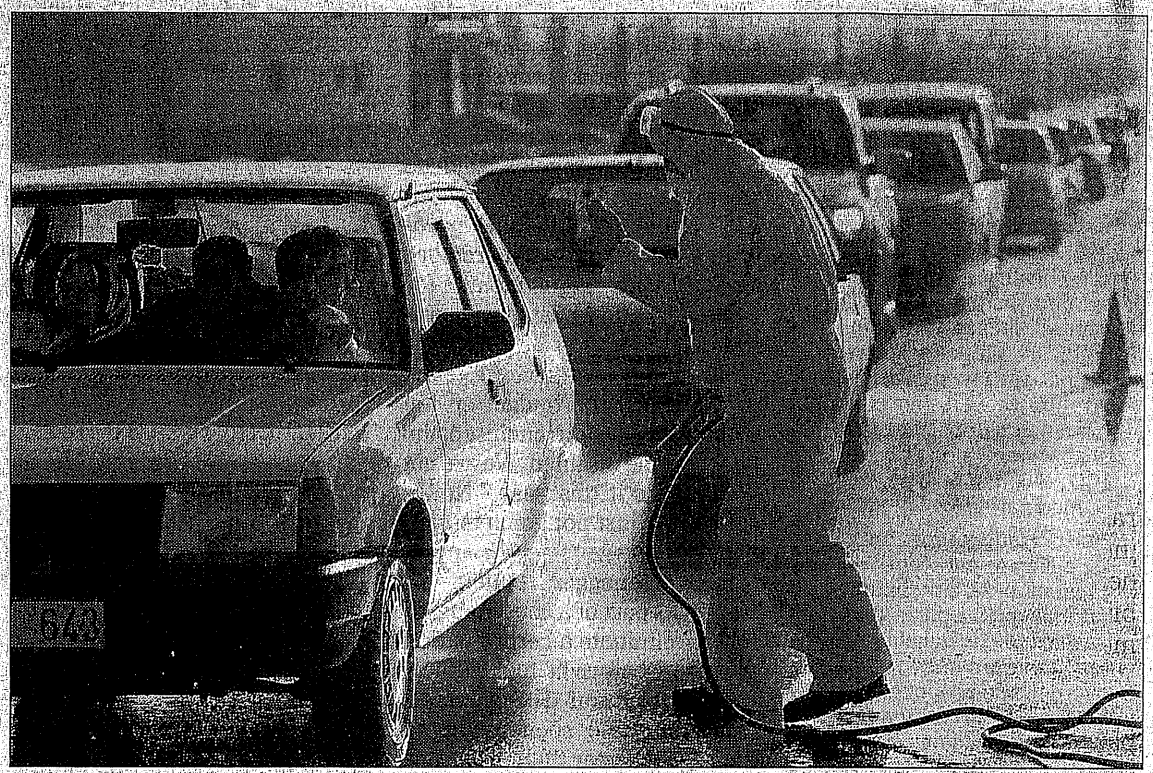
"Far more human and animal exposure to the virus will occur if strict containment does not isolate all known and unknown locations where the bird flu virus is currently present."

Danzon said there were no signs that the deadly strain was being transmitted person to person. Health experts have warned of the possibility that H5N1 could mutate into a potent form easily passed between people, triggering a pandemic capable of killing millions.

WHO said earlier Wednesday that two more people sickened by bird flu in China have died, bringing the total number of humans killed by the disease in that country to five and pushing the death toll worldwide to 78.

Asked about whether countries should ban or restrict their citizens from traveling to Turkey, Danzon called it a "non-story" and said there was no reason in his view to take such measures.

In Turkey, all of the cases appeared to have involved adults or children who touched or played with infected birds.



AP PHOTO

A Turkish Agriculture Ministry worker disinfects cars driving in the eastern Turkish city of Van today.

Doctors: OTC Cough Syrups Not Effective
LINDSEY TANNER
Washington Post - AP
January 10, 2006

CHICAGO -- Despite the billions of dollars spent every year in this country on over-the-counter cough syrups, most such medicines do little if anything to relieve coughs, the nation's chest physicians say. Over-the-counter cough syrups generally contain drugs in too low a dose to be effective, or contain combinations of drugs that have never been proven to treat coughs, said Dr. Richard Irwin, chairman of a cough guidelines committee for the American College of Chest Physicians. But "the best studies that we have to date would suggest there's not a lot of justification for using these medications because they haven't been shown to work," said Irwin, a professor of medicine at the University of Massachusetts Medical School in Worcester, Mass. The group's new cough treatment guidelines discourage use of over-the-counter cough medicines. Irwin said that not only are such medicines ineffective at treating coughs due to colds _ the most common cause of coughs _ they can also can lead patients to delay seeking treatment for more serious coughs, including whooping cough. The guidelines strongly recommend that adults receive a new adult vaccine for whooping cough, approved last year. Many popular over-the-counter cough medicines proudly advertise that they don't cause drowsiness, but Irwin said that is because they do not contain older antihistamine drugs that do help relieve coughs that are due to colds. These antihistamines, including diphenhydramine _ an active ingredient in Benadryl _ are also available over the counter but are not marketed as cough medicines, he said. Some over-the-counter politically untenable to keep putting healthcare ahead of other priorities, such as education, housing and transportation. "I don't think there's any magic tipping point," Palmer said. "Whether this is sustainable politically is a different question. In all probability, there is going to have to be some political action to address these broader issues. I don't think the political climate is such that we are ready."

http://www.latimes.com/news/nationworld/nation/la-na-health10jan10,1,1423663.story?coll=la-headlines-nation

New vending machine dispenses generic prescription drugs
The Boston Globe
January 3, 2006

PROVIDENCE, R.I. --Rhode Island's largest health insurer is trying to keep costs down by offering doctors a new vending machine that dispenses free 30-day samples of generic drugs. San Diego-based MedVantx, which supplies the machine, has contracts with health insurance companies in six other states. Blue Cross & Blue Shield of Rhode Island is its first customer in New England, according to Tuesday's Providence Journal. Brand-name drug companies have offered doctors monthlong samples of their more-expensive products for years. Dr. Stephen Scott, of Johnston, said one result is that doctors tend to prescribe brand-name drugs because they can immediately put a sample in a patient's hand. Now, doctors at Scott's practice can walk to the MedVantx Sample Center, a photocopier-sized machine, and scan a patient's medical records. Seconds later, a drawer pops open with the free medication. "It's making life easier for us," Scott said. "I don't know why anyone didn't think of this before." Blue Cross pays MedVantx a fee and covers the costs of drugs dispensed to Blue Cross subscribers, said Dan Curran, the health insurer's pharmacy manager. MedVantx pays for patients who have different health insurance plans or no health coverage at all. Six practices in Rhode Island have been equipped with the machine, and two more are scheduled to get it next week, Curran said. A dozen more practices are considering installing it. "We're just trying to work with the providers directly, to give them another tool to help patients to get started on the right therapy," Curran said.

http://www.boston.com/news/local/rhode_island/articles/2006/01/03/new_vending_machine_dispenses_generic_prescription_drugs/

Jan Perez

01/12/2006 10:01 AM

To: joshua.room@doj.ca.gov, LaVonne Powell/EXEC/DCANotes@DCANotes, Virginia Herold/Pharmacy/DCANotes@DCANotes, Patricia Harris/Pharmacy/DCANotes@DCANotes
cc:
Subject: Press Clips - Thursday, January 12, 2006

2006-07: Overview of the Governor's Budget
The Legislative Analyst's Office has just issued the following report:

The 2006-07 Governor's Budget now projects that the state will be able to fund much more than a current-law budget and still maintain fiscal balance in 2006-07. The plan, however, moves the state in the wrong direction in terms of reaching its longer-term goal of getting its fiscal house in order. Given the state's current structural budget shortfall, we believe that the 2006-07 budget should focus more on paying down existing debt before making expansive new commitments. (22 pp.)

http://www.lao.ca.gov/2006/budget_ov/2006-07_budget_ov.htm

Foreign Prescriptions Pose Risk
WSJ - DOW JONES NEWSWIRES
January 12, 20006

WASHINGTON -- The Food and Drug Administration warned health-care professionals and consumers that filling prescriptions abroad may have adverse health consequences, saying confusion with drug brand names could inadvertently lead consumers to take the wrong medication. "An FDA investigation has found that many foreign medications, though marketed under the same or similar-sounding brand names as those in the United States, contain different active ingredients than in the United States," the agency said. "Taking a different active ingredient may not help, and may even harm, the user." Dr. Murray Lumpkin, deputy FDA commissioner for international and special programs, said consumers who fill U.S. prescriptions abroad, either when traveling or when shopping at foreign Internet pharmacies, need to be aware of this potential health hazard. The FDA said, for example, that in the U.S. "Flomax" is a brand name for tamsulosin, a treatment for an enlarged prostate, while in Italy, the active ingredient in the product called "Flomax" is morniflumate, an anti-inflammatory drug. The FDA said it found 105 U.S. brand names with foreign counterparts that look similar but could lead customers astray.

http://online.wsj.com/article/SB113703863100844615.html?mod=health_hs_pharmaceuticals_biotech

Ready or not, the new federal drug plan is here
Carol Harrison
The Eureka Reporter
1/11/2006

What some are calling the most significant benefit change in the 40-year history of the Medicare program debuted this month to mixed reviews on the North Coast and jammed telephone lines throughout the country. "We had 1,000 people cued up and a one-hour-and-45-minute wait," said a Medicare benefits service specialist, who picked up a reporter's call after a 23-minute wait Sunday night on the national hotline at (800) 633-4227. "We fielded 12 million calls in December, and we did that many in the first week of this year." Our techs have been on the phone all week," said Rich Spini of Cloney's Pharmacy on Harrison Avenue. "We've been working tons of hours, even on Saturdays when we're not usually open." "For the most part, it's a little more hectic," said Mike Cent, managing pharmacist for Costco in Eureka. "There's a learning curve, but once we get it, it will be a piece of cake."..."We had one woman whose diabetes medicine wasn't on the formulary for the plan she was in," Spini said. "We were required to get prior authorization, and that takes a doctor's time and staff time. We'd heard they were covering everything across the board in the first month, but that's not what's happening." "In the first week of the year, we tried to call the number they'd set up for pharmacies and we had a two-hour-and-25-minute wait,"

said Kristin Campbell, pharmacy technician for Lima's Professional Pharmacy in McKinleyville. "We can't hold an hour for one patient." Online checks of registrations have gone well, but some have seen their share of glitches. "Of our dual enrollees, 25 percent have received their cards, 50 percent have some sort of information and 25 percent are just not in the system," Campbell said. "Thank God for our software. When you get a prescription or a refill that comes up with no glitches, you almost want to jump up and down." "For the people who have done their homework, it sails through smoothly," said Risa Less, pharmacy manager in Longs of Arcata. "Tuesday afternoon, I spent the whole day out here answering questions. We can't legally give advice, but we can tell them how to go about it." "Maybe 25 percent of ours have had problems," said one Walgreens pharmacist who chose not to be identified. "Some plans aren't going through because they haven't been completely assigned or they're missing paperwork. But we have a relatively good computer system and we usually get results pretty quickly." She also had to deal with them the last week of December as media publicity created a crush of 100-day supply requests. "The whole thing's created a cash flow problem," said Campbell. "We were inundated with requests for 100-day supplies. I couldn't believe the tremendous amounts we were dishing out. And it takes three to four weeks to get a reimbursement."....Costco's Cent does not get involved in assisting patients with the Part D prescription drug registration process. "Some people ask, but we don't provide that service," he said. "Doing so requires a lot of time we don't have." Nor does Costco service Medi-Cal patients. "Medi-Cal is a time-intensive entitlement and one way we keep costs low is to run a streamlined operation," Cent said. "Medicare Part D is straightforward and its underlying infrastructure is the same as the insurance industry that is already in place." Asked if he felt the new program could ultimately be seen as an improvement, Cent replied, "Absolutely. I think a lot of people who criticize it don't understand what's going on."

http://www.eurekareporter.com/ArticleDisplay.aspx?ArticleID=7225

New Medicare law trips up the poor, Doctors, pharmacists say some will die for lack of medicine
By Cheryl Clark
Union-Tribune
January 12, 2006

Martha Reagan controls her heart disease and other health problems with 26 drugs that she used to get free through Medi-Cal. But her new Medicare prescription drug plan doesn't cover anywhere near that many, and she can't find a plan that will. "I'm afraid I'm going to have a stroke any minute just worrying about it," said the Chula Vista resident, whose Social Security checks can't pay the drugs' cost. Since Jan. 1, many of the more than 1 million Californians like Reagan – about 66,000 of them in San Diego County – have found themselves in similar straits. Pharmacists, physicians, family members and health advocates fear for such patients' health and are frustrated with the long hours spent fighting a bureaucracy that seems unwilling to bend, even when essential drugs are at issue. This portion of the new Medicare Part D was supposed to help the sickest of the sick – the blind, disabled and low-income, many of them with behavioral or psychiatric diagnoses. These patients are the least likely to fight for themselves, their advocates said...."Come live in my pharmacy for a week and see the people who walk out without their medicine because they don't have $3," said Fadi Atiya, owner of Galloway Pharmacy in Logan Heights. Health advocates, doctors and pharmacists complain of missing patient records, computer delays, poorly staffed hotlines for Medicare and drug plans, uninformed insurance company representatives, and many patients being asked to pay hundreds of dollars for drugs they should be able to get for a co-payment of $1 to $5 per drug. Many companies' drug lists are inadequate, they said, and it's virtually impossible to obtain an exception. "We're only 10 days in," said Dr. Maria Puig, a South Bay ophthalmologist. "But by the end of the month, I'll be able to get you stories of patients who drop dead in the streets because they can't get their heart medication. And if they don't die, they'll just get sick, go to the emergency room and be hospitalized. This is a total and complete disaster." Puig said she and her colleagues have realized that many of the plans operating in California aren't covering some of the most basic prescription medications needed to treat glaucoma, diabetes, high cholesterol, arthritis and other common health problems. Puig said that on Tuesday, for example, she was unable to prescribe drugs for 12 of her 30 patients because their plans didn't cover the right medications. So Puig and her staff spent hours on hold with Medicare and the drug plans, she said, often failing to get emergency exceptions.

"These are people who never had a co-pay (with Medi-Cal)," said Greg Knoll, director of the San Diego Consumer Center for Health Education and Advocacy, which has been trying to help many dual eligibles find the right drug plans. "The patients are in tears, and the pharmacy people are in tears. "They've created one of the greatest public health disasters in our history in a group that never had problems getting medicines before, but are suddenly forced to choose between food and co-pays they shouldn't have to pay."...**John Cronin**, general counsel for the California Pharmacists Association and an Escondido pharmacy owner, recalled a patient in his pharmacy who needed insulin syringes and insulin every day. "We tried to reach (her drug plan), but it was busy for four days," he said. When Cronin finally found her name on an eligibility list, the patient came back to pick up her prescription but was surprised about having to make a $3 co-payment. "She just walked out without it. If a diabetic is not taking insulin, she's going to end up in the hospital," he said.

http://www.signonsandiego.com/uniontrib/20060112/news_1n12medicare.html

A Lesson in Political Math From the Governor
Michael Hiltzik
LA Times
January 12, 2006

Gov. Schwarzenegger's State of the State address and his budget proposal brightened the post-New Year's doldrums this week by demonstrating that the governor still possesses an endearing faith in the power of political math. Political math is unlike real math in that it has no correlation with the natural world. It's what allows the governor to propose a $68-billion infrastructure bond, nearly twice the size of the state's current general-obligation debt load, while assuring us in almost the same breath that this can be done without raising taxes. Political math also allows him to claim that his proposed budget is balanced, also without a tax increase. Wrong on both counts. First of all, it's not balanced, insofar as it anticipates general-fund spending of $97.9 billion and revenue of $91.5 billion. The plan is to fill the gap by raiding the state's reserve fund, which has been stocked with borrowed money. In other words, for the third year running, the governor will spackle over a deficit with debt. This is known as not "living within our means." As for avoiding tax increases, he means only the sort of increases that strike chiefly at the wealthy and powerful, such as raises in the top income tax brackets. Of the hidden taxes that strike at middle- and lower-income workers and the poor, the Schwarzenegger budget is, as always, a feast. He proposes to suspend for another year a tax break for schoolteachers, many of whom pay for classroom supplies out of their own pockets. Eliminating this tax credit, which ranges from $250 to $1,500 depending on a teacher's years of service, will extract $210 million in revenue from about 305,000 educators and their families. The richest 300,000 state taxpayers, who avoid tax increases via budget provisions such as this, report average annual incomes of more than $500,000. The average salary of a full-time K-12 teacher in California last year: $38,845. Other groups drafted to subsidize the wealthy include the disabled and poorest of the poor. The governor wants to delay a cost-of-living increase due next year for recipients of supplemental security income by 18 months, to July 2008. These recipients are, by definition, needy seniors, the blind, and the disabled. The proposal would deprive them of a total of $233 million, keeping the money for the general fund, over two budget years. Another $307 million would be saved for the rich by withholding cost of living increases, or COLAs, scheduled to be paid to recipients of CalWORKS grants. The recipients generally are poor families with children. The governor reassured the press at his post-budget news conference this week that "we're not picking on anyone." Indeed, I wouldn't wish to suggest that wealthy taxpayers aren't being asked to make sacrifices of their own. The governor proposes to extend for another year the state's policy of collecting sales tax on luxury cars, boats and aircraft purchased out of state and brought into California within a year of acquisition. As a result of this stringent policy, buyers of such trophies will be forking over an estimated $35 million, or fully one-sixth of what's being squeezed out of the teachers alone.....

http://www.latimes.com/business/la-fi-golden12jan12,1,2558152.column?coll=la-headlines-business

Gov. Gets Earful From GOP: Republican legislators want Schwarzenegger to slash borrowing for

his $222-billion public works plan and ease environmental rules.
Peter Nicholas
LA Times
January 12, 2006

Republican lawmakers on Wednesday laid out conditions that Gov. Arnold Schwarzenegger must meet to get their crucial votes for his $222-billion public works program. The legislators gave Schwarzenegger a list of demands in a private meeting in the Capitol, where the governor had hoped to assuage their concerns that he may be saddling the state with too much debt without enough to show for it. At the top of the list was a request that the governor pare the $68 billion in state borrowing his plan envisions and relax environmental protections as a means to speedily shore up roads, levees and other infrastructure. Schwarzenegger needs a two-thirds majority of the Legislature to send his sweeping proposal to the ballot, giving the Republicans special leverage. Even if he gets every Democratic vote, he would need at least six Republican votes in the Assembly, and two in the Senate. The meeting was attended by Assembly Republicans. "A two-thirds vote is required to put this on the ballot, and they need Republican votes," said one participant, Assemblyman Roger Niello (R-Fair Oaks). "If we have certain principles that are extremely important to us ... then those principles will have to be included." Schwarzenegger laid out his proposal in his annual State of the State speech last week. It calls for 550 miles of new carpool lanes, 750 new highway miles, 600 miles of new commuter rail lines and the repair of 9,000 miles of existing freeways. The $222-billion cost would be over 10 years, paid through a mix of borrowing, federal and local money, new tolls, fees and contributions from private industry....

http://www.latimes.com/news/local/la-me-arnold12jan12,0,5898178.story?coll=la-headlines-california

Woman named as state tax chief The surprise choice edges out interim FTB Director Will Bush.
Andrew McIntosh
SacBee
January 12, 2006

A Sri Lankan attorney who came to California in 1986 will take the reins as the state's new tax czar, the first time a woman has been named executive officer of the Franchise Tax Board in its 55-year history. Selvi Stanislaus, 45, was the unanimous choice of the three-member Franchise Tax Board on Wednesday, following several hours of closed-door deliberations. She edged out interim FTB Director Will Bush, who until this week was widely considered the leading contender for the top job. Stanislaus' appointment, which is subject to Senate confirmation, is effective Tuesday. She succeeds Gerald H. Goldberg, who retired in 2005. Stanislaus told The Bee she was humbled and thrilled to be picked for the $129,418-a-year job as head of the second-most-important tax agency in the United States, next to the Internal Revenue Service. "I am so honored to have this great chance," said Stanislaus, who will oversee 6,000 FTB employees nationwide. A senior tax attorney at the Board of Equalization since 1996 and a tax law professor, Stanislaus will meet FTB staff today to develop a transition plan....

http://www.sacbee.com/content/business/taxes/story/14064606p-14895495c.html

Schwarzenegger Announces Appointments to Several State Boards, Offices
California Healthline
January 12, 2006

Gov. Arnold Schwarzenegger (R) on Wednesday announced several appointments to state boards and offices, including the following health-related positions: Steven Klompus (R) was appointed to the Physician Assistant Committee of the Medical Board of California. Klompus is a physician assistant with East Edinger Industrial Urgent Care and is a clinical instructor of physician assistant education at Western University of Health Sciences, the University of Southern California and Loma Linda University. The position pays $100 per diem and does not require Senate confirmation. Kathleen Webb (D) was appointed director of the Office of the Insurance Advisor. Webb currently is a legislative specialist for State Farm

Agenda Item I

Update on the Board's Public Outreach Activities

State of California | Department of Consumer Affairs

Memorandum

To: Communication and Public Education Committee Members

Date: December 19, 2005

From: Virginia Herold

Subject: Public Outreach Activities

The board strives to provide information to licensees and the public. To this end, it has a number of consumer materials to distribute at consumer fairs and attends as many of these events as possible, where attendance will be large and staff is available.

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

Public and licensee outreach activities performed since the last report to the board that have been reported to me are:

- Board President Goldenberg participated on an NABP Task Force on Telepharmacy and the Implementation of the Medicare Drug Benefit Medication Therapy Management Provisions conference call on October 27.
- Board President Goldenberg was keynote speaker at a conference of long-term care executives on Medicare Part D in Los Angeles on November 4.
- Supervising Inspector Ming presented information about pharmacy law and board pharmacy inspections to a group of UCSD pharmacy students on November 14.
- Assistant Executive Officer Herold presented information about the board to a group of UCSD pharmacy students on November 28.
- Supervising Inspector Ming presented information about sterile compounding to a group of pharmacy technician students at Santa Ana College on November 30.
- Board Member Jones presented information about pharmacy technology at the NABP Fall Conference in Florida on December 4.
- Board Member Fong will present information about new pharmacy laws to pharmacists at the Diablo Valley Pharmacists Association Meeting on December 28.
- Supervising Inspector Ratcliff will present information to the California State University Pharmacists on current law topics on January 12.
- Board President Goldenberg and Supervising Inspector Ratcliff will present information about the board and new pharmacy law on January 19 to USC students.

- The board will staff an information booth on February 4 at the San Diego Health Protection Day
- The board will staff a booth at the CPhA Outlook Meeting on February 17 and 18.