



# newsletter

National Association of Boards of Pharmacy®

July 2006 / Volume 35 Number 6

aid to government  
the profession  
the public  
1904 to 2006

## Well-conceived Impairment Assistance Programs Help Protect the Public While Providing a Second Chance

### This Month on [www.nabp.net](http://www.nabp.net):

#### Special Items

NABP Releases 102<sup>nd</sup> Annual Meeting Passed Resolutions

NABP Releases 102<sup>nd</sup> Annual Meeting Defeated Resolutions

102<sup>nd</sup> Annual Meeting Officer Reports

NABP Releases 2005-2006 Committee and Task Force Reports

#### Headlines

NABP 2006-2007 Executive Committee Inaugurated at 102<sup>nd</sup> Annual Meeting in San Francisco

### Upcoming Meetings

**Sunday-Tuesday  
August 6-8, 2006**

NABP/AACP District III Meeting  
Charleston, SC

**Thursday-Saturday  
August 10-12, 2006**

NABP/AACP District V Meeting  
Inn at the Forks,  
Winnipeg, Manitoba, Canada

**Friday-Saturday  
November 3-4, 2006**

NABP Fall Educational Conference  
Hyatt Regency Savannah  
Savannah, GA

**Saturday-Tuesday  
May 19-22, 2007**

NABP's 103<sup>rd</sup> Annual Meeting  
Hilton Portland &  
Executive Tower  
Portland, OR

In a profession that is often characterized by stressful working environments and long hours that can lead to drug or alcohol abuse – and the potential for illicit use or diversion of prescription medications – pharmacist impairment assistance programs can serve as a crucial safety net and useful tool for boards of pharmacy to address impaired pharmacists. Several state boards of pharmacy have produced positive results by implementing effective programs that allow pharmacists, and in some cases technicians and interns, to overcome personal struggles with addiction while ensuring that the public is protected

and receives the best available professional judgment in receiving its prescription medications.

The *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy* (*Model Act*) addresses this important issue in Section 402, Grounds, Penalties, and Reinstatement. According to the *Model Act*, “[a] licensee who is physically or mentally impaired due to addiction to Drugs or alcohol may qualify as an impaired Pharmacist and have disciplinary action deferred and ultimately waived only if the Board is satisfied that such action will not endanger the public and the licensee enters

into an agreement with the Board for a treatment and monitoring plan approved by the Board, progresses satisfactorily in such treatment and monitoring program, complies with all terms of the agreement . . .”

In addition, NABP’s Committee on Law Enforcement and Legislation met in January 2006 and recommended that state boards adopt impairment assistance programs or consider ways to address impairment issues that support the decisions of the state boards of pharmacy and preclude federal or other state agencies from disregarding the boards’ actions. The

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## Impairment

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implementation of such programs is common among the state boards of pharmacy; a March 2005 NABP survey indicated that of 33 boards that responded, 20 conveyed that their respective state administers such a program or contracts with an outside agency to administer such a program.

Increased awareness of impairment issues is driving the implementation of these programs. According to a 2001 article titled "Onset of Illegal Use of Mind-altering or Potentially Addictive Prescription Drugs Among Pharmacists" in the *Journal of the American Pharmaceutical Association*, almost 40% of respondents to a journal survey admitted to using potentially addictive prescription drugs without a prescription, which is considerably higher than the overall substance abuse rate of 10% among the general population. Ensuring that an impaired pharmacist is ready to resume practicing requires careful monitoring and their adherence to commitments. Several state board executives and impairment program administrators recently shared their thoughts on the best ways to ensure that impaired pharmacists are ready to go back to practicing, and prevent

their licenses from being permanently revoked.

## Reporting of the Problem

Many state board-sanctioned impairment programs provide some opportunity to report a problem not to the board but directly to the program and protect the impaired licensee's confidentiality during treatment.

Pharmacists enter treatment with the Kentucky Professionals Recovery Network (KyPRN), a third-party impairment program administrator, either after referral from the Kentucky Board of Pharmacy when a complaint has been received, or after referral from a concerned family member, employer, or the pharmacist. In the case of Board referral, an investigation is launched following a complaint and, if it is determined that impairment exists, the individual is required to surrender their license to the Board. In cases of referral by someone other than by the Board, the pharmacist surrenders their license to the KyPRN and there is no need to report enrollment to the Board so long as no complaints are received and the pharmacist demonstrates that they pose no danger to the public, according to Brian Fingerson, RPh, who oversees the KyPRN.

The West Virginia Pharmacist Recovery

Network (WVPRN) provides confidential 24-hour-a-day, seven-day-a-week telephone support for pharmacists, technicians, and interns who may need help before the West Virginia Board of Pharmacy intervenes. Michael O'Neil, PharmD, WVPRN executive director, notes exceptions to confidentiality, such as diversion other than for self or when these individuals are caught stealing.

Most pharmacists who enroll in the Oklahoma Pharmacists Helping Pharmacists (OPHP) program are referred by the Oklahoma State Board of Pharmacy, according to Cindy Hamilton, DPh, Board inspector and the Board liaison to OPHP.

## Impaired Pharmacist Commitments

Enrollees in the KyPRN commit to a treatment agreement that is customized to each situation. Requirements might include random drug screenings, limits on work hours, and periodic reports. "These problems are not best dealt with using a 'cookie cutter' approach," says Fingerson.

Typically, an individual program under the KyPRN includes removal from practicing for four to 16 weeks and a treatment program length of five years. The key to treatment, notes Fingerson, is monitoring.

"If you can monitor a

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## Clear Message Key to Effectively Communicating With the Media

Knowing the message you want to convey and condensing it to a brief and memorable sentence is key to having your message heard. Boards of pharmacy members and staff are often called upon to communicate board policy to the media and other stakeholders, and conveying their message can be difficult – sometimes even intimidating. Rea Blakey, a media training consultant, offered several techniques to stay on message and maintain control of the message at NABP’s 102<sup>nd</sup> Annual Meeting, held April 8-11, 2006, in San Francisco, CA.

When dealing with the media, Blakey says, the primary objective is to have your message heard and understood, and this means that the message must be repeated often. Staying on message can be difficult as those being interviewed often feel as if they are not in control; however, Blakey

points out, the interviewee is the empowered person – without them the reporter has no story. In addition, practice is very important to feeling in control and staying on message. Rehearsal can help you hone your message as well as make it a natural part of your dialogue. Finally, she instructs those dealing with the media to buy time whenever possible. When ambushed by the media, asking them to wait even five minutes can help establish control because it gives the interviewee time to organize their thoughts and the message.

Defining objectives will also help the interviewee maintain control during the interview. Some questions that will help define the objective include:

- Why are you being interviewed?
- What is your potential gain or loss?

- How much controversy is involved?
- How will your colleagues react to the interview?
- Will the public understand your message?
- What do you want understood.

According to Blakey, when it comes to dealing with the media the best defense is a strong offense. It is important to get news to the media within 24 hours of it occurring so that the situation does not creep up on you and result in an ambush situation. To create a strong offense, know what you are going to say, when you are going to say it, and why you are going to say it.

When conveying a message to the public it is best to use a brief, simple message to avoid confusion. The general public has a short attention span and is bombarded daily with information, so your message needs to stand out and be easily understood. Scientific and medical jargon as well as quoting exact figures or citing previous studies should be avoided. Blakey explains that “avid” news watchers only view the news three times each week, and the average viewer has only a ninth-grade comprehension level.

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### Executive Committee

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One-year term

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One-year term

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Serving second year of a three-year term  
NABP’s Executive Committee is elected each year at the Association’s Annual Meeting. The 103<sup>rd</sup> Annual Meeting is May 19-22, 2007, at the Hilton Portland & Executive Tower, Portland, OR.

### Blakey’s Ten Media Rules to Live By

1. Always tell the truth.
2. Nothing is “off the record.”
3. State the most important facts first.
4. Repeat Must Air Points (MAP) often during the interview.
5. Listen carefully.
6. “Be” interesting. (Let your personality show.)
7. Bridge questions, do not evade questions.
8. Never, ever say “No comment.”
9. Do not fake answers. If you don’t know say so.
10. Do not lose your temper.

## Bond: You Only License Twice

By Dale J. Atkinson, JD

**L**icensees and others accused of violating the pharmacy practice act are many times also potentially violating criminal statutes. The interplay between the administrative disciplinary process and the contemporaneous criminal prosecution of defendants can create interesting issues. Strategies over how and when to administratively proceed and the potential for advantages and disadvantages of pursuing one prosecution before the other must be taken into consideration. The role of the criminal courts in determining licensure issues also implicates interesting jurisdictional issues. Consider the following.

The owner of three pain management clinics and two pharmacies in the New Orleans, LA area and three physicians employed at the clinics were accused of criminal conspiracy to distribute and dispense prescription pain medications without medical necessity and outside the scope of professional practice. Following an arraignment, all defendants pled not guilty to the charges and were released on bond. In addition to these businesses, the owner was also licensed as a nurse in Louisiana.

Pursuant to warrants issued by Drug Enforcement Administration (DEA), the government seized

bank accounts, vehicles, cash, and other assets, and placed liens on 11 parcels of property based upon the belief that such assets were acquired from the proceeds of illegal activities. As a condition of bond securing her appearance at the criminal trial, the criminal judge ordered that the owner surrender her nursing license to the court's Pretrial Services and be confined to her home through electronic monitoring systems.

Based upon motions later filed by the defendants, the court ordered the release of \$300,000 of the seized assets to allow for the payment of attorneys fees and certain living expenses. In addition,

the judge removed the bond conditions related to the owner's home confinement in order to allow her to seek employment outside the home.

Thereafter, the owner filed a motion to modify her bond conditions related to the surrender of her nurse license. She argued for the right to seek employment as a nurse and agreed to a prohibition from employment in a pain management facility or clinic. The owner argued that the bond condition related to the surrender of her license was unduly broad in that it restricted her from any type of nursing practice, including practice unrelated to pain management. She also argued that there was a heightened need for medical personnel in the wake of Hurricane Katrina.

Prior to the motion to modify the conditions of bail, the Louisiana State Board of Nursing held an adversarial hearing and suspended the owner's nurse license pending the final disposition of the criminal prosecution. Based upon the actions of the Board of Nursing as well as the severity of the criminal accusations, the government opposed the owner's motion to modify the conditions of bond. The government

argued that any modification by the court would be moot because of the action by the Board suspending her nursing license.

After hearing arguments, the court held that the condition upon the owner's bond that she surrender her nursing license should be modified. The court held that the owner could apply for reinstatement of her nursing license; however, she must go through state channels to seek such reinstatement and must meet all conditions imposed by the Board. The criminal court specifically stated that it has no authority to reinstate her license.

An essential procedural process in this matter is the action of the Board of Nursing to hold a hearing and formally suspend the license of the nurse. The fact that the criminal court required the nurse to surrender her license to Pretrial Services does not necessarily conclusively determine the issue of practice privileges or the property interest in the license. Such decisions are vested in the Board of Nursing.

Further, and if the Board of Nursing failed to administratively pursue the license issue, the criminal court would effectively be determining eligibility-to-

practice issues. Thus, when the nurse filed a motion seeking the return of her license, the criminal court would be determining issues related to the reinstatement decisions. Again, such authority should be vested with the Board of Nursing to use its expertise in licensure reinstatement determinations.

Finally, surrendering one's license based upon a bond hearing as mandated by a criminal court would likely not result in report to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the disciplinary databank held by the National Council of State Boards of Nursing (the nursing counterpart of NABP).

From an administrative perspective, boards of pharmacy should be vigilant in their responsibilities to protect the public through the regulation of the practice of pharmacy. Reliance upon the criminal sector to prosecute licensees as a means to protect the public may not always produce the results desired by the board. Criminal prosecutions operate under a burden of proof (beyond a reasonable doubt) that is based upon the potential for loss of life and liberty, higher than the

administrative burden of proof (either preponderance of the evidence or clear and convincing evidence). Thus unsuccessful criminal prosecutions of licensees do not preclude the board from pursuing administrative prosecutions.

Criminal prosecutions are also subject to negotiated pleas that may reduce charges in order to expeditiously resolve matters. Negotiated pleas may reduce felony charges to misdemeanors, thus potentially limiting the authority of the board of pharmacy to base a collateral administrative action on such a criminal "conviction." Boards must assess the statutory grounds for discipline related to felony and misdemeanor convictions when confronted with such a scenario.

Boards of pharmacy should consult with their respective attorneys on the complexity of contemporaneous criminal and administrative prosecutions. However, various policies to consider include suggesting an automatic notice from the criminal and/or civil courts to the respective regulatory board upon the conviction or final judgment against a licensee. Ⓢ

*United States of America v. Prejean*, 2005 WL 3543817 (D. C. LA 2005)



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

## NABP Releases Update of Model Rules for the Licensure of Wholesale Distributors

In 2006, the state boards of pharmacy and state legislatures have continued to address the licensure of wholesale drug distributors and establishment of a pedigree system to help protect the United States drug distribution chain. Over the past several months, NABP has recognized several trends in various legislative and regulatory proposals and has identified areas of the March 2005 version of the Model Rules for the Licensure of Wholesale Drug Distributors (Model Rules) that are in need of amendment. The amendments are a result of direction from the state boards of pharmacy and input received from interested industry stakeholders. The 2006 version of the Model Rules, which was approved by the Executive Committee, includes many changes that will make the Model Rules easier for the boards to implement and enforce, and also address some reasonable concerns raised by members of the industry, while still maintaining a regulatory framework that will protect the drug distribution system.

To further explain the steps in the wholesale drug distribution system, several new definitions were added and some existing definitions were amended (ie, Pedigree, Wholesale Distributor, Wholesale Distribution); the definition for Authorized Distributor was deleted. In addition, significant changes were made to the requirements for licensing, pedigrees, and accreditation. The details of these amendments are as follows.

### New Definitions

*Chain Pharmacy Warehouse* – a permanent physical location for Drugs and/or Devices that acts as a central warehouse and performs intracompany sales and transfers of Prescription Drugs or Devices to chain Pharmacies, which are members of the same affiliated group, under common ownership and control. Chain Pharmacy Warehouses must be licensed as Wholesale Distributors.

*Co-Licensee* – a pharmaceutical manufacturer that has entered into an agreement with another pharmaceutical manufacturer to engage in a business activity or occupation related to the manufacture or distribution of a Prescription Drug.

*Drop Shipment* – the sale, by a Manufacturer, that Manufacturer’s Co-Licensee, that Manufacturer’s Third-Party Logistics Provider, or that Manufacturer’s Exclusive Distributor, of the Manufacturer’s Prescription Drug, to a Wholesale Distributor whereby the Wholesale Distributor takes title but not possession of such Prescription Drug and the Wholesale Distributor invoices the Pharmacy and the Pharmacy receives Delivery of the Prescription Drug directly from the Manufacturer, that Manufacturer’s Co-Licensee, that Manufacturer’s Third-Party Logistics Provider, or that Manufacturer’s Exclusive Distributor, of such Prescription Drug. Drop Shipments shall be part of the “Normal Distribution Channel.”

*Exclusive Distributor* – an entity that:

1. Contracts with a Manufacturer to provide or coordinate warehousing, Wholesale Distribution, or other services on behalf of

- a Manufacturer and who takes title to that Manufacturer's Prescription Drug, but who does not have general responsibility to direct the sale or disposition of the Manufacturer's Prescription Drug; and
2. Is licensed as a Wholesale Distributor under this chapter.

*Normal Distribution Channel*— a chain of custody for a Prescription Drug that goes from a Manufacturer of the Prescription Drug, the Manufacturer's Co-Licensee, the Manufacturer's Third-Party Logistics Provider, or the Manufacturer's Exclusive Distributor to:

1. A Wholesale Distributor to a Pharmacy to a patient or other designated persons authorized by law to dispense or administer such Prescription Drug to a patient; or
2. A Wholesale Distributor to a Chain Pharmacy Warehouse to that Chain Pharmacy Warehouse's intracompany Pharmacy to a patient or other designated persons authorized by law to dispense or administer such Prescription Drug to a patient; or

3. A Chain Pharmacy Warehouse to that Chain Pharmacy Warehouse's intracompany Pharmacy to a patient or other designated persons authorized by law to dispense or administer such Prescription Drug to a patient; or
4. As prescribed by the Board's regulations.

The definition of "Normal Distribution Channel" provides the structure for the pedigree system in the Model Rules. It defines three channels through which a prescription drug may travel without requiring a pedigree. These channels recognize many of the new definitions in the Model Rules, including "Chain Pharmacy Warehouse," "Co-Licensee," "Exclusive Distributor," and "Third-Party Logistics Providers."

The concept of the "Normal Distribution Channel" is the pedigree system that is being most widely introduced in state legislation. NABP views the normal distribution channel as being an interim solution for boards that want to provide some security to the distribution system prior to the establishment of an electronic pedigree system that tracks all prescription drugs from point of manufacture to final dispensing to the patient.

*Third-Party Logistics Providers* – an entity that:

1. Provides or coordinates warehousing, Distribution, or other services on behalf of a Manufacturer, but does not take title to the Prescription Drug or have general responsibility to direct the Prescription Drug's sale or disposition; and
2. Is licensed as a Wholesale Distributor under this chapter.

### Deleted Definition

*Authorized Distributor* – Due to the inclusion of the "Normal Distribution Channel" concept, the definition for "Authorized Distributor" was deleted from the Model Rules. The definition was no longer needed, as the pedigree systems proposed in the Model Rules do not recognize the term.

### Licensing Requirements

As the boards of pharmacy have started to implement some of the components of the Model Rules, NABP has witnessed some issues that have arisen as a result of the surety bond requirements. Some states have built in a waiver to their surety bond requirements, to allow for the board to recognize another state's surety bond, or to waive the requirement altogether for publicly traded companies.

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## Impairment

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health care professional, the evidence suggests that they have an 85% to 90% chance of recovery, whereas it's only about a 15% to 20% chance for a person who goes into Alcoholics Anonymous (AA)," he says.

Those who enter the WVPRN in West Virginia are allowed to keep their license as long as they meet the requirements of their agreements, although they may be prohibited from practice until they are deemed safe and competent after treatment. Usually, program enrollees are asked to surrender their licenses to the WVPRN as a sign of good faith, notes O'Neil. A typical WVPRN agreement consists of 90-day inpatient treatment for substance abuse, AA or Narcotics Anonymous meetings, and urine testing. The typical contract covers two to five years, O'Neil notes, and enrollees must call in every day to make themselves available for random drug screening.

Hamilton reports that OPHP contracts require enrolled pharmacists to submit to random drug testing, calling in each workday and entering an identification number that randomizes testing. Randomizing testing and putting the onus on enrollees to carry through on their commitments are

effective approaches to implementing a program, Hamilton says. In addition, notes Hamilton, there

**"If you can monitor a health care professional, the evidence suggests that they have an 85% to 90% chance of recovery, whereas it's only about a 15% to 20% chance for a person who goes into Alcoholics Anonymous (AA)."**

**Brian Fingerson, RPh  
KyPRN**

have been cases in which program enrollees have been forced to stop taking legal or illegal drugs and turned to alcohol instead, which is also prohibited during the length of an enrollee's agreement. For this reason, OPHP also tests enrollees for alcohol use.

### Reinstatement and Post-program Monitoring

When a pharmacist has been referred to the Kentucky Board of Pharmacy and has completed the KyPRN program, the Board typically suspends the license for six months and the pharmacist needs to show proof of sobriety, eg, letters of

recommendation from the KyPRN administrators or documentation of passing drug screens, and appear before the Board in order to begin practicing again. In addition, limits are typically applied to the pharmacist's working hours. (Fingerson notes that a limit on hours can create a Catch-22 as pharmacists who undergo treatment often have financial problems, yet limiting hours is intended to reduce the stress and fatigue that can contribute to impairment issues in the first place.) When a pharmacist is referred to the KyPRN by someone other than the Board, the KyPRN administrators meet with the individual in treatment to determine whether or not the individual should be allowed to practice again and the KyPRN handles the pharmacist's post-program monitoring. Fingerson notes that many pharmacists who complete treatment choose to be monitored indefinitely after being reinstated.

In Wyoming, pharmacists who enroll in the Wyoming Professional Assistance Program (WPAP) are protected from penalties by three statutes. Post-program monitoring requirements include making someone at the pharmacist's work site aware that the pharmacist has completed the program.

West Virginia-licensed pharmacists, technicians, and interns who go through

the WVPRN program are considered finished with the program when they have completed all of the commitments in their agreement. O'Neil says that the program administrators stay in touch with enrollees during treatment and enrollees sometimes opt to keep being monitored after the terms of their agreements have been fulfilled.

In Oklahoma, those who complete an OPHP program must undergo a six-month transition period in which drug screening continues and in which attendance at AA meetings and the like are still encouraged, though not required. The OPHP board of administrators must approve the conditions of this transition period.

### Recommendations for Success

KyPRN's Fingerson says that a key element of a successful impairment assistance program is funding; these programs should not be staffed by volunteers and state boards need to finance them, he says. In order to finance the program, the Kentucky Board of Pharmacy collects a \$10 assessment that is added to each licensure renewal application. "Most states don't fund these programs and they use volunteers," he says. "People can burn out on running these programs; if you can't pay


for it, accountability to the board will suffer and accountability to the board is key.”

James T. Carder, RPh, executive director of the Wyoming State Board of Pharmacy, notes that a strong agreement between the enrollee and the program is crucial. In the event of a relapse, he adds, records must be available to the board of pharmacy, so the enrollee must sign a release for this information.

The contract – five years in Wyoming – should be long enough to ensure effectiveness, Carder adds. Noting that the Board has a representative on WPAP’s board of directors, WPAP Executive Director George Vandel adds that the board of pharmacy must have a voice in how the program is administered. Vandel adds that the pharmacist should be able to self-refer or be referred to the program by someone else without the threat of disciplinary action.

Vandel, who oversees WPAP for multiple health care professions in Wyoming, says that a thorough evaluation of pharmacists to determine the exact causes of impairment using a multidisciplinary approach (eg, physical, substance abuse, spiritual, psychological) is necessary.

Hamilton of the Oklahoma State Board of Pharmacy states that drug testing should cover everything, including synthetic opiates.

O’Neil of WVPRN explains that an important factor in the success of an impairment assistance program is a supportive board and ongoing communication between the program administrators and program enrollees. Another important element of a successful program is a multidisciplinary network of professionals with various treatment backgrounds, which can provide accurate evaluations of impairment issues. 

## Course Offered for Impairment Program Administration

Since the early 1980s, the American Pharmacists Association (APhA) has sponsored the Pharmacy Section of the University of Utah School on Alcoholism and Other Drug Dependencies. The school is held once a year in Salt Lake City, UT, and includes general sessions and group sections including pharmacy.

According to APhA’s Marcie Bough, PharmD, who helps to administer the Pharmacy Section, the school is based on the findings of an “Evidence-based Treatment Practices for Substance Use Disorders” workshop ([www.qualityforum.org/txSUDforweb.pdf](http://www.qualityforum.org/txSUDforweb.pdf)) that was conducted by the National Quality Forum in December 2004. The

workshop identified seven core treatment practices that are supported by sufficient scientific evidence to merit widespread implementation and four attributes of high-performing substance use disorder treatment programs.

General University of Utah School sessions provide networking opportunities and cover the theory of addiction. The Pharmacy Section, one of several specific to various health care disciplines, focuses on how attendees can implement impairment assistance programs. Sessions include:

- “Pre-School Annual Workshop for State Pharmacy Recovery Program Administrators and State Boards of

Pharmacy Members/ Employees” – Brian Fingerson, who helps conduct this workshop, is executive director of the Kentucky Pharmacist Recovery Network. The workshop provides specifics on how to set up and administer an impairment assistance program at the state board level.

- “Introduction and Overview of Addiction Issues”
- “Chemical Dependency Among Healthcare Professionals” – Ways in which pharmacy personnel can detect problems among their peers.
- “Pain Management in the Recovering Addict” – Dealing with chronic

pain during the recovery process.

- “Pharmacy Ethics and Law” – Pharmacy personnel may be faced with situations in which peers need intervention, or in which accessibility to medications results in temptations. This session raises awareness about the implications of these situations.

In addition to the sessions, the School also features open AA meetings to introduce attendees to the format of a 12-step program. More information about the University of Utah School on Alcoholism and Other Drug Dependencies is available at <http://uuhs.c.uu.edu/uas/phaprog.htm>.



nabp newsletter

Model Rules

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NABP believes that is important for the boards to have the flexibility to waive the bond requirement, but still guarantee that the applicant is financially stable and unlikely to try to avoid paying fines and penalties levied by the board. Accordingly, the Model Rules has been amended to provide for such a waiver.

As few state boards have specifically created or approved formal continuing education programs for designated representatives, the Model Rules have been amended to allow for in-house training programs to be conducted that would ensure compliance with relevant state and federal laws.

Pedigrees

As a result of the lack of adoption on the part of state legislatures, NABP’s Executive Committee recommended that the National Specified List of Susceptible Products

be eliminated from the Model Rules and be replaced with the “Normal Distribution Channel.” This concept will serve as the interim pedigree solution, while a full pedigree system for each prescription drug is being implemented on a large scale and across the entire supply chain.

NABP recognizes that in order to achieve an effective electronic pedigree system for all prescription drugs, such a system must be implemented on a large scale and across the entire supply chain. Accordingly, the Model Rules have been revised to include a statement that the board must consider large-scale implementation of the technology and ensure that there is not a negative impact on the safety or efficacy of the prescription drug, prior to setting an implementation date. However, implementation should not be unnecessarily delayed.

Accreditation

As the boards of pharmacy have been faced with implementing and enforcing the increased licensing requirements – with ever limited human and fiscal resources – the demand for the recognition of a third-party accreditation body has increased. Accordingly, NABP has inserted suggested language for boards of pharmacy that want to recognize a third-party accreditation body, such as NABP’s Verified-Accredited Wholesale Distributors™ program.

The accreditation section provides for:

- 1. Authority for the board to utilize a third-party accreditation body to inspect and accredit wholesalers;
2. The board to waive the certain requirements if a facility is accredited;
3. Reciprocity for applicants that are accredited for the

purposes of licensure in other states;

- 4. Due process for applicants that are denied accreditation, with the board and with the accreditation body;
5. The protection of proprietary information collected by the accreditation body; and
6. A waiver of due diligence requirements if the information has been affirmed by a third-party accreditation body.

The updated version of the Model Rules for the Licensure of Wholesale Distributors may be downloaded from NABP’s Web site, located at www.nabp.net. Boards are encouraged to contact Eleni Z. Anagnostiadis, NABP board services director, for more information on the Model Rules or for legislative assistance in this matter.

Media

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Constructing a message for the media can be difficult, but by using Must Air Points (MAP) the task becomes easier. MAP is the premise of thinking of the message in a headline format, which in turn will create a clear, concise message, Blakey says. In addition, a headline approach is easily transferable to

television, a media that only allows enough time for a brief sound byte. Other important things to consider when constructing a message is that it must resonate with the audience. She notes that messages for trade, scientific, and medical media must be complex; conversely, messages for consumer media should be simple and easy for a lay audience to understand.

During an interview, the interviewer may pull you

off message, but there are several ways to get back to your point. Blakey identifies several ways to bridge back to the key message:

- Importance – “That’s a major factor, but what’s most important . . .”
● Affirmation – “Yes, and furthermore . . .”
● Contradiction – “No, let me explain . . .”
● Time – “In the past that was true, but today we’re . . .”

- “Don’t know” to “do know” – “I simply can’t give you an answer to that, but I do know . . .”
● Contrast – “That applies to manufactured drugs, but not to compounded prescriptions . . .”

Blakey notes that if a question is asked that the interviewee does not know the answer to, they should say that they do not know but that they can get back

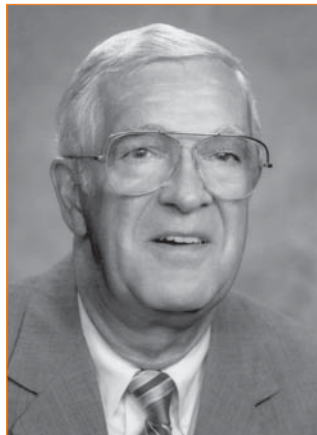
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## Fred T. Mahaffey, NABP Executive Director Emeritus, Passes

On June 19, 2006, Fred T. Mahaffey, RPh, PharmD(Hon), NABP executive director emeritus, passed away at the age of 82. His contributions to NABP, state boards of pharmacy, and the protection of the public health were significant and established NABP as one of the leading pharmacy organizations. Dr Mahaffey will be greatly missed.

Dr Mahaffey became NABP's third executive director in 1962. He joined NABP in 1956 as the assistant to the executive director following a term on the Missouri Board of Pharmacy. Dr Mahaffey was charged by then-Executive Director P. H. Costello and the NABP Executive Committee with developing

a national licensure examination for the state boards of pharmacy. He achieved that goal and also served as the chairperson of the Advisory Committee on Examinations. During the 25 years he served as executive director/secretary he nurtured the Association from its humble beginnings of just three staff members to a growing organization that served as the national clearinghouse for licensure transfer for the state boards of pharmacy, and successfully introduced the National Association of Boards of Pharmacy Licensure Examination in 1976. He was involved in the development of the national drug code for pharmaceutical products, implemented the NABP



Number for pharmacies, led national manpower studies, introduced the Federal Drug Law Examination and the Foreign Pharmacy Graduate Examination Committee™ Certification Program, and was the relentless champion for advocating the importance of the state boards of pharmacy.

Dr Mahaffey's leadership and contributions to the pharmacy profession continued even after his retirement in 1988 and he was awarded the coveted Hugo H. Schaefer Award by the American Pharmacists Association (APhA) in 2001 for his "outstanding voluntary contribution to society, the profession of pharmacy, and APhA." Dr Mahaffey graduated from the University of Missouri-Columbia with a bachelor of arts degree in zoology in 1949 and a bachelor of science degree in pharmacy from the University of Missouri-Kansas City in 1952. In 1973, he was awarded an honorary doctor of pharmacy degree from the Massachusetts College of Pharmacy and Health Sciences. ⑧

## Media

(continued from previous page)

to the interviewer with the answer. Also, it is important to remember that an interview begins when the interviewer arrives and does not end until they leave. Anything you say before or after the formal interview time can be used – there is no such thing as "off the record," Blakey stresses.

During an interview, there are several types of

questions that can confuse or throw the interviewee off message, Blakey explains.

- Loaded Preface – a long preamble, sometimes containing misinformation, on which the interviewer then asks you to comment.
- Multi-question – several questions in one. Answer the question you want to address or simply make the points you need to get across.

- What If – hypothetical, asking for your reaction. Ignore it and bridge to your message points.
- Unidentified Charge – avoid responding to articles or publications you have not read, ask who has made the charge, but avoid "he said/they said."
- Proprietary – say you cannot release the information because it is confidential or premature and explain why.

- Preposterous – if the question is "off the wall," ignore it and bridge to your message points.

With preparation and practice, dealing with the media does not have to be hazardous or intimidating, Blakey says. Through practice, boards of pharmacy can present a poised demeanor and stay on point with their messages to the media. ⑧

## 2006 District Meeting Schedule

### NABP/AACP District I and II Meeting

Thursday-Saturday,  
October 12-14, 2006  
Renaissance Harborplace  
Hotel  
Baltimore, MD

### NABP/AACP District III Meeting

Sunday-Tuesday,  
August 6-8, 2006  
Double Tree Suites  
Charleston, SC

### NABP/AACP District IV Meeting

Wednesday-Friday,  
November 8-10, 2006  
Hotel TBA  
Detroit, MI

### NABP/AACP District V Meeting

Thursday-Saturday,  
August 10-12, 2006  
Inn at the Forks  
Winnipeg, Manitoba,  
Canada

### NABP/AACP District VI Meeting

Wednesday-Saturday,  
October 25-28, 2006  
Peabody Hotel  
Little Rock, AR

### NABP/AACP District VII and VIII Meeting

Wednesday-Saturday,  
October 4-7, 2006  
Disneyland Hotel  
Anaheim, CA

## District Meetings Provide Opportunity to Discuss Regional, National Issues

Every year, each of the eight districts of NABP hold meetings with colleges and schools of pharmacies, members of the American Association of Colleges of Pharmacy (AACP), in order to discuss topics of mutual interest as well as address items of business.

The District Meetings are an opportunity for the boards of pharmacy to collaborate with the colleges and schools of pharmacy, as pharmacy curriculum and educational requirements are reviewed and changes made to educational guidelines and standards. In addition, AACP and NABP are involved in a number of cooperative efforts and initiatives, such as the Pharmacy Curriculum Outcomes Assessment program, that will assist boards, colleges, and schools of pharmacy in their efforts to support pharmacy education. The leadership AACP provides in representing the colleges and schools of pharmacy at both the district meetings and nationally is appreciated by the Executive Committee and members of NABP.

The authority of the boards to create resolutions at district meetings enables the district to formalize a

plan of action for issues or trends that are affecting the boards of pharmacy and/or schools and colleges of pharmacy in that district. Each district appoints a Resolutions Committee that will compile the resolutions developed at the district meeting and forward them to NABP.


Topics that are important to pharmacy regulators today and that are excellent discussion items at district meetings include:

- Licensing of Wholesale Distributors;
- Medicare Part D – Impact on Pharmacy and the Public Health;
- Continuing Professional Development;
- Multi-state Pharmacy Practice;
- Curriculum Assessment Mechanisms for Boards and Colleges; and

Other events that take place at district meetings include reports presented by the NABP president and a report from a representative of AACP; break out sessions during which attendees from NABP and AACP can discuss matters of importance, and business sessions with reports from the treasurer and various district committees.

Since 2005, the district meetings are also the forum for the election of nominees for the NABP Executive Committee if there is an open member position for the district. This year, districts that will be holding elections for open member positions are Districts I, II, and V. Boards also elect representatives (one delegate and one alternate) to serve on NABP's Committee on Resolutions at the Association's Annual Meeting.

In addition to the networking opportunities that the district meetings provide, attendees have the opportunity to earn continuing education (CE) credits, as CE is a major component of the programming. Topics that have recently been covered in CE sessions at district meetings include compounding, product integrity, professionalism, trends in the regulation of pharmaceutical wholesalers, and predicting pharmacists' errors.

NABP encourages members of state boards of pharmacy to attend their district meetings and take full advantage of the opportunity to discuss important issues affecting the practice of pharmacy. 

## Board Staff Invited to Participate in NABP's Annual Program Review and Training Sessions

Board of pharmacy staff are invited to learn more about NABP programs and services that will aid board staff in facilitating their duties at the Association's 10<sup>th</sup> annual program review and training sessions, which will be held Monday, September 25, 2006, and Friday, September 29, 2006. Both sessions will be held at NABP's Headquarters in Mount Prospect, IL.

The two interactive training sessions are scheduled to include a review of NABP's Electronic Licensure Transfer Program® (ELTP®), North American Pharmacist Licensure Examination™ (NAPLEX®), Multistate Pharmacy Jurisprudence

Examination® (MPJE®), the Foreign Pharmacy Graduate Examination Committee™ (FPGEC®) Certification Program, the Pre-NAPLEX® and the Pre-FPGEE®, and the Verified Internet Pharmacy Practice Sites™ (VIPPS®) accreditation program, and the National Clearinghouse of Licensure, Certification, and Accreditation. Board staff will also learn about more recent programs such as the Pharmacy Authenticated Licensure Service (PALS) program, the Pharmacy Curriculum Outcomes Assessment (PCOA) tool, and the Verified-Accredited Wholesale Distributors™ (VAWD™) program. Additionally, NABP staff


will provide training on the use of computer software for licensure verification, Clearinghouse/Healthcare Integrity and Protection Data Bank reporting; MPJE and NAPLEX score replication and views; and state and pharmacy school roster reports and retrieval procedures.

NABP's staff will provide the training and answer specific questions.

"We are pleased to offer these annual training sessions to board staff because not only does it provide an excellent opportunity for them to gain an intimate knowledge of how NABP works and

what services the Association offers, but they also have the opportunity to network with other board of pharmacy staff," says NABP President Lawrence H. Mokhiber.

The training sessions have expanded since 1996, when they only covered the Association's ELTP program; now the curriculum includes information about a wide range of NABP programs and services.

Questions about the training sessions or registration should be directed to the Customer Service Department by calling 847/391-4406 or e-mailing [custserv@nabp.net](mailto:custserv@nabp.net). 

### NABP Districts

*District I:* Connecticut; Maine; Massachusetts; New Brunswick; New Hampshire; Nova Scotia; Prince Edward Island; Quebec; Rhode Island; and Vermont.

*District II:* Delaware; District of Columbia; Maryland; New Jersey; New York; Ontario; Pennsylvania; Virginia; and West Virginia.

*District III:* Alabama; Florida; Georgia; Kentucky; Mississippi; North Carolina; Puerto Rico; South Carolina; Tennessee; and the Virgin Islands.

*District IV:* Illinois; Indiana; Michigan; New South Wales, Australia; Ohio; South Africa; and Wisconsin.

*District V:* Iowa; Manitoba; Minnesota; Nebraska; North Dakota; and South Dakota.

*District VI:* Arkansas; Kansas; Louisiana; Missouri; Oklahoma; Texas; and Victoria, Australia.

*District VII:* Alaska; Alberta; British Columbia; Idaho; Montana; Oregon; Washington; and Wyoming.

*District VIII:* Arizona; California; Colorado; Guam\*; Hawaii; Nevada; New Mexico; New Zealand; and Utah.

\*The NABP Executive Committee has withdrawn Guam as a member of NABP; formal action will take place at the Association's 103<sup>rd</sup> Annual Meeting held in May 2007.

**Around the Association**

**New Board Member**

**Richard C. Holm, RPh**, has replaced Margaret Soden, RPh, as a member of the Alaska State Board of Pharmacy. Holm’s term expires on March 1, 2010.

**New Board Officers**

**Charles A. Dutcher, RPh**, has been elected president of the Arizona State Board of Pharmacy and **Thomas James Van Hassel, RPh**, is the Board’s new vice president, replacing Dutcher.


**Vernon A. Kassekert, RPh**, has been elected to the Minnesota Board of Pharmacy as president with a term expiration date of January 2007.

**Carleton Crawford** was also elected vice president and has a term expiration date of January 2007.

**Board Reappointments**

**James R. Bradham, RPh**, has been reappointed to the South Carolina Department of Labor, Licensing, and Regulation – Board of Pharmacy, with a term expiration date of June 30, 2011.

**New Board Contact Information**

The Delaware State Board of Pharmacy’s e-mail address has changed to debop@state.de.us. 

**Combat Methamphetamine Epidemic Act Now In Effect**

This year, new requirements of the federal Combat Methamphetamine Epidemic Act of 2005 passed by Congress for the sale of all single- and multi-ingredient pseudoephedrine (PSE)- and ephedrine-containing products will become effective. The new law places non-prescription ephedrine, PSE, and phenylpropanolamine in a new Controlled Substances Act category of “scheduled listed chemical products.” Drug products containing ephedrine, PSE, and phenylpropanolamine are subject to sales restrictions, storage requirements, and record keeping requirements.

A 3.6-grams-per-day base product sales limit, 9-grams-per-30-days base product purchase limit, a blister package requirement, and mail-order restrictions went into effect on April 8, 2006, for all sellers of these products. All other provisions of the law require compliance by September 30, 2006. If a state has more stringent requirements, the stronger requirements remain in place.

**Prescription Monitoring Programs and Uniformity**

In October 2002, the Alliance of States with Prescription Monitoring Programs and the National Association of State Controlled Substances

Authorities (NASCSA) jointly adopted the Prescription Monitoring Program Model Act. The Model Act provides a statutory framework for establishing and operating a prescription monitoring program. Both organizations

recommend that states use the Model Act to establish new and update existing monitoring programs.

The Model Act is a consensus document that reflects the best practices of states that currently run

**States with Prescription Monitoring Programs**

State	Program Type	Schedules Covered	Year Enacted
Alabama	Electronic	C II-V	2004
Colorado	Electronic	C II-V	2005
California	Single-copy Serialized Electronic	C II-V	2005
Hawaii	Electronic	C II-IV	2002
Idaho	Electronic	C II-V	2001
Illinois	Electronic	C II	1999
Indiana	Electronic	C II-V	2004
Kentucky	Electronic	C II-V	1998
Maine	Electronic	C II-IV	2003
Massachusetts	Electronic	C II	1992
Michigan	Electronic	C II-V	2002
North Carolina	Electronic	C II-V	2005
New Mexico	Electronic	C II-IV	2004
Nevada	Electronic	C II-IV	1995
New York	Single-copy, Serialized/ Electronic (state-issued)	C II, Benzos	1998
Ohio	Electronic	C II-V	2005
Oklahoma	Electronic	C II	1990
Rhode Island	Electronic	C II, III	1997
Tennessee	Electronic	C II-IV	2002
Texas	Single-copy, Serialized/ Electronic (state-issued)	C II	1997
Utah	Electronic	C II-V	1995
Virginia	Electronic	C II-V	2002
West Virginia	Electronic	C II-IV	1995

monitoring programs as well as the knowledge of many other states that have a longstanding interest in such programs. The prescription monitoring states cover half the United States individual and practitioner populations and have over 100 years of combined experience in operating monitoring programs.

The Model Act is available online at [www.nascsa.org/PDF/PMPmodelact02.pdf](http://www.nascsa.org/PDF/PMPmodelact02.pdf) and a background statement that explains the rationale for the development of the Model Act is available at [www.nascsa.org/PDF/PMPmodelact02bg.pdf](http://www.nascsa.org/PDF/PMPmodelact02bg.pdf). A "Report on Prescription Monitoring Standards" is available at [www.nascsa.org/PDF/Standards303.pdf](http://www.nascsa.org/PDF/Standards303.pdf).

As of January 2006, 23 states had prescription monitoring programs; these are listed in the table on page 136.

## FDA Advances Federal E-Health Effort

US Food and Drug Administration (FDA) has adopted the Systematized Nomenclature of Medicine (SNOMED) as the standard computerized medical vocabulary system to be used to electronically code important terms in the Highlights section of prescription drug labeling, a measure that advances the federal effort to create electronic health records for Americans within the next decade by making it easier for health care professionals nationwide to access and

share critical health and treatment information electronically.

"Today's action moves us closer to our goal of establishing electronic medical records for most Americans within 10 years. With the increasing use of electronic medical records and other computerized methods for managing health care data, the issues around electronic data standards and standardized terminologies will become increasingly important," says Dr Andrew C. von Eschenbach, acting commissioner of FDA. "Once we have implemented a national e-health record, health professionals will have quick, reliable, and secure access to patient information that can be cross-referenced with critical treatment information, including the information in the Highlights section of drug labeling."

Specifically, FDA is adopting the "Problem List" Subset of SNOMED for use in this electronic labeling initiative for prescription drug products. SNOMED, developed by the College of American Pathologists, is one of the terminologies chosen by the federal government as part of the health information technology infrastructure for clinical language. The Problem List Subset was created through a health technology partnership between the Department of Veterans Affairs (VA) and

Kaiser Permanente. This use of SNOMED for medical product labeling will improve the domestic exchange of product information in FDA-approved package inserts.

The Problem List Subset of SNOMED can electronically code certain terms in the Highlights data elements of the new format for prescription drug information. This format will be required beginning June 30, 2006, for recently approved (within the past five years) and newly approved drug products. The SNOMED system has been developed to provide coding for clinical terminology to make it computer readable across systems. For example, what is commonly known as a heart attack can also be called a myocardial infarction, infarct, or an MI. SNOMED provides one code for all of these terms for use in product labeling, enabling the electronic exchange of important health information from system to system.

"The use of SNOMED in this way opens the door to establishing another key element in building a unified electronic health information infrastructure in the United States," says Dr von Eschenbach. "We likewise are committed to electronic exchange of safety information on prescription drug products globally, and we will continue to support our [International Conference on Harmonisation of Technical Requirements for Registration

of Pharmaceuticals for Human Use] agreements in this regard."

The new labeling format will be integrated into FDA's other e-health efforts through a variety of ongoing initiatives. As prescription information is updated in this new format, it will be used to provide medication information for DailyMed – an interagency online health information clearinghouse, sponsored by the National Library of Medicine, which is maintaining the most up-to-date medication information free to consumers, health care professionals, and health care information providers. DailyMed is making up-to-date information about FDA-regulated products widely available on the Internet at no cost.

"VA will use the FDA DailyMed messages to increase the quality of its pharmacy terminology, used to deliver over 110 million outpatient prescriptions per year to our nation's veterans. [Structured Product Labeling] and DailyMed will also support VA's electronic Problem List and related administrative applications. VA is excited to be collaborating with Kaiser, FDA, and others to provide up-to-date medical information that improves patient safety and care quality," says Michael J. Lincoln, MD, chief terminologist, Department of Veterans Affairs Office of Information. 



*The Task Force on Telepharmacy and the Implementation of the Medicare Drug Benefit Medication Therapy Management Provisions reconvened May 18-19, 2006, at NABP Headquarters in Mount Prospect, IL. The first meeting of this Task Force was held October 26-27, 2005. The members include (back row, from left) Dan Luce, Walgreen Co; Susan Ksiazek, Task Force chair and member, New York State Board of Pharmacy; Oren M. Peacock, Jr, representative from NABP's Committee on Law Enforcement/Legislation; Michael A. Podgurski, member, Pennsylvania State Board of Pharmacy; Hal Wand, executive director, Arizona State Board of Pharmacy; (front row, from left) Monica K. Franklin, member, Tennessee Board of Pharmacy; Mary Ryan, Medco Health Solutions, Inc; Gary A. Schnabel, Executive Committee Liaison.*

**Reminder**

The updated version of the Model Rules for the Licensure of Wholesale Distributors may be downloaded from NABP's Web site, located at [www.nabp.net](http://www.nabp.net).



**nabp newsletter**

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