Prescription Medication Preparedness Initiative

MAY 28, 2015 COLLABORATIVE MEETING PROCEEDINGS

OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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EXECUTIVE SUMMARY

After a disaster, the interruption of routine healthcare can lead to an exacerbation of chronic illness and the onset of secondary outcomes that result from the deterioration of existing health conditions. Medication maintenance is particularly problematic during and after disasters due to point-of-care closures, disruptions of the supply chain, lost or damaged prescriptions, evacuees forgetting to take prescriptions with them, and patients being unsure of the exact prescription type and dosage that they are prescribed.

The Prescription Medication Preparedness Initiative Collaborative Meeting explored possible ways to improve the preparedness and resiliency of patients who rely on prescription medications during disasters. Stakeholders from the public and private sectors convened to envision an improved system for ensured access to prescription medications in the days before, during, and after a hurricane or other "notice" disaster.

Barriers to Medication Adherence During Disasters

Before a disaster: Policies that enable emergency prescription medication access are often tied to disaster declarations, which frequently occur after the event and therefore allow no advance warning to refill prescriptions and prepare supply chains; a more preemptive trigger should be identified. Furthermore, many payors have policies and payment practices that can prevent beneficiaries from refilling medications "too soon" and there is currently no coordinated mechanism to relax these polices. Finally, patients are not often educated or empowered to plan for prescription medication adherence in the event of an emergency. While many pharmacies have the technological capability to push public health messaging out to individuals, there may be some barriers to doing this routinely (cost, regulations, etc).

During a disaster: Patients are not always knowledgeable about the possibilities for obtaining prescription medication refills should they evacuate outside their region, lose or damage the prescription, or be unable to access their regular pharmacy/retailer. Pharmacy continuity of operations plans may not include provisions to ensure adequate supplies and staff in stores, facilitate patient verification, or plan for alternate dispensing sites should the facility be damaged. Pharmacies are also often disconnected from their local and state emergency management officials and the overall response and would benefit from better integration.

After a disaster: Patients may experience prolonged loss of access to pharmacies, pharmaceuticals, and providers due to evacuation, infrastructure damage, disruptions in supply chains and manufacturing, and social and economic factors. Medically dependent patients may have been adversely affected by the event and require new or different treatments but be unable to access healthcare services.

Priorities Identified

After the meeting, ASPR staff reviewed the meeting proceedings in an effort to identify the most commonly identified barriers to creating an effective emergency prescription medication system. Identified priorities are listed below, in no particular order. For each priority, groups that felt they had a significant role to play are indicated in parentheses.

- Improve current education and messaging for community and providers by addressing any Telephone Consumer Protection Act barriers and ensuring better alignment between local and state response. (Pharmacists/Patient Care, Retailers/Corporate, Government, Payors)
- Draft model legislation for early prescription refill authority in a disaster, including provisions for provider credentialing, exceptions for certain drug types, and allowances for alternate dispensing sites. (Government)
- Draft model language for payor policy, including the circumstances under which payors should authorize early prescription refills and addressing potential issues regarding customer copays. (Pharmacists/Patient Care, Government, Payors)
- Increase prescription medication access outside the pharmacy using assets such as the Medical Reserve Corps, mobile medical units, alternate pharmacy sites, and partnering with other caregivers (e.g. home health). (Pharmacists/Patient Care, Retailers/Corporate)
- Improve pharmacy continuity of operations planning to ensure pharmacies are able to stay open in the event of an extended power outage, flood, or other event. Ensure pharmacies understand and are prepared for the effect a closure may have on refilling prescription medications. (Pharmacists/Patient Care, Retailers/Corporate, Payors)
- Support data sharing among payors, pharmacy benefit managers, and providers in order to streamline care and identify and notify patients who are likely to need additional medication refills in a disaster. (Government, Payors)
- Partner with academia to establish predictive analytics that better identify vulnerabilities at the community-level. (Retailers/Corporate, Government)

Identified Action Items By Group

Each group brainstormed "action items" or solutions they could contribute to in order to address the identified barriers.

The Government Role
1. Convene relevant stakeholders to continue efforts toward a sustainable solution.
2. Convene payors, facilitators, and retailers to determine what advance communication/messaging to consumers can be done within existing laws.

The Payor Role
1. Determine a procedure for refilling lost prescriptions in an emergency and understanding how this may differ from what is authorized every day.
2. Determine a procedure for relaxing where and how the prescription is billed (e.g. are out-of-network billing and whether non-traditional provider billing is allowed).
3. Add messaging to Explanation of Benefits for recipient education, and work with other stakeholders to ensure customer education is coordinated across all points of care.

The Retailer and Corporate Pharmacy Role
1. Print bag stuffers with preparedness information, push out reminders for prescription refill (as allowable), and encourage the culture shift toward early refill of prescriptions.
2. Develop better strategies for evaluating facility-level continuity of operations plans, including provisions for increasing support staff in a surge.
3. Plan for mobile pharmacies.
4. Work with local emergency management to devise a strategy for pharmacy representation in local emergency operations center.

The Pharmacists and Patient Care Role
1. Work with corporate to understand the role of stores outside the disaster impact zone, plan for the allocation of mobile pharmacies, and implement consistent override codes.
2. Work with all other points of care to provide patient education and promote the maintenance of a medication list and the habit of early refills.
3. If the authority exists, incorporate auto refills as a daily practice.
4. Work with governmental and corporate entities to find an appropriate means for pharmacists to be more involved in local preparedness and response, and engage providers in preparedness activities.

Conclusions

This activity resulted in the identification of a number of barriers to successful prescription medication preparedness. Participants furthermore identified potential solutions to these barriers, and offered concrete action items that could be pursued in order to address the barriers. This process was a successful first step toward improving the system to streamline medication refills in a disaster, and efforts should be made to continue this collaboration. A successful system will rely on the efforts of many actors working in tandem, so each group is strongly encouraged to remain engaged on the proposed action items as the project progresses.

INTRODUCTION

After a disaster, the interruption of routine healthcare can lead to an exacerbation of chronic illness and the onset of secondary outcomes that result from the deterioration of existing health conditions. Medication maintenance is particularly problematic during and after disasters due to point-of-care closures, disruptions of the supply chain, lost or damaged prescriptions, evacuees forgetting to take prescriptions with them, and patients being unsure of the exact prescription type and dosage that they are prescribed. A recent systematic review found that among Hurricane Katrina survivors, between 32 and 48.4% of people were without medication supplies after the event. Among patients with severe and/or chronic conditions, 53% of HIV positive patients experienced treatment disruption for greater than 1 week; 19.7% of pediatric outpatients ran out of medications; and 28% of patients with hypertension ran out of their supply.[1] Similar findings were reported for other US and international disasters.

In the aftermath of 2012's Hurricane Sandy, widespread flooding and power outages stranded many people in their homes or required them to live in shelters. Again, thousands of people were without their prescriptions. Some used emergency departments to access medications; others received prescriptions from National Disaster Medical System providers. In a number of cases, individuals could not afford the copay because they could not access funds. Ultimately, several of the national pharmacy chains agreed to waive those copays. However, while copays can be waived on a case by case basis when a pharmacy determines the circumstances are appropriate, federal anti-kickback laws prevent the routine waiver of copays.[2]

In the 10 years since Hurricane Katrina, systems to ensure access to prescription medications before events with warning (e.g. hurricanes) and in the immediate aftermath of no-notice disasters have been developed. The In Case of Emergency Prescription Database (ICERx.org), for example, was launched in June of 2007. Pharmacists used it to access medical records and prescription information, enabling providers to review essential information prior to authorizing refills or providing prescriptions. Prescription history information was pooled from a variety of sources, including community pharmacies, pharmacy benefit managers, and state Medicaid programs. The system was estimated to house information for 70-75% of all Americans, but there was no easy way to verify whether individual records were in the system.

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[1] Ochi S, Hodgson S, Landeg O, Mayner L, Murray V. Disaster-Driven Evacuation and Medication Loss: a Systematic Literature Review. PLOS Currents Disasters. 2014 Jul 18 . Edition 1. doi: 10.1371/currents.dis.fa417630b566a0c7dfdbf945910edd96.

[2] "The statute makes it illegal to offer, pay, solicit or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them." HHS OIG Special Fraud Alert 12.19.1994

The Emergency Prescription Assistance Program (EPAP) was a joint program of the Federal Emergency Management Agency and the Department of Health and Human Services. EPAP served as a safety net for individuals who had no health insurance coverage. It provided a means for pharmacies to process claims for prescription medications and limited durable medical equipment (DME) for individuals from disaster areas declared by the President. EPAP customers included those who did not participate in individual health insurance policies, employer-sponsored coverage, public insurance, such as Medicare, Medicaid, or other third party coverage.

The experience following Hurricanes Katrina and Sandy, and that of other recent events, has highlighted some of the remaining systemic challenges in ensuring the provision of prescription medications in the days prior to and immediately following a catastrophic event. The purpose of this meeting was to bring together stakeholders to discuss ways to further develop a system that is able to provide necessary medications to patients in the 5 days before and 3 days after a hurricane (or any other event with advance warning).

> Please note that throughout the document, participants sometimes used the terms "Payor" and "PBM" interchangeably. We recognize that in some cases, the Payor and the PBM are run by the same entity, and in other cases they are separate and the PBM is not the payor. Future PMPI efforts will include education regarding this detail, and the accurate terminology to be used.

MEETING OBJECTIVES

Purpose

The workshop explored possible ways to improve preparedness and resiliency of patients who rely on prescription medications during disasters. Following a major disaster, vulnerable populations often find themselves without access to critical prescription medications. Without medicines to manage their chronic diseases, patients can – and do – become medically compromised. Emergency Departments and disaster medical systems are often overwhelmed by those who simply need prescription refills or are medically compromised from being without their medications. This workshop brought together stakeholders from the public and private sector to share ideas for an improved system for ensured access to prescription medications in the days preceding and immediate following a "notice" disaster, such as a hurricane.

Goal

Within the context of an imminent major hurricane, this workshop explored options for the formation of a streamlined prescription medication refill process to be initiated ahead of and immediately following a hurricane, and the obstacles associated with building such a system.

Collaboration

The workshop was conducted in the spirit of "letting every voice be heard." The meeting outcomes reflect of the diversity of opinion across the attendees and are not meant to suggest consensus recommendations but rather to identify the challenges in our current system for dispensing emergency prescription medications, opportunities for collaboration, and innovative ideas for the way forward.

ACKNOWLEDGEMENTS

Thank You to Our Collaborators
1. Alex Adams, National Association of Chain Drug Stores
2. Pamela Allweiss, Centers for Disease Control and Prevention
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4. Andy Cosgrove, Pharmaceutical Care Management Association
5. John Coster, Centers for Medicare and Medicaid Services
6. Stephen Curren, Office of the Assistant Secretary for Preparedness and Response
7. Debbie Garza, Walgreens
8. Stephanie Hammons, Centers for Medicare and Medicaid Services
9. Jeffrey Kelman, Centers for Medicare and Medicaid Services
10. Jennifer Lumpkins, Association of State and Territorial Health Officials
11. Erin Mullen, Rx Response
12. Rachel Morgan, National Conference of State Legislatures
13. Peter Nadimi, SureScripts
14. Charlie Oltman, Target Pharmacy
15. Sanjay Rayathatha, Rite Aid
16. Megan Reeve, National Academy of Medicine
17. Andrew Roszak, National Association of County and City Health Officials
18. Mitchel C. Rothholz, American Pharmacists Association
19. Michael Schoenbaum, National Institute of Mental Health
20. Lisa Schwartz, National Community Pharmacists Association
21. Susan Sherman, Office of the General Counsel
22. Rebecca Snead, National Alliance of State Pharmacy Associations
23. Bellinda Schoof, American Academy of Family Physicians
24. Marisa Schlafer, CVS Health

Moderators & Presenters
1. RADM Nicole Lurie, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services
2. Mr. Don R. Boyce, Director of the Office of Emergency Management, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services
3. Dr. Cynthia Hansen, Senior Advisor, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services
4. CDR Bruce Dell, US Public Health Service, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

5. Mr. Murad Raheem, Regional Administrator, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

Thank You to ASPR Staff

1. Dr. Gregg Margolis, Director, Division of Health Systems Policy , Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
2. Mr. Victor Harper, Director of the Division of Logistics, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
3. CAPT Mike Bourg, US Public Health Service, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
4. Mr. Kevin Horahan, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
5. Ms. Lauren Walsh, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
6. Ms. Tara Holland, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
7. Ms. Aisha Hasan, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
8. Ms. Sheila Viera, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
9. Mr. William Moore, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
10. Mr. Gerry Stines, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.
11. Ms. Jeanette Dickenson, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.

ACRONYM LIST

ADHD – Attention Deficit Hyperactivity Disorder

ASAP – As Soon As Possible

ASPR – Office of the Assistant Secretary for Preparedness and Response

BOP – Board of Pharmacy

CMS – Center for Medicare and Medicaid Services

COOP – Continuity of Operations Planning

CPA – Collaborative Practice Agreements

DEA – Drug Enforcement Administration

DME – Durable Medical Equipment

DOS – Days of Supply

EHR – Electronic Health Record

EMS – Emergency Medical Services

EOB – Explanation of Benefits

EOC – Emergency Operations Center

EPAP – Emergency Prescription Assistance Program

GOV EO – Governor's Executive Order

HDHP – High Deductible Health Plan

HIPAA – Health Insurance Portability and Accountability Act

HHS – U.S. Department of Health and Human Services

ICERx – In Case of Emergency Prescription Database

IVR – Interactive Voice Response

LOE – Level of Effort

MOU – Memorandum of Understanding

MRC – Medical Reserve Corps

MTM – Medication Therapy Management

NCPA – National Community Pharmacists Association

NHSS – National Health Security Strategy

NPI – National Provider Identifier

NWS – National Weather Service

PBM – Pharmacy Benefit Manager

PDMP – Prescription Drug Monitoring Program

PMPI – Prescription Medication Preparedness Initiative

Rx – Prescription

TCPA – Telephone Consumer Protection Act

METHOD & AGENDA

Overview & Introductions: 20 minutes

Opening Remarks: 10 minutes

Activity One: Individual Brainstorming: 25 minutes

Activity Two: Group Design Development: 45 minutes

Break: 15 minutes

Group Discussion: 25 minutes

Activity Three: Boggle Wall: 70 minutes

Activity Four: Group Brainstorming: 25 minutes

Closing Remarks: 10 minutes

Total Duration: 4 hours[3]

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[3] Please see Appendix for additional detail regarding the outline and strategy for the day.

OPENING REMARKS

Speakers

RADM Nicole Lurie, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

Mr. Murad Raheem, Regional Administrator, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

Mr. Don R. Boyce, Director of the Office of Emergency Management, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

Dr. Nicole Lurie welcomed the participants to the Office of the Assistant Secretary for Preparedness and Response (ASPR) and made the opening remarks to the session. She lauded this effort by both public and private partners to build community resilience and strengthen emergency response systems, and highlighted that the National Health Security Strategy (NHSS) is a 'national' strategy – not a 'federal' strategy – and is successful because of initiatives such as this. Dr. Lurie envisioned a resilient nation, with citizens well-prepared to confront adversity and healthcare systems capable of anticipating population-level needs. She referenced a number of creative approaches toward achieving this end, including current work done in partnership with the Centers for Medicare and Medicaid Services (CMS) that uses hospital claims data to identify vulnerable populations in advance of a notice-event with the goal of ensuring continuity of essential patient care in an emergency. Those participating in the workshop were encouraged think evermore creatively about how to build a system that could better ensure access to essential medications before, during, and after an emergency. Dr. Lurie closed by voicing her willingness to provide support and resources towards this effort, and thanking the collaborators for their ongoing contributions.

Dr. Lurie's presentation was followed by that of Mr. Raheem, who grounded the workshop's objective and goals in recent disaster experiences. Mr. Raheem indicated that though the workshop scenario was largely inspired by the experiences after Hurricane Sandy, many other events have and will continue to result in the same complications. He noted that following Hurricane Sandy, New York City had a mechanism in place to provide support to residents in their homes. A central challenge was that people did not anticipate staying in their homes without heat and electricity as long as they did, and that this was a particular problem for those with chronic or severe medical conditions. Exacerbating the issue was that patients were sometimes unable to tell the volunteer medical teams what medications they had been prescribed or provide an accurate medical history. Mr. Raheem, too, referred to the ASPR/CMS partnership that enables emergency managers the capability of locating medically-dependent

patients prior to an event and noted the positive impact that innovating projects such as this have on the appropriate and timely provision of healthcare services post-disaster. He closed his presentation by encouraging the group to think about better ways to ensure availability of sufficient pharmaceutical staff and supplies to meet emergency demands.

The opening session was closed out by Mr. Boyce. Mr. Boyce shared two personal stories, each of which highlighted the importance of effective communication and taking the time to ensure that what you say is received as you have intended. He reiterated that good communication is the most important tool in situations such as these, where people are meeting and convening for what may be the first time. He suggested that though we may be convinced that others truly understand our intention and our meaning that may not necessarily be the case, so we must be cognizant of the words we choose and the questions we ask of one another. He closed his presentation by requesting the group to think carefully about what their task is, what their questions are, and how each person represents a different piece of a feasible, sustainable solution.

SUMMARY OF ACTIVITIES

Activity One: Individual Brainstorming
> Moderator: Dr. Cynthia Hansen, Senior Advisor, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

> *How would you design a system to ensure access to prescription medication refills in the 5 days preceding and the 3 days immediately following a notice event such as a hurricane?*

At the end of the opening session, participants were given 10 minutes to jot down their thoughts for designing components of a system to streamline prescription medication refills in the 5 days immediately preceding and the 3 days immediately following landfall of a hurricane. Designs were to incorporate the following attributes:

- o Build on daily systems of care;
- o Be a simple process to streamline actions for all involved (e.g. the patient, pharmacy, prescribers, and payors);
- o Be implemented up to 5 days prior to landfall and within 3 days after landfall;
- o Identify pre-design capabilities and/or planning assumptions.

Activity Two: Group Design Development

After sketching their individual designs, participants were separated into 5 groups, such that each "Design Development" team had a diverse representation of public and private sector stakeholders.

Teams were given 40 minutes to discuss their individual designs and sketch out a new, collaborative design on a large piece of paper. Participants were then encouraged to look at other groups' designs before reconvening as a whole group to discuss commonalities among the proposed systems and potential obstacles to implementation of each of the proposals.

<div align="center">——— GROUP 1 DESIGN ———</div>

Group 1 created a graphical timeline design. The timeline begins at time "T-5" and ends at time "T+3." Time T-5 includes the declaration of a disaster, notification of need for medication refills, and determining who may run out of medications in the next 8-10 days. Time "T-2" includes patient reminders to refill and repeating the process to determine who is likely to run out.

Group 1 then identified the entities that should be included in planning efforts as nursing homes, hospitals, pharmacy, payors, etc.

They listed "macro-level options" for an improved prescription refill system as:

- Uniform disaster prescription (Rx) filling rules
- Interoperability of data sources such as DEA numbers and National Provider Identifiers (NPI) (see below)
- Emergency Medical Therapy Management (MTM)
- Zip code/ geo scanning
- Encourage blue button and similar systems (e.g. 4 digit PIN to get medications anywhere)
- Universal Electronic Health Records (EHRs)
- State emergency prescribing laws (e.g. to displaced patients)

- Existence of standardization
- Emergency delivery mechanisms
- State emergency allowances for mobile dispensing (satellite pharmacies)

The data sources that would be needed included:

- Health insurers and Pharmacy Benefit Managers (PBMs) – call centers
- SureScripts hub
- State Prescription Drug Monitoring Program (PDMP)
- Public health departments (registries, ideally – bi-directionally)
- Emergency Medical Services (EMS)
- Emergency Management Agency
- State Medicaid agencies
- Pharmacies/ pharmacy chains
- Blue button
- Electronic Health Record (EHR) universality

Possible notification plans included:

- Autofill
- Mobile texting
- Auto emailing
- Reverse 911

Group 1 paid particular attention to the following elements:

1. The difference between the systems needed for a notice versus a no-notice event.
2. How to build on the systems that are already in place for pharmacy closures (e.g. over holidays) to create an emergency system.
3. The need for improved infrastructure to support interoperable systems and data sharing across insurers, pharmacists, state and federal systems, and program registries.
4. How to identify the medications that are most essential for refill
5. The role of SureScripts, which connects 95% of pharmacies, a lot of the health records, and many of the payers.
   a. How to add the chain of pharmacies, state prescription drug programs, health insurers, providers with EHRs, pharmacy benefit managements, public health departments, EMS, Medicare/ Medicaid, and emergency management.
6. The existence and/or need for policy that indicates which drugs can be refilled early in a declared disaster.
7. Methods for delivering or otherwise ensuring access to prescription medications to people that cannot come to the pharmacy.
8. Whether there is an emergency medication therapy management procedure included in the system?

9. What to do when people forget to take their medication with them when they go to the shelter.
10. The fact that most payors allow refills 7-8 days in advance already.
11. How to mitigate the fear of lost revenues due to extra prescriptions.

——— GROUP 2 DESIGN ———

Table 1. Group 2 Design

Timeline of Stakeholder Activities	All Stakeholders	Federal Stakeholders	State and Local Stakeholders	Payors and Plans	Pharmacy Stakeholders
Pre-Event	Plan accreditation standards; Address pre event prep; Contracts allow early refill pre event	No activity provided.	No activity provided.	No activity provided.	No activity provided.

Timeline of Stakeholder Activities	All Stakeholders	Federal Stakeholders	State and Local Stakeholders	Payors and Plans	Pharmacy Stakeholders
T -5	No activity provided.	Educate Public about importance and "how to" refill; Emergency order (anticipatory compounding, DEA issues, HIPAA); Feds activate EPAP	Educate Public about importance and "how to" refill; Executive Order (waive "tech ratio" or workload limits; allow anticipatory compounding; authority for emergency refills; licensure laws; state government has authority to declare emergency early; states activate EPAP.	Educate Public about importance and "how to" refill; early refills (30 day) permitted; mail/preferred; claims submissions documentation; staffing up call centers.	Educate Public about importance and "how to" refill; Analyze queue for inventory needed; order inventory wholesale invoice grace period (?); call/text sync autofill patients; ideal 30-day supply.
T -4	No activity provided.	No activity provided.	No activity provided.	No activity provided.	Call/text sync autofill patients
T -3	No activity provided.	No activity provided.	No activity provided.	No activity provided.	Call/text sync autofill patients; fill, encourage pickup as pharmacy may be closed or inaccessible
T -2	No activity provided.	No activity provided.	No activity provided.	No activity provided.	Call/text sync autofill patients

Timeline of Stakeholder Activities	All Stakeholders	Federal Stakeholders	State and Local Stakeholders	Payors and Plans	Pharmacy Stakeholders
T -1	No activity provided.	No activity provided.	No activity provided.	No activity provided.	Call/text sync autofill patients; website update/IVR system update; forward pharmacy phone to call an out of danger landline; secure inventory, anticipate closed and inaccessible
Hurricane	No activity provided.	No activity provided.	Engage MRC; Evaluate patient status and utilize state and local distributions systems including MRC	No activity provided.	Call/text sync autofill patients; pharmacy open activated (Rx Open)

Timeline of Stakeholder Activities	All Stakeholders	Federal Stakeholders	State and Local Stakeholders	Payors and Plans	Pharmacy Stakeholders
T +1	No activity provided.	No activity provided.	No activity provided.	No activity provided.	Call/text sync autofill patients; inventory assessment (usable); contact patient with will call Rx; website update/IVR update; closed-door inpatient pharmacies can dispense
T +2	No activity provided.	No activity provided.	No activity provided.	No activity provided.	Call/text sync autofill patients
T +3	No activity provided.	No activity provided.	No activity provided.	No activity provided.	Call/text sync autofill patients

Group 2 discussed the following points:

1. The biggest impact affecting the timely/preventive delivery of prescription meds will be pre-event.
2. There are existing methods to mitigate the problem of authorization for early refills. (1) Most prescribers allow for pick up three days prior to due date. (2) Many prescribers allow for synchronization of refills.
3. Many regional, state and local plans do not include pharmaceutical distribution as an integral part of the pre-positioning plan, and most stakeholders don't have access to state and local emergency plan to comment on the viability or existence of a pharmaceutical distribution plan.
4. Waivers and exemptions of many of types and levels (state and federal) in a highly regulated industry are essential for rapid, efficient distribution plans prior to a hurricane. For example, industry representatives are at criminal and license risk and

without legal standing against the enforcement of many statutes by the Drug Enforcement Agency (DEA).

5. Patient education must be at the forefront of any systemic change for any hope of success. Patient web based "portals" and other technological solutions could be a viable step in this direction improving communication before, during and after any disaster.

6. Industry representatives believe that their individual staffing/COOP plans have room for improvement. Noted as a model was the Waffle House continuity business plan.

7. Industry cache priorities need improvement in discerning the type and amount of medications that could be more effectively forecast for distribution.

8. Pharmaceutical representatives have empirical evidence that early prescription distribution prior to an impending disaster make good business sense.

9. All industry participants expressed a desire/need to continue a dialog among all industry sectors and governmental sponsors in order to build viable solution to the stated problem.

——— GROUP 3 DESIGN ———

Table 2. Group 3 Design

Pre-Event Activities	Activities at T -5	Activities from T-5 to T-1	Activities at T	Activities at T-3
Load up inventory	Now: benefit design modified by employer, Medicaid, Medicare to authorize emergency fill quantity	BOP/legislation to allow therapeutic interchange when emergency state is declared	Activate ICERx share prescription history	Mail service overnighted to any location or transferred to retail
Auto-notify MD/emergency management for prescription pick up	BOP/GOV E.O. for emergency fill	Activate disaster credentials for pharmacy	EPAP activation uninsured and underinsured	Use emergency fill, PBM overrides alternate Authorization at T -5

Pre-Event Activities	Activities at T -5	Activities from T-5 to T-1	Activities at T	Activities at T-3
Need to understand benefit deductible may not permit reimbursement. How to deal? Educate.	Payor PBM overrides	Push out zip codes for disaster	No activity provided.	No activity provided.
Education/HDHP	Queue up <20 DOS Rx to be filled	Educate pharmacies to get disaster area address	No activity provided.	No activity provided.
No activity provided.	Text/email for Rx pickup	Mail service – prepared to ship to any designated address	No activity provided.	No activity provided.

Group 3 discussed the following:

- Assumptions
    - Education on high deductible health premiums
    - Need to understand that the benefit deductible may not permit reimbursement. How can we address this?
- At time T-5, the payor/ (PBM) should override [illegible], and Board of Pharmacy and federal/state legislation should allow therapeutic interchange under an emergency declaration, Board of Pharmacy and/or an executive order for emergency refills should be issued, benefit design should be modified by employer, Medicaid and Medicare should authorize emergency fill quantity, anyone with less than a 20 day supply of medications should be contacted by text or email to refill, healthcare provider/emergency management agency should be notified automatically, and essential inventory should be increased.
    - At times T-4 through T-1, pharmacies in the disaster area should receive notice and educational materials to address emergency refills, mail services should prepare to ship to any designated address, Disaster Credentialing for Pharmacists should be activated, a program like ICERx and shared Rx history should be activated, and zip codes that will be covered in the declaration should be shared.

- At time T (disaster hits), EPAP should be activated.
- At times T+1 to T+3, emergency fill PBM overrides should be used, and mail service should be overnighted to any location or transferred to another retail.

<center>——— *GROUP 4 DESIGN* ———</center>

1. Prior to Landfall, Idealized Response/Things to Consider
   A. National Weather Service (NWS) gives trajectory and expected landfall
   B. Official disaster warning announced
   C. Communication to residents, pharmacy, payors, and prescribers
      - Pharmacies would plus up supply and focus on chronic distributors plus up activities to match
   D. Patients fill prescription, then pharmacies communicate refill reminders
      - Establish an overdrive code for disaster fills; consistent use plus approval of codes by payors
      - Activation of EPAP, needs to cover underinsured and uninsured; modify to expand to state/governor declared disaster
      - Mail order and independent deliveries to patients
      - Electronic records sharing (ICERx capability restored) and 2 way electronic health records
   E. Harmonizing state boards response across state lines
      - Transfers
      - Licensure
   F. Synchronize regulations allowing emergency refills
      - Authorities allow access to helpers if access to area is restricted

In summary, the group centered on 5 things that would help to address the issue:

1) Public messaging to inform the public that they need to get early refills
2) Pharmacy early refill reminder messages
3) Insurance plan streamlined processes
4) Standardization of payer codes
5) EPAP activation that will include the underinsured

<center>——— *GROUP 5 DESIGN* ———</center>

Table 3. Group 5 Design

Activity by Time	Pre-Event	Post-Event
Federal trigger: expected disaster in defined area	Pharmacy refills prompts/ASAP after fed trigger	Info on which pharmacies are open

Activity by Time	Pre-Event	Post-Event
After trigger, white list of eligible refills and black list of ineligible refills	If patient contacts pharmacy, can prepare refill	Inventory check methods across open pharmacies
Payment pool to indemnify pharmacies and insurers for wasted stock/effort	Work with delivery partners/delivery from pharmacy to patients	--
Defined standards for what equals valid verification of refills/eligible prescriptions	Communicate info in pharmacies outside of the impacted area	--
Extend emergency prescription stockpiles to cover chronic prescription inventory (not zero sum with current mission)	Retail pharmacy/anticipatory inventory stocking at the federal trigger	--
Idea: personal prescription card that records current meds at fil; separate from bottles, etc.; small, plastic and waterproof	Mail order equivalent to FedEx ship 30 days refill based on federal trigger	--

Group 5 discussed the following items:

1. A "portal" or some way to access information remotely (i.e. not sitting at a computer) would be useful for provider and consumer.
2. Policy support is needed to activate, in advance of a notice event, a federally declared "trigger" that defines potential or real disaster area and allows for special refill rules to be put in place.
3. Special rules should be defined based on drug type and frequency.
4. How do we address inventory concerns? It isn't ideal to package medications prior to an event and then run out of inventory.
5. How can we best make use of mail order pharmacy vs in person pharmacy? Where are pharmacies located outside of impact zone?
6. People should be issued plastic cards with a list of their meds (because people take pills out of bottles and package them into Ziplocs and weekly pill bottles. etc.). The pharmacist should produce and update a card that contains both electronic and written information.
7. Need to think about how to ensure legal compliance and be sure not to violate Health Insurance Portability and Accountability Act (HIPAA).

8. Seems like the best systems are the ones we use every day, how do we build on the logistics systems that are there?
9. Pharmacy schools and nursing facilities have mobile units. Can we use these to connect to the systems that already exist and get critical meds stocked?
10. How can we work with other programs (e.g. home health) to identify patients and deliver medications?
11. What are the system differences post-disaster, when pharmacies are closed, stockpiles have been used, etc.?
12. Today, at an emergency declaration we can give a 30 day supply of chronic medications with no questions even if you aren't our customer; we can get the information from elsewhere on the back end. So there may need to be two lists, one for chronic medications and one for pain management medications.
13. How can retailers better anticipate what they need in advance, so they can be sure to get more in stock?
14. What are the payment issues that need to be figured out?

END-OF-ACTIVITY GROUP DISCUSSION

A lot of commonalities were seen across the groups' system designs, especially in regards to the timing of the declaration and the willingness of payors to address refill needs when the emergency is declared. Many participants voiced the need for some sort of federal declaration *before* the hurricane's landfall so that early refill can be activated, payors can allow emergency dispensing plans, patients can be educated, and retailers can better prepare for patient surge. There was a concern that advance declarations may predict overly large geographical impact areas; thus, thought should be given to how enacting potentially unnecessary business changes would affect premiums and payors' willingness to pay for additional prescription benefits. Participants also thought it important to distinguish between the entities that authorize what is eligible for payment (health plans, self-insured employers, and the government) and the pharmacy benefits managers (PBM) that take the payment.

Overall, it was agreed that proactivity is important. There are certain "bureaucratic burdens" associated with getting medications to patients, and these need to be taken into consideration while planning an emergency prescription medication system. One such burden is that patient identification laws and pharmacist documentation and reporting requirements vary from state to state. Also, certain prescription medications have more stringent patient identification requirements than others necessitating different dispensing rules for different drugs. Finally, payors may not be willing to pay for "extra" prescription refills or for proactive packaging of medications that do not end up in the hands of patients.

Patient education was also seen as an essential component of any successful system. Patients need to know if they are eligible for early refills or if lost or damaged medications can be replaced, and at what cost; this is likely to vary depending on the patient's insurance plan and the preferences of the payor. Likewise, patients should be made aware of the possibilities for obtaining prescription medication refills should they evacuate outside the region or be unable to access their regular pharmacy/retailer. Citizens should also be educated to "stock up" on medications in the same way they would prepare for an impending natural disaster by stockpiling food and water.

Relatedly, pharmacies need to have the ability to notify individuals in advance of an event to come get their medications. However, current regulations such as the Telephone Consumer Protection Act (TCPA) may inhibit the ability to send unsolicited notifications out to patients. Furthermore, the increased influx of patients may overwhelm pharmacies because (1) each payor will have their own process for emergency refills, adding to the time burden to process each claim and (2) providers licensed in another state and working for another retailer may not be able to provide the needed surge staff support. Improved standards for emergency planning must address these obstacles for an emergency system to properly function.

Activity Three: Boggle Wall

Armed with the collaboratively-derived ideas for a prescription refill system, participants were separated into groups depending on their primary role as government personnel, pharmacies/corporate representatives, pharmacists/patient care providers, or payors/insurers.

Each group was asked to list the actions they could initiate in order to achieve the desired outcomes identified previously. Each action item was to be accompanied by the level of effort that would be necessary to achieve success (1 being low level, 5 being high level).

The groups then rotated around the room and were given 50 minutes to add to each of the remaining groups' lists. Groups ultimately returned to their own idea list, discussed the additions that others had made, and reported their thoughts out to the whole group.

——— Group 1: Pharmacists and Patient Care Providers ———

Listed by Pharmacists and Patient Care Providers

1. All care providers, including public health, can educate the patient to maintain current medication list that is easily accessible. LOE = 3
2. Incorporate mediation synchronization
   a. Allow auto refill authority during declared emergency

Additions by Other Groups

3. Create a consistent override code for payor. LOE = 1 (if codes are followed) and 5 (if retail pharmacy has to call insurance company for code each time)
4. Establish rules for stores outside of the impact zone. LOE = 1
5. Establish a protocol for deliveries to patients who have transportation challenges. LOE = 1-2 before, for those who already have delivery services; 2-3 if not already part of the service because it will be ad hoc and need surge staff. NOTE: Can use MRC and CERT volunteers or health department volunteers.
6. Build mobile pharmacies. LOE = 3 timeline variable after landfall
7. Assuming that state laws are sufficiently relaxed, allow pharmacies and pharmacists to participate in the emergency response; connect with preparedness groups already in existence (for example, healthcare coalitions). LOE = 2
8. Contribute to public education about general disaster preparedness.

——— *Group 2: Retailers and Corporate Pharmacy* ———

Listed by Retailers and Corporate Pharmacy

1. Develop a mechanism to do patient outreach (e.g. push notifications) after the disaster declaration. LOE = 1-3
2. Develop a protocol for sending out automatic reminders for existing refills prior to an event, taking into consideration the limitations under the Telephone Consumer Protection Act.
3. Work with the government to get a waiver of some of the limitations of TCPA under a disaster declaration.
4. Continue to work with pharma to plan for supply chains. LOE = 1
5. Work with state planners to develop a plan for staff surge support and workload balancing allowances; create a common database of existing and potential surge staff; partner with the Rx Response group to know what facilities are open and ensure a better allocation of staff. LOE = 3-4.

Additions by Other Groups

6. Work with the state and local pharmacy board to plan for and allocate mobile dispensing stations in affected areas. LOE = 3
7. Facilitate the conversation about extra prescriptions (e.g. to replace lost medications) vs early prescriptions (e.g. to get a refill 5-7 days early).
8. Develop a training program for retail pharmacy and store staff.
9. Increase continuity of operations planning at the store level and consider outreach to the groups that know the patient population (local health departments, long term care, etc.)
10. Investigate opportunities for a role as a liaison in the local EOC and assure inclusion in the regional/state plans, hazard vulnerability analyses, and community needs assessments, especially in high risk areas.
11. Hand out patient literature/education about what to expect in a disaster scenario.
12. Work with advocacy groups to get cross-state credentialing privileges and to modify existing laws.

——— Group 3: Government ———

Listed by Government

1. Facilitate local and state partnerships/memoranda of understanding (MOUs) with pharmacies and collaborative practice agreements (CPAs). LOE = 4
2. Expand the use of registry systems to include more than vaccines. LOE = 4-5
3. Ensure that appropriate credentials for prescriptions to get across checkpoints (pharmacists to be recognized as first responders). LOE = 2
4. Partner with public and private sector stakeholders to do community outreach and education and issue media messages to the public to remind them of medication refills. LOE = 3-4
5. Coordinate datasets including those from EMS, Emergency management, public health, pharmacy, payors, etc. LOE = 4
6. Allow disaster declarations to be made pre-event at all levels of government. LOE = 4

Additions by Other Groups

7. Relax or change certain federal regulations such as the TCPA and the DEA regulations for controlled substances allowed days' supply.
8. Allow EPAP activation without a Stafford Act declaration and change the program coinsurance and copay coverage.
9. Convene a meeting with relevant stakeholders including state and local levels, state legislatures, to discuss state/local laws that may need to be relaxed or changed to support a medication refill system. LOE = 3
10. Change state and local laws (state licensing laws, anticipatory compounding, licensing across state lines, technician ratios, coordination of emergency stockpile). LOE = 4-5
11. Consider a parallel processes for anticipated vs unanticipated disasters and evaluate current state, federal, and local disaster plans. LOE = 4-5
12. Collaborate to reduce red tape and increase consistency across jurisdictions.

——— Group 4: Payors ———

Listed by Payors

1. Draft a contract clause between Payor and PBM to allow for disaster activity.

Additions by Other Groups

2. Work with pharmacies to investigate the return rate when emails are sent in advance of an event for patients to get their prescription refilled before a disaster.

3. Relax the rules for where a prescription is filled (allow out of network refills) and who is allowed to fill it (allow non-traditional prescribers such as CPAs).
4. Issue waivers for early refills and emergency dispensing, especially for certain critical meds, and have a specially coded emergency supply.
5. Eliminate patient copay requirement and deductible.
6. Create and disseminate Explanation of Benefits (EOB) messaging and recipient education.
7. Standardize refill override (30 days/90 days; standard refill; number of days out from storm/landfall).
8. Recognize that some controlled substances may be used for chronic disease treatment (eg ADHD, anxiety, narcolepsy).
9. Determine the difference between "Early" refill for vacation, etc. vs. for disasters (sometimes the accumulation equals 13 refills a year vs. 12 and that needs to be addressed by whoever is paying)

Activity Four: Group Brainstorming

Boggle Wall Report-Outs and Group Action Items

The Government Group felt that all suggestions on their list were reasonable and within the scope of the government's authority. They identified the following action items:

1. Bring people together to discuss ways to prevent payment issues.
2. Convene payors, facilitators, and retailers to determine what advance communication/notification can be done within existing law.

The Payor Group agreed with the suggestions on their list, except for one. They felt the elimination of patient copay and deductibles was not a good idea because ultimately someone will be held financially responsible. They also indicated that most payors already allow for refills at 75% of prescription use, so patients can usually get a refill 1 week early with no problems for most drugs (not including controlled substances). However, this may not be possible for lost or damaged prescriptions. The following action items were identified:

1. Pharmacy Benefit Managers to work with primary payor to determine a procedure for refilling lost prescriptions in an emergency and understanding how this may differ from what is authorized every day.
2. Pharmacy Benefit Managers to work with primary payor to determine a procedure for relaxing where and how the prescription is billed (e.g. are out-of-network billing and non-traditional provider billing allowed).
3. Add messaging to Explanation of Benefits for recipient education, and work with other stakeholders to ensure customer education is coordinated across all points of care.

The Retailer and Corporate Pharmacy Group felt most of the suggestions on their list were doable, at varying levels of effort. This group believed that planning efforts already included supply chain management and allocation of supplies to vulnerable areas, so additional effort is not needed in that domain. Though they supported increasing planning efforts with local partners, they did not believe it can/should be done as a condition of licensure as suggested. They also supported the addition of a pharmacy liaison to local Emergency Operation Centers, but thought this would be easier for large corporate pharmacies than for small independent pharmacies; furthermore, they pointed out that should each pharmacy send a representative the EOC would be over crowded. Finally, they felt the TCPA is a barrier to implementing patient awareness and education messaging. This group identified the following action items:

1. Continue to contribute to patient education efforts by printing bag stuffers with preparedness information, pushing out reminders for prescription refill (as allowable under TCPA), and encouraging the culture shift toward early refill of prescriptions.

2. Develop better strategies for planning for support staff in surge.
3. Plan for mobile pharmacies, with the caveat that location and implementation could not be optimized until after an event.
4. Retailers to work with national and regional companies to develop and evaluate facility-level continuity of operations/business continuity plans.
5. Increase planning efforts with local partners (not as a condition of licensure).
6. Work with local emergency management to devise a strategy for pharmacy representation in local EOC.
7. Work with government to advocate for staffing and resourcing for disaster preparedness.

The Pharmacists and Patient Care Group indicated that while all suggestions on their list were important, they would likely need support from corporate to implement consistent override codes, understand the role of stores outside the disaster impact zone, and assist with the allocation of mobile pharmacies. They also felt that the assumption that state laws are relaxed enough to allow pharmacists to participate in disaster response was not realistic, and asked for governmental help on this issue. The following action items were identified in this group:

1. Work with corporate to understand the role of stores outside the disaster impact zone, plan for the allocation of mobile pharmacies, and implement consistent override codes.
2. Work with all other points of care to provide patient education and promote the maintenance of a medication list and the habit of early refills.
3. If the authority exists, incorporate auto refills as a daily practice.
4. Work with governmental and corporate entities to find an appropriate means for pharmacists to be more involved in local preparedness and response.
5. Enhance communications through existing structures to educate providers regarding how to get more involved in community disaster efforts.

FINAL GROUP DISCUSSION "TAKE-AWAYS"

1. This scenario is based on a "notice" event, but how to create a system that would also support access to essential medications in a "no-notice" event should also be considered.

2. Community education of both providers and consumers is essential to the success of any system, and should be provided at all points of care and in national media campaigns. How do we get them to remember to refill their medications? Do they have a reliable medication list and medical history? What should they do if they're away from home?

3. Greater consistency of state and local laws is needed across jurisdictions to save time, money, and resources and to ensure interoperability of local, state, and federal plans. The National Association of Boards of Pharmacy can help write model legislation.

4. Certain federal regulations (e.g. TCPA and DEA regulations for controlled substances) are barriers to implementation of an optimally effective system.

5. Contracts should have a 'disaster clause' that recognizes that the PBM is not the "ultimate" payor; contracts should allow for disaster activity while accounting for the financial requirements of the primary payor and the PBM.

6. Primary payors and PBMs must have a plan for authorization of refill of prescriptions lost during disasters.

7. Relaxation of requirements regarding where pharmacy services are provided, who constitutes an authorized provider, and what medications are allowed early refills would support a functional system and help keep patients out of the emergency department.

8. Additional collaborators, such as the Drug Enforcement Agency, wholesalers, and pharmaceuticals would be beneficial to moving this conversation forward.

9. Our current systems are built around the declaration of a national disaster, which comes too late to be effective preventatively. Is it possible to grant allowances pre-event without causing too many payment or legal issues?

10. Increased data sharing would help build the evidence base to support a functional and reliable system for medication refills and pre-placed medication caches.

"JUST ONE THING"

At the conclusion of the meeting, participants were asked to disclose the one thing that most resonated with them throughout the course of the day, whether it be something they could do to assist in building the system, an obstacle that needs to be overcome, or a recommendation for the future. Participants said the following:

- We must be entrepreneurial about problem solving in terms of the policy needed to improve outcomes for people with mental disorders, and in using population-based data to understand gaps and identify better ways to do things. (Schoenbaum)
- Better education is needed for patients regarding the need to take medications on a consistent basis. (Marissa Schlaifer)
- We could better leverage in-store advertising. For example, before a notice disaster floor signs that say 'did you get your Rx refilled?' may be placed strategically around the store, beginning with the bread and toilet paper aisles.
- I will talk to my MRC coordinator about the ability to deliver prescriptions for patients who can't get to a pharmacy to get meds before and after a disaster. I will also work on a message for National Community Pharmacists Association (NCPA) members. (Lisa Schwartz)
- We need to develop a credentialing standard and an interoperability framework between credentialing systems. We need to advocate for each state to implement these programs and for the private sector to enroll in Rx Response. (Erin Mullen)
- State and territorial health agencies should be encouraged through advocacy efforts to partner with state and national associations like the state boards of health, state boards of pharmacy, etc., to revisit laws around dispensing medications during disasters and to add or relax emergency refill requirements. EPAP should also be relaxed and allowed to be used in state/governor declared disasters rather than only in Stafford Act declarations. (Jennifer Lumpkins)
- Knowing the scope of burden of chronic diseases in local areas will help with resiliency (identify the small area estimates of disease). (Pam Allweiss)
- Public health and pharmacy partnerships and engagement should be promoted. The 2016 Preparedness Summit in April in Texas has the theme of resiliency and recovery, and a pharmacy track may be added so there may be an opportunity to continue this dialogue. (Andy Roszak)
- At the Institute of Medicine, we can promote connections between pharmacies, local healthcare coalitions, and state and local EOCs at all of our relevant workshops and meetings, and in all of our risk communication work we can also advocate for prescription refills ahead of emergencies and promote media partnerships to do the same. (Megan Reeve)

- I will follow up on the issues discussed to gain a better understanding of how SureScripts can help. (Peter Nadimi)
- I will look at the prescriptions to be filled pre-disaster (the people who have less than the defined number of days supply) to see if the Walgreens business continuity plan includes a way to queue up disaster supply.
- Together we can identify state laws that impede pharmacy response before and after an emergency. (Alex Adams)
- I will review all existing company disaster planning details and see how it can be used to build the plan for natural disaster relief. (Sanjay Rayathatha)
- We can educate state pharmacy associations regarding issues and opportunities to harmonize state laws and be proactive before the need arises. (Rebecca Snead)

DISCUSSION SYNTHESIS & CONCLUSIONS

Final Priorities Identified

After the meeting, ASPR staff reviewed the meeting notes and all of the model systems in an effort to identify the most commonly identified barriers to creating an effective emergency prescription medication system. The priorities that were identified are listed, briefly, below:

1. Model legislation for early prescription refill authority in a disaster
   a. Credentialing
   b. Drug types
   c. State vs. federal disaster declarations
   d. Allowances for alternate sites
2. Model legislation for payor policy
   a. Will payor allow early Rx?
   b. Who pays copay?
   c. What is the trigger?
3. Education and messaging for community and providers
   a. Address TCPA barriers
   b. Align with local and state response
   c. Prepare prior to a disaster
4. Increased access outside the pharmacy
   a. Role of MRC
   b. Use of mobile units
   c. Partner with home health and other programs
   d. Allowances of pharmacy alternate site
   e. Availability of specialty medications
5. Improve pharmacy COOP
6. Support data sharing
   a. Combine federal datasets
   b. Restart ICERx or similar
7. Better analytics to identify vulnerabilities
   a. Local burden of disease estimates
   b. Prepare supply and distribution

Final Priorities by Industry

Taking into consideration the outcomes of the Boggle Wall exercise and the group system design exercise, the following chart graphically depicts the priorities that each industry identified as one they may have a lead role in. All groups agreed that each priority would require strategic partnership with other industries, and could not be accomplished by one group. All groups felt all priorities were important, but focused on those they felt they had control or significant impact over.

Table 4. Priorities by Industry

Priority by Industry	Pharmacists/ Patient Care	Retailers/Corporate	Government	Payors
Early Activation	No	No	YES	No
Payment	YES	No	YES	YES
Education	YES	YES	YES	YES
Access	YES	YES	No	No
COOP/Surge/EP	YES	YES	No	YES
Data Sharing	No	No	YES	YES
Analytics	No	YES	YES	No

CONCLUSIONS

This activity resulted in the identification of a number of barriers to a successful early prescription medication refill process. Participants furthermore identified potential solutions to these barriers, and offered concrete action items that could be pursued in order to address the barriers. This process was a very successful first step toward improving the system to streamline medication refills in a disaster, and efforts should be made to continue this collaboration. A successful system will rely on the efforts of many actors working in tandem, so each group is strongly encouraged to remain engaged on the proposed action items as the project progresses.

APPENDIX.

Table 5. Collaboration Session Agenda and Methodology

Time	Topic	Lead	Activity	Staff	Writers	Notes to Capture
8:00 (1 hour)	Security and Registration	Staff	Participants check in at security and check in at Willow.	Escort. Check in participants. Welcome participants. Adapt groups and seating if participants change.	[List]	N/A
9:00-9:10 (10 minutes)	Welcome and orientation	Coordinator and Speaker 1	See talking points for Speaker 1	Escort, check in and orient late arrivals.	[List]	Take notes on any additional charges to the group that Speaker 1 mentions
9:10-9:30 (20 minutes)	Introductions	Moderator	Each participant will state their name, role and something you bring to today's discussion topic (organizational resource, personal experience, case study, etc.)	Be prepared to introduce yourself, your role, and something you bring directly related to today's topic. Help Moderator with handheld microphones. Escort, check in and orient late arrivals.	[List]	Take notes on resources and experiences identified by the participants.
9:30-9:35	Overview of first activity	Moderator	During the next 20 minutes we'll hear perspectives from Regional Staff and Partner on the problem posed by individuals needing prescription refills after a disaster. Before they get started, I'll provide an overview of the work you'll do after their	Escort, check in and orient late arrivals. Provide dots for anyone whose badge is missing them.	[List]	Introduction, Scenario

Time	Topic	Lead	Activity	Staff	Writers	Notes to Capture
			presentations. The goal of this activity is to generate designs that can streamline prescription refills before and after a hurricane to maintain continuity of care for patients, reduce emergency department surges, and prevent adverse medical outcomes. You all have dots on your name badges that indicate which group you will go to, and I'll tell you where your group will meet after the presentations. Your group will have 40 minutes to draw a design that would streamline prescription refills five days prior to and three days after a hurricane landfall. You will have butcher paper, markers and post it notes at each station. Because we want to generate a report about this meeting, which will be non-attributional, each group will also have an observer who will be taking notes for the report. The design that you draw should have the following attributes: • Build on existing daily systems • Be a simple process that streamlines actions for all involved • Be implementable up to 5 days before, and 3 days after, landfall			

Time	Topic	Lead	Activity	Staff	Writers	Notes to Capture
			• Identify pre-design capabilities and/or planning assumptions Okay, let's get started by hearing from _____, who will present the perspective of ASPR regional staff as experienced in Hurricane Sandy			
9:35-9:45 (10 minutes)	Statement of the problem (contd)	Coordinator and Speaker 2	Speaker 2 will present the ground truth from stakeholders and ASPR Regional Staff as experienced in Hurricane Sandy	Escort, check in and orient late arrivals.	[List]	Context
9:45-9:55	Statement of the problem (contd)	Coordinator and Partner	Partner will present a case study about their response to Hurricane Sandy.	Escort, check in and orient late arrivals	[List]	Case Study
9:55-10:00	Design Development	Moderator	All right. I mentioned that you will all be moving to your groups to work on a design together, but first let's take a few minutes for each of you to do some of your own thinking about this design. In front of you are 2 sheets of paper and a pen. Please take a few minutes to sketch out your own ideas about the best design to streamline prescription refills 5 days before, and 3 days after, landfall. Remember to • Build on existing daily systems • Be a simple process that streamlines actions for all involved • Be implementable up to 5 days before, and 3 days after,	Escort, check in and orient late arrivals. Provide extra paper and pens if needed.	[List]	Scenario

Time	Topic	Lead	Activity	Staff	Writers	Notes to Capture
			landfall • Identify pre-design capabilities and/or planning assumptions You'll have about 3 minutes to get your ideas down on paper.			
10:00-10:40	Design Development (contd)	Moderator	Ok great. Now, please take your individual design drawings and move to your groups. One of you will be the group leader – you'll know who you are by seeing the black dot on the back of your badge. Red is at this table, blue over there, green there, yellow there and orange right there. I'll be moving around to answer any questions. It's ok to ask for expertise from someone in another group if you find that you need information that you know someone has because of the earlier introductions.	Help people find their groups. Help with supplies and logistics – flagging Moderator, Coordinator or Assistant if needed.	[List]	Diagram Concepts (important!) Areas of Contention Unsolved Questions/Issues
10:40-10:50	Break	Moderator	At 10:50 we'll reconvene so that everyone can look at each other's designs. Please hang your butcher paper up on the wall before taking a break, and we'll see you back here at 10:55.	Help with bathroom and water logistics. Let Moderator know about any facilitation issues, let Coordinator know about any meeting logistics issues.	[List]	Photograph Diagrams Check in with Lead Writer about concerns

Time	Topic	Lead	Activity	Staff	Writers	Notes to Capture
10:50-11:05	Gallery Walk	Moderator	For the next 20 minutes, you'll all have a chance to view the other group's designs. Each group's leader should assign someone to stay with your butcher paper to provide an overview of your design and answer any questions. I'll ring a bell at 5 minute intervals so you can pace yourself around the room.	Let Moderator know about any facilitation issues, let Coordinator know about any meeting logistics issues. Assist participants with questions.	[List]	Additions to Diagrams Conceptual Q&A Unsolved Questions/Issues Overall Level of Agreement
11:05-11:20	Group discussion	Moderator	Let's spend about 15 minutes now discussing what you all observed about the designs as you walked around the room. What were the touch points for success? What was common ground? What were some interesting differences? What surprised you? What innovations stood out? What resources were required or additional needs identified? What did you learn? Now that you think about this problem and solutions a little more, what is missing?	Help Moderator with hand-held microphones and identifying who wants to speak.	[List]	Common Themes
11:05-11:35	Boggle Wall	Moderator	What a great discussion! We have another activity now that will focus on the actions required to achieve many, if not all, of the outcomes identified in the designs you all generated. This time, each group will consist of colleagues who have similar roles. For example, government colleagues will all be in the same group. Coordinator is	Help Coordinator with handing out the assignment sheets.	[List]	Reorganize into Affinity Gps.

Time	Topic	Lead	Activity	Staff	Writers	Notes to Capture
			handing out a paper listing each group membership, so take a minute to find your name. Each group will gather around an easel. The government group will be here, the payor group there, the pharmacies there and the providers over here. On each easel, please write the following information for each action that your group thinks that organizations having your role could do that would streamline prescription refills before, during and after a hurricane: • What needs to be done • Who needs to do it • How can it be best accomplished • What is the level of effort (1-5) You'll have about 10 minutes to generate this list with your colleagues, and if you forget all of the information required, it's written right here. Please write clearly so that others can understand the action by reading it.			

Time	Topic	Lead	Activity	Staff	Writers	Notes to Capture
11:35-11:42 (7 minutes)	Boggle Wall (contd.)	Moderator	Now, each group will move one easel over and read the actions identified by that group. Please add any actions that you think this group could also do that would streamline prescription refills, before, during and after a hurricane, using the same format and information from the first round.	Assist with taking notes.	[List]	Action Items in Each Group (who, what, how)
11:42-11:49 (7 minutes)	Boggle Wall (contd.)	Moderator	Now, each group will move one easel over and read the actions identified by that group. Please add any actions that you think this group could also do that would streamline prescription refills, before, during and after a hurricane, using the same format and information from the first round.	Assist with taking notes.	[List]	Action Items in Each Group (who, what, how)
11:49-11:56 (7 minutes)	Boggle Wall (contd.)	Moderator	Now, each group will move one easel over and read the actions identified by that group. Please add any actions that you think this group could also do that would streamline prescription refills, before, during and after a hurricane, using the same format and information from the other rounds.	Assist with taking notes.	[List]	Action Items in Each Group (who, what, how)
11:56-12:03 (7 minutes)	Boggle Wall (contd.)	Moderator	Now, each group will move one easel over and read the actions identified by that group. Please add any actions that you think this group could also do that would streamline prescription refills, before, during and after a hurricane, using the same format and information from the other rounds.	Assist with taking notes.	[List]	Action Items in Each Group (who, what, how)

Time	Topic	Lead	Activity	Staff	Writers	Notes to Capture
12:03-12:10 (7 minutes)	Boggle Wall	Moderator	Now you're back to where you started! Take a few minutes to review the additional actions added by the other groups, and discuss whether you agree with the addition or want to modify it in some way.	Assist with taking notes.	[List]	Action Items in Each Group (who, what, how) Areas of Contention Overall Level of Agreement Additions and Deletions
12:10-12:25 (15 minutes)	Brief out	Moderator	For the next 15 minutes, we'll go around the room and spend a few minutes discussing the possible actions by each group. Let's start with group 1 – what issues or discussion points do you want to highlight for all of us? Any points of controversy? What are your thoughts about the actions added by the other groups? Anything else? Ok, group 2….group 3…group 4…group 5.	Help Moderator with getting handheld microphones to next group's speakers. Let Moderator know about any facilitation issues, let Coordinator know about any meeting logistics issues. Assist participants with questions.	[List]	Major Discussion Points Areas of Contention Overall Thoughts

Time	Topic	Lead	Activity	Staff	Writers	Notes to Capture
12:25-12:45 (20 minutes)	Group Discussion	Moderator	What great work! Thank you all. Please return to your seats around the table so we can pull all of these discussions together and consider some possible next steps. What really stands out for you from the work we did here today? What opportunities for collaboration? What areas of contention? Where is more information needed? Who else needs to be included in these collaborations? Anything else come to mind?	Let Moderator know about any facilitation issues, let Coordinator know about any meeting logistics issues. Assist participants with handheld microphones. Help identify participants waiting to speak.	[List]	Next Steps Opportunities for Collaboration Areas of Contention Additional Info Needed Overall Thoughts
12:45-12:50 (5 minutes)	"Just one thing"	Moderator	So, to conclude this great discussion, I'd like to go around the room one more time and ask each of you to say "just one thing" that you could do in the coming months that might contribute to streamlining prescription refills before, during and after a hurricane.	Assist participants with handheld microphones.	[List]	"Just One Thing"
12:50-1:00 (10 minutes	Closing remarks	Speaker 3	Talking points from Coordinator	Assist with taking notes.	[List]	Talking Points
1:00	Adjourn	[Coordinator]	No activity.	Assist participants in exiting the building and going through security.	No notes needed.	No notes needed.