



newsletter

National Association of Boards of Pharmacy®

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aid to government
the profession
the public
1904 to 2008

Upcoming Events

May 17-20, 2008
NABP 104th Annual Meeting
Baltimore Marriott Waterfront
Baltimore, MD

June 5-6, 2008
MPJE Item-writing Workshop
NABP Headquarters
Mount Prospect, IL

June 28, 2008
FPGEE Administration
New York City, NY
Northlake, IL
San Mateo, CA

July 30-31, 2008
NABP Program Review and Training Session
NABP Headquarters
Mount Prospect, IL

Health Information Technology Advances

According to federal, state, and private sector stakeholders, health information technology, or HIT, has the potential to dramatically improve overall patient care, cut health care costs, streamline operations, and reduce medical errors. Conventional wisdom holds it up as a vitally important avenue to pursue – and investment to make – throughout the health care industry.

Yet, HIT also presents thorny problems, if it is to be successful on a large scale. As discussed previously in the *NABP Newsletter*, these problems include compatibility and standards, privacy guarantees, and access rights. (See “Electronic Prescriptions, Networked Medical Records Aid in Patient Care; Uniformity and Security Concerns Remain” in the October 2007 issue of the *NABP Newsletter*.)

Efforts to solve these problems are moving forward on the local, state, regional, and

national levels in both private and public sectors, at the same time that the actual use of HIT in its various manifestations becomes increasingly widespread.

State Activities

Many states are in the process of initiating HIT strategies, and have established entities and/or working groups to develop action plans or coordinate HIT efforts within the state. More often than not, these are public-private collaborations. The New York eHealth Collaborative, for example, describes itself as “a public-private partnership that will serve as a focal point for health care stakeholders to build consensus on state HIT policy priorities, and collaborate on state and regional HIT implementation efforts.” The Delaware Health Information Network takes a similar tone, defining itself as “a public-private partnership, which provides the organizational infrastructure to support a



clinical information exchange across the State of Delaware.” Its mission: “To facilitate the design and implementation of an integrated, statewide health data system to support the information needs of consumers, health plans, policymakers, providers, purchasers, and research to improve the quality and efficiency of health care services in Delaware.”

Some states have developed HIT “roadmaps” and are working towards HIT implementation. The Vermont Information Technology Leaders (VITL)

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Health Information Technology

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last year undertook a pilot project to provide an electronic medication history service in hospital emergency rooms, in which hospital emergency room personnel were able (with the patient's permission) to electronically request a list of all prescription medications that participating payers had paid for in the last 12 months. The pilot project was deemed a success – more than 90% of patients opted in, and data was matched to 80% of them – and the program is now being expanded. In addition, another pilot project is underway in which VITL will provide monetary grants to up to 18 independent primary care physicians in small practices, to assist them in installing electronic health record systems.

For the most part, however, statewide efforts to establish comprehensive HIT capabilities are still in their infancy; the barriers of privacy concerns and standardization have yet to be fully overcome.

Jack W. "Jay" Campbell IV, JD, RPh, executive director of the North Carolina Board of Pharmacy, applauds the mission and goals of the North Carolina Healthcare Information and Communications Alliance, Inc (which spearheads that state's HIT efforts), and points out some of the difficulties of truly widespread and effective HIT usage. HIT would be "a tremendous plus for patients and all health care providers," helping to provide best possible outcomes, he notes. Plus, "EHRs [electronic

health records], if implemented to have maximum portability, can only be a tremendous benefit for patients," he says, noting that the more information contained in the EHR and the greater its portability, the higher its value to patients and providers – and the greater the privacy concerns.

"The real barriers to widespread adoption [of HIT] are standardization and privacy."

Jack W. "Jay" Campbell IV, JD, RPh, Executive Director, North Carolina Board of Pharmacy

Campbell says the technological challenges facing large-scale HIT implementation can be overcome more easily than other elements. "The real barriers to widespread adoption are standardization and privacy," Campbell says. He sees the privacy issues as "important but solvable," although they remain unresolved thus far. Standardization – dealing with how HIT information looks and how it is communicated, for example – can be either imposed from federal or state agencies or developed in the private market. Again, it is a work in progress.

Another issue to be resolved, Campbell points out, involves access to the health record information. Would pharmacists, for example, have access to patient histo-

ries? While a "best outcomes" approach would argue for greater information sharing, says Campbell, "I would not be surprised to see some push-back" from some health care provider groups that might mistakenly fear that greater information sharing would provide "a Trojan horse" for allowing non-physicians (such as pharmacists) to increase their scope of practice to include such activities as providing diagnostic services.

At present, most boards of pharmacy tend not to be directly involved in the HIT process, other than modifying regulations to address electronic prescribing. And even e-prescribing, while increasingly common, is far from universal. Campbell sees the restriction against electronic transmission of controlled substance prescriptions as a large impediment to the widespread adoption of e-prescribing. With controlled substance prescriptions averaging 20% of prescriptions written, Campbell notes, a shift to e-prescribing might not make business sense. And while Drug Enforcement Administration (DEA) has voiced its commitment to issuing e-prescribing rules for controlled substances, a timeline is still pending. (A group of 19 United States senators sent a letter to Attorney General Michael Mukasey in December 2007, urging him to speed DEA's issuance of regulations.) "Once that barrier is overcome," says Campbell, "the gates for e-prescribing will open."

Meanwhile, DEA must strike a balance between the advantages of e-prescribing and the need to ensure a

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NABP Coordinating Project to Evaluate Distribution, Quality of Consumer Medication Information

These days, most patients receive printed information when they collect their prescription medications from community pharmacies. The quality of that information, however, failed to meet federally mandated standards about 50% of the time in a 2001 nationwide assessment. Whether the overall quality is any better today will be revealed by the results of a current NABP study.

NABP is conducting a project to evaluate the progress of community pharmacies in meeting federally mandated goals for dispensing useful written consumer medication information (CMI), with a grant provided by Food and Drug Administration (FDA). The purpose of the study is to determine whether today's practices are in line with target compliance levels for 2006.

As part of the study, during January, February, and March 2008, professional shoppers visited community pharmacies to fill prescriptions provided by FDA through participating physicians and collect written materials provided by the pharmacies at the point of purchase. A national expert panel will use procedures and criteria similar to those used in the 2001 study to assess whether the written materials meet the agreed-upon criteria.

Not to be confused with Medication Guides, which

FDA requires manufacturers to provide with certain medications to educate patients on specific risks associated with the drugs, the purpose of CMI is to help all patients receiving new prescriptions to understand key information about the medication, eg, how to take it, how to store it, how to monitor improvement, warnings of potential adverse events, and what to do if one occurs. Whereas Medication Guides must be FDA-approved, neither FDA nor the drugs' manufacturers review or approve CMI, which is typically developed by independent drug information companies.

The catalyst for the previous and current CMI assessment projects was the adoption of federal legislation in 1996, Public Law 104-180, which specifies compliance rates for the distribution of CMI to patients having new prescriptions filled. A steering committee convened by the Keystone Center and comprising NABP and health care professionals, consumer organizations, voluntary health agencies, pharmaceutical manufacturers, prescription drug wholesalers, CMI developers, and drug information database companies developed a long-range Action Plan for the Provision of Useful Prescription Drug Information to meet these goals.

The action plan includes agreed-upon criteria for what constitutes effective

written patient information. The plan specifies that the material should be scientifically accurate, unbiased in content and tone, sufficiently specific and comprehensive, presented in an understandable format that is readily comprehensible to consumers, timely and up-to-date, and useful, ie, enables patients to use the medicine properly and appropriately, receive the maximum benefit, and avoid harm.

The legislation specifies that, by the end of 2000, CMI would be distributed to 75% of patients receiving new prescriptions for medicines, and by the end of 2006, to 95% of such patients.

The law requires the Secretary of the US Department of Health and Human Services to evaluate the private sector's progress toward meeting the goals in the law and, if the goals are not met, to seek public comment on other initiatives to meet the goals. The law prohibits FDA from taking further regulatory steps specifying uniform content or format for CMI if private-sector initiatives meet the goals of the plan within the specified time frames.

NABP conducted the national study in 2001 to assess the extent to which private-sector efforts had achieved the year 2000 goals specified in the law. An expert panel, subcontracted by NABP to evaluate the CMI

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Executive Committee

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The NABP Executive Committee is elected each year at the Association's Annual Meeting.

Liar, Liar, License on Fire?

By Dale J. Atkinson, JD

Periodically, this column covers a criminal case that has relative significance to boards of pharmacy and the regulatory community. The nuances between elements necessary to criminally convict an individual and those necessary to administratively or civilly convict can present interesting scenarios. Likewise, the delegation of authority to a regulatory board to enforce its practice act through the licensure and disciplinary process can be equally complex. When facts constituting potential criminal prosecutions may also give rise to administrative proceedings, the potential for confusion escalates. Consider the following matter, which involves applications for licensure, perjury, forgery, drug samples, and theft:

In 1992, an individual applied for licensure as a physician in Alaska. On the application, the individual misrepresented completion of his postgraduate internship. Specifically, the individual answered a question on the application by stating that he had completed his “postgraduate year one” at a medical center in Pennsylvania, when in fact he had not. The Alaska State Medical Board issued the applicant his license and, in 1993, the licensee began practicing medicine in Alaska.

In 1997, the Alaska Medicaid Fraud Control

Unit began investigating the licensee for potential overbilling. Eventually, a search warrant was issued, and documents seized from his apartment, which doubled as his office, revealed that the licensee had not completed the postgraduate year one requirements. Based upon the investigation, charges were filed against the licensee including counts related to forgery; perjury; eight counts of first, second, and fourth degree theft; and 224 counts of second- and third-degree misconduct involving a controlled substance. The licensee was convicted on

all counts and sentenced to concurrent terms of 10 years’ imprisonment, with three years suspended on the perjury, forgery, first- and second-degree theft counts, and the second-degree misconduct involving a controlled substance. The licensee appealed these criminal convictions.

The perjury charges related to the licensee knowingly and falsely claiming to the Board under oath and notarized on his application for licensure to have completed the postgraduate year one program in Pennsylvania. The criminal indictment was returned on April 28, 2000, almost eight years after the alleged act. On appeal, the licensee raised the statute of limitations as his defense. A statute of limitations requires that certain action be commenced within a specified period of time, after which no legal action can be brought or enforced. The statute of limitations for prosecuting crimes in Alaska is five years. If the crime involves a material element of fraud, the limitation period may be extended for an additional three years; however, if the state relies upon the statutory extension, it must commence prosecution within one year of the discovery of the offense.

The state argued that perjury is a crime that involves a material element of fraud entitling it to the

extended period and that it commenced prosecution within one year of discovering the conduct of the licensee that constituted perjury. In rejecting the arguments of the state, the court held that the state had reasonable belief that the licensee committed perjury “by the end of March 1999” based upon the affidavit filed by the investigator that was used to support the issuance of the subpoena. Under any circumstances, the reasonable determination of perjury was known as of the April 12, 1999 date of the subpoena. The indictment was returned on April 28, 2000, more than one year from the date of discovery. Thus, the court held that the perjury prosecution was time barred and the conviction must be vacated.

The licensee next challenged the forgery conviction arguing that there was insufficient evidence to support the convictions. The court referenced the statutory definitions of second- and third-degree forgery. Both second- and third-degree forgery involves the alteration of documents and/or instruments with the intent to defraud. The state charged the licensee with forgery based upon the assertion that he submitted an application for licensure that contained false statements. But, as noted by the court, “such conduct does not constitute forgery unless the false statements are

designed to misrepresent the true identity of the person who prepared the application.” In other words, “an instrument or document is forged only if it is altered, completed, or otherwise created so as to falsely appear or purport to be an authentic creation of someone other than its true maker.” While the document contains false assertions of fact, those false assertions did not misrepresent the identity of the person who prepared the document. Thus, the court reversed the conviction for forgery.

Regarding the fourth-degree theft charges, the licensee was accused of taking samples from one of the clinics where he worked. Indeed, while filling in for a vacationing doctor the licensee took two plastic garbage bags full of samples from the clinic. However, prior to taking the samples, the licensee had asked a medical assistant if he could have some of the samples. The medical assistant said that the licensee could take some of the samples and that clinic employees occasionally used samples to treat cold or headache symptoms they were experiencing. The medical assistant testified that she was surprised by the amount of samples taken from the medicine cabinet by the licensee, but that she never confronted him or called it to the attention of her superiors.

The court identified the elements of theft as requiring an intent to deprive another of his or her property through unlawful means. Noting that the licensee received “express permission of a regular member of the clinic staff,” the court held that the licensee’s actions did not constitute theft and an acquittal must be entered on that particular count. At another clinic, the licensee engaged in similar actions appropriating numerous samples and the court upheld the theft convictions due to the fact that he did so without permission.

Finally, the court addressed the first-degree theft counts propounded by the state, which were premised upon the argument that the licensee was paid for services that he performed under the authority of an invalid license. Citing a previous case and deferring to the authority of the medical board, the court rejected the arguments of the state and reversed the theft convictions premised upon the invalid license theory. The court agreed with the arguments of the licensee that the state could not contest the validity of the license in the criminal case, in that such authority rests with the Medical Board. The court cited the authority and wisdom of the Board and held that the proper forum to challenge

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Attorney Dale J. Atkinson is a partner in the law firm of Atkinson & Atkinson, counsel for NABP.

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Health Information Technology

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closed system of distribution for controlled substances to minimize the risk of diversion and misuse. Joseph T. Rannazzisi, deputy assistant administrator for the DEA Office of Diversion Control, testified before the Senate Judiciary Committee in December 2007, “[i]t is critical that the technology and standards to be employed include adequate security that incorporates authentication, nonrepudiation, and integrity in the recordkeeping process.” DEA has sent a proposed rule to the Department of Justice (DOJ) regarding e-prescribing of controlled substances and is awaiting response. DEA officials stated in a February 1 letter to Rhode Island Senator Sheldon Whitehouse. Once DOJ and subsequently the DEA Office of Management and Budget have approved it, the proposed rule can be published in the *Federal Register*. DEA then will accept comments on the proposal and draft a final rule.

The National Front

HIT activity continues on the national front, as well, sometimes with uncertain progress. “[I]t cannot be said that the nation is substantially closer to a ubiquitous, interconnected, interoperable HIT system now than [*sic*] when the president called for action in 2004,” concluded an analysis of federal HIT efforts, *Gauging the Progress of the*

National Health Information Technology Initiative: Perspectives from the Field, conducted for the California HealthCare Foundation and published in January 2008. “[H]ope for a nationwide EHR remains an unfulfilled goal, still beyond our collective grasp.” Rather, progress has been made on a more sporadic, smaller-scale basis.

While numerous bills dealing with HIT have been presented in the US Congress, they generally have not met with success. The Department of Health and Human Services (HHS), on the other hand, has continued to forge ahead with its HIT agenda. In a January 2008 address to the American Health Information Community (AHIC), HHS Secretary Michael Leavitt listed several accomplishments, including recognition of a number of interoperability standards, certification of EHR products, contracts awarded for trial implementation of the Nationwide Health Information Network (the planned “secure, nationwide, interoperable health information infrastructure,” a network of networks), and establishment of a Medicare demonstration program that offers incentives to smaller physician practices that adopt interoperable EHRs.

The federal government, however, is not the only entity concerned with HIT programs on a national scale. The non-profit eHealth Initiative has brought together stakeholders from the public and

private sectors to increase cooperation and facilitate adoption of HIT. Among other activities, it tracks ongoing HIT developments and offers programs to help its members develop HIT strategies and plans.

Meanwhile, pressure to move forward more rapidly on privacy and standardization policies is coming from the private sector . . .


In a similar vein, the National Governors Association established its State Alliance for e-Health in 2006 to “collectively address state-level health information technology . . . issues and challenges to interoperable electronic health information exchange.” It plans, in part, to “address barriers to health information exchange and adoption of health IT” and to “build consensus in seeking the harmonization of the variations in state policies, regulations, and laws, where appropriate.”

Meanwhile, pressure to move forward more rapidly on privacy and standardization policies is coming from the private sector, as heavy-hitting, non-health care companies like Microsoft and Google jump into the HIT arena. Both companies have announced ventures that would allow patients to store (and access) health information in online accounts. While the projects

originally began as collaborations with prestigious health care providers (Microsoft teamed up with the Mayo Clinic, Google with the Cleveland Clinic), they are already expanding: At the end of February, Google announced that it had signed deals with hospitals and companies, including Quest Diagnostics, Inc, Aetna Inc, Walgreen Co, and Wal-Mart Stores, Inc.

Such private ventures represent a development that has many people concerned, largely because of privacy issues, despite the companies’ vows to protect privacy. Patient confidentiality provisions required by the Health Insurance Portability and Accountability Act of 1996 do not apply to non-health care companies like Microsoft or Google.

It is doubtful that these ventures will go forever unregulated; whether that means federal and/or state regulation, however, remains to be seen. What is clear, however, is that developments affecting HIT programs are evolving rapidly, even as stakeholders have been taking a longer, slower path to implementation. The rapid momentum among private ventures may force the hands of those in other areas where movement has been slower (eg, spelling out general standardization requirements or privacy protections).

Thus, private sector developments may end up driving the evolution of HIT – and resulting regulatory developments – in the years to come. 

NPI Contingency Deadline Approaches

Health care entities employing contingency plans for compliance with the National Provider Identifier (NPI) regulations have until May 23, 2008, to begin using the NPI numbers.

The final rule establishing the NPI as the standard unique identifier for health care providers, a provision of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, was published in 2004. The rule requires all covered entities to be in compliance with its provisions by May 23, 2007, with the exception of small health plans, which

must be in compliance by May 23, 2008.

In April 2007, however, Centers for Medicare and Medicaid Services (CMS) implemented a contingency plan for covered entities that would not meet the deadline for using the NPI numbers. In its "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule," CMS describes its policy to exempt covered entities from enforcement action if they demonstrate a "good faith" effort to come into compliance, and they develop and implement contingency plans to enable them and their trading

partners to move toward compliance. Contingency plans may include acceptance of legacy provider numbers on HIPAA transactions, and they may not extend beyond May 23, 2008.

CMS notes on its Web site that, as of March 1, 2008, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields; claims that do not include an NPI will be rejected.

More information on NPI requirements is available on the CMS Web site at www.cms.hhs.gov/NationalProvIdentStand. ☎

Legal Briefs

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the validity of a physician's license, in the first instance, was with the Medical Board, not the superior court. Thus, the theft convictions related to an invalid license were reversed.

This case helps identify the interplay between the licensure process and the authority of a regulatory board with the criminal prosecution of a licensee. Coordinating efforts in protecting the public through administrative and criminal prosecutions is essential.

Gottlieb v State of Alaska, 175 P 3d 664 (App Ct AK 2008) ☎



NEWLY ACCREDITED VAWD FACILITIES

The following facilities were recently accredited through the NABP Verified-Accredited Wholesale Distributors® (VAWD®) program:

B. Braun Medical, Inc
Atlanta, GA
Accredited February 12, 2008

B. Braun Medical, Inc
Breinigsville, PA
Accredited February 12, 2008

B. Braun Medical, Inc
Westminster, CA
Accredited February 27, 2008

Bellco Drug Corp
North Amityville, NY
Accredited March 7, 2008

Bound Tree Medical, LLC
Visalia, CA
Accredited March 7, 2008

CVS Pharmacy, Inc dba CVS Distribution Center
La Habra, CA
Accredited February 15, 2008

Exel, Inc
Mechanicsburg, PA
Accredited March 13, 2008

Fresenius USA Manufacturing, Inc dba Fresenius Medical Care North America
Charlotte, NC
Accredited February 4, 2008

Generics Bidco I, LLC dba Qualitest Pharmaceuticals
Huntsville, AL
Accredited February 15, 2008

McKesson Corporation
Salt Lake City, UT
Accredited January 25, 2008

Medical General Corporation dba MGC Supplies, Inc
Evansville, IN
Accredited March 7, 2008

Merry X-Ray Chemical Corporation dba Merry X-Ray Corporation
Hamilton, OH
Accredited February 15, 2008

PCCA
Houston, TX
Accredited February 14, 2008

VaxServe, Inc, a Sanofi Pasteur Co
Kansas City, MO
Accredited March 18, 2008

VaxServe, Inc, a Sanofi Pasteur Co
Sparks, NV
Accredited March 18, 2008

VaxServe, Inc, a Sanofi Pasteur Co
Taylor, PA
Accredited March 18, 2008

Wal-Mart Stores East, LP dba Wal-Mart Pharmacy Warehouse #13
Tifton, GA
Accredited January 25, 2008

Wal-Mart Stores East, LP dba Wal-Mart Pharmacy Warehouse #32
Hanford, CA
Accredited February 15, 2008

A full listing of accredited VAWD facilities is available on the NABP Web site at www.nabp.net. ☎

New 2008-2009 FRC Members Announced


NABP is pleased to announce the Foreign Pharmacy Graduate Equivalency Examination® (FPGEE®) Review Committee (FRC) members for 2008-2009. The FRC, developed to ensure the integrity and validity of the NABP examination, acts under the policy and planning guidance of the NABP Advisory Committee on Examinations and the NABP Executive Committee. The dedicated volunteers are responsible for reviewing and verifying the examina-

tion questions and assisting with the development of new test questions. The FRC is composed of pharmacists and/or faculty who are representative of the diversity of pharmacy practice. NABP appreciates the assistance of these committee members as they evaluate examination content and ensure that it meets the specified competency assessment statements, which, in essence, determine the question pool. The FRC members began their term on February 1, 2008.

June FPGEE Administration

The June 28, 2008 FPGEE administration is soon approaching and the three testing sites will be in Northlake, IL; New York City, NY; and San Mateo, CA. The New York site has reached its capacity for the June examination and is now closed. The next FPGEE administration will be held December 6, 2008.

NABP provides the Foreign Pharmacy Graduate Examination Committee™ (FPGEC®) Certification Program as a means of

documenting the educational equivalency of an applicant's foreign pharmacy education, as well as his or her license and/or registration to assist state boards of pharmacy in qualifying applicants for US licensure. The FPGEE is one component of this program. In addition, during the FPGEC certification process, applicants are required to submit certain documents submitted from educational or licensure institutions that present their educational backgrounds and licensure and/or registration to practice pharmacy. 

FRC Members

Member Barbara Adamcik
Idaho State University

Member John H. Block
Oregon State University

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Member Dale Eric Wurster, Jr
University of Iowa

Proposed Law Would Mandate E-Prescriptions

In December 2007, the Medicare Electronic Medication and Safety Protection (E-MEDS) Act of 2007 was introduced in the Senate and a similar bill was introduced in the House that would provide new incentives to push adoption of e-prescribing among prescribers. The act would amend title XVIII of the Social Security Act to require physician utilization of the Medicare electronic prescription drug program.

The bill cites several congressional findings, including that “[e]-prescribing can help to eliminate medical errors, injuries, hospitalizations, and even death that can result from illegible prescriptions and bad drug interactions, in addition to reducing patient medication non-adherence.”

The bill has been referred to the Committee on Energy and Commerce and to the Committee on Ways and Means and is posted at www.govtrack.us/congress/billtext.xpd?bill=h110-4296.

HHS Proposes Patient Safety Reporting Rule

On February 12, 2008, the Department of Health and Human Services (HHS) released a proposed rule to establish the authorities, processes, and rules necessary to implement the Patient Safety and Quality Improvement Act of 2005. The proposed regulation establishes the process by which patient

safety organizations will be certified by HHS to accept patient safety data from health care providers to reduce the incidence of medical errors.

The proposed rule allows providers, including pharmacists, to voluntarily report data to a patient safety organization without fear of legal liability. More information is available in the Federal Register at <http://a257.g.akamaitech.net/7/257/2422/01jan20081800/edocket.access.gpo.gov/2008/pdf/E8-2375.pdf>.

Popularity of Mail-Order Pharmacies Increases

The popularity of mail-order pharmacies has grown, particularly among elderly patients, according to the results of a Medical Expenditure Panel Survey (MEPS), released in February 2008.

The survey shows that the proportion of United States patients buying prescription medications from mail-order pharmacies increased from 8.8% in the year 2000 to 13.2% in 2005. In the same time period, results showed decreases in the proportion of prescriptions filled at drug stores (65.1% to 60.9%); HMOs, clinics, or hospitals (15.2% to 12.9%); and in other stores (31.6% to 28.2%).

Among patients age 65 and older, a larger proportion used mail-order pharmacies (37.1%) compared to those buying medications at drug stores (17.2%); an

HMO, clinic, or hospital (20.6%); or other stores (20.8%). As a whole, the total number of US outpatients who bought prescription medications increased from 173.3 million in 2000 to 187 million in 2005.

The analysis is available on the MEPS Web site at www.meps.ahrq.gov/mepsweb/data_files/publications/st200/stat200.pdf.

Medicaid Tamper-Proof Prescription Pad Rule in Effect

As of April 1, 2008, all written prescriptions for Medicaid recipients must be on paper with at least one tamper-resistant feature, as outlined by Centers for Medicare and Medicaid Services (CMS) and defined by the states.

Beginning October 1, 2008, Medicaid prescriptions must be on paper that meets all three baseline characteristics of tamper-resistant pads: they must (1) prevent unauthorized copying; (2) prevent erasure or modification; and (3) prevent the use of counterfeit prescription forms.

States are responsible for defining specific features that meet the baseline characteristics for a prescription to be considered tamper-resistant in that state. Prescriptions that are electronic, faxed, or telephonic are exempt from this requirement. More information is available on the CMS Web site at www.cms.hhs.gov/DeficitReductionAct/30_GovtInfo.asp.

FDA Proposes Guidance on Reprint Practices

Food and Drug Administration (FDA) has issued a draft guidance, “Good Reprint Practices,” for industry regarding the distribution of medical or scientific journal articles and reference publications that involve unapproved uses of FDA-approved drugs and medical devices.

The guidance recommends principles manufacturers should follow when they distribute these materials, such as ensuring that the articles are published by an organization that has an editorial board and that discloses any conflicts of interest; that they are peer-reviewed and published according to specific procedures; that they are not funded by the manufacturer of the product in the article; and that they are supported by credible medical evidence.

FDA retains legal authority to determine whether distribution of an article or publication constitutes promotion of an unapproved “new use,” or causes a product to be considered misbranded or adulterated under the Federal Food, Drug and Cosmetic Act.

More information is available in the *Federal Register* (Docket No. FDA-2008-D-0053) at www.regulations.gov/fdmspublic/component/main?main=DocumentDetail&o=0900064803b8db8.

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ASCP Issues Guidelines on Medical Information for the Blind

Through a collaborative project with the American Foundation for the Blind, the American Society of Consultant Pharmacists (ASCP) Foundation has issued "Guidelines for Prescription Labeling and Consumer Medication Information for People with Vision Loss."

These guidelines provide pharmacists and pharmacies with specific recommendations for making important medication information accessible for patients with vision loss. The guidelines also serve as a resource for individuals with vision loss and organizations serving this population. The document is available on the ASCP Web

site at www.ascpfoundation.org/downloads/Vision_GLS.pdf.

Fentanyl Pain Patches Recalled Due to Risk from Cut Edge

PriCara and Sandoz Inc recently announced a nationwide recall of all lots of 25 mcg/hr Duragesic® (fentanyl transdermal system) patches sold in the United States. The product has been recalled because the patches may have a cut along one side of the drug reservoir within the patch, which may result in the possible release of fentanyl gel that may expose patients or caregivers directly to fentanyl gel on the skin.

Fentanyl is a potent Schedule II opioid medication, and exposure to the gel may lead to serious

adverse events, including respiratory depression and possible overdose, that may be fatal. Patches with a cut edge should not be used. These recalled patches have expiration dates on or before December 2009 and are all manufactured by ALZA Corporation. More information is available on the FDA MedWatch site at www.fda.gov/medwatch/safety/2008/safety08.htm#Duragesic.

London Court Blocks Eli Lilly's Effort to Stop Re-importation of its Drugs

London's High Court rejected an attempt by Eli Lilly and Company to stop a British pharmacy from buying supplies of its drugs in Turkey and selling them to Internet pharmacies in

Canada, according to a Reuters report (www.reuters.com/article/companyNews/idUSL0583032020080205).

Eli Lilly won a temporary injunction in November 2007 preventing UK pharmacy 8PM Chemists from shipping drugs from Turkey and then sending them to US patients via Canada, Reuters reports. The pharmacy reportedly appealed the case, however, and persuaded the court to overturn that decision, stating that the drugs were shipped in plain brown boxes and never released by customs in Britain. Thus, the trademarks Eli Lilly was seeking to protect were never seen by the public in Britain. The court agreed with the pharmacy and determined Eli Lilly's European trademarks were not jeopardized by the trade. ©

Around the Association

Board Member Appointments

- **Josephine Anne Galindo**, has been appointed a public member of the Arizona State Board of Pharmacy. Galindo's appointment will expire on January 16, 2012.
- **Daniel Milovich, RPh**, has been appointed a member of the Arizona State Board of Pharmacy. Milovich's appointment will expire on January 21, 2013.

- **Stanley Weisser, RPh**, has been appointed a member of the California State Board of Pharmacy. Weisser's appointment will expire on June 1, 2011.
- **Shirley Wheat**, has been appointed a public member of the California State Board of Pharmacy. Wheat's appointment will expire on June 1, 2010.
- **Clarence Pearson, MD**, has been appointed a public member of the New Mexico Board of Pharmacy. Pearson's appointment will expire on July 1, 2012.

- **Pauline R. Montgomery, BS**, has been appointed a member of the Pennsylvania State Board of Pharmacy. Montgomery's appointment will expire on January 29, 2014.
- **Hubert Mobley, RPh**, has been appointed a member of the South Carolina Department of Labor, Licensing, and Regulation – Board of Pharmacy. Mobley's appointment will expire on June 30, 2013.
- **Timothy Boehmer, RPh**, has been appointed a member of the Wisconsin

Pharmacy Examining Board. Boehmer's appointment will expire on July 1, 2008.

Board Officer Changes

The New Mexico Board of Pharmacy has elected the following officer to the Board:

- **Rudolph Nolasco, RPh, Vice Chairperson**

The Oklahoma State Board of Pharmacy has elected the following officer to the Board:

- **Dorothy Neal Gourley, DPh, Vice President** ©

Bill Would Give WV Board Authority over Clinics

The West Virginia Senate passed a bill in late February 2008 that would grant regulatory authority over free and reduced-cost health clinics to the West Virginia Board of Pharmacy. One of the requirements of the Board would be to have a pharmacist-in-charge at each clinic to supervise the dispensing of prescription drugs. The potential cost of meeting this requirement fueled some concern among clinic operators. Proponents of the bill, however, say this provision will help to protect patient safety.

Quoted in the March 7, 2008 *Charleston Daily Mail*, Board Executive Director David Potters, JD, said the bill creates a special category for the clinics, designating them as charitable pharmacies and enabling the state to tailor regulations according to the clinics' particular circumstances. For instance, while full-time pharmacies require a pharmacist-in-charge to be on hand at least 30 hours per week over at least three days, some free clinics are only open a few days a week; thus, Potters said, the regulations would be crafted to allow flexibility in that requirement. Free clinics also would be allowed to recruit volunteer pharmacists, rather than pay a staff pharmacist.

DC Board Mandates Valid Patient-Practitioner Relationship

The District of Columbia Board of Pharmacy has revised its regulations to include a requirement for a valid patient-practitioner relationship. The new regulations state that a pharmacist must not dispense a prescription if the pharmacist knows that the prescription was issued without a valid patient-practitioner relationship.

An Internet-based or telephone consultation or questionnaire evaluation does not establish a valid patient-practitioner relationship except (1) in the event of a documented medical emergency; (2) in an on-call or cross-coverage arrangement; or (3) if the patient care is in consultation with a practitioner with an ongoing relationship with the patient and who has agreed to supervise the treatment.

Pharmacist Administration of Vaccinations, Immunizations Proposed

The District of Columbia Board of Pharmacy and the Pharmaceutical Control Division, in collaboration with the District of Columbia Board of Medicine, have proposed legislation to allow pharmacists to administer vaccinations and immunizations in the District. If enacted, the Pharmacy

Moving? Need to Transfer Your License?

It is easy – go to the Licensure Programs section of www.nabp.net.

Questions? Call Customer Service at 847/391-4406.

NABP – Serving Pharmacists with Licensure Transfer Since 1904

Practice Amendment Act of 2007 would allow pharmacists meeting the specified education and training requirements to administer approved vaccinations and immunizations upon receipt of a written physician protocol and a valid prescription or physician standing order.

Pharmacists providing the service must show completion of an Accreditation Council for Pharmacy Education-approved course that is evidence-based, includes study material and hands-on training in techniques for administering immunizations or vaccines, requires testing with a passing score, and meets Centers for Disease Control and Prevention training guidelines. The course must also provide a minimum of 20 hours of instruction and hands-on training in basic immunology and vaccine protection; vaccine-preventable diseases; vaccine storage and management; informed consent; physiology and techniques for vaccine administration; pre- and post-vaccine assessment and counseling; immunization record management; and identification, appropriate response, documentation, and reporting of adverse events.

OH Board Warns Pharmacists of Internet Scams

In February 2007, the Ohio State Board of Pharmacy *Newsletter* published an article warning pharmacists about scams involving Internet prescriptions, doctors, and pharmacies. The article was written in response to pharmacists being bombarded with offers from illegitimate Internet drug distributors.

Nothing has changed in the last 12 months, the Board reports in its February 2008 *Newsletter*. The offers continue, primarily targeting independent pharmacies. Unfortunately, the Board reports, a few pharmacists have given in to the temptation of higher than usual dispensing fees and have agreed to do business with these types of entities. The Board has had one hearing already and has a few others pending. The first hearing on this Internet prescription issue resulted in the revocation of both the pharmacist's license and the pharmacy's license.

While this is not necessarily indicative of what will happen in future cases, since each situation is viewed independently, it does point out the Board's

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State Board News

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concern about pharmacists who engage in this type of behavior.

In addition to pharmacists being recruited to break the law, now the Internet drug dealers are also targeting consumers, businesses, schools, and others – apparently anyone with a fax number. The initial wave of unsolicited faxes offering dangerous drugs without a prescription through Web sites first appeared in mid-June 2007, followed by a second wave in mid-October 2007.

Most people seem to recognize that this is indeed an illegal activity and have been forwarding the faxes to the Board office. All the faxes sent to the Board have been similar, promoting the ability to acquire medication without a prescription after answering questions on the Web site.

What the Board has learned:

- The Web sites promoted in the June and July 2007 faxes were linked to *MyPharmaNow.com*, whose IP address was on a server in Hong Kong, China, with the registrants mostly based in the Philippines. This site is part of the Alliance Health Group/*myfirstpharma* outfit, whose Web sites include *MyPharma1.net*, *AmericaPharmacyWorld.com*, *MyPharmaCentral.com*, and *MyPharmastop.net*.

- The Web sites promoted in the October 2007 faxes all had the exact same screen content with the exception of the name of each site. They referred to “Your Safe Med” online pharmacy as part of the Hardy Healthcare Group and were all registered on October 11 by various people in Singapore. All these Web sites are located on the same server in Hong Kong as the *MyPharmaNow.com* sites. Web sites include *Directdoclink.com*, *Ezmedlink.com*, *Ezdoclink.com*, *Medhaven.net*, and *YourSafeMed.com*.

- Other site names that recently have come to the Board’s attention include *Myfirstpharma.com*, *Suredoclink.com*, *Ezdoconline.com*, *Medicaltouch.net*, and *Ezpharmalink.com*.

- All these sites target the United States and require credit card information (the only choice is VISA) including the three-digit security number on the back of the card.

The Board has observed that, as domain names become available, these foreign Web sites are snatching them up and adding them to their network of Internet sites. As the Board of Pharmacy has no jurisdiction internationally, the Board forwards the Web site information to NABP and/or Food and Drug Administration. As none of the sites appear to be offering to sell controlled substances, Drug Enforcement Administra-

tion (DEA) has no jurisdiction.

The Board expects this type of criminal activity will continue and asks its licensees to help educate the public regarding the risks of identity theft, credit card theft, and counterfeit drugs associated with ordering drugs online, without the involvement of local physicians and legitimate pharmacies. The Board notes that any Internet site marketing prescription drugs to individuals by unsolicited fax is probably illegal and dangerous.

VA Prescription Monitoring Program Expands in 2007

The Virginia Prescription Monitoring Program finished 2007 by fulfilling 22,156 dispensing history requests compared to 6,333 requests in 2006. As in most states, prescribers made the most requests for dispensing history information, at 72%, followed by pharmacists at 13%, the Virginia State Police at 7%, the Department of Health Professions at 3%, the Virginia Medical Examiner’s Office at 3%, the Health Practitioners’ Intervention Program at 1%, and DEA at 1%.

The program database now houses more than 19.6 million records, with pharmacies submitting almost 1 million records each month. Going forward into 2008, the program will look to expand service to 24/7 access and “automatic response.”

IN Passes Legislation Requiring VIPPS Accreditation

In an effort to protect its citizens from unscrupulous Web sites pretending to be legitimate Internet pharmacies, the state of Indiana passed legislation to help prevent such sites from doing business in its state. The legislation developed as an amendment to a related bill originally introduced by the Indiana Board of Pharmacy. With the Board serving as the champion for the new bill, Governor Mitch Daniels signed into law Senate Bill 302 on March 21, 2008. The bill, among other things, requires nonresident pharmacies utilizing the Internet to obtain Verified Internet Pharmacy Practice Sites™ (VIPPS®) accreditation from NABP, or an equivalent program approved by the Indiana Board of Pharmacy, before shipping drugs into Indiana. The new law affects those nonresident pharmacies that dispense more than 25% of their prescription volume as a result of prescription orders received or solicited through the Internet and will be effective July 1, 2008. Indiana joins Kentucky and North Carolina in requiring VIPPS accreditation for Internet pharmacies practicing in their states. Nine additional states recognize the VIPPS accreditation in their regulations. ☺

May 17-20, 2008

Baltimore Marriott Waterfront

Baltimore, MD

Saturday, May 17, 2008**10 AM - 7 PM***Harborside Registration***Registration/Information Desk Open****2 - 4 PM***Laurel A-D*

Pre-Meeting CPE Programming

Teen Addiction – Prescription**Medications: The New Heroin?**

Sponsored by Walgreen Co

*Program #205-000-08-001-L04-P**(0.2 CEUs – 2 contact hours)*Speakers: **Thomas A. Hedrick, Jr, BA,**

Senior Communications Officer and Founding Member, Partnership for a Drug-Free America

Barbara Delaney, MBA, Director of Research, Partnership for a Drug-Free America**Phil Bauer,** Member, Parent Advisory Board, Partnership for a Drug-Free America**5 - 6 PM***Laurel A-D***Annual Meeting Orientation**Speakers: **Carmen A. Catizone, MS,****RPh, DPh,** NABP Executive Director/Secretary**Dale J. Atkinson, JD,** NABP Counsel**Loretta Simonson,** Professional Registered Parliamentarian**7 - 10 PM***Harborside Ballroom C-E***President's Welcome Reception**

Sponsored by Wal-Mart Stores, Inc

Honoring NABP President Oren M.

Peacock, Jr, RPh, and his wife Elizabeth.

*Dinner will be served.**Dress: business casual***Sunday, May 18, 2008****6:30 AM - 5:15 PM***Harborside Registration***Registration/Information Desk Open****6:30 - 7:30 AM****Fun Run/Walk**

Sponsored by Pfizer Inc

*Meet at the front entrance of the hotel at**6:15 AM. Participants will be escorted to**the Katyn Memorial Circle for the start of**the event.***8 - 11:30 AM***Harborside Ballroom A-B***Hospitality Brunch**

Sponsored by Pearson VUE

Educational Table Top Displays:

- Accreditation Council for Pharmacy Education
- Drug Enforcement Administration
- Food and Drug Administration
- Maryland Board of Pharmacy
- National Association of Boards of Pharmacy
- Pharmacy Technician Certification Board

8 - 11:30 AM*Harborside Ballroom A-B*

Joint CPE Programming

Educational Poster Session –**Protecting the Public Health***Program #205-000-08-002-L04-P**(0.1 CEU – 1 contact hour)*

Presenters:

- California State Board of Pharmacy
Virginia “Giny” Herold, MS,
Executive Officer
- Eunice Kennedy Shriver National Institute of Child Health and Human Development
John McGrath, PhD,
Communications Director
- Kentucky Board of Pharmacy
Steve Hart, RPh, Pharmacy and Drug Inspector
- North Dakota State University College of Pharmacy, Nursing, and Allied Sciences
Howard C. Anderson, Jr, RPh,
Executive Director, North Dakota State Board of Pharmacy
Alexis Barr, PharmD Candidate
Krista Berge, PharmD Candidate
Anne Gorder, PharmD Candidate
Malory Lange, PharmD Candidate
Jennifer Metz, PharmD Candidate
Sarah Reinhart, PharmD Candidate
Ashlee Zimelman, PharmD Candidate
- Oregon State University (OSU) College of Pharmacy and Oregon State Board of Pharmacy
Daniel Rackham, PharmD Candidate
Gary A. Schnabel, RPh, RN,
Executive Director, Oregon Board

Ann Zweber, RPh, Senior

Instructor, OSU College of

Pharmacy, and President, Oregon Board

- Temple University School of Pharmacy

Radha Kadiwar, PharmD Candidate

- University of Maryland School of Pharmacy

Cynthia J. Boyle, PharmD,**FAPhA,** Associate Professor,

Pharmacy Practice and Science,

Director, Experiential Learning Program

Michael Filtz, PharmD/MPH Candidate**Hoai An Truong, PharmD,****MPH, AE-C,** Assistant Director,

Experiential Learning Program

- University of Southern Nevada College of Pharmacy

Immanuel Ijo, PharmD Candidate, Drug Abuse Awareness Team (DAAT)**Paul J. Oesterman, PharmD,** Assistant Professor of Pharmacy Practice and DAAT Faculty Co-Advisor**Krystal Riccio,** PharmD Candidate, DAAT**Noon - 4 PM***Harborside Ballroom C-E***First Business Session**

- Welcome Remarks
- Call to Order
- Presentation of Colors
- National Anthem
- Greetings from the Host State
- Keynote Address
Sponsored by Abbott Laboratories
Tom Daschle, Former Senate Majority Leader
- Report of the Executive Committee
- President's Address
- Report of the Treasurer
- Report of the Committee on Constitution and Bylaws
 - Reading of Proposed Amendments to the Constitution
 - Reading of Proposed Amendments to the Bylaws

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nabp newsletter

- Announcement of Candidates for Open Executive Committee Officer and Member Positions

4 - 5 PM

Harborside Ballroom C-E

Joint CPE Programming

Legislative and Regulatory Update

Sponsored by Medco Health Solutions, Inc

Program #205-000-08-003-L03-P

(0.1 CEU – 1 contact hour)

Speakers: **Joshua M. Bolin, BA**, State

Relations Manager, NABP

Eileen Lewalski, PharmD, JD,

Professional Affairs Manager, NABP

Monday, May 19, 2008

7 AM - 2 PM

Harborside Registration

Registration/Information Desk Open

7 - 8 AM

Grand Ballroom V

NABP/USP Breakfast

Sponsored by United States Pharmacopeia

Speaker: **Ben Firschein, JD**, Director of

Government Affairs, United States

Pharmacopeia

8:15 - 10:15 AM

Harborside Ballroom C-E

Joint CPE Programming

Pedigree Update: RFID and Diversion from Common Carriers

Sponsored by CVS Caremark

Corporation

Program #205-000-08-004-L03-P

(0.2 CEUs – 2 contact hours)

Speakers: **Ryan Toole**, Supervisory Special

Agent, Federal Bureau of Investigation

Ilisa Bernstein, PharmD, JD, Director

of Pharmacy Affairs, Food and Drug

Administration

10:30 AM - noon

Harborside Ballroom C-E

Second Business Session

- Report of Executive Director/Secretary
- Report of the Committee on Resolutions - First Reading of Resolutions

- Discuss and Vote on Proposed Amendments to the Bylaws
- Candidate Speeches for Open Executive Committee Officer and Member Positions

Noon - 12:30 PM

Harborside Foyer

Informal Member/Candidate

Discussion

1:30 - 5 PM

Optional Tour: Baltimore Charm

City (Reservation required.)

Meet at the front entrance of the hotel at

1:15 PM. Participants will be escorted to

the Katyn Memorial Circle for the start of

the tour.

Tuesday, May 20, 2008

7:30 AM - 4:15 PM

Harborside Registration

Registration/Information Desk Open

8 - 9 AM

Essex A-C

Continental Breakfast

9 - 10:30 AM

Harborside Ballroom A

Executive Officer and Board Member CPE

Programming

Medicaid Fraud: Tamper-Resistant

Prescription Pads and Beyond

Sponsored by Merck & Co, Inc

Program #205-000-08-005-L03-P

(0.15 CEUs – 1.5 contact hours)

Speakers: **Jason Weinstock, JD**, Law

Enforcement Coordinator, Centers

for Medicare and Medicaid Services

Medicaid Integrity Group

Michael A. Burleson, RPh, Executive

Director, Kentucky Board of Pharmacy.

9 - 10:30 AM

Harborside Ballroom B

Compliance Officer CPE Programming

Case Strategy: How to Investigate an

Internet Pharmacy

Program #205-000-08-006-L03-P
(0.15 CEUs – 1.5 contact hours)

Speaker: **Benjamin N. Gluck, MA,**

JD, Partner and Shareholder,

Bird, Marella, Boxer, Wolpert,

Nessim, Drooks, and Lincenberg, A

Professional Corporation

10:45 AM - 12:15 PM

Harborside Ballroom C-E

Joint CPE Programming

Compounding Update: Where is USP 797?

Program #205-000-08-007-L03-P

(0.15 CEUs – 1.5 contact hours)

Speakers: **Claudia C. Okeke, PhD, RPh**,

Scientific Fellow, United States

Pharmacopeia

Ruth K. Miller, JD, Senior Counsel,

United States Pharmacopeia

12:15 - 1:30 PM

Lunch Break

(On your own.)

1:30 - 4 PM

Harborside Ballroom C-E

Final Business Session

- Election of 2008-2009 Executive Committee Officers and Members
- Remarks of the Incoming President
- Installation of 2008-2009 Executive Committee Officers and Members
- Final Report of the Committee on Resolutions
- Invitation to the 2009 Annual Meeting in Miami, FL

5:45 - 6:45 PM

Harborside Foyer

NABP/NACDS Reception

Sponsored by the National Association of

Chain Drug Stores

7 - 10:30 PM

Harborside Ballroom A-E

Annual Awards Dinner

Entertainment: Round Midnight

(Live music)

Dress: semiformal

Program subject to change.



NABP and the NABP Foundation is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a provider of continuing pharmacy education. ACPE Provider Number: 205. Participants may earn up to nine hours of ACPE-approved continuing pharmacy education credit from NABP. Participants in continuing pharmacy education programs will receive credit by completing a "Statement of Continuing Pharmacy Education Participation" and submitting it to NABP. A validated Statement of Continuing Pharmacy Education Credit will be sent as proof of participation within approximately six weeks. Full attendance and completion of a program evaluation form for each session are required to receive continuing pharmacy education credit and a Statement of Continuing Pharmacy Education Credit.

Continuing Legal Education (CLE) Policy: NABP staff will be available to assist attendees on an individual basis to apply for CLE credit for attending conference CPE sessions. To apply for CLE credit, attendees must initiate the program approval process in their own states by completing and submitting the appropriate application materials and forms. NABP will provide documentation as necessary.

Consumer Medication Information

(continued from page 79)

collected during the study, developed eight categories, based on the Keystone action plan criteria, by which to measure the usefulness of the CMI:

1. Drug names, indications for use, and how to monitor for improvement
2. Contraindications and what to do if they apply
3. Specific directions about how to use and store the medicine, and overdose information
4. Specific precautions and warnings about the medicine
5. Symptoms of serious or frequent possible adverse reactions and what to do

6. Certain general information, including encouraging patients to communicate with health care professionals, and disclaimer statements
 7. Information that is scientifically accurate, unbiased in tone and content, and up-to-date
 8. Information in an understandable and legible format that is readily comprehensible to consumers
- The results of that study indicated that, while most community pharmacies did provide printed patient information with every new prescription, the quality of that information varied widely. Findings showed that 89% of patients received some form of written medication information but that the average *usefulness* of the information was only

about 50%. Ratings were especially low on criteria dealing with the risks of drug treatment and general information. The evaluation also revealed frequent problems with print size, print quality, line spacing, and overall ease of reading.

To help bring about improvements in CMI quality in the US, FDA published guidelines, available at www.fda.gov/cder/guidance/7139fnl.htm, in July 2006 to assist CMI developers in producing useful written CMI.

A separate evaluation of CMI in the United States, Europe, and Australia, funded by a grant from the Drug Information Association and published in the November/December 2007 *Journal of the American Pharmacists Association*,

also found CMI in the US lacking. The evaluation, based on the US Keystone Criteria, found Australian CMI performed well across all criteria, receiving a mean overall score of 90% adherence to the criteria. CMI in the UK received an overall mean score of 81%, with relatively poor adherence to criteria in the areas of instructions for medication use and advice on adverse drug reactions. US CMI received a mean overall score of 68%, with particularly poor adherence scores for contraindication and precaution information.

FDA plans to publish the results of the current CMI evaluation in the fall of 2008. Results also will be provided in the *NABP Newsletter* when they become available. ©




NABP Welcomes New Executive Officers

On March 27, 2008, NABP welcomed five recently named state board of pharmacy executive officers during the New Executive Officer Orientation Program, which was held at NABP Headquarters. The orientation was chaired by NABP President Oren M. Peacock, Jr, RPh, and is designed to acquaint attendees with NABP membership and governance as well as the programs and services. Pictured above from left to right are Peacock; Mark D. Johnston, RPh, executive director, Idaho Board of Pharmacy; Ronald J. Huether, RPh, executive secretary, South Dakota State Board of Pharmacy; Mary Walker, RPh, executive director, Wyoming State Board of Pharmacy; Ronald J. Klein, RPh, executive director, Montana Board of Pharmacy; and Kevin K. Eidson, PharmD, executive director, Tennessee Board of Pharmacy. ©



Committee Works to Safeguard Examinations

On March 10, 2008, the Advisory Committee on Examinations met at NABP Headquarters to discuss ways to further safeguard the integrity and validity of the Association's examination and certification programs. Pictured above from left to right are: Tom M. Houchens, RPh, FASCP, director of pharmacy services, Laurel Housing Inc; Kendall M. Lynch, DPh, vice president, Maxor Correctional Pharmacy Services; Judy Gardner, PharmD, member, Georgia State Board of Pharmacy; Arthur I. Jacknowitz, MS, PharmD, professor and distinguished chair, West Virginia University School of Pharmacy; and Stephen M. Gross, MA, EdD, professor of pharmacy administration and dean, Long Island University, Arnold and Marie Schwartz College of Pharmacy and Health Sciences. 



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NABP 104th ANNUAL MEETING

Register on site. Meeting to be held May 17-20, 2008, at the Baltimore Marriott Waterfront in Baltimore, MD.