

INNOVATIONS®



Interprofessional Practice:

Supporting Team-Based Health Care,
Improving Patient Outcomes





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*NABP Executive
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Association’s Annual
Meeting.*

Innovations

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Interview With a Board Executive Director



**Deena Speights-Napata, MA,
Executive Director Maryland
Board of Pharmacy**

Deena Speights-Napata, MA, Executive Director Maryland Board of Pharmacy

How long have you served as executive director/secretary of the Maryland Board of Pharmacy? What was your role prior to working with the Board?

My start date was February 3, 2016, so I've been here 16 months. Prior to my tenure here, I was deputy director at the Maryland Department of Health and Mental Hygiene's Center for Immunization for seven years, where I supervised and managed the federally funded Vaccines for Children program. Prior to that, I was deputy director for outreach for AARP Maryland for three and a half years, and prior to that, I was deputy director for planning and development for Maryland Medicaid for four years.

What is one of the most significant challenges or issues your board addressed in the past year or so?

Initiating and maintaining avenues of communication with Maryland stakeholders on key issues impacting the practice of pharmacy, such as expedited partner therapy, increased services requested of pharmacists related to the opioid abuse crisis, and new Medicaid policies requiring new prescribing, counseling, and prescription drug monitoring program (PDMP) verification procedures. The board is also concerned about the increase of pharmacy robberies in Maryland and is discussing ways to support pharmacies and pharmacists in addressing this issue. We are also challenged by the current board commissioner term. Board commissioners – pharmacists and public representatives appointed by the governor of Maryland – serve four-year terms that are straddled, meaning all commissioners are not appointed at the same time. Some may be reappointed to another four-year term; some may not. The governor solicits three recommendations for board seats from stakeholder groups that sometimes do not provide the recommendations in a timely manner. This can result in a commissioner whose term has expired, or who has not been reappointed, staying on the board beyond the intended term because a replacement has not been provided or not confirmed by the Senate. Fifty percent of our appointed board commissioners have been appointed during my tenure.

What actions were taken by the Board to address the issue?

The Board is active in several stakeholder groups. We are using public board meetings; our quarterly newsletter; our website; Facebook; blast emails to all Maryland pharmacists, technicians, and pharmacies; and lobby TV monitors to educate and update stakeholders and the public on relevant issues.

What other key issues has the Board been focusing on?

The Board has also been focusing on the sale of syringes in pharmacies and PDMP registration and use.

What insights do you have for other states that may be facing similar challenges?

Increase partnerships with other relevant boards and disciplines, such as physician boards and medical and pharmacy associations. It is also important to partner with local law enforcement and support drug treatment programs to address the opioid abuse epidemic. ■

Maryland Board of Pharmacy

Number of Board Members: 10 pharmacist members, 2 public members

Number of Compliance Officers/Inspectors: 8 (1 compliance officer, 2 investigators, 4 full-time and 2 half-time inspectors)

Rules and Regulators Established by: Board of Pharmacy

Number of Pharmacist Licensees: 11,224

Number of Pharmacies: 1,957 (in-state)

Number of Wholesale Distributors: 1,164

Criminal Defendant SOL: Case Timely Filed



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

“Activities of health care providers that fall outside the scope of acceptable practice may violate not only the Practice Act, but also criminal statutes.”

As administrative agencies of the state, boards of pharmacy act in the interest of protecting the public by regulating the practice of pharmacy through enforcement of the Pharmacy Practice Act and relevant regulations. Enforcement by regulatory boards comes in the form of administrative prosecutions against persons or entities that violate such laws. These administrative prosecutions are undertaken on behalf of the citizens of the state and, among other administrative remedies, may limit or remove the authority to practice. At times, criminal cases are relevant to the regulatory community. There is no doubt that criminal prosecutions against professionals not only protect the public, but act as a deterrent to certain future acts by licensees. Activities of health care providers that fall outside the scope of acceptable practice may violate not only the Practice Act, but also criminal statutes. Consider the following:

A physician (Defendant), licensed in Indiana since 2008 and board-certified in neurology, was the subject of an investigation by the Office of the Attorney General (OAG). The OAG investigation was stimulated by complaints filed with the Indiana Licensing Enforcement Section by two former patients and an addiction counselor. The complaints, filed in 2012, alleged that the Defendant had prescribed large amounts of narcotics to pain management patients between 2008 and 2012. The investigation revealed a list of patients for whom the Defendant prescribed controlled substances

(CS); this list was provided to the Indiana State Department of Vital Statistics Department (Department). The Department then turned the list over to the OAG, including death information for those on the list.

The list revealed that several patients had “died from drug intoxication, overdose, or related causes of death” and had received their prescriptions from the Defendant within 30 days prior to death. One patient had received 10 prescriptions for methadone, hydromorphone, and diazepam within a four-month period. Such patient died of “pharmacologic intoxication” eight days after the last of the scripts was dispensed. Another patient received a total of 17 prescriptions for hydromorphone, alprazolam, morphine, dronabinol, and fentanyl during a five-month period. The patient died five days after the last of those scripts was filled and an autopsy concluded the cause of death to be “polydrug intoxication.” A third patient was prescribed 81 prescriptions over a 29-month period, again for methadone, hydrocodone, Lyrica®, fentanyl, and oxycodone. This patient died approximately one month after the last prescription was filled, with the cause of death categorized as “fentanyl toxicity.”

In addition to these three deceased patients, multiple other patients were identified to have been prescribed significant numbers of CS beyond the acceptable standards of practice. On August 5, 2015, the State of Indiana charged the Defendant with three counts of reckless homicide and additional counts of issuing invalid prescriptions for legend drugs. In all, the state charged the Defendant with 19 counts of various classes of

felonies. The Defendant filed motions to dismiss the charges for a variety of reasons, including that some of the events occurred outside the five-year statute of limitations period. In his motions, the Defendant also argued that the Indiana Legend Drug Act is unconstitutionally vague.

In November 2015, the trial court held a hearing on the Defendant's motions to dismiss. In its conclusions of law, the court found that the reckless homicide charges included events that occurred outside the five-year statute of limitations and were subject to dismissal. The court also found that numerous other counts included a range of dates of alleged issuance of invalid prescriptions that also occurred outside of the statute of limitations and were also subject to dismissal. For these counts, the court provided a window to the prosecution to amend its charges to allege a singular offense within the statute of limitations. Certain other charges were dismissed as failing to allege an offense. And finally, the court found that the Indiana Legend Drug Act was not unconstitutionally vague and, thus, the Defendant's motion to dismiss was denied. In the wake of the trial court ruling, the remaining charges only included five counts of issuing invalid prescriptions. The state appealed the case to the Court of Appeals of Indiana.

The crime of reckless homicide requires that a "person . . . recklessly kills another human being." Conduct is deemed to be reckless if it occurs ". . . in plain, conscious, and unjustifiable disregard of harm that might result and the disregard involves a substantial deviation from

acceptable standards of conduct." The state based its charges on the fact that the prescribing actions of the Defendant were reckless in that they were substantial deviations from the acceptable standards of conduct and resulted in the death of the three patients. But, the trial court held that the act of writing or issuing prescriptions "alone" cannot cause death and that intervening events of filling the prescriptions and ingesting the drugs must occur. In other words, there was no causation between the acts and the deaths. (At this point, one might question the role and/or involvement of the pharmacist, whether the scripts should have been filled in the same pharmacy, and the role of the prescription monitoring programs.)

On appeal and addressing previous jurisprudence, the state argued that in order to sustain its burden regarding causation, the prosecution must prove that the Defendant's conduct was a "proximate cause" of death, rather than the sole cause of death. The Court of Appeals held that, while writing a prescription in and of itself is not a crime, the charges by the state allege the crime of reckless homicide, which is a deviation from acceptable standards. Thus, the Court of Appeals reversed the lower court and held that the dismissal of the reckless homicide counts was in error.

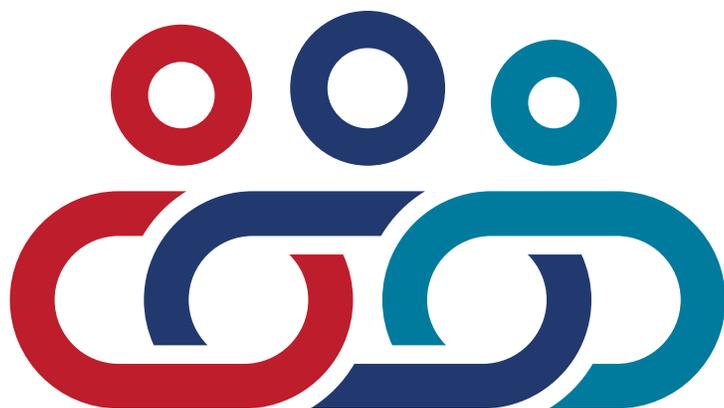
Addressing the statute of limitations, the Court of Appeals noted the purpose of a limit on the time period under which prosecutions must occur. It also noted the balance between the potential unfairness to the physicians and the right of the state to investigate and prosecute a matter. There is no statute of

limitations on murder charges, but there is a five-year limit on reckless homicide charges. Thus, the issue was whether the criminal prosecution of the Defendant was barred by the five-year period. The court determined that the five-year period is not triggered until the death of a patient and, therefore, the state's August 2015 commencement of the case was timely. Accordingly, the Court of Appeals reversed the dismissal of the relevant count and recognized the right of the state to proceed.

Finally, the Court of Appeals rejected the Defendant's arguments related to double jeopardy and that the statutes were unconstitutionally vague. Thus, the findings of the trial court related to dismissal were reversed and the finding that the Indiana Legend Drug Act was not unconstitutionally vague was affirmed. Because this ruling addressed the Defendant's motion to dismiss, the case will now proceed to a trial on the merits.

Access by health care providers to relevant information related to prescribing and dispensing of CS is critical to deterring physician and pharmacy shopping by those who wish to take advantage of the systems. Further, comprehensive data can prevent prescribers and pharmacists from abusing their respective roles in the health care system. Actions outside the scope of acceptable standards may result in criminal prosecutions and, perhaps, convictions.

State v. Sturman, 56 N E 3d 1187 (App Ct IN 2016) ■



Connect & Protect **Educating, Sharing, and Leading**

Interactive Executive Officer Forum
October 3-4, 2017

**Interactive Compliance Officer
and Legal Counsel Forum***
November 29-30, 2017

This year's forums provide attendees a unique opportunity to discuss today's important issues with fellow pharmacy regulation experts. Highlights of the forums include:

- Network with colleagues
- Participate in discussions on topics submitted by fellow attendees
- Discover solutions for shared challenges
- No registration fee
- Travel, hotel, and meal expenses paid by NABP

Invitations to attend the Executive Officer Forum were sent in August. Executive officers will receive registration information for the Compliance Officer and Legal Counsel Forum in October. For more information about the forums, contact ExecOffice@nabp.pharmacy.

**One compliance officer and one legal counsel per board may attend at no charge.*

FDA Training for Compliance Officers

Prior to the start of the Interactive Compliance Officer and Legal Counsel Forum, compliance officers will have the opportunity to attend an educational session on compounding facility inspections presented by Food and Drug Administration (FDA). This session will begin the afternoon of November 28 and conclude the morning of November 29.

Annual Program Review and Training Gives Board Staff Opportunity to Network and Learn About NABP

To further familiarize themselves with NABP programs and services, board of pharmacy staff – both new employees and those seeking a refresher course – attended the NABP Annual Program Review and Training session on June 27-28, 2017, at NABP Headquarters. Nineteen participants representing 18 state boards of pharmacy attended the two-day interactive session, which provided information about NABP’s examinations, licensure transfer, accreditation programs, and more. In addition, the informational session provided attendees with a unique opportunity to network with other board of pharmacy staff. The next Program Review and Training will take place June 26-27, 2018. More information about the 2018 sessions will be provided in future issues of *Innovations*. ■



(Above) NABP Program Review and Training session attendees were given a tour of the newly renovated NABP Headquarters and learned about the Association’s competency, licensure, accreditation, and inspection programs.

NAPLEX Review Committee Meets in July 2017

The North American Pharmacist Licensure Examination® (NAPLEX®) Review Committee convened in July 2017, at NABP Headquarters. Twenty-eight Review Committee members worked together to review and develop new examination questions. ■



(Left) NAPLEX Review Committee members (clockwise, from left) Christopher Betz, PharmD, RPh, BCPS, Sullivan University; Arthur I. Jacknowitz, PharmD, RPh, professor emeritus, West Virginia University; Siu-Fun Wong, PharmD, RPh, FASHP, Chapman University; and Darla Gallo, RPh, Philadelphia, PA.

(Right) NAPLEX Review Committee members (clockwise, from left) Christina “Tina” Minden, PharmD, RPh, CGP, FASCP, Little Rock, AR; Tom M. Houchens, RPh, FASCP, London, KY; Jack L. Szarek, PhD, Geisinger Commonwealth Medical College; and David W. Newton, PhD, Shenandoah University.



Interprofessional Practice: Supporting Team-Based Health Care, Improving Patient Outcomes



“Numerous studies in recent years have demonstrated that pharmacist involvement in the delivery of patient care services improves patient outcomes while helping to control health care costs.”

With the primary goal of providing optimal patient care, team-based practice models have demonstrated improved patient outcomes in both preventing and managing chronic disease. When pharmacists collaborate with prescribers – including physicians, physician assistants, and advanced nurse practitioners – the pharmacist may perform services such as refill authorization, drug substitution, and hypertension management. When pharmacists practice within their authorized scope, team-based care arrangements may be informal and develop through provider coordination, agreement on the goals of a patient’s treatment plan, and trust. Team-based care can also be formalized through collaborative practice agreements (CPAs), which allow the prescriber to delegate additional responsibilities to a pharmacist, further benefiting the patient’s care.

Forty-eight state laws allow CPAs, with requirements and restrictions varying from state to state. NABP, through the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act)* and the Association’s participation in the Tri-Regulator Collaborative, assists its member boards of pharmacy in supporting and appropriately regulating team-based care models, including CPAs.

Team-Based Care: An Overview

Pharmacist involvement in team-based care is not a new concept. Starting in the 1960s, the federal government authorized collaboration between pharmacists and other health care providers to manage disease states and offer other pharmacist care services through such avenues as the Indian Health Service and the Veterans Health Administration. It has become more widespread in recent years, however, and some of the benefits of increased pharmacist involvement in patient care – including better patient outcomes, control of health care costs, increased access to care, and amelioration of the primary care provider shortage – have received more widespread attention and

spurred efforts to increase adoption of the model within the last decade.

As noted above, team-based care does not require a CPA to be implemented; health care providers from different professions can still work in collaboration to provide high-quality care across settings, with the mutual goal of providing optimal patient care. Just as with interprofessional care happening under the auspices of a CPA, elements of an effective non-CPA, team-based approach include various practitioners communicating effectively as they operate in clearly defined roles, working toward shared goals with measurable outcomes. The primary difference from the CPA model is that pharmacists participating in a team without a CPA perform only patient care tasks that fall under the normal, autonomous scope of practice permitted by their state.

A CPA creates a formal relationship between a pharmacist and a prescriber and allows the prescriber to delegate certain functions to the pharmacist. In general, CPAs give pharmacists more autonomy to affect a patient’s medication therapy; delegated functions may include initiating, modifying, or discontinuing

such therapy, and can also include ordering, performing, and interpreting laboratory tests. Functions allowed under CPAs vary widely from state to state, depending on what is addressed in a state's CPA-related laws and regulations and on that state's scope of practice for pharmacists. CPAs themselves are also situation-specific. They may allow for a group of providers to manage care for patients with a particular chronic health condition. Each CPA, however, is specific to the prescriber(s) and the pharmacist(s) covered by the agreement.

Benefits of Team-Based Care

It has been estimated that by 2020, nearly 50% of the United States population will have at least one chronic health condition, and nearly 25% will have more than one. These conditions dominate the health care system; they account for the vast majority of all hospital admissions, prescriptions filled, physician visits, and (consequently) health care spending. Team-based care holds particular promise in this climate. Numerous studies in recent years have demonstrated that pharmacist involvement in the delivery of patient care services improves patient outcomes while helping to control health care costs. This has held true across various chronic conditions, from congestive heart failure (reduced hospitalization rates, particularly for heart failure patients) to diabetes (significant reductions in patients' hemoglobin A1C levels), hypertension (significantly reduced systolic blood pressure), or dyslipidemia (significant reduction in both total and LDL cholesterol levels).

Pharmacists have long been recognized as one of the most accessible health care professionals. When a collaborative arrangement with a provider allows the pharmacist greater authority to perform medication therapy management, this accessibility helps provide greater and more convenient access to care for the patient and less disruption in medication therapy, among other benefits; downstream effects include prevention or better management of the relevant health condition, leading to better quality of life for the patient and less drain on the health care system. At the same time, delegation of appropriate functions allows prescribers

to spend more time with more critically ill patients, allowing for a more efficient overall use of resources. Moreover, pharmacists' greater accessibility can help to address the problem of medically underserved and vulnerable populations, whose health care needs might otherwise go unmet.

State Laws, Pharmacist Education

As of May 2016, 48 states (and the District of Columbia) recognize and regulate some form of prescriber-pharmacist collaborative practice authority, according to a Centers for Disease Control and Prevention 2016 team-based care resource document. But just as state laws, rules, and regulations governing a pharmacist's scope of practice vary widely from state to state, so do those addressing CPAs. Some of the variables addressed by state CPA laws and regulations include who can participate in a CPA and in what setting, what functions can be delegated, whether additional continuing education is required, and how long a CPA is valid, among other requirements and restrictions.

States may allow CPAs only within certain practice settings, or only between a single physician and a single pharmacist per agreement. But in general, states have trended to become less restrictive in some of these areas over time. For example, Arizona originally restricted the sites where a pharmacist could participate in collaborative therapy to federally qualified health centers and hospitals, and required the pharmacist to have an individual CPA with each physician, even within a single center or practice. Amendments made to the law in 2011 allow pharmacists in any practice setting to collaborate with both physicians and nurse practitioners, and agreements may include multiple prescribers. Other states, like Connecticut and Texas, have also seen some loosening in site restrictions (although Texas still does not allow CPA in the community pharmacy setting). Some states, like Maine, Nevada, or Rhode Island, explicitly allow CPAs in virtually any practice setting; others, like New York, still allow CPAs only at specific sites, like hospitals.

As a general rule – and with many state-specific variations – almost all states allow

pharmacists operating under a CPA to modify existing medication therapy, and more than three-quarters also allow them to initiate a new therapy. Nearly two-thirds of states with CPA laws allow pharmacists to order laboratory tests. While less than half explicitly allow pharmacists to perform a physical assessment or interpret laboratory tests, the CPA laws in many states do not specifically address those functions.

Meanwhile, schools and colleges of pharmacy are tasked with ensuring that tomorrow's pharmacists are prepared to adequately provide medication therapy management (MTM) services, and to work within an interprofessional team environment. Both the Accreditation Council for Pharmacy Education and the American Association of Colleges of Pharmacy consider that pharmacy graduates should be able to assess, manage, and monitor medication regimens. Thus far, MTM core elements and interprofessional education appear to have generally been incorporated more as elective and/or experiential courses rather than as core courses unto themselves – perhaps because it is assumed that the relevant concepts and skills are being acquired throughout the pharmacy curricula.

Support for the Boards

NABP has long supported a more robust utilization of the pharmacist within health care teams. In the late 1990s, the Association convened a task force to review available information on CPAs and develop model guidelines on the topic for utilization by the state boards of pharmacy. The Task Force on Collaborative Practice Agreements met in 1998, and relevant language on CPAs was subsequently incorporated into the *Model Act*.

CPA language in the *Model Act*, updated over the years, continues to provide a template for the states. It defines “collaborative pharmacy practice” as “that Practice of Pharmacy whereby one or more Pharmacists have jointly agreed, on a voluntary basis, to work in conjunction with one or more Practitioners

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Model Act Updates Address Telepharmacy Practice, PMP Data Use, Naloxone, and More



NABP recently amended the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act)* to provide the state boards of pharmacy with model language that may be used for developing state laws or board rules for purposes of protecting the public health. Amendments to the *Model Act* were incorporated as a result of the NABP Executive Committee-approved recommendations suggested by the Task Force on the Regulation of Telepharmacy Practice and the 2016-2017 Committee on Law Enforcement/Legislation. The following is a summary of the *Model Act* changes.

Telepharmacy Update

The Committee on Law Enforcement/Legislation agreed with the Task Force on the Regulation of Telepharmacy Practice that the telepharmacy regulations in the *Model Act* should be left broad to encompass advancements in technology. Committee members also agreed with some of the task force's proposed edits to the definition of "practice of telepharmacy" and recommended adding to the definition language from an associated footnote stating that telepharmacy is deemed to occur in the jurisdiction where the patient is located and the jurisdiction where the pharmacy or pharmacist are located. In addition, committee members concurred with the task force's recommendation to add the definition of "telepharmacy technologies."

The committee also recommended that specific examples of pharmacist care services be deleted from the *Model Act* to avoid including language that will become outdated as the pharmacy profession evolves and new practices emerge. Furthermore, the Practice of Telepharmacy rules section was placed under the Shared Pharmacy Services section to align with the recommendations made previously by the 2012 Task Force on Pharmacy Practice Technology Systems. The committee

“The updated *Model Act* will be available in mid-September for free download in the Publications and Reports section of the NABP website at www.nabp.pharmacy.”

also determined that the General Requirements subsection should be removed, as those requirements apply to all pharmacies and are included in other sections of the *Model Act*. Additionally, the committee decided that the wording addressing requirements for remote dispensing site locations should be less specific and recommended removing detailed requirements for staffing, record-keeping, signage, and technology.

Emergency-Use Medications

The Committee on Law Enforcement/Legislation also recommended that *Model Act* language be amended using language from a memo sent by NABP to state boards of pharmacy regarding emergency-use medications, such as epinephrine auto-injector products. The memo encouraged boards to adopt or modify their position on beyond-use dates printed on prescription labels and allow pharmacies to dispense such products through the manufacturers' expiration date. According to the committee, doing so enhances the availability of and access to such drugs in an emergency and decreases the financial burden of patients. Therefore, a footnote was added to the *Model Act* that states boards of pharmacy may determine that "use-by" dates do not apply to all drugs.

Increased Patient Access to Naloxone

Members of the Committee on Law Enforcement/Legislation agreed that, in light of the opioid epidemic gripping many states across the country, pharmacists should have individual prescriptive authority to prescribe and dispense naloxone to expand access and protect public health. Furthermore, the committee agreed that pharmacists should

be able to facilitate the delivery of medication needed in an emergency to prevent injury or death. Therefore, amendments were made to the *Model Act* to grant pharmacists authority to dispense other emergency medication based on the potential for harm reduction and confounding factors such as geography.

PMP Data Use

In response to Resolution 112-3-16, Utilization of PMP and Other Data to More Accurately Measure and Report the Scope of Prescription Drug Abuse, members of the Committee on Law Enforcement/Legislation reviewed *Model Act* amendments to support providing prescription monitoring program (PMP) data to appropriate entities to evaluate data impacting the identification and reporting of prescription drug injuries and deaths. The committee determined that the suggested language in the footnote granting PMP data access to entities that study the reporting of drug injuries and deaths be edited and moved within the body of the Model Prescription Monitoring Program Act, which is included in the *Model Act*. Furthermore, the committee recommended that other appropriate entities include agencies listed in the footnote, such as drug courts, district attorneys' offices, addiction treatment professionals, etc. The committee recommended removing "as determined by the Board of Pharmacy" following other appropriate entities to be more encompassing.

Prescription Container Labeling

After reviewing the revised United States Pharmacopeia (USP) General Chapter <17> Prescription Container Labeling, the Committee on Law Enforcement/Legislation added a footnote to the *Model Act* to indicate that alternative-access methods

may be used to convey critical information to visually impaired patients or caregivers. Furthermore, the committee agreed with the USP recommendation that directions for use should be simplified. Therefore, committee members added a second footnote to the Labeling subsection to encourage using the universal medication schedule and standardized time periods.

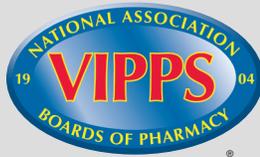
Additional Updates

Amendments were also made to the *Model Act* to address a state request to define NABP e-Profile ID as a means to facilitate the adoption of such language into state rules that require the collection of e-Profile ID numbers. In addition, amendments were made to align with NABP competency assessment policies.

After being informed about NABP's initiative to develop a specialty pharmacy accreditation program, committee members determined that the suggested definitions for "Specialty Pharmacy" and "Specialty Pharmacy Practice" were appropriate for inclusion into the *Model Act*.

Further, after reviewing Food and Drug Administration's (FDA's) definition of "adulterated drugs and devices" in FDA's *Insanitary Conditions at Compounding Facilities Guidance for Industry* document, the Committee on Law Enforcement/Legislation agreed to add an additional reference to insanitary conditions in the Quality Assurance subsection that encompasses the principles elucidated in the FDA guidance document.

The updated *Model Act* will be available in mid-September for free download in the Publications and Reports section of the NABP website at www.nabp.pharmacy. ■



Newly Accredited VIPPS Facilities

The following internet pharmacies were accredited through the NABP Verified Internet Pharmacy Practice Sites® (VIPPS®) program:

**Carepoint Healthcare, LLC, dba
Carepoint Pharmacy**
www.carepointrx.com

Empire Specialty Pharmacy Corp
www.empiresrx.com

A full listing of the accredited VIPPS pharmacy sites representing more than 12,000 pharmacies is available on the NABP website at www.nabp.pharmacy.



2018 PCOA Testing Windows

The 2018 Pharmacy Curriculum Outcomes Assessment® (PCOA®) testing windows are:

- **January 15, 2018 – February 16, 2018**
School registration deadline: October 17, 2017
- **April 9, 2018 – May 10, 2018**
School registration deadline: January 8, 2018
- **June 18, 2018 – June 29, 2018**
School registration deadline: March 21, 2018
- **August 20, 2018 – September 14, 2018**
School registration deadline: May 23, 2018
- **November 12, 2018 – December 7, 2018**
School registration deadline: August 13, 2018

More information about the PCOA, including registration details, is available in the Programs section of the NABP website at www.nabp.pharmacy.

Interprofessional Practice

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under protocol and in collaboration with Practitioner(s) to provide patient care services to achieve optimal medication use and desired patient outcomes.” In keeping with the original task force’s assessment, the model regulation’s wording remains broad enough to encompass the individual nature of each CPA while addressing such important topics as the requirement for the practitioner involved to be collaborating within the scope of his or her current practice, documentation requirements that allow collaborated, integrated care with other health care professionals while protecting information privacy, and the content areas required by any CPA (such as identification of the agreeing parties; functions the pharmacist may perform; processes to initiate care; methods for the practitioner to monitor compliance and outcomes, and intercede with or override treatment decisions; description of a

continuous quality improvement program to evaluate effectiveness and ensure positive patient outcomes; and procedures to cancel or review/renew the agreement).

NABP is also supporting team-based care – and its attendant public health benefits – through participation in the Tri-Regulator Collaborative, an initiative that includes NABP, the Federation of State Medical Boards, and the National Council of State Boards of Nursing. In keeping with the three associations’ focus on patient health and safety, the Collaborative issued a position statement in 2014, endorsing “a team-based approach to patient care that utilizes the education, training, expertise, and abilities of individual team members in order to deliver health care that is efficient, interprofessional, cost-effective, and evidence-based.” Through conferences and ongoing information sharing, the

Collaborative’s members continue to discuss how to maximize collaboration among licensees as a means of improving patient access to care and outcomes. The Collaborative met most recently in July 2017.

Team-based health care, conducted either with or without formal CPAs, continues to hold great promise as an effective approach to the prevention and management of chronic disease, benefiting both patient care and health system efficiency. As these efforts continue to expand, they will present new challenges to state boards in their mission to protect the public health. NABP will continue to inform its members of new developments and support them as they deal with this promising evolution. ■

VPP Participation Continues to Grow as More States Require Inspections for Nonresident Pharmacies

Applications for NABP's Verified Pharmacy Program® (VPP®) have increased throughout 2017 due to additional states recognizing VPP as a resource for conducting qualified inspections of nonresident and resident compounding pharmacies. VPP inspections provide verified data on pharmacy operations and are performed by registered pharmacists who are experts in the practice and regulation of pharmacy. NABP inspectors are highly qualified RPhs with careers in various specialties of pharmacy practice including hospital, retail, infusion, and nuclear. Additionally, while all have pharmacy practice experience, many are also current or former state officials involved in the regulation of pharmacy. As the program continues to grow, boards of pharmacy now have more verified data available in NABP e-Profile Connect. Specifically, boards of pharmacy can access a facility's profile in e-Profile Connect, which can help boards make nonresident licensure decisions.

At press time, almost 700 pharmacies have sought VPP inspections. Verified data on these inspections is, or soon will be, available for boards to view. More than 130 pharmacies have

reapplied to undergo a second or third inspection. Information obtained on pharmacies through the VPP pharmacy inspection process revealed the following:

- 287 pharmacies engage in only nonsterile compounding;
- 88 pharmacies engage in only sterile compounding (four of which are also registered as outsourcing facilities);
- 238 pharmacies engage in both sterile and nonsterile compounding (five of which are also registered as outsourcing facilities);
- 86 pharmacies are general retail or mail-order pharmacies with no compounding; and
- 12 pharmacies are nuclear pharmacies.



VPP facilitates the communication of important inspection and licensure information among the state boards of pharmacy and serves as an information hub that provides verified data to support the boards' licensure processes for nonresident pharmacies.

To learn more about VPP or the inspection sharing network, contact the NABP VPP team at vpp@nabp.pharmacy. ■

Most States Recognize VPP

To date, 48 boards now recognize the Verified Pharmacy Program® (VPP®) as meeting their state inspection requirements for nonresident pharmacies. In addition, a growing number require VPP as a component of achieving licensure in certain cases. See the November/December 2016 issue of *Innovations* for more details on how states are utilizing VPP.

Kansas State Board of Pharmacy Wins Survey of Pharmacy Law Luncheon Drawing

NABP would like to congratulate the Kansas State Board of Pharmacy for winning the 2018 *Survey of Pharmacy Law* Luncheon Drawing. The Board was awarded \$175 toward a Board member and staff luncheon for returning updates to the *Survey* by the July 27 deadline. These important updates are requested annually by NABP from all boards

of pharmacy for inclusion into each updated issue of the *Survey*. NABP would like to thank all boards for their participation, which makes the publication a valuable resource for many.

Revised and published each December, the *Survey of Pharmacy Law* serves as a convenient

reference source for individuals seeking an overview of laws and regulations that govern pharmacy practice in 53 jurisdictions. More information about the *Survey* is available in the Publications and Reports section of the NABP website at www.nabp.pharmacy. ■

Kentucky Addresses Immunizations, Prescription Consolidation, and DQSA

During the 2017 Kentucky legislative session, Governor Matt Bevin signed into law the following pharmacy-related bills.

- Immunizations: Senate Bill (SB) 101 gives pharmacists increased authority to administer vaccinations recommended by the Centers for Disease Control and Prevention via protocol beginning at age nine. Current Kentucky law allows pharmacists to administer only the flu vaccine to children starting at age nine, and this change brings all other age-appropriate vaccinations in line with the flu vaccine.
- Consolidation of Prescription and Refills: SB 205 allows a pharmacist in his or her professional judgment to consolidate a prescription for a non-controlled maintenance medication written with refills into no more than a 90-day supply. A pharmacist can currently consolidate prescription medication for a 30-day supply with two refills, but he or she must contact the prescriber before making such a change.
- Pharmaceutical Drug Supply Chain: House Bill (HB) 364 allows the Kentucky Board of Pharmacy to create classifications to parallel the Drug Quality Security Act (DQSA) of 2013. The Board will be developing the licensure requirements for third-party logistics providers, outsourcers (503B), and virtual manufacturers. The law also gives a classification for medical gas wholesalers. As the DQSA moves away from pedigrees to a track-and-trace model, there will be changes in the wholesale distributor license.

Montana Passes Pharmacy-Related Bills

The 2017 Montana legislative session passed several pharmacy-related bills that were signed into law by Governor Steve Bullock.

- HB 141 provides licensing boards with active supervision in antitrust liability cases. This Montana Department of Labor and Industry bill clarifies oversight and active supervision regarding actions of all boards pursuant to a United States Supreme Court decision.
- SB 68 revises the current single wholesale drug distributor license type through the Montana Board of Pharmacy to four separate license types of wholesale distributor, third-party logistics provider, repackager, and manufacturer (such license types are currently all licensed as wholesaler drug distributors) and defines sterile compounding outsourcing facilities. This bill also provides authority to comply with federal law and implement Food and Drug Administration requirements for security and safety of the drug supply chain.
- HB 177 revises administration of immunization laws and clarifies the list of immunizations that pharmacists can independently prescribe and administer without a

collaborative practice agreement, allowing for any pneumococcal vaccine (37-7-105, Montana Code Annotated).

- HB 276 revises reimbursement for pharmacies, provides greater price transparency from pharmacy benefit managers when claims are less than the acquisition cost of a drug (negative claim), allows for an opt-out of providing the prescription or service, and provides for a pharmacist to discuss reimbursement criteria with a patient.
- HB 323 authorizes emergency use of an opioid antagonist in a school setting and identifies a school as a patient for access to naloxone.
- HB 333 adopts the Help Save Lives from Overdose Act, which provides greater access to naloxone by identifying certain facilities/others as a patient, allows for a statewide standing order (in addition to existing prescription and collaborative practice authority), and addresses liability issues.

Wyoming Revises Naloxone and Telepharmacy Rules

The following statute changes from the 2017 Wyoming legislature became effective July 1, 2017.

- Senate File (SF) 0042 allows a practitioner or a pharmacist acting in good faith and exercising reasonable care, without a prescriber-patient relationship, to prescribe an opiate antagonist to a person at risk of experiencing an opiate-related drug overdose; a person in a position to assist a person at risk of experiencing an opiate-related drug overdose; and a person who, in the course of the person's official duties or business, may encounter a person experiencing an opiate-related drug overdose. Further, a pharmacist who prescribes an opiate antagonist shall provide education and is personally immune from civil or criminal liability for any act or omission resulting in damage or injury.
- SF 0062 removes the requirement for a telepharmacy to be located in a medical clinic or community health center; reduces the restriction of 25 miles' distance from a retail pharmacy to 10 miles, with no mileage restriction in Natrona or Laramie counties; and allows dispensing by using a lockable cabinet, by unit of issue packaging, or by manually dispensing from a stock bottle into a vial. The legislation also requires a pharmacist to complete an on-site inspection of the telepharmacy. ■

AVMA Warns Pharmacists and Pet Owners About Xylitol Pharmaceutical Products

Pharmaceutical products containing xylitol may be dangerous and fatal to dogs, warns the American Veterinary Medical Association (AVMA). Xylitol stimulates an insulin release that can result in severe hypoglycemia and fatal liver damage. Pharmacists and pet owners need to be aware of and protect against xylitol toxicoses, indicates AVMA. Food and Drug Administration (FDA)-approved gabapentin capsules and tablets do not contain xylitol, but the liquid form does. In addition, xylitol-containing media might be used in compounding products if the pharmacist is uninformed about not using it.

AVMA urges pharmacists to not use xylitol-containing products when compounding for canine patients and to contact the veterinarian if a prescribed product contains xylitol. The veterinarian may be unaware that this sweetener is in the product. AVMA also encourages pet owners and caretakers to verify with the pharmacist when picking up their dog's medication at a human pharmacy that the medication does not contain xylitol. Xylitol-containing peanut butter should not be used to help a dog take its medication.

For more information, visit atwork.avma.org/2017/05/30/eliminate-xylitol-from-canine-prescriptions.

CDC Publishes Guide to Help Pharmacists Initiate CPAs With Prescribers

Centers for Disease Control and Prevention (CDC) published a guide that provides pharmacists with information and resources to empower them to initiate collaborative practice agreements (CPAs) with collaborating prescribers. The guide, *Advancing Team-Based Care Through Collaborative Practice Agreements: A Resource and Implementation Guide for Adding Pharmacists to the Care Team*, contains a sample CPA and sample language that can be customized by pharmacists and prescribers using their specific state laws to create a CPA. Cardiovascular disease and hypertension were used as examples of disease states that can be managed using a CPA, but the concepts presented in the guide can also be applied to many other chronic conditions, treatments for acute illness, and preventive health measures. The guide is available at www.cdc.gov/dhdsp/pubs/docs/CPA-Team-Based-Care.pdf.



DEA Releases New Edition of Drugs of Abuse Resource Guide

Drug Enforcement Administration (DEA) released the 2017 edition of *Drugs of Abuse, A DEA Resource Guide*, which serves as a resource on the most commonly abused and misused drugs in the United States. The latest edition, which is an update to the 2015 publication, describes the consequences of drug use, a drug's effects on the body and mind, overdose potential, origin, legal status, and other key facts. It also includes the most current information on new and emerging trends in drug misuse and abuse, including fentanyl, other opioids, and synthetic drugs. The 2017 edition can be found at www.dea.gov/pr/multimedia-library/publications/drug_of_abuse.pdf.

FIP Highlights Pharmacists' Roles in Reducing Drug-Related Harm

During the 70th World Health Assembly in Geneva, Switzerland, the International Pharmaceutical Federation (FIP) informed attendees about pharmacists' efforts to reduce drug-related harm. FIP highlighted pharmacists' contributions to needle exchange programs, opioid substitution therapy, promoting responsible use of medicines with high risk of addiction, and educational campaigns in Portugal, France, and the US. FIP requested to have pharmacists' perspectives and experiences included in the World Health Organization mechanism for surveillance of psychoactive substances. Additional information is available in the FIP press release, which can be found at www.fip.org in the News and Publications section. ■

Health care providers and patients are encouraged to report adverse events or quality problems to FDA's MedWatch Safety Information and Adverse Event Reporting Program at www.fda.gov/MedWatch.



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UPCOMING EVENTS

PARE Administration

September 12-22, 2017

NABP/AACP Districts 1 & 2 Meeting

September 14-16, 2017

Groton, CT

Task Force on Definition of a Patient-Pharmacist Relationship

September 18-19, 2017

NABP Headquarters

NABP Interactive Executive Officer Forum

October 3-4, 2017

NABP Headquarters

FPGEE Administration

October 10, 2017

NABP/AACP Districts 6, 7, and 8 Meeting

October 8-11, 2017

San Antonio, TX

NABP/AACP District 4 Meeting

November 1-3, 2017

Toledo, OH

NABP Interactive Compliance Officer & Legal Counsel Forum

November 29-30, 2017

PARE Administration

December 5-16, 2017