



# newsletter

National Association of Boards of Pharmacy®

September 2009 / Volume 38 Number 8

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the profession  
the public  
1904 to 2009

## Executive Committee Proposes New Vision for NABP, Member Boards of Pharmacy

### Upcoming Events

**September 15-16, 2009**  
Task Force on Electronic Prescribing Software Standards and Data Storage  
Northbrook, IL

**September 24-26, 2009**  
NABP/AACP  
District 1 & 2 Meeting  
Providence, RI

**September 30-October 2, 2009**  
NABP/AACP  
District 6, 7, & 8 Meeting  
New Orleans, LA

**October 6-7, 2009**  
Task Force on Pharmacy Technician Education and Training Programs  
Rosemont, IL

**October 28-29, 2009**  
Task Force on Prescription Monitoring Program Standards  
Northbrook, IL

**November 11-13, 2009**  
NABP/AACP  
District 4 Meeting  
Clayton, MO

Building on NABP President Gary A. Schnabel's initiative to focus on pharmacist care, at its July meeting the NABP Executive Committee structured a concept and implementation plan to help the state boards of pharmacy fill regulatory and patient safety gaps created by cuts in funding and changes in the governance of state boards of pharmacy. The concept will draw upon the solid foundation laid by the community pharmacy accreditation program and once again vest the boards of pharmacy and pharmacists with the ability to determine the appropriate and necessary standards for pharmacy practice. With this plan, the Executive Committee hopes to revolutionize how state boards of pharmacy are funded and to help improve and expand the services

currently provided. To this end, NABP will make available to the state boards of pharmacy the opportunity to partner with NABP in a public-private partnership that sustains and increases the services and protections provided by the boards of pharmacy.

The Executive Committee is optimistic that NABP can work together with its member boards of pharmacy to empower them and assist state legislatures in their critical missions to support the boards and protect the public health. The new order proposed by NABP is a vehicle intended to inspire pharmacists and board members on behalf of the patient and improved pharmacy practice.

To embrace the future vision of pharmacy that President Schnabel outlined just before his inauguration at the 105<sup>th</sup> An-

... the Executive Committee hopes to revolutionize how state boards of pharmacy are funded and to help improve and expand the services currently provided.

nual Meeting, the boards need support beyond what the states can provide, and the concept of public-private partnerships set forth by the Executive Committee is a means toward meeting what all regulators want – a system that supports pharmacist care. Speaking of the Future Vision of Pharmacy Practice 2015, which was crafted

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## 2010 PCOA Approaching; Schools and Colleges of Pharmacy Encouraged to Sign up Now for the Third Annual Administration

The NABP Newsletter (ISSN 8756-4483) is published 10 times a year by the National Association of Boards of Pharmacy (NABP) to educate, to inform, and to communicate the objectives and programs of the Association and its 66 member boards of pharmacy to the profession and the public. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of NABP or any board unless expressly so stated. The subscription rate is \$35 per year.

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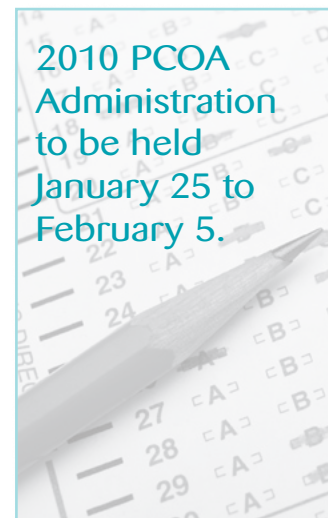
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*Communications  
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The third annual Pharmacy Curriculum Outcomes Assessment® (PCOA®) administration is scheduled to be held January 25 to February 5, 2010. To ensure that schools and colleges of pharmacy are provided with timely reports, as well as to avoid interference with spring break schedules, the testing window for 2010 will be held earlier in the year than in years past. Recently, NABP provided all schools and colleges of pharmacy with information on this upcoming administration and notified them of the opportunity to choose one day within the two-week time period to administer the PCOA to their students.

The PCOA is a comprehensive assessment tool developed by NABP and key stakeholders in response to the need expressed by the United States schools and colleges of pharmacy for assistance with curriculum development and measurement of student performance and growth. The valuable data provided in the students' score reports will allow participating schools to compare results of their students in the same professional year across the United States.

Interested schools and colleges of pharmacy are encouraged to contact the NABP Competency Assessment Department at 847/391-4406 or via e-mail at [custserv@nabp.net](mailto:custserv@nabp.net). The



cost of the assessment is \$75 per student.

Additional information regarding the PCOA is also available in the Assessment Programs section of the NABP Web site at [www.nabp.net](http://www.nabp.net).

### New Vision for NABP

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by the Joint Commission of Pharmacy Practitioners (JCPP), a coalition of the major national pharmacy organizations, Schnabel declared "As boards of pharmacy, I feel that it is also imperative for us to embrace this future vision and, through our statutes and regulations, define and advance that vision in the context of patient care

and protection of the public health." As proposed and defined within the JCPP Vision Statement, it is hoped that pharmacists will have the authority and autonomy to manage medication therapy and will be accountable for patients' therapeutic outcomes. In doing so, they will communicate and collaborate with patients, care givers, health care professionals, and qualified support personnel.

In the upcoming months, NABP will be releasing more information about opportunities for public-private partnerships and looking to the boards of pharmacy for ways to partner with all of the interested stakeholders. A more detailed announcement and plan will be released at the 106<sup>th</sup> Annual Meeting, which will be held May 22-25, 2010, in Anaheim, CA.

## Survey Results Provide Insights into Pharmacy Boards' Responsibilities, Structure

The NABP 2009 biennial Resources and Responsibilities Survey gathered data from the state boards of pharmacy on what duties the boards perform and the resources they have to perform them. The detailed statistics paint a picture of how the 54 state boards of pharmacy function as they perform their regulatory duties and protect the public health.

Data gathered include information on the boards' licensure and disciplinary functions, fiscal information, emergency preparedness, office and human resource functions, members, and inspectors. Thirty-seven boards, or 68.5%, participated in the 2009 survey.

### General Structure and Responsibilities

Of the participating boards, 20 described themselves as functioning autonomously, while 16 are attached to an umbrella organization, with a board executive officer whose primary responsibility is to the umbrella agency. One board reported operating under elements of both.

Almost all (36) of the responding boards reported that licensure and discipline fell under the board's purview, and most (33) also included inspections among their primary functions. Twenty-six of the boards handle enforcement of the Controlled Substances Act,

and 20 enforce the Federal Food, Drug, and Cosmetic Act. About a third of the boards (12) certify or accredit colleges or schools of pharmacy.

Most of the boards participating in the survey perform licensure and disciplinary functions that include evaluating the qualifications of candidates for licensure (34), holding disciplinary hearings (34), and making the final determination whether a law or regulation has been violated (34). Most boards also grant licenses (33), set practice standards (32), and determine penalties (32). More than 70% of reporting boards issue examination scores (26), process pharmacist and pharmacy license renewals (29), receive complaints (28), and conduct investigations (28).

Reflecting the trend toward licensing pharmacy support personnel and wholesalers, more than two-thirds of the boards process license renewals for pharmacy technicians, and 78% (28) issue licenses to wholesale distributors. Fewer than half issue controlled substance licenses to pharmacy licensees, and about 35% administer examinations and issue controlled substance licenses to non-pharmacy licensees. Eight boards reported issuing licenses to dispensing practitioners. (See Table 1 on page 162.)

For most licensing and disciplinary functions, those that are not performed by the board of pharmacy are instead the responsibility of a central agency. Some duties, however, are entrusted to – or often shared with – NABP: The majority (31) of the responding boards reported that NABP is responsible for administering examinations, and nearly two-thirds (22) said NABP is responsible for issuing examination scores, with 13 giving NABP responsibility to evaluate qualifications. Nineteen percent of boards (6) also indicated that NABP evaluates the qualifications of candidates for licensure, and 9% of boards (3) said NABP sets practice standards.

Despite an emphasis on emergency preparedness over the past few years, only 20 boards reported having in place a preparedness or response plan in the case of an external emergency that affects the board's ability to operate. Slightly more, 25 boards, reported having in place an emergency response plan in case of an internal event that would keep the board from performing its usual activities and services.

### Fiscal Data

Roughly 80% of the responding boards are responsible for various fiscal functions, including devel-

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## Executive Committee

**Rich Palombo**  
*Chairperson*  
One-year term

**Gary A. Schnabel**  
*President*  
One-year term

**William T. Winsley**  
*President-elect*  
One-year term

**Malcolm J. Broussard**  
*Treasurer*  
One-year term

**Karen M. Ryle**  
*Member, District 1*  
Serving third year of a three-year term

**Elizabeth Scott "Scotti" Russell**  
*Member, District 2*  
Serving third year of a three-year term

**Michael A. Burleson**  
*Member, District 3*  
Serving second year of a three-year term

**Gregory Braylock, Sr**  
*Member, District 4*  
Serving second year of a three-year term

**Lloyd K. Jessen**  
*Member, District 5*  
Serving third year of a three-year term

**Joseph L. "Joe" Adams**  
*Member, District 6*  
Serving first year of a three-year term

**Cathryn J. Lew**  
*Member, District 7*  
Serving first year of a three-year term

**Hal Wand**  
*Member, District 8*  
Serving second year of a three-year term

NABP Executive Committee elections are held each year at the Association's Annual Meeting.

## Go Directly to Jail, Do Not Pass Go, Do Not Collect \$200

By Dale J. Atkinson, JD

Technological advancements continue to revolutionize the practice of professions, providing licensees with new alternatives to service consumers in need of care. At the same time, such advancements challenge the antiquated statutes and regulations as legal issues increase in complexity. Perhaps no profession has been more impacted by technology than health care and, in particular, medicine and pharmacy practice. Consider the following:

In May 2006, the San Mateo County (California) district attorney filed a criminal complaint charging a physician (defendant) with the felony offense of practicing medicine without a license. California law provides that any person who practices or attempts to practice medicine (as defined) without a license is guilty of a public offense punishable by a fine not to exceed \$10,000 and/or by imprisonment in a state or county jail for a period of time not to exceed one year. In this matter, the conduct of the defendant consisted entirely of "Internet mediated communications" which resulted in the issuance of prescriptions.

The criminal complaint was predicated upon information gathered by the Medical Board of California and turned over to the

district attorney as part of its referral of the case for criminal prosecution. The Board report found that a consumer residing in San Mateo County initiated an online purchase of fluoxetine (generic Prozac®) through an interactive Web site (*www.usanetrx.com*) located outside the United States. The consumer completed an online questionnaire that identified him as a California resident and answered additional health-related questions. The questionnaire was electronically submitted via the Web site and was forwarded by the Web site to a company in Florida for processing. The Florida company processes such requests through servers located in Texas.

The purchase request was processed and electronically forwarded to a "physician-subcontractor" (defendant)

who resided in Fort Collins, CO. The defendant, at the time of the alleged wrongful acts, was duly licensed as a physician in Colorado. After reviewing the consumer's questionnaire, the defendant issued an online prescription of the requested medication and electronically returned it to the processing company's servers. The processing company forwarded the prescription to a pharmacy located in Biloxi, MS, which filled the script and forwarded the requested amount of fluoxetine to the consumer at his California address.

Some weeks later, the consumer, intoxicated by alcohol and with detectable amounts of fluoxetine in his blood, committed suicide by means of carbon monoxide poisoning. The Board report found that the defendant was at all times located in Colorado and never directly communicated with anyone in California regarding the prescription. Interestingly, and not deemed relevant in the ultimate criminal prosecution, the report also indicated that the defendant's medical license was restricted to "research and independent medical exams only."

The May 2006 criminal charge alleged that the defendant "willfully and unlawfully practiced medicine in this state [California] without a valid license . . ."

On that same date, the trial court issued a warrant for the arrest of the defendant and set bail at \$500,000. The defendant sought to have the complaint dismissed, arguing that the court lacked jurisdiction because all the alleged criminal acts occurred outside the state of California. The trial court denied the motions to dismiss, and that defendant appealed to the court of appeals.

On appeal, the court examined the traditional notions of jurisdiction and when a defendant is subject to the authority of California courts. It noted that the complex issues surrounding minimum contacts resulting in personal jurisdiction over a particular party based upon Internet- or network-mediated contacts has “drawn far more judicial and academic attention in civil than in criminal proceeding.” The court also noted the expansion of the authority of California courts over out-of-state defendants has occurred through the adoption of specific statutes beyond the jurisdictional notions set forth in common law. With that in mind, the parties agreed that the jurisdictional question in this matter hinged on two specific California statutes. In short, one statute (California Penal Code, section 27) requires that defendants

are liable under California laws “who commit, in whole or in part, any crime within this state.” Another statute (California Penal Code, section 778) states that out-of-state defendants are liable in California based upon the use or intervention of an innocent or guilty agent to effectuate such criminal activity in California.

In its analyses, the court first noted that because a determination of jurisdiction over a defendant is procedural and does not implicate the elements of a crime, jurisdictional facts need only be proven by a preponderance of the evidence, rather than under the criminal standard of beyond a reasonable doubt. The parties agreed that the defendant was not physically located within California at any time between the commencement of the alleged offense and no agent located within California ever intervened on his behalf during the period of time in question.

In short, the defendant argued that he committed no part of the alleged offense in California and that he did not use an agent in California to consummate the crime. He noted that the writing of the prescription by him as a Colorado licensee occurred under a separate act and license than that of the pharma-

cist who filed the script in Mississippi. He argued that the California court lacked jurisdiction to adjudicate the offense because no part of the crime was committed either by him or his agent within the boundaries of California.

The court held that the jurisdictional question turned on an interpretation of section 778 and undertook an in-depth analysis of the statute and its 135-year history. The court, using numerous cited cases, held that the defendant need not be physically present at any time during the commission of the crime, nor must the agent through whom such crime is effectuated be physically present in order to trigger sufficient contacts upon which to base judicial jurisdiction. It also noted the statute alleged to have been violated whereby unlicensed practice of medicine has been criminalized was a reasonable exercise of the state’s police powers. Causing or intending injury is not an element of the offense of unlicensed practice.

The court also rejected arguments by the defendant that his actions were not consummated within the boundaries of California and thus would not allow for jurisdiction of the California criminal courts, as well as rejecting defendant’s argument that

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

**Survey**

(continued from page 159)

oping the board of pharmacy’s budget (24), setting fees (24) and fines (25), and collecting fees (25). Seventy percent of the respondents also collect fines (21) and make purchasing decisions (21), while fewer than half (17) process accounts payable. When the board itself is not responsible for a function, it is performed by a central agency. In some cases, the state legislature

provides budget oversight or approval, and fees and fines are set by legislation.

More than half the boards (22) responding reported that their budgets were fixed by legislative appropriation; 15 were not. Thirty-three states provided information on their budgeted expenditures and revenues/appropriations. Of these, the number of boards showing budgeted expenditures for 2009 less than \$1 million was 12; between \$1 million and

\$2.49 million, 15; and more than \$2.5 million, six. The number of boards showing budgeted revenues and/or appropriations for 2009 less than \$1 million was 10; between \$1 million and \$2.49 million, 15; and in excess of \$2.5 million, eight. (See Figure 2 on page 163.)

The great majority – between 90% and 100% – of the boards’ revenues are derived from license or permit fees. Other revenue sources include fines and examination and reciprocity fees; “other” sources may include such items as the sale of law books, interest, or administrative fees (such as for copies or certifications). For 26 boards, revenues (part or all) are for the use of the board; 23 boards reported that, under normal circumstances, the revenues are not available for other uses by the state government.

Thirty-one of the boards, or 84%, are allowed to impose fines for infractions of laws or regulations. In 2008, the amount of fines collected in a state ranged from less than \$500 to more than \$844,000.

**Board of Pharmacy and Support Staff**

The boards of pharmacy range in size, with the smallest boards consisting of five members (not including the executive officer or other ex officio members) and the largest, 17. Most boards (30) reported nine or fewer members, with the greatest concentration (13) maintaining a seven-member board.

Compensation for board members ranges from \$30 to \$300 per diem, with 23 boards reporting that the state reimburses members for their travel expenses. (See Figure 3 on page 163.)

To support the boards of pharmacy, 27 boards reported they employ one full-time board executive. Two boards reported an executive officer devoted less than full time to the board of pharmacy, two boards reported two full-time executive positions, three boards reported three, and one board reported one full-time executive shared with nine boards.

The survey also revealed the number of administrative, non-inspector support staff used to support the boards of pharmacy. Eighteen boards reported having three or fewer full-time support positions, 13 boards reported having between four and seven full-time administrative positions, and nine boards reported having seven or more full-time positions. Eight boards indicated that, of their support personnel, at least one is an information technology (IT) specialist. Other boards indicated that IT support came from a state agency or via a contractor.

These support personnel, including the executive officers and inspectors, generally receive employment benefits from the state. Thirty boards reported that executive officers, administrative personnel, and inspectors all receive benefits, including family health insurance, life insur-

Board of Pharmacy Licensing Responsibilities	
Function	Number of Boards
Evaluate qualifications of candidates for licensure	34
Hold disciplinary hearings	34
Make final determination whether law/regulation violated	34
Grant licenses	33
Set practice standards	32
Determine penalties	32
Process pharmacist license renewals	29
Process pharmacy license renewals	29
Receive complaints	28
Conduct Investigations	28
Issue licenses to wholesale distributors	28
Issue examination scores	26
Process pharmacy technician license renewals	25
Issue controlled substances licenses to pharmacy licensees	16
Administer examinations	13
Issue controlled substances licenses to non-pharmacy licensees	13
Issue licenses to dispensing practitioners	8

**Table 1:** More than two-thirds of the 37 responding boards process license renewals for pharmacy technicians, and 78% (28) issue licenses to wholesale distributors. Fewer than half issue controlled substance licenses to pharmacy licensees (16), and about 35% (13) administer examinations and issue controlled substance licenses to non-pharmacy licensees. Eight boards reported issuing licenses to dispensing practitioners.

ance, and a retirement plan with both employee and state contributions. Common but less universal benefits include disability insurance, reimbursement of travel expenses, and (mostly for inspectors) a car allowance. In four states, just the executive officer was reported as receiving benefits.

### Inspectors and Inspections

The 2009 survey elicited various details about the boards' inspection functions. Of the 34 boards providing such information, half of the boards (17) reported having between four and six full-time inspector positions; 10 boards reported having three or fewer inspectors, and six boards have seven or more inspectors. Of these, 22 boards directly employ their inspectors, while nine boards have inspectors employed by another state agency or umbrella agency, and two boards use private contractors. Two boards have a mix of inspectors employed by the board of pharmacy and another state agency or private contractor.

Sixteen boards reported that they are legally required to hire pharmacists as inspectors, and 21 are not. Nonetheless, 22 boards reported that all their inspectors are pharmacists. The inspectors in 23 states, or 64%, have training in pharmaceutical compounding. In two states, board of pharmacy members act as inspectors, and 10 boards reported that the board's executive officer acts as an inspector.

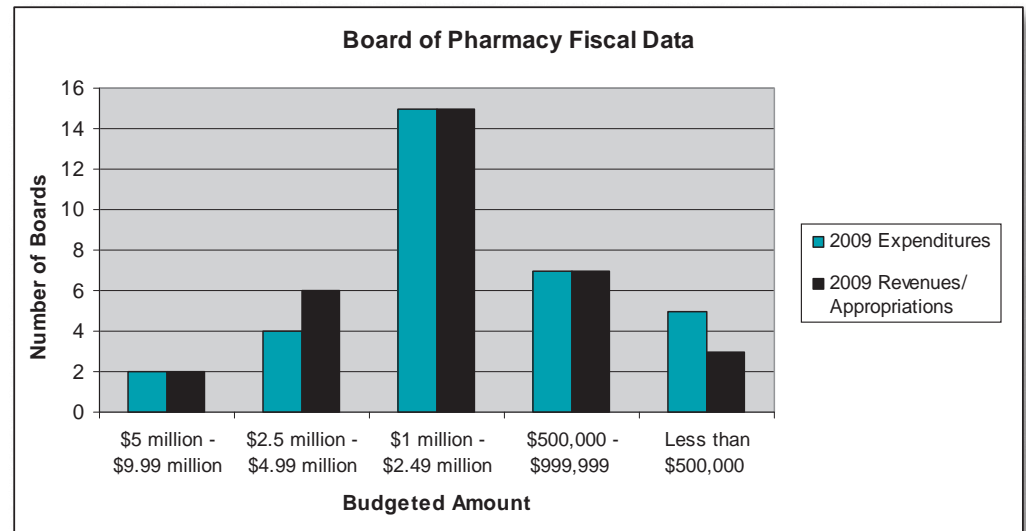


Figure 2: Thirty-three of the 37 responding boards provided information on their budgeted expenditures and revenues/appropriations. Of those 33 states, the most common range was between \$1 million and \$2.49 million for both budgeted expenditures for 2009 and budgeted revenues/appropriations for 2009.

Six states authorize their board of pharmacy inspectors to bear arms, and four boards reported one or more inspectors actually do bear arms while in the field. About half the boards (18) noted that their inspectors have civil service status; inspectors in 16 states do not.

Twenty-three boards have procedures in place to monitor the effectiveness of their inspectors; 13 do not.

In about 57% of the states (21), inspectors meet at least monthly with board members or the board's executive officer to discuss problems encountered in the field. In 10 states the inspectors meet between two and four times

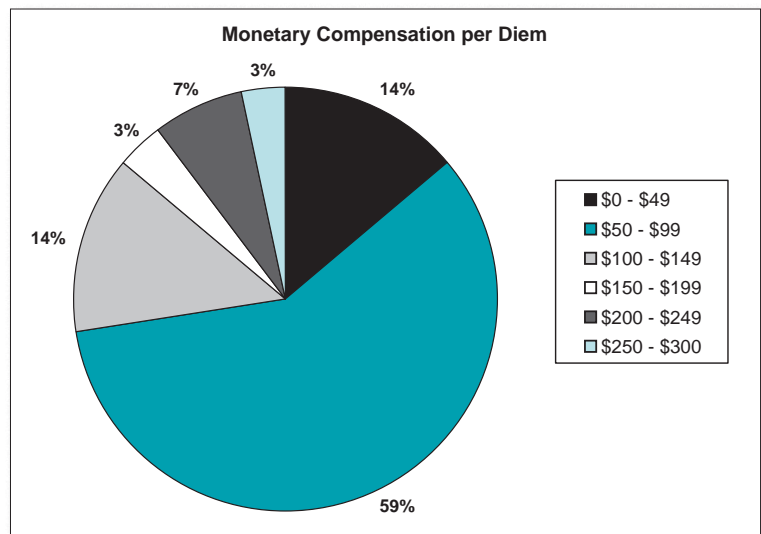


Figure 3: Of the 37 responding boards, 29 reported data on monetary compensation for members. The compensation data ranges from \$30 to \$300 (not including reimbursement for travel or other expenses). More than half of the 29 responding boards (17) reported member compensation between \$50 and \$99 per diem.

a year with board members or the executive officer, in two states they meet less than once a year, and four boards reported such meetings never occur.

Boards of pharmacy were provided with pass-

word-protected access to the Resources and Responsibilities Survey results in July via the Internet. Boards may also contact NABP at [exec-office@nabp.net](mailto:exec-office@nabp.net) to obtain a printed version of the survey results. ©

## Stakeholders Debate Educational Program Requirements for Pharmacy Technician Certification

Most states require some form of pharmacy technician training, but the content and quality of that training can vary widely. Some stakeholders maintain that accreditation of educational and training programs for pharmacy technicians is the only reliable way to ensure that technicians applying for certification possess the skills and knowledge they need to safely and reliably assist in the practice of pharmacy. Others, however, argue that a one-size-fits-all approach may not be appropriate for every practice setting, and that site-specific training would benefit employers of those technicians.

NABP will convene a task force on October 6-7, 2009, to explore these issues and to recommend educational and training program standards for pharmacy technician certification. (See sidebar “NABP Convenes Task Force to Establish Uniform Technician Training Program Requirements.”) This meeting serves as a follow-up to the 2008 NABP Task Force on Standardized Pharmacy Technician Education and Training, which recommended that the state boards not only license or register pharmacy technicians, but that, as of 2015, they also require all pharmacy technicians to be certified.

The 2008 task force recognized that pharmacy technicians are among the few ancillary personnel in the health care field that

remain unlicensed in several states, and that pharmacy technician-attributable medication errors and diversion continue to endanger the public health. To ensure that pharmacy technicians are properly trained, the task force recommended that the states require technicians to obtain certification from an organization that uses a nationally recognized competency assessment test. The NABP Executive Committee strengthened the recommendation to specifically assert that NABP encourage states that certify technicians to recognize certification by the Pharmacy Technician Certification Board.

Members agreed, however, that standardization of pharmacy technician

education and training is an ongoing issue that should be addressed on a regular basis until at least such a time when all states license or register pharmacy technicians and a national licensure transfer program is operational.

To further the discussion, NABP included in its 105<sup>th</sup> Annual Meeting a continuing pharmacy education session to address issues related to the standardization of pharmacy technician education and training. Leading the session were Michael J. Rouse, BPharm (Hons), MPS, assistant executive director, International and Professional Affairs for the Accreditation Council for Pharmacy Education (ACPE); Kevin N. Nicholson, RPh, JD, vice president of Pharmacy Regulatory Affairs for the National Association of Chain Drug Stores (NACDS); and Janet L. Teeters, RPh, MS, director of Accreditation Services Division for the American Society of Health-System Pharmacists (ASHP). Moderating the session was NABP Executive Committee member Hal Wand, MBA, RPh.

There was little argument among the presenters or participants who offered comments that, as pharmacists take on more cognitive duties, the practice is becoming increasingly reliant on technicians to perform additional and

more complex tasks, and that some standardization of training and certification requirements is in order. The appropriate level of uniformity of those requirements, however, remains a matter of debate.

In his discussion, Rouse drew a comparison to the mandatory educational and competency standards for pharmacists. While the schools and colleges of pharmacy in the United States do not adhere to any one uniform model for the doctor of pharmacy degree, all such programs must meet the same ACPE standards to qualify graduates as candidates for pharmacy licensure. Additionally,

all graduates must demonstrate their competency by means of the standardized and psychometrically sound North American Pharmacist Licensure Examination®.

Rouse also noted that training programs for pharmacy technicians generally require fewer and a more variable number of contact hours than training programs for support personnel in other health professions in the US. While acknowledging the wide diversity of opinions regarding national program standards and accreditation that were reflected during 2003 profession-wide discus-

sions, he noted that many other countries do license, register, or certify pharmacy support personnel in adherence with national standards.

Rouse outlined a credentialing framework for pharmacy technicians that has been adopted by the Council on Credentialing in Pharmacy (CCP) and that will be recommended by CCP to the profession and other key stakeholders.

Speaking on behalf of NACDS, Nicholson expressed support for the recommendations of the 2008 NABP task force, including the uniform requirement for licensure/registra-

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## NABP Convenes Task Force to Establish Uniform Technician Training Program Requirements

NABP will convene a task force on October 6-7, 2009, to establish uniform educational and training program requirements for pharmacy technician certification.

The task force came about in response to Resolution No. 105-5-09, passed at the NABP 105<sup>th</sup> Annual Meeting in Miami, FL, calling for its development. The resolution acknowledges that “new pharmacy technician educational and training programs are being established in community colleges

and trade schools across the country,” and that “no standards are currently in place to guide the quality and appropriateness of the course curriculum for such programs.”

Noting the responsibility of the state boards of pharmacy “to oversee the training and practice of pharmacy technicians in the interest of the patient health and safety,” the resolution states the intent of NABP to “assist and encourage state boards of pharmacy to evaluate and approve training programs for pharmacy technicians

licensed or registered in their states.”

As described in the resolution, the task force will “review existing state requirements for educational and training programs and national accrediting organizations’, such as the American Society of Health-System Pharmacists and the Accreditation Council for Pharmacy Education, core competencies to recommend national standards for technician education and training programs to be considered by boards of pharmacy.”

nabp newsletter

### Technician Certification

(continued from page 165)

tion and certification of all pharmacy technicians. However, he said, NACDS opposes mandatory accreditation of pharmacy technician educational and training programs. He cited concerns that a single accrediting body might impose a one-size-fits-all approach to training that may not be appropriate in all settings. On the other hand, he noted, having multiple, competing accreditation programs that differ from state to state would be equally problematic. Rather than requiring technicians to complete a nationally accredited training program, Nicholson asserted, site-specific train-

ing and employer-based examinations would allow employers the necessary flexibility to train technicians to meet the specific needs of the setting.

He recommended that stakeholders first develop and agree to a set of standards they would expect all technician training programs to meet. Determining how to enforce those standards, he said, would be a secondary step. To mandate accreditation now, he said, would be “putting the cart before the horse.”


Acknowledging the frequency of medication errors, Teeters countered, “now is the time for action.” Citing the Joint Commission of Pharmacy Practitioners’ call for en-

hanced training and education of pharmacy technicians in its “Future Vision of Pharmacy Practice 2015,” Teeters asserted that standardized competencies are needed to ensure adequate training, and that accreditation is necessary to ensure those standards are being met.

Not all training programs are equally worthy or reputable, Teeters said, noting the proliferation of online accreditation and degree “mills” that dispense unfounded credentials for a fee. She recommended that the boards of pharmacy turn to a national accrediting body that is a programmatic accreditator, such as ASHP, rather than attempt to review and approve training

programs on their own, noting the added benefit of making pharmacy technician certification transferable between states.

Regarding concerns that there may not be enough programs that meet national standards, Teeters stated that if it is required and enough lead time is given, programs will be developed. The boards of pharmacy, are the ones who can make this happen, she noted.

The upcoming task force will explore these issues and make their recommendations to the Executive Committee. Upon approval, these recommendations will be published on the NABP Web site and in a future *NABP Newsletter*. 



### Newly Accredited DMEPOS Facilities

The following facilities were accredited through the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) program:

**Citizens Pharmacy Services**

Havre de Grace, MD  
Accredited June 16, 2009

**Drug City Pharmacy, Inc**

Baltimore, MD  
Accredited May 11, 2009

**Eastern Valley Drugs, Inc**

Bessemer, AL  
Accredited June 18, 2009

**Garden Pharmacy**

Neptune, NJ  
Accredited June 16, 2009

**Lincoln Care Drugs**

Bronx, NY  
Accredited June 23, 2009

**Minh Pharmacy**

New York, NY  
Accredited June 23, 2009

**Myrtle Ave Pharmacy**

Brooklyn, NY  
Accredited June 16, 2009

**Oakdale Pharmacy**

Catonsville, MD  
Accredited May 29, 2009

**Omnicare, Inc**

Covington, KY  
Accredited June 11, 2009

**Preston Pharmacy**

Jacksonville, FL  
Accredited June 23, 2009

**Roosevelt Drugs & Surgicals**

Jackson Heights, NY  
Accredited June 16, 2009

**Simon's Discount Pharmacy**

Los Angeles, CA  
Accredited June 23, 2009

**The Medicine Center**

Dunn, NC  
Accredited June 16, 2009

**Turnpike Pharmacy**

Fresh Meadows, NY  
Accredited June 16, 2009

A full listing of more than 140 accredited DMEPOS facilities is available on the NABP Web site at [www.nabp.net](http://www.nabp.net). 

## Board Staff Attend NABP Annual Program Review and Training Session; New Executive Officers Receive Orientation

To further familiarize themselves with NABP programs and services, board of pharmacy staff, both new and those seeking a refresher course, attended the NABP Annual Program Review and Training Session on July 22-23, 2009, at NABP Headquarters.

Sixteen participants representing 14 state boards of pharmacy attended this two-day interactive session that provided board staff an overview of the policies and procedures of NABP programs and services, as well as the opportunity to network with other board of pharmacy staff.

Rocio Cruz-Tapia, licensing assistant from the New Mexico Board of Pharmacy, said visiting NABP is a helpful and informative way to learn about the Association. "It's great that NABP does this for new board staff. It gives us a better understanding of things and informs us of any new changes within the organization."

For Missy Betz, administrative assistant from the North Carolina Board of Pharmacy, the information provided at the training session gave a beneficial overview of the Association's programs and services. "I now feel more comfortable with NABP. I'm happy that I can put a face with a name."

Held concurrently with the Program Review and Training, the New Executive Officer Orientation Program was chaired by NABP President-elect William T. Winsley, MS, RPh. The orientation, which welcomed five new executive officers, is designed to acquaint new executive officers with NABP membership and governance, NABP programs and services, and how those programs and services may help in assisting the state boards of pharmacy.

On July 22, a group dinner was held giving all the attendees the opportunity to network. The educational portion of the session was held on July 23 when both groups attended the training introduction presented by Winsley.

After the introduction, the groups separated and NABP staff provided attendees with an overview of the following programs and services:

- Electronic Licensure Transfer Program® (ELTP®), license verification, e-mail, and data transfer functions
- Healthcare Integrity and Protection Data Bank (HIPDB) reporting and NABP Disciplinary Clearinghouse reporting
- North American Pharmacist Licensure Examination® (NAPLEX®) and Multistate Pharmacy Jurisprudence Examination® (MPJE®)



Board of pharmacy staff learned of the various NABP programs and services during the Annual Program Review and Training. Back row left to right: Susan Teil Boyer, executive director, Washington State Board of Pharmacy; Jay Queenan, executive secretary/director, New Hampshire Board of Pharmacy; Kim Grinston, executive director, Missouri Board of Pharmacy; and Phil Wickizer, director, Indiana Board of Pharmacy. Front row left to right: Peg Clifford, chief compliance investigator, New Hampshire Board of Pharmacy; Dana Crenshaw, bureau director, Mississippi Board of Pharmacy; Amicha Chatman, licensing assistant, Louisiana Board of Pharmacy; and Bryan Proctor, administrative specialist, Kentucky Board of Pharmacy.

- Application, examination, and certification processes for the Foreign Pharmacy Graduate Examination Committee™ (FPGEC®) certification program
  - Verified Internet Pharmacy Practice Sites™ (VIPPS®), Veterinary-Verified Internet Pharmacy Practice Sites™ (Vet-VIPPS™), Verified-Accredited Wholesale Distributors® (VAWD®), and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) accreditation programs
  - Pharmacy Curriculum Outcomes Assessment® (PCOA®) program
  - Internet Drug Outlet Identification program
  - Pharmacist and Pharmacy Achievement and Discipline® (PPAD®)
- Many of the board staff that attended the training session left NABP with positive feedback to share. For Dana Brown, chief fiscal officer from the Arkansas State Board of Pharmacy, the Program Review and Training Session provided her with valuable information to help her and her Board. "I very much enjoyed my first NABP training. I look forward to discussing the items learned with my board staff to reconsider our own business processes."
- For more information about future training sessions or to obtain training materials provided at the session, please contact NABP at [custserv@nabp.net](mailto:custserv@nabp.net). 

## Task Force to Examine e-Prescribing Standards

**E**lectronic prescribing continues to account for an increasing percentage of prescriptions filled, pushed by support from a broad range of stakeholders in the public and private sectors. Between 2007 and 2008, prescriptions routed electronically more than doubled – from 29 million to 68 million, or from 2% to about 4%, of eligible prescriptions – according to Surescripts’ *2008 National Progress Report on E-Prescribing*. As the adoption of e-prescribing rapidly expands, maximizing the technology’s effectiveness – and realizing its anticipated benefits of greater accuracy (and hence patient safety), increased workplace efficiency, and lower health care costs – demands similar leaps in areas such as standard-setting and regulation to ensure system compatibility, security, and information sharing.

To address these aspects of e-prescribing, an NABP task force is meeting September 15-16, 2009. The task force is charged with three main tasks:

1. evaluating the current regulatory and operational status of the electronic transmission of prescriptions and prescription data;
2. developing standards for software and systems used in e-prescribing; and
3. reviewing the current requirements for the storage of hardcopy prescription and electronically

transmitted prescription data in order to explore the possibility of eliminating the physical storage of hard copies of electronically transmitted prescription data.

Last year’s rate of increase in the number of prescriptions routed electronically is impressive, but not necessarily surprising. In its 2008 report, Surescripts (which operates a health information network that allows prescribers to connect electronically with pharmacies and payers, and issues a progress report annually) attributes the in-

crease to many of the same factors that drove increases between 2006 and 2007, including a continued focus on e-prescribing at the federal and state policy levels, and national programs encouraging e-prescribing and offering tools to foster adoption of the technology.

Other factors contributing to the increased adoption of e-prescribing among payers, prescribers, and pharmacies included state- and community-based initiatives, and Medicare and Medicaid encouragement of the technology. In addition, in a long-anticipated step, Drug Enforcement Administration took steps toward the development of standards that would allow controlled substances to be prescribed electronically. When finalized, this ability would remove a barrier for prescribers to convert to e-prescribing, as they would not have to support one system for most prescriptions and revert to old workflow patterns for controlled substance prescriptions.

### Federal Influences on Standards

The federal government, not surprisingly, with its wide reach, continues to provide significant influence on systems standards. The Medicare Improvements for Patients and Providers Act (MIPPA), which passed in July 2008 and took effect January 1, 2009, establishes a series of financial incentives and penalties related to e-prescribing. MIPPA

offers gradually decreasing incentives in the form of an increase in the amount of total allowed charges for covered professional services starting in 2009 at 2%, and phasing out after 2013. Graduated penalties, in the form of a decrease in the amount of total allowed charges for covered professional services, begin at 1% in 2012. To qualify for incentives (or avoid penalties), a prescriber must use a “qualified e-prescribing system,” which may stand alone or be integrated into an electronic health record system. Qualified systems must accomplish the following tasks:

1. communicate with the patient’s pharmacy;
2. help the prescriber identify appropriate drugs and provide information on lower-cost (but therapeutically appropriate) alternatives;
3. provide information on formulary and tiered formulary medications; and
4. generate alerts about possible adverse events, such as improper dosing, drug-to-drug interactions, or allergy concerns.

These system requirements generally track with private sector companies’ emphasis on e-prescribing software that enables a prescriber to electronically access a patient’s prescription benefit information and prescription history, and to electronically route the

prescription to the patient’s choice of pharmacy, as well as the pharmacist’s ability to then electronically send a prescription renewal request to the prescriber’s office.

For several years, the US Department of Health and Human Services’ Centers for Medicare & Medicaid Services (CMS) has been working to promote electronic prescribing for Medicare Part D prescribers, and to establish relevant standards. (While prescribers are not required to prescribe electronically, they must comply with designated uniform standards when they do.) “Foundation” e-prescribing standards, published as a final rule in the *Federal Register* in 2005, include prescription and eligibility standards. “Initial uniform standards” for e-prescribing, published as a final rule in April 2008, included medication history, formulary and benefits, and provider identifier information. (See also “Record Number of Electronic Prescriptions Routed in 2007; More Expected in 2008” in the August 2008 issue of the *NABP Newsletter*.) Standards still to be finalized include prior authorization (allowing a prescriber to access real-time preapproval from a patient’s health plan, when necessary), structured and codified SIG (standardizing instructions to patients on how to take their medica-

tions), and RxNorm (the National Library of Medicine’s standardization of names for clinical drugs).

CMS notes in its September 5, 2008 Medicare Prescription Drug Manual, “[t]o satisfy these [e-prescribing] requirements, CMS expects Part D sponsors to have all the necessary contracts and systems in place should prescribers desire to electronically transmit prescriptions for their Medicare eligible patients. This includes ensuring that network pharmacies can receive electronic prescriptions (with allowance for exceptions when it is impractical or otherwise could jeopardize beneficiary access) in accordance with the adopted standards . . . Part D plans will also be responsible for complying with future e-prescribing standards that are adopted as part of the industry standard or regulatory process.”

### States Address Issue

States also continue to address the e-prescribing issue. The Minnesota legislature, for example, in 2008 passed an electronic prescribing mandate requiring all providers, group purchasers, prescribers, and dispensers to establish and maintain an electronic prescription drug program by 2011, and specifying standards. Other states, like California, have considered similar measures that ultimately did not pass.

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## NABP Position Statement Provides Guidelines to Assist Boards in Medication Collection Program Development

NABP has issued a position statement to provide guidelines to assist the boards of pharmacy in developing medication collection programs. The statement addresses the question of whether prescription medications, in the community pharmacy setting, can be safely returned and reused. Such programs are permissible, NABP maintains, “when it is demonstrated that integrity and stability of the medication is maintained, that the medication has not been tampered with, and the process results in the dispensing of safe medication to patients.” The statement provides elements for inclusion in a safe return and reuse protocol for medication collection programs in community pharmacies.

A safe return and reuse protocol in the community pharmacy setting may include, but is not limited to, the following elements:

- Returned and reused medications refer to those medications that have been removed from the pharmacy for delivery by pharmacy staff, a pharmacy contracted delivery service, or an approved common carrier and returned because the product is not deliverable or the patient refuses delivery and such medications have not left the control of the pharmacy staff, pharmacy contracted delivery service, or approved common


carrier. Medications that have been delivered to the patient cannot be returned and reused.

- If a pharmacy attempts, but is not able, to deliver prescription medications using its own staff or its own local delivery service, then such prescription medications may be returned and reused by the pharmacy if:
  - packaged in:
    - the manufacturer’s original, sealed, and tamper-evident bulk, unit of use, or unit dose packaging; or
    - the dispensing pharmacy’s original packaging; and
  - returned to the pharmacy immediately after the unsuccessful delivery attempt.
- If a pharmacy attempts, but is not able, to deliver prescription medications using an approved common carrier, then such prescription medications may be returned and reused by the pharmacy if:
  - packaged in:
    - the manufacturer’s original, sealed, and tamper-evident bulk, unit of use, or unit dose packaging; or
    - the dispensing pharmacy’s original, sealed, and

tamper-evident packaging, if the pharmacy demonstrated to the board of pharmacy that such packaging maintains the product quality as per United States Pharmacopeia (USP) standards; and

- returned to the pharmacy within 14 days of the unsuccessful delivery attempt.
- All returned packaging must demonstrate that the products’ integrity and stability have been maintained (the pharmacy must furnish data from studies affirming the integrity and stability).
- All returned prescription medications must have an expiration of at least six months from the date of return.
- All returned prescription medications must be evaluated by appropriate pharmacy staff to ensure such medications are not adulterated or misbranded.

A state-licensed pharmacist must verify compliance with all of the above elements prior to dispensing.


The “Position Statement on the Return and Reuse of Prescription Medications in the Community Pharmacy Setting” is posted under News on the NABP Web site. 

### e-Prescribing Standards

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At least five states have established Medicaid e-prescribing programs, according to the National Council of State Legislatures’ February 2009 report, “Health Information Technology and States.” Florida, for example, started its program by providing its 1,000 highest-volume Medicaid prescribers with free, stand-alone e-prescribing systems that allowed the prescribers

to access the Medicaid drug formulary, see a patient’s recent medication history, and receive drug interaction alerts.

The NABP Task Force on Electronic Prescribing Software Standards and Data Storage will submit its recommendations to the NABP Executive Committee, along with any recommended revisions to the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy*. 

# Updated Model Act Addresses Quality and Safety in Patient Care

NABP recently amended the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act)* to further protect the public during the dispensing of prescription drugs and improve quality and safety in patient care. These changes were incorporated as a result of the Executive Committee-approved recommendations of the Task Force on Uniform Prescription Labeling Requirements, the Task Force on Standardized Pharmacy Technician Education and Training, the Task Force on Medication Collection Programs, and the Committee on Law Enforcement/Legislation, as well as from Resolution 105-03-09, entitled Valid Patient-Practitioner Relationships, which was passed by the voting delegates at the NABP 105<sup>th</sup> Annual Meeting.

## Task Force on Uniform Prescription Labeling Requirements

Amendments recommended by the Task Force on Uniform Prescription Labeling Requirements include a completely revised labeling subsection that consciously removed some data elements historically included on prescription labels to make room for the most critical patient information. Information is designated as either critical or important to ensure prescription labels are organized in a patient-centered manner and mandate that the following summarized data elements appear on the prescription label:

1. Critical Information for Patients – Critical information must appear on the label with emphasis (highlighted or bolded), in a sans serif (such as “arial”), minimum 12-point font,

and in “sentence case.” Field size and font size may be increased in the best interest of patient care. Critical information text should never be truncated.

- a. Patient name
  - b. Directions for use
  - c. Drug name
  - d. Drug strength
  - e. “Use by” date
2. Important Information for Patients – Must appear on the label but should not supersede Critical Information for Patients.
    - a. Pharmacy name
    - b. Pharmacy telephone number
    - c. Prescriber name
    - d. “Fill date”
    - e. Prescription number
    - f. Drug quantity
    - g. Number of refills
    - h. Product description
    - i. Auxiliary information

Additionally several comments were added to clarify certain informa-

Download the updated Model Act in the Publications section of the NABP Web site at [www.nabp.net](http://www.nabp.net).

tion, such as if a physician instructs a patient to “take as directed,” that this should not be used in lieu of patient counseling. Other comments concerned record-keeping requirements, phone numbers, “fill date” and “discard after date,” and auxiliary information. Examples of suggested labeling formats are below.

Along the same line, the Committee on Law Enforcement/Legislation added a definition for *fill date*, which “means the actual date a new or refilled prescription is dispensed but not necessarily delivered to a patient from a pharmacy.” The committee also advised that bar codes,

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## Sample Labels

<p>Pharmacy Name: _____ Date Filled: MM/DD/YY _____                  Phone: _____ Rx No.: _____</p> <p><b>Purpose:</b>  <b>Patient Q. Name</b>                  Prescriber: _____  <b>Take 1 tablet in the morning and 2 tablets at bedtime.</b>  <b>Drug Name and Strength</b>  <b>Generic for:</b> _____ Qty: _____  <b>Use by: MM/DD/YY</b> Refills: _____</p> <p>Cautions: _____                  Description: _____</p>	<p>Pharmacy Name: _____                  Phone: _____</p> <p><b>Patient Q. Name</b></p> <p>Rx No.: _____                  Date Filled: MM/DD/YY _____                  Prescriber: _____</p> <p><b>Drug Name and Strength</b>  <b>Generic for:</b> _____ Qty: _____ Refills: _____  <b>Use by: MM/DD/YY</b></p> <p><b>Purpose:</b>  <b>Take 1 tablet in the morning and 2 tablets at bedtime.</b>                  Cautions: _____                  Description: _____</p>
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The recommendations from the Task Force on Uniform Prescription Labeling Requirements to completely revise the labeling subsection of the Model Act were approved by the Executive Committee. These updates remove some data elements historically included on the labels to make room for the most critical patient information.

**Model Act**

(continued from page 171)

the pharmacy address, and store number may appear on the prescription label as additional information for patients.

**Task Force on Standardized Pharmacy Technician Education, Training**

Amendments resulting from recommendations of the Task Force on Standardized Pharmacy Technician Education and Training include clarification of several existing definitions and revision of the provisions for the registration of certified pharmacy technicians and the pharmacist-in-charge responsibilities.

For instance, the definitions for *certified pharmacy technician* and *pharmacy technician* were clarified to explicitly list which activities they may perform and those that they are excluded from performing.

A *certified pharmacy technician* may perform, under the supervision of a pharmacist, the following activities:

- receiving new prescription drug orders;
- prescription transfer; and
- compounding;

but excluding:

- drug regimen review;
- clinical conflict resolution;
- prescriber contact concerning a prescription

drug order clarification or therapy modification;

- patient counseling; and
- dispensing process validation.

A *pharmacy technician* may perform, under the supervision of a pharmacist, the following activities:

- assisting in the dispensing process;
- processing of medical coverage claims;
- stocking of medications; and
- cashiering;

but excluding:

- drug regimen review;
- clinical conflict resolution;
- prescriber contact concerning prescription drug order clarification or therapy modification;
- patient counseling;
- dispensing process validation;
- prescription transfer; and
- receipt of new prescription drug orders.

Additionally, the Committee on Law Enforcement/Legislation further revised the definition of *certified pharmacy technician* to include in the allowable activities, “assisting in the dispensing process” to remove any ambiguity.

A comment was also added that states that “the term *pharmacy technician* will continue to be utilized until 2015.” The comment further explains that at that time, the *Model Act* “will be amended to require that all pharmacy technicians be certified,” and that the term *pharmacy technician* will be replaced with the term *can-*

*didate for certified pharmacy technician*. This new term will then be “redefined to provide a path to certification for non-certified pharmacy technicians,” and will allow for a one-time renewal.

The revised *Model Act* also includes modifications of the registration requirements for certified pharmacy technicians. These include the new requirement of either having graduated from high school or obtained a certificate of general educational development or equivalent. Also modified were the board-approved pharmacy technician training program requirements, which now require that the program is competency-based, site-specific, and provides for an educational component. A comment was added to recommend that states adopting this requirement, do so through “a process that incorporates provisions for grandfathering.” An additional revision was made to the examination requirement in that it must be “developed using nationally recognized and validated psychometric and pharmacy practice standards.”

**Task Force on Medication Collection Programs**


Pursuant to the Task Force on Medication Collection Programs’ recommendation, the patient counseling provisions of the *Model Act* were amended to include “appropriate disposal method(s) of unwanted or unused medication.”

**Resolution 105-03-09 Valid Patient-Practitioner Relationships**

Resolution 105-03-09, which was passed by the membership at the 105<sup>th</sup> Annual Meeting in May 2009, adds the following language to clarify the definition of a *valid patient-practitioner relationship*:

A face-to-face physical examination is not required to establish a valid patient-practitioner relationship if:

- a. the prescribing practitioner is issuing a prescription or dispensing a legend drug in accordance with expedited partner therapy in the management of sexually transmitted diseases guidance document issued by the United States Centers for Disease Control and Prevention; or
- b. the prescription, administration, or dispensing is through a public health clinic or other distribution mechanism approved by the state health authority in order to prevent, mitigate, or treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of a biological, chemical, or radiological agent.

The updated *Model Act* is available in the Publications section of the NABP Web site at [www.nabp.net](http://www.nabp.net). 



**Committee Members Review Potential MPJE Content**

Multistate Pharmacy Jurisprudence Examination® (MPJE®) Review Committee members met at NABP Headquarters to evaluate examination content for the MPJE to ensure that it meets the specified competency assessment statements. Pictured at left: Denise Frank, RPh, pharmacist, Cub Pharmacy, and Vance Alexander, RPh, JD, administrative hearing officer, Alabama Board of Pharmacy.



**Newly Accredited VAWD Facilities**

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

**AmerisourceBergen Drug Corporation**

Washington  
Accredited June 10, 2009

**Cardinal Health 110, Inc dba Cardinal Health 411, Inc**

Auburn, WA  
Accredited June 18, 2009

**E.R. Squibb & Sons, LLC dba Bristol-Myers Squibb Company**

Mt Vernon, IN  
Accredited June 10, 2009

**McKesson Medical-Surgical Minnesota Supply, Inc**

Swedesboro, NJ  
Accredited June 10, 2009

**McKesson Medical-Surgical, Inc**

Swedesboro, NJ  
Accredited June 10, 2009

**Midlothian Laboratories**

Montgomery, AL  
Accredited June 10, 2009

**Professional Veterinary Products, Ltd**

Omaha, NE  
Accredited June 10, 2009

**RedPharm Drug**

Eden Prairie, MN  
Accredited June 10, 2009

**UPS Supply Chain Solutions, Inc**

Duluth, GA  
Accredited June 15, 2009

**Walgreen Company**

Windsor, WI  
Accredited June 17, 2009

A full listing of more than 350 accredited VAWD facilities is available on the NABP Web site at [www.nabp.net](http://www.nabp.net) .


## Online Registration Now Available for NABP 2009 Symposium Early Registrants Eligible for Special Rate through October 14

Online registration is now available for the NABP 2009 Symposium. The meeting will offer valuable and interactive continuing pharmacy education (CPE) sessions on medical marijuana and the development of partnerships between public and private organizations. In addition, attendees will have the opportunity to earn up to 11.25 hours (1.125 CEUs) of Accreditation Council for

Pharmacy Education-approved CPE credit.

Returning to the serene desert landscape of Arizona, the Symposium will once again be held at the J.W. Marriott Starr Pass Hotel in Tucson. Those who register on or before **Wednesday, October 14**, will receive the special early registration rate.

Online registration is available in the Meetings section of the NABP

Web site, [www.nabp.net](http://www.nabp.net), under 2009 Symposium. NABP offers three payment options: (1) mailing in the payment, (2) using a credit card – American Express, MasterCard, or Visa, or (3) paying in Tucson. A printable registration form, as well as a direct link to the special group reservations Web page to book hotel rooms, is also available on the NABP Web site. 

December 3-4, 2009

J.W. Marriott Starr Pass Hotel

Tucson, AZ

### Wednesday, December 2, 2009

3 - 6:30 PM

**Registration/Information Desk Open**

### Thursday, December 3, 2009

7 AM - 6 PM

**Registration/Information Desk Open**

7:15 - 8 AM

**Continental Breakfast**

8 AM - noon

CPE Session

**Legalization of Drugs: Is the Time Right for Medical Marijuana?**

ACPE Program #205-000-09-008-L03-P  
(0.375 CEUs – 3.75 contact hours)

Noon - 1:15 PM

**Luncheon**

1:30 - 5 PM

CPE Session

**Are We Going to Legalize Medical Marijuana?**

ACPE Program #205-000-09-009-L03-P  
(0.325 CEUs – 3.25 contact hours)

6 - 6:30 PM

**Meet and Greet . . . a networking opportunity**

(Cash bar will be available.)

6:30 - 8 PM

**Dinner Under the Desert Sky**

(Buffet dinner will be served and a cash bar will be available.)

### Friday, December 4, 2009

7 AM - noon

**Registration/Information Desk Open**

7:15 AM - 8:30 AM

**Continental Breakfast**

8:30 AM - 1 PM

CPE Session

**Public-Private Partnerships: Stimulus Packages for Dwindling State Resources**

ACPE Program #205-000-09-010-L03-P  
(0.425 CEUs – 4.25 contact hours)

Note: The NABP 2009 Symposium schedule is subject to change.

Additional information on the continuing pharmacy education (CPE) sessions is available in the Meetings section of the NABP Web site, [www.nabp.net](http://www.nabp.net), under CPE Descriptions.



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 11.25 contact hours (1.125 CEUs) 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 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.

## NABP 2009 Symposium to Address the Legalization of Medical Marijuana and the Benefits of Public-Private Partnerships

Addressing new and timely topics about the legalization of medical marijuana and public-private partnerships, the NABP 2009 Symposium, will provide attendees the opportunity to collaborate with peers. To be held December 3-4, 2009, at the J.W. Marriott Starr Pass Hotel in Tucson, AZ, the one-and-one-half day Symposium welcomes board of pharmacy executive officers, members, and compliance officers to hear from experts in the field, and discuss these issues with state and federal regulators and stakeholders in the practice of pharmacy. Attendees may also earn up to 11.25 hours (1.125 CEUs) of Accreditation Council for Pharmacy Education-approved CPE credit.

### Educational Programs

**Thursday, December 3**  
8 AM - noon

#### *Legalization of Drugs: Is the Time Right for Medical Marijuana?*

Speakers will provide participants with facts about the medical use of marijuana, emphasizing evidence-based medicine, including scientific evidence bearing on potential medical use. This session will open the door for further discussion regarding science, medicine, policy,

and the law. Participants of this session will earn 3.75 contact hours (0.375 CEUs) of continuing pharmacy education credit as they hear from experts on the following topics:

- The Federal Status of Marijuana in the United States
- Should Marijuana be a Medical Option?
- Are These Medical Miracles?
- Medical Marijuana: Point-Counterpoint

1:30 - 5 PM

#### *Are We Going to Legalize Medical Marijuana?*

Representatives from state agencies will share with participants how medical marijuana programs have been incorporated into their state's law and regulations. Additionally, experts will provide participants with their insights on what impact legalizing marijuana could bring. Participants will also brainstorm during a facilitated round-table discussion on two opposite visions of the medical marijuana issue.

In addition, 3.25 contact hours (0.325 CEUs) of continuing pharmacy education credit will be offered to participants of this session as they hear from experts on the following topics:

- A Regulatory Approach to Medical Marijuana – What are the States Doing?

- A Regulatory Approach to Medical Marijuana – What has Canada Done?
- Legalizing Medical Marijuana – Creating a Slippery Slope?

**Friday, December 4**

8:30 AM – 1 PM

#### *Public-Private Partnerships: Stimulus Packages for Dwindling State Resources*

In this session, Symposium participants will be provided with an overview of the concept of public-private partnerships. Representatives from various federal agencies will describe current and proposed public-private partnerships from highways to health care, as well as learn about current state public-private partnerships from around the country.

Participants of this session will earn 4.25 contact hours (0.425 CEUs) as they hear from experts on the following topics:

- Current Federal Public-Private Partnership Projects
- Current State Public-Private Partnership Projects
- Panel Discussion

For more details on the CPE sessions visit the Meetings section of the NABP Web site.



2009 Symposium

December 3-4, 2009

J.W. Marriott Starr Pass Hotel  
Tucson, AZ

### Symposium Special Events


**Thursday, December 3**  
6 - 8 PM

#### *Meet and Greet; Dinner Under the Desert Sky*

This special outdoor event serves as the perfect opportunity for attendees to relax, network with colleagues, and meet new people while enjoying music and a buffet dinner under the Arizona desert sky.

Gene Privett, one of the most sought-after country music entertainment performers in Arizona, will delight Symposium attendees with songs of the dusty trail and cowboy life during dinner. Well known throughout Arizona as an exceptional "Cowboy Balladeer," Gene will sing songs made famous by Gene Autry, Roy Rogers, and Sons of the Pioneers.

In addition, as attendees enjoy their dessert and coffee, campfire stories of the great southwest will be shared. Please note, a cash bar will be available.

To register or for additional information about the NABP 2009 Symposium, visit the Meetings section on the NABP Web site at [www.nabp.net](http://www.nabp.net). 

## Interested in Contributing to Pharmacy Practice Standards? NABP Seeks Item Writers for NAPLEX and FPGEE

NABP is accepting letters of interest from individuals interested in serving as item writers for the North American Pharmacist Licensure Examination® (NAPLEX®) and the Foreign Pharmacy Graduate Equivalency Examination® (FPGEE®).

The NAPLEX is an examination consisting of 185 selected-response and constructed-response test questions, the majority of which are asked in a scenario-based format, that covers important information about the knowledge, judgment, and skills an entry-level pharmacist is ex-

pected to demonstrate. The FPGEE is a comprehensive examination consisting of 250 multiple-choice questions that measures four major pharmacy content areas: basic biomedical sciences, pharmaceutical sciences, social/behavioral/administrative pharmacy sciences, and clinical sciences.


Pharmacists in all areas of practice, and faculty from schools and colleges of pharmacy, are encouraged to apply.

Interested individuals may mail or fax a letter of interest indicating their current practice/educa-

tional setting, specialties/certifications, and years of experience, along with a resume or curriculum vitae, to NABP Executive Director/Secretary Carmen A. Catizone at 1600 Feehanville Drive, Mount Prospect, IL 60056 or via fax at 847/391-4502. Applications are accepted on a continuous basis and kept on file for a period of five years.

Item writers will be selected based on the specific needs of the programs. Those who are chosen will be asked to attend a workshop at NABP Headquarters with travel, lodging,

and ancillary expenses paid by NABP. These workshops occur several times per year. Attendees will receive detailed instructions and training materials describing the item-writing process and content-related requirements for their designated examination. Item writers will then be asked to develop new test items that will be considered for inclusion in NABP licensure and certification examination programs.

For more information about item writing, contact NABP at [custserv@nabp.net](mailto:custserv@nabp.net). 

### Legal Briefs

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the availability of a civil remedy may defeat criminal jurisdiction based upon defendant's interpretation of the statute. The court held that the availability of a civil remedy did not preclude any other remedy provided by law and that the state may "impose both a criminal and a civil sanction in respect to the same act or omission."

The court held that by a preponderance of the evidence, the defendant, without having a valid California license, prescribed fluoxetine to a patient he knew to be a California resident and knew that such prescription would cause the dispensing of medica-


tion to the California patient. As a result, the court concluded that such acts subjected the defendant to the jurisdiction of the criminal courts of California under the territorial principle codified in section 778. Indeed, the court noted that if the defendant's communications had been by letter or facsimile, "there is little doubt jurisdiction would lie [in the California court]."

Accordingly, the court denied the defendant's motion to dismiss the criminal matter and held that the acts of the defendant under these circumstances subjected him to the jurisdiction of the California criminal court. Thus, the criminal prosecution was allowed to proceed.

Readers will note that the following cited opinion was rendered in May 2007. Since that time, the criminal prosecution has progressed through the processes resulting in recent resolution through a plea agreement. According to media sources, in March 2009, the defendant/physician pled no contest to the criminal charges and, in April 2009, was sentenced to serve nine months in county jail, placed on probation for three years, and ordered to repay certain costs of investigation to the Medical Board of California.

From a criminal prosecution perspective, the analysis of judicial jurisdiction is essential for the respective states to successfully prosecute

activities that involve cyber presence, rather than physical presence. From a pharmacy board perspective, the authority of the board to be empowered to administratively prosecute unlicensed practice is equally important in fulfilling the important public protection mission of the boards. Boards are encouraged to review their practice acts and determine whether the board has the authority (or jurisdiction) over unlicensed activities. At some point in time, the issue of where or whether such activities occurred within a particular state will also need to be addressed.

*Hageseth v Superior Court*, 59 Cal Rptr. 3d 385 (CA App Ct 2007) 

## Pharmaceutical Company Manager Sentenced for Off-Label Marketing

A Branchburg, NJ woman was sentenced on June 18, 2009, by United States Magistrate Judge Judith Dein to pay a \$75,000 fine and serve two years of probation for the distribution of a misbranded drug. According to a June 18 news release from the US Attorney's Office for the District of Massachusetts, Mary Holloway pled guilty to charges of violating the Federal Food, Drug and Cosmetic Act by marketing the drug Bextra® for uses and dosages that were not approved by Food and Drug Administration (FDA) while employed from approximately November 2001 through April 2005 as a regional manager for a pharmaceutical company. Bextra was withdrawn from the market in April 2005.

## NCL Developing National Medication Adherence Campaign

The National Consumers League (NCL), a private, nonprofit advocacy group representing consumer interests on marketplace and workplace issues, is developing a national campaign to promote the importance of taking medications as instructed. In addition to this broad message, the campaign will include additional outreach efforts targeted toward patients with certain chronic conditions, such as diabetes and cardiovascu-

lar disease. NCL convened nearly 100 stakeholders in early 2009 to help refine an action plan for the development and execution of the campaign. In April, NCL conducted a series of preliminary focus groups, including two patient groups and three practitioner groups, to explore many of the concepts and issues included in the initial plan. NCL plans to hold a second stakeholder meeting in early fall to further this initiative.

## Palm Springs Attorney Sentenced for Prescription Drug Diversion

An attorney from Palm Springs, CA, was sentenced to serve jail time for his role in a drug diversion scheme, according to a news release issued May 20, 2009, by the United States Attorney's Office for the District of New Hampshire. Robert McFadden, 63, was sentenced on May 19 to three years of incarceration to be followed by two years of supervised release for his involvement in the illegal purchase and distribution of the HIV drug Serostim®. Large quantities of the drug were illegally purchased from illegitimate sources and then illegally distributed to wholesale distributors using falsified paperwork. McFadden was also ordered to pay a money judgment of \$96,639. The entire news release can be found at [http://www.usdoj.gov/usao/nh/press/may09/MI\\_McFadden.html](http://www.usdoj.gov/usao/nh/press/may09/MI_McFadden.html).

## FDA Warns of Serious Liver Injury Associated with Anti-Thyroid Drug

FDA has issued a warning to health care professionals about the risk of serious liver injury associated with the use of the anti-thyroid drug propylthiouracil for the treatment of Graves' disease. FDA has identified an increased risk of liver injury with propylthiouracil when compared to an alternative treatment for

this condition, methimazole. FDA has received reports of 32 cases of serious liver injury associated with the use of propylthiouracil from 1969 through 2008. Of the 22 adult cases, FDA identified 12 deaths and five liver transplants. Of the 10 pediatric cases, there was one death and six reports of liver transplants. More information is available in the June 3, 2009 FDA news release at [www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm164207.htm](http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm164207.htm).<sup>®</sup>

## Around the Association

### Executive Committee Member Receives Bowl of Hygeia Award

**Karen M. Ryle, MS, RPh**, was announced as a 2008 recipient of the Bowl of Hygeia Award for her outstanding service, dedication and personal contributions to her community. Ryle is serving the third year of a three-year member term representing District 1 and was re-elected to serve on the Executive Committee after serving a one-year member term from 2006 to 2007. An active member of NABP since she was appointed to the Board, Ms Ryle has served as chairperson for both the Task Force to Develop Recommendations to Best Reduce Medication Errors in Community Pharmacy

Practice and the Task Force on Telepharmacy and the Implementation of the Medicare Drug Benefit Medication Therapy Management Provisions. Currently, Ms Ryle is the director of Outpatient Pharmacy Services at Massachusetts General Hospital. She earned both her bachelor of science degree in pharmacy and her master of science degree in drug regulatory affairs from Massachusetts College of Pharmacy and Health Sciences.

### Executive Director Change

**Susan Teil Boyer, MS, RPh, FASHP**, has been appointed the executive director of the Washington State Board of Pharmacy. Boyer's start date

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nabp newsletter

### **Kansas Board Announces 2009 Legislative Changes**

The Kansas State Board of Pharmacy's 2009 legislative session produced several changes to the Kansas Pharmacy Act.

Senate Bill (SB) 248 was amended into SB 33, creating a statewide electronic logging system for the sale of methamphetamine precursors. This action was recommended by the Kansas Methamphetamine Precursor Scheduling Task Force that met over the last year pursuant to a proviso from the 2008 legislative session. The task force was chaired by Board member Michael Coast, RPh, of Cimarron, KS, and included many stakeholders from health care, law enforcement, and public communities.

SB 33 requires the Kansas Board to establish and maintain a statewide electronic logging system documenting the sale of any compound, mixture, or preparation containing pseudoephedrine, ephedrine, or phenylpropanolamine. Sales of methamphetamine precursors that are prescribed are excluded from the requirements of the logging system. The act became law on July 1, 2009, and the Kansas Board is required to promulgate rules and regulations within six months of the effective date of the act.

The Kansas Board will be allowed to issue a waiver exempting a pharmacy from compliance with electronically submitting the information under certain limited

circumstances. The cost of establishing and maintaining the system will be borne by the state, other non-state units of government, private entities, or others. As written in the law, pharmacies are not required to bear the costs associated with establishing or maintaining the program.

In addition, SB 33 amended existing law regarding the maintenance of a list of the names of pharmacy technicians currently on duty on a duty board posted conspicuously in the prescription area of the pharmacy. The amended statute requires the pharmacy technician registration card, provided by the Kansas Board, to be posted in the prescription area of the pharmacy at all times, regardless of whether the technician is on duty, so that inspectors can access the registration information at any time.

Pharmacy technicians who are floaters can make a copy of their card for other pharmacy locations. This change will assist the pharmacist-in-charge and the inspectors in the validation of technician registrations.

SB 33 also increases the number of Kansas Board members from six to seven, effective July 1, 2009. The Board will consist of six pharmacists and one public member. Additionally, the term of office was extended from three years to four years, effective July 1, 2009. The terms of each existing member will be extended by one year, effective July 1, 2009 as well.

The final provision of SB 33 permits the Kansas Board to fingerprint and background check any original license or registration applicant, any reinstatement license or registration applicant, or any licensee or applicant who is being investigated.

The fee for fingerprinting shall be borne by the licensee or registrant and will be passed through to the Kansas Bureau of Investigation to cover costs associated with providing a record of criminal history to the Board. The statute became effective July 1, 2009, and the Board will promulgate rules and regulations implementing the backgrounding requirements. It is anticipated that the rules will be in place in 2010.

### **Kansas Board Requires Pharmacies to Establish CQI Programs**

In July 2008, KSA 65-1695 began requiring each pharmacy in the state of Kansas to establish a continuous quality improvement (CQI) program. Effective April 10, 2009, KAR 68-19-1 requires that each CQI program meet minimum requirements. Specifically, each pharmacy other than a hospital pharmacy, must hold a meeting at least once each quarter of each calendar year, with the first meeting held by September 30, 2009.

The pharmacist-in-charge must attend the meeting and review each incident report generated during the past quarter. For each incident,

the meeting personnel must establish steps to be taken to prevent a recurrence of the incident. A report shall be maintained that states the list of persons in attendance, a list of the incident reports reviewed, and a description of steps taken or to be taken to prevent a recurrence of the incident.

On October 24, 2008, the Kansas Board revised the definition of an incident pursuant to KAR 68-7-12b. As soon as possible after discovery of an incident the pharmacist-in-charge shall be notified of the incident and a report prepared. Each employee involved in the incident shall sign the incident report. Reports shall be maintained for a period of five years.

### **Kentucky Board Reports 2009 Legislation Updates**

On June 6, 2008, 201 KAR 2:300 regarding common database became law in Kentucky. *Common database* means information shared among pharmacists and pharmacies for the purpose of dispensing medications or providing other forms of pharmacist care to a patient.

On February 18, 2009, 201 KAR 2:105, as amended, regarding licensing and drug distribution requirements for wholesale distribution became law. This regulation was amended due to the new statutes passed during the 2008 legislative session regarding wholesale distributors and new requirements including a change of name from wholesaler to wholesale

distributor, additional definitions, pedigree requirements, and additional requirements on the application and others.

On March 11, 2009, 201 KAR 2:230, as amended, regarding central refill pharmacy became law. This amended regulation now allows a central refill pharmacy located in the Commonwealth to provide central refill services to another pharmacy, whether it is located inside or outside of Kentucky.

On March 11, 2009, 201 KAR 2:310 regarding compounding for a practitioner's office or institutional administration became law. This regulation allows a pharmacist, pharmacist intern, or pharmacy technician to prepare a compounded drug for a practitioner's office or institutional administration.

The regulations are available in their entirety on the Kentucky Board of Pharmacy Web site at [www.pharmacy.ky.gov](http://www.pharmacy.ky.gov), under Statutes and Regulations, Title 201, Chapter 2 Kentucky Administrative Regulations, Chapter 2.

### West Virginia Board Fights Prescription Drug Diversion Across Borders

In April 2009, a pharmacist and a pharmacy technician called the West Virginia Board of Pharmacy to ask for advice on how to handle a suspicious prescription, the Board reported in its June 2009 newsletter. Several patients, some related, some not, arrived at the pharmacy together, with others coming shortly there-

after, asking for prescriptions of oxycodone to be filled. They came across the border from Kentucky to a pharmacy in West Virginia. The prescriptions were written by prescribers at a pain clinic in Florida.

The Rules of Professional Conduct require pharmacists to contact the prescriber before filling a prescription if they suspect that a prescription is not for a proper medical purpose, contains irregularities, or has ambiguities. In this case, they did confirm that the prescriptions were from the pain clinic, and were written to the patients by the prescriber. Still, it has been highly publicized that people are using clinics in Florida to obtain prescriptions and then traveling back to Kentucky and West Virginia to get them filled, the Board reported. Given the suspicious situation here, the West Virginia Board recommends that pharmacies contact law enforcement. In this case, law enforcement felt there was enough suspicious conduct present to seize the prescriptions and obtain a warrant to search the patients' homes; they found a combined street value of over \$32,000 in Schedule II through IV narcotics at their homes, along with prescriptions for hundreds of more pills. Because of the tip from the pharmacy, four arrests were made for felony possession with intent to deliver and felony conspiracy.

On a similar note, just one month earlier, on March 9, 2009, the fed-

eral court in Ashland, KY, sentenced almost a dozen individuals for traveling back and forth to Florida to obtain OxyContin® and other pain medications that they then abused or distributed in Kentucky, Ohio, and West Virginia. The prosecutors said that "the players participated in an organized crime network which flooded Kentucky, Ohio, and West Virginia streets with OxyContin pills by the thousands," the Board reported.

Since then, the West Virginia state police have started a new media campaign to reiterate that they have several officers trained and working specifically as drug diversion investigators. The West Virginia

Board of Pharmacy has devoted certain federal grant funds and other federal dollars to fund two of those positions. In the media spot recently aired on a local television station, the reporter interviewed a pharmacist and noted that pharmacists and pharmacy technicians are often directly on the front line of this initiative. The West Virginia Board encourages pharmacies to keep up the good work, and reminds them the Board has direct contact with the drug diversion investigators. The West Virginia Board asks pharmacies to contact the Board if they suspect criminal activity. The Board will assess the situation and connect the pharmacist with law enforcement. Ⓢ

### Around the Association

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was May 20, 2009. Prior to this position, she was vice president, pharmacy and laboratory services, at MultiCare Health System in Tacoma, WA, and vice president, professional services, at Good Samaritan Hospital in Puyallup, WA. Boyer served eight years as a member and chair for the Washington Board from 2000-2008, was president of the Washington State Society of Health-System Pharmacists, and a member of the board of directors of the American Society of Health-System Phar-

macists. Boyer received her bachelor of science degree in pharmacy from the University of Washington and her master of science/residency program in pharmacy practice and administration from Ohio State University.

### Board Member Reappointment

● **Thomas Van Hassel, RPh**, has been reappointed a member of the Arizona State Board of Pharmacy. Van Hassel's appointment will expire on January 20, 2014. Ⓢ



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