As reported in the May/June 2001 NABP Newsletter, NABP and the American Pharmaceutical Association (APhA) have joined forces to create a one-stop Web portal that will be “the Internet home to pharmacists and the practice of pharmacy.” The results of this collaboration will be showcased when pharmacist.com is launched in late October 2001.

In a recent speech, NABP President Richard K. “Mick” Markuson described pharmacist.com as “the portal, or gateway, to an interactive, online, activity zone offering breaking pharmacy news; a relicensure facility for pharmacists; a center with Web-based career information tools and job postings; a complete suite of continuing education services that may be completed and graded online; an online drug information center; and online practice exams for NABP-produced competency assessment examinations.”

In addressing the joint effort between NABP and APhA, APhA’s Executive Vice President, John A. Gans, PharmD, says that “We’ve always found that our efforts are stronger and reach farther when we collaborate with the right partners. This Web site will join the capabilities of two great associations to provide the profession with top-notch services, developed by pharmacists, for pharmacists.”

Together NABP and APhA will monitor and update the site to ensure that it continues to serve the public and the pharmacy community. Both associations will provide components to the Internet portal. APhA will provide the continuing education (CE) section, which is scheduled to be activated first. Through the online order mechanism, pharmacists will be able to complete their CE programs and obtain real-time scoring. In addition, APhA’s online drug information center will allow pharmacists access to drug database information and information about breaking drug issues. NABP’s contributions to pharmacist.com will include an online relicensure facility (NABP’s Renewal and Application Process [RAP]) that will allow pharmacists and pharmacies to renew their licenses with their state boards of pharmacy.

Pharmacist.com will not replace either NABP’s or APhA’s individual Web sites; rather, it will expand and enhance the services currently offered by the two organizations to practicing pharmacists, members of the profession, and the public.

Future Looks Bright for pharmacist.com

September 11, 2001

NABP offers its heartfelt prayers and condolences to the families and friends of the victims of the tragedy in New York, Washington, DC, and Pennsylvania.
Disease State Management Exam Program Evolves

Pharmacists who have earned credentials through the National Institute for Standards in Pharmacist Credentialing (NISPC), by passing one or more of the Disease State Management examinations, now qualify for the designation “Certified Disease Manager” (CDM).

NISPC, which utilizes examinations developed by NABP to credential pharmacists in diabetes, asthma, and anticoagulation therapy, is making some modifications to its DSM exam program.

Reinstatement of Paper-and-Pencil Format

In response to requests from organizations wishing to offer the DSM exams to groups of pharmacists, NISPC will now provide DSM examinations in both computer-based and paper-and-pencil formats.

The first of the new paper-and-pencil administrations was October 15 and 16, during the National Community Pharmacists Association’s (NCPA) Annual Convention in Philadelphia, Pa. The paper-and-pencil exams will also be offered at the American Pharmaceutical Association (APhA) Annual Convention in Philadelphia in March 2002.

“We are excited about the reinstatement of the paper-and-pencil exams,” said Eleni Z. Anagnostiadis, RPh, executive director of NISPC. “Many pharmacists expressed a preference for taking the DSM exams in the paper-and-pencil format and are pleased with the Board’s decision.”

NABP President Richard K. “Mick” Markuson agrees, noting, “There has been a great deal of interest from companies, organizations, and professional associations who want to offer these exams to a group of pharmacists.” An added benefit of the paper-and-pencil format is that it enables the DSM exams to be administered in conjunction with continuing education programs, which are usually provided in a group setting.

NISPC will continue to offer DSM examinations at Laser Grade test centers across the country. The computer-based format has the advantage of providing an access file and conversion testing experience for pharmacists interested in earning their CDM.

New Fee Structure

Effective October 20, 2001, the DSM examination fees will increase to:
- $250 for one exam
- $400 for two exams
- $550 for three exams
- $650 for four exams

Multiple-exam discounts may be taken when a pharmacist registers for two or more exams on the same registration form. These fees apply to both the computer-based and paper-and-pencil exams and include the NISPC certification.

Dyslipidemia Discontinued

The NISPC Board of Directors has decided to “indefinitely discontinue the administration of the dyslipidemia exam. No registrations for the dyslipidemia exam are being accepted at this time.” NABP has been requested to perform a feasibility study for the creation of a cardiovascular examination, which will include dyslipidemia.

NISPC was established in 1998 by APhA, NABP, the National Association of Chain Drug Stores (NACDS), and NCPA to create nationally recognized, disease state management credentials for pharmacists. Since 1998, NISPC has credentialled nearly 1,000 pharmacists nationally in anticoagulation therapy, asthma, diabetes, and dyslipidemia.
FDA Restricts Dispensing of Mifepristone

Although the use of mifepristone (trade name Mifeprix™, previously known as RU-486) was approved by the Food and Drug Administration (FDA) in September 2000, the method by which women can receive the drug is restricted, causing confusion among physicians and pharmacists, specifically about the dispensing and administration of the product.

Under federal law, only physicians with the following qualifications, or health care practitioners under the supervision of those qualifying physicians, can administer the drug to their patients:

- Ability to accurately assess the duration of the pregnancy.
- Ability to diagnose ectopic pregnancies.
- Ability to provide surgical intervention in cases of incomplete abortion/severe bleeding, or have made plans to provide such care through other parties and are able to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation if necessary.
- Has read and understood the prescribing information on mifepristone.

The distribution of mifepristone is subject to specific requirements that are imposed by the distributor, including procedures for storage, dosage tracking, and damaged product returns.

Mifepristone is only supplied to licensed physicians who sign and return a Prescriber’s Agreement.

In addition to these qualifications, the qualified physician must provide mifepristone in a manner consistent with the following guidelines:

- Under federal law, each patient must be provided with a Medication Guide, a leaflet that contains FDA-approved information written especially for patients. The FDA determined that such a guide was necessary for women to use mifepristone effectively and safely. The patient should also receive a copy of the Patient Agreement form.
- The physician must ensure that the patient fully understands the details, consequences, and side effects of the procedure.
- Physicians must obtain the patient’s signature on the Patient Agreement form, as well as sign the form themselves.

Other equally important guidelines in the administration of mifepristone concern recordkeeping and follow-up visits for each patient.

- The physician must meet with the patient for a follow-up appointment approximately 14 days after the patient ingested the drug to confirm that a complete termination of pregnancy has occurred and that there are no complications.
- The physician must notify Danco Laboratories, the sole distributor of mifepristone, in writing, in the event an ongoing pregnancy was not terminated subsequent to the conclusion of the treatment procedure.
- The physician must report any serious adverse events and/or hospitalization, transfusion, etc., identifying the patient by package serial number to ensure patient confidentiality.
- Finally, the physician must keep the serial number of the mifepristone package in the patient’s file for recordkeeping purposes.

Mifepristone is an anti-progestrone drug that blocks receptors of progesterone, a key hormone in the establishment and maintenance of human pregnancy. Mifepristone is taken orally followed by misoprostol, a prostaglandine analogue that causes uterine contraction that helps end pregnancy.

Both the drug sponsor and the 1996 Reproductive Drug Products Advisory Committee have recommended that the FDA restrict distribution of mifepristone to “qualified” doctors. The FDA concluded that these restrictions are necessary for use of the drug.
Legal Briefs

“Notice” Anything Missing?

By Dale Atkinson, JD

The due process clauses of the state and the US Constitu-
tions generally provide for certain protections to
licensees and applicants for licensure of the
various professions. Once
obtained, individuals have a
property interest in their
professional license and are
protected by certain due
process rights prior to any
adverse action taken against
such license. At least one
element of due process afforded
to licensees is appropriate
notice of charges made by a
board against a practitioner in
an administrative proceeding.
Licensees are entitled to
appropriate notice so that they
may prepare a defense to the
pending administrative proceed-
ing. Improper or inadequate
notice may provide grounds for
reversal or remand of board
action if contested within the
judicial system.

In response to a report received
from the Columbus Division of
Police, Narcotics Bureau,
regarding an alleged theft of
controlled substances from a
pharmacy, an audit was
undertaken by the Ohio State
Board of Pharmacy. Eventual
testimony revealed that the
audit identified a shortage of
more than 80,000 doses of
controlled substances. The
investigation by the Board also
revealed that the responsible
pharmacist, the full-time and
part-time nonregistered phar-
macy technicians, and the
registered pharmacist and
owner of the pharmacy all
denied knowledge of any thefts
or unauthorized entries into
the pharmacy during the period
of time subject to the audit.
Testimony also revealed that
neither the Board nor the
police department ever deter-
mimed precisely what happened
to the missing drugs. Appar-
ently there were no break-ins
reported and no evidence
suggested that someone other
than one of the pharmacy’s
employees removed the drugs.

Testimony also revealed that
the responsible pharmacist
slept part of the time while on
duty and the nonregistered
pharmacy technician placed
the majority of drug orders,
supervised the day-to-day
operations, and occasionally
worked in the pharmacy
without a pharmacist present.
Furthermore, college students
were employed to prepackage
controlled substances, part-
time pharmacists covered the
pharmacy when the responsible
pharmacist was not on duty,
and the owner visited the
pharmacy only “about once a
month.” Based upon these
facts, a conclusion was drawn
by the Board that the drugs
must have been stolen by one
of the employees.

Accordingly, the licensed
terminal distributor of danger-
ous drugs (pharmacy) under the
Ohio Revised Code was provided
with a “Notice of Opportunity
for Hearing” based upon alleged
violations of the relevant
practice act. Such allegations
included, among other charges,
that the pharmacy:

... did knowingly sell controlled
substances in amounts
exceeding 50 times the bulk
amount ... and sold con-
trolled substances without
prescriptions and not for a
legitimate medical purpose ...

... did knowingly sell con-
trolled substances in an
amount exceeding five times
the bulk amount but not
exceeding 50 times the bulk
amount ... and sold the
controlled substances
without prescriptions and
not for a legitimate medical
purpose ...

... failed to keep a record of all
controlled substances
received or dispensed by the
pharmacy ...

... failed to provide effective
and approved controls and
procedures to guard against
theft and diversion of
dangerous drugs ... and

... failed to maintain the
minimum standards for a
pharmacy, to wit: pharmacy
did not possess a copy of
current federal and state
laws, regulations and rules
governing the legal distribu-
tion of drugs in Ohio.

Upon conclusion of the admin-
istrative hearing, the Board
issued an order revoking the
terminal distributor license of
the pharmacy. In its findings of fact, the Board substantially repeated the allegations contained in the Notice of Opportunity for Hearing. The pharmacy appealed the order of the Board. The Court of Common Pleas affirmed in part and reversed in part the order of the Board. In short, and among other findings, the court upheld the decision by the Board that the pharmacy failed to keep a record of all controlled substances received or dispensed by the pharmacy. Additional grounds supporting the revocation of the license were also upheld by the Court of Common Pleas.

The matter was appealed to the Court of Appeals by the pharmacy. On appeal, the pharmacy argued many issues. Of significance was a contested issue for appeal by the pharmacy that the Board's order was based upon grounds not charged in the Notice of Opportunity for Hearing, thereby depriving the pharmacy of due process of law. In review, the pharmacy was charged with violating applicable Ohio law by failing to keep a record of all controlled substances “received or dispensed” by the pharmacy. Based upon this language and other charges, the Board interpreted the conclusions of the audit that employees of the pharmacy sold or stole controlled substances but failed to keep a record of such activities.

While the Court of Common Pleas upheld the Board’s order based upon the failure of the pharmacy to maintain a record of the missing drugs, the Appellate Court noted that such a finding improperly altered the Board’s allegation in its notice from a specific charge geared to the sale of drugs to a charge that the pharmacy failed to track stolen controlled substances. According to the Appellate Court, the lower court ignored the plain language set forth in the specific paragraph of the Notice of Opportunity for Hearing, which did not mention failure to keep a record of stolen drugs as a basis for violating applicable law.

According to the Appellate Court, nowhere in the plain language of either the statute or rule does the Board require that a terminal distributor of dangerous drugs keep a record of controlled substances that have been stolen, misappropriated, or lost from the pharmacy. Because the Board could not and did not prove that the pharmacy “sold” the drugs and, if so, failed to keep adequate records of such “sales,” the notice was fatally flawed. Further, and because no individual could be identified as the party who removed the large quantity of drugs from the premises, there was no proof that the drugs were “transferred.” Accordingly, based on the conclusion that evidence of record did not support the violation charged within that portion of the notice, the Appellate Court held that the Court of Common Pleas abused its discretion in affirming that portion of the Board’s order.

It must be noted that additional charges against this pharmacy were upheld relative to record-keeping violations. However, the matter was remanded to the lower court for further proceedings in accordance with the appellate court opinion.

Boards of pharmacy must be keenly aware of the language within the statute and the strict interpretation of such statutory verbiage. If an investigation reveals that additional or modified charges must be made relative to an administrative proceeding, boards must modify the “charges” or notice to ensure an appropriate opportunity to prepare by the respondent licensee. Final orders administered by a regulatory board that do not coincide with the formal charges may be subject to legal scrutiny and potential reversal by the courts. 

Linden Medical Pharmacy, Inc v. Ohio State Board of Pharmacy, 2001 WL 477150 (Ohio App. 10th Dist. 2001).

Notice Rule 2 of the Ohio Supreme Court Rules for the Reporting of Opinions Imposes Restrictions and Limitations on the Use of Unpublished Opinions.

Attorney Dale J. Atkinson is a partner in the law firm of Atkinson & Atkinson, counsel for NABP.
Solving the OxyContin Abuse “Crisis”

By David B. Brushwood, JD, RPh

Media attention on reported OxyContin® abuse has led law enforcement authorities in many states to the conclusion that a growing crisis exists with opioid addiction and that state health care regulators should more seriously involve themselves in the search for a solution to this problem. Politically correct lip service is being paid to the idea that “drugs do not cause drug abuse” and that “no specific product should be singled out.” Great care is taken (sometimes) to guard against interference with legitimate pain patients. But the message from law enforcement authorities is clear: health care regulators should find a workable internal solution to the problem, or a solution will be found by others, and the external solution could be an unattractive one for the health care professions.

On August 29, at a meeting of the Florida Board of Medicine Quality Assurance Committee, my state began its formal, coordinated efforts to solve the problem of OxyContin abuse. Florida Attorney General Bob Butterworth addressed the committee and suggested that OxyContin should be withdrawn from the market by the Food and Drug Administration (FDA) until it can be reformulated to prevent abuse. A representative of the state “drug czar” cited a “tremendous number of overdose deaths” from OxyContin. He indicated that his office’s concern is “creating a system that will prevent drug abuse in the future.” A state senator, who chairs the Florida Senate’s Criminal Justice Committee, grilled the executive director of the Florida Board of Pharmacy regarding the steps being taken by the Pharmacy Board to address the problem of inappropriate opioid prescribing. Pharmacists in the audience shook their heads, breathed a deep sigh, and began to perspire a bit. The law enforcement authorities had made their point. There is a problem with substance abuse, and we are a small part of the problem. We are also a big part of the solution.

Clearly, the time has come for the pharmacy profession to collaborate with law enforcement authorities, and with other health care professions, in the development of a more effective but balanced approach to opioid regulation. We hold the key to the medicine chest and, while we need to lock the chest when inappropriate requests are made of us, we need to open the chest when legitimate patients in need of pain relief seek our products and services. How can we all work together to make sure that the medicine chest is closed when it should be and open when it must be? The Florida meeting provided these suggested solutions:

**The Education Solution**

Dr Gary Winchester, chairman of the Florida Board of Medicine’s Quality Assurance Committee, opened the meeting by referring to the Florida Board of Medicine guidelines on the use of controlled substances for pain. These guidelines have been adapted from a template produced by the Federation of State Medical Boards. With regard to the guidelines, Dr Winchester said: “If physicians knew about these guidelines and followed them, our problems would disappear.” Clearly, part of the opioid problem is that health care providers do not have a sufficient understanding of appropriate pain management. Educational programs could effectively address this deficiency.

**The Information Solution**

No matter how well a health care practitioner understands the basic concepts of pain management, if the practitioner does not have complete information about a patient’s medication use, there is the possibility that opioid analgesics will be inappropriately prescribed, dispensed, and administered. At the meeting there
was a great deal of interest in developing an electronic database of information regarding opioid prescribing, so that physicians could quickly know, prior to prescribing an opioid, whether another physician had prescribed a similar opioid for the same patient in the not-too-distant past.

■ The Technology Solution
There were several interesting suggestions about technological fixes for this social problem. The use of tamper-resistant prescription containers or packages is one idea that generated interest, as well as the product reformulation to which the Florida attorney general referred. Apparently, Purdue Pharma has a “blueprint” for an OxyContin product in which they could embed beads of naltrexone that would only release if the product were crushed or chopped. This formulation would prevent both oral and intravenous abuse of the product.

■ The Coordination Solution
It was obvious at the meeting that law enforcement authorities were learning a lot from health care regulators and that health care regulators were learning a lot from law enforcement authorities. Criminal prosecutions and administrative actions against licenses did not always seem to be coordinated. There was frustration expressed on both sides about lack of cooperation between each other. Periodic meetings between law enforcement and health care regulators seem to be a productive solution to the problem of the lack of coordination. These meetings would have to be frequent because new developments in substance abuse and patient care are constantly evolving.

■ The Standardization Solution
Health care practitioners who want to “do the right thing” for their patients may wonder what the right thing is. They may feel at risk for regulatory oversight if they prescribe or dispense large quantities of opioids, uncertain about what regulators expect of them. As part of the educational programs for health care providers, clear standards should be provided, and practitioners should be given a means for comparing their practices with the standards.

■ The Enforcement Solution
Everyone attending the meeting seemed to be in agreement that there are two different circumstances under which opioid analgesic medications are diverted by prescription. First, there are a few licensed physicians who have simply ended their legitimate practices and are creating bogus pain management clinics, at which prescriptions are sold with no pretense of quality care. Second, there are compassionate and caring physicians who are periodically duped into prescribing opioids for addicts or dealers, believing these people to be legitimate patients. Law enforcement authorities indicated that the effective prosecution of the first group is difficult because the offenders claim to be within the second group. All agreed that one result of improved coordination could be more effective enforcement directed toward the first group.

■ The Promotion Solution
Criticism of the pharmaceutical industry centered on the promotion of opioids for appropriate pain management, without accompanying cautions regarding diversion prevention. Stories were told of sales representatives who were well versed in the pharmacologic aspects of their medications but not well informed of the regulatory challenges for their products. While an institutional focus at many manufacturers does include the regul-
The Institute of Medicine’s (IOM) recently released *Crossing the Quality Chasm: A New Health System for the 21st Century* follows up on the revelations of its 1999 report *To Err is Human: Building a Safer Health Care System*, with a discussion of the growing demand for changes in the American health care delivery system’s approach to the quality of health care.

According to the new report, “The American health care delivery system is in need of a fundamental change. Many patients, doctors, nurses, and health care leaders are concerned that the care delivered is not, essentially, the care we should receive. Health care today harms too frequently and routinely fails to deliver its potential benefits.”

**Better Quality Health Care Needed Now**

*Crossing the Quality Chasm* reports that health care safety and quality problems exist because of outdated work systems. “If we want safer, higher-quality care we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes,” says the report.

Transforming the health care system will not be an easy task. The committee has proposed the following agenda for redesigning the 21st Century health care system:

- That all constituencies commit to a national statement of purpose for the health care system as a whole and to a shared agenda of six goals for improvement that can raise the quality of care to unprecedented levels;

- That the Department of Health and Human Services (HHS) set priority conditions, which focus on initial efforts, provide resources to provoke innovation, and initiate the change process;

- That health care organizations should design and implement more effective organizational support processes to make the change in the delivery of care possible; and

- That purchasers, regulators, health professions, educational institutions, and the HHS should create an environment that fosters and rewards improvement by 1) creating an infrastructure to support evidence-based practice, 2) facilitating the use of information technology, 3) aligning payment incentives, and 4) preparing the workforces to better serve patients in a world of expanding knowledge and rapid change.

The “six aims for improvement” the committee proposed are 1) Safety, 2) Effectiveness, 3) Patient-centeredness, 4) Timeliness, 5) Efficiency, and 6) Equitability.

The committee endorses and adopts the words of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998), which appear in their report as 13 recommendations for better health care.

**The Recommendations**

**Recommendation 1:** All health care organizations, professional groups, and private and public purchasers should adopt the definite purpose to reduce illness, injury, and disability to improve the health and function of the United States population.

**Recommendation 2:** All health care organizations, professional groups, and private and public purchasers should adopt the six aims listed above. Without some sort of tracking system that checks for the achieving of these six aims, progress would be difficult to determine.

**Recommendation 3:** Congress should continue to accredit and receive funds for, and the HHS should move forward with, the establishment of monitoring and tracking processes used to evaluate the progress of the health system in pursuit of the six aims.

**Recommendation 4:** The redesign of the health care process should follow these 10 rules 1) Care based on continuous healing relationships, 2) Customization based on patient needs and values, 3) The patient as the source of control, 4) Shared knowledge and the free flow of information, 5) Evidence-based decision making, 6) Safety as a system property, 7) The need for transparency, 8) Anticipation of
needs, 9) Continuous decrease in waste, and 10) Cooperation among clinicians.

Even though these steps can be implemented immediately, the complete application will require a commitment to evidence-based care geared toward an individual patient’s needs and preferences. In order to change the health care delivery process, the report explains that more attention needs to be focused on the development of care processes for the common conditions that afflict many people. According to the most recent Medical Expenditure Panel Survey, the top 15 priority conditions are cancer, diabetes, emphysema, high cholesterol, HIV/AIDS, hypertension, ischemic heart disease, stroke, arthritis, asthma, gall bladder disease, stomach ulcers, back problems, Alzheimer’s disease and other dementias, and depression and anxiety disorders.

**Recommendation 5:** Strategies, goals, and action plans to improve quality should be developed over the next five years for each of the listed conditions. Priority should be given to possible projects that may result in new programs, tools, and technologies that are applicable throughout the health care sector.

**Recommendation 6:** Congress should establish a Health Care Quality Innovation Fund to assist projects aimed at the six aims and/or producing substantial improvements in quality for the priority conditions.

**Recommendation 7:** In order to face the challenges of a redesign, a series of workshops should be offered to identify, adapt, and implement state-of-the-art approaches to addressing any challenges.

Among the changes the new health care delivery system faces is a change of environment. The two types of environmental changes needed are “focus and align toward the six aims for improvement and provide, where possible, assets and encouragement for positive change,” the report states.

These environmental changes are needed in the following areas:

1. The infrastructure that supports the distribution and application of new clinical knowledge and technologies
2. The information technology infrastructure
3. Payment policies
4. Preparation of the health care workforce

**Recommendation 8:** The HHS should have the responsibility and necessary resources to develop and maintain a program aimed at making scientific evidence more useful and accessible to clinicians and patients.

The development of more sophisticated information systems is needed to promote quality and upgrade efficiency. “The committee believes information technology must play a central role in the redesign of the health care system if a substantial improvement in quality is to be achieved over the coming decade. Automation of clinical, financial, and administrative transactions is essential to improving quality, preventing errors, enhancing consumer confidence in the health system, and improving efficiency,” states the report.

**Recommendation 9:** An information infrastructure should be built to support health care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education. This infrastructure should eventually eliminate most handwritten data by the end of the decade.

**Recommendation 10:** Private and public purchasers should study current payment methods to remove barriers that presently hinder quality improvement and to build stronger incentives for quality enhancement.

**Recommendation 11:** A research agenda should be developed in order to identify, pilot test, and study different payment options.

**Recommendation 12:** There should be a meeting among health profession leaders to discuss and develop strategies for 1) restructuring clinical education to be consistent with 21st Century health system principles throughout undergraduate, graduate, and continuing education for medical nursing and other professional training programs.

(continued on page 146)
and 2) determining the implications of these changes for provider credentialing programs, funding, and sponsorship of education programs for health professionals.

**Recommendation 13:** The Agency for Healthcare Research and Quality should fund research to evaluate how the current regulatory and legal systems 1) facilitate or inhibit the changes needed for the 21st Century health care delivery system, and 2) can be modified to support health care professionals and organizations that seek to accomplish the six aims mentioned previously.

The IOM formed the Committee on Health Care in America in June 1998 and was assigned the task of developing a strategy to improve the quality of health care within the next 10 years. In the past, the committee has focused on the personal health care delivery system; particularly the provision of preventative, acute, chronic, and end-of-life care for individuals.

In *To Err Is Human*, the committee concluded that tens of thousands of Americans die each year from health care errors, and hundreds of thousands suffer from nonfatal injuries that a high-quality care system would prevent.

According to the IOM, this report is “a call for action to improve the American health care delivery system as a whole, in all its quality dimensions, for all Americans.” The IOM has determined that, even though medical science and technology have rapidly advanced, the health care delivery system has floundered in its ability to provide consistent high-quality care to all Americans. The committee’s research reveals a health care system that usually falls short in its ability to turn knowledge into practice, and to apply new technology safely and appropriately.

**A Way to Go**

“The 21st Century health care system envisioned by the committee providing care that is evidence-based, patient-centered, and systems-oriented also implies new roles and responsibilities for patients and their families, who must become more aware, more participative, and more demanding in a care system that should be meeting their needs,” the report concludes.

Ever-changing information technology will be key in implementing these changes and will be the catalyst for moving the health care delivery system forward.

This report can be viewed on the IOM’s Web site at [www.nap.edu/books/0309072808](http://www.nap.edu/books/0309072808). These new recommendations will affect the role, self-image, and work of doctors, nurses, and other staff on the frontline.
During its July 19, 2001 meeting, NABP’s Executive Committee discussed and took action on the following items.

**VIPPS Update**

**FIP MOU - International VIPPS**
The Executive Committee was advised that discussions concerning the Memorandum of Understanding (MOU) with the International Pharmaceutical Federation (FIP) to co-market and manage the international Verified Internet Pharmacy Practice Sites™ (VIPPS™) program is continuing.

**NABP/NAPRA MOU**
In other VIPPS news, Barbara Wells, executive director of the National Association of Pharmacy Regulatory Authorities (NAPRA), met with NABP Executive Director/Secretary Carmen A. Catizone to discuss the MOU between the two organizations that would authorize NAPRA to manage the VIPPS program in Canada.

**VIPPS Recertification**
The Executive Committee established a policy and procedure requiring reinspection of a VIPPS-certified pharmacy site every three years.

**California Audit**
Staff advised the Committee that the California Board of Pharmacy would be receiving and reviewing the recommendations of a special audit team of nationally recognized psychometrists commissioned by the California legislature to review the North American Pharmacist Licensure Examination™ (NAPLEX®) and recommendations of the Board’s Licensing Committee in regard to California’s use of the NAPLEX.

**Resolutions**
The Committee reviewed the resolutions adopted by the member boards at the 97th Annual Meeting in Seattle, Wash. The following actions were directed.

- **Resolution 97-01-01** – Mutual Recognition of American and Canadian Accredited Education Programs: The item is referred to the Executive Committee Subcommittee on Government Affairs for action.
- **Resolution 97-02-01** – Task Force to Study the Electronic Transmission of Prescriptions and Prescription Information via Electronic Devices: The Committee approved funding for NABP President Richard K. “Mick” Markuson to appoint a task force.
- **Resolution 97-03-01** – Uniform Definition of “Live” Continuing Education: The American Council on Pharmaceutical Education (ACPE) definition of “live” continuing education will be referenced in the comment section of the Model State Pharmacy Act and Model Rules of NABP to notify states of its existence and encourage uniformity in definition among the states.
- **Resolution 97-04-01** – Opposition to Mandated Tablet Splitting: A letter to the involved parties will be forwarded to highlight the dangers of the practice when mandated for purely economic reasons not in the best interest of the patient.
- **Resolution 97-05-01** – Drug Product Formulation Changes: A letter will be forwarded to the interested parties expressing the Resolution and asking for assistance.
Arizona Board Assists FDA

The following article appeared in the Summer 2001 issue of S.A.I.L., State Action Information Letter, an Internet newsletter published by the US Food and Drug Administration’s (FDA) Division of Federal-State Relations. This newsletter serves as a forum for the United States, the FDA, and all agencies engaged in protecting public health to share information. S.A.I.L. can be found on the FDA/DFRS Web site at www.fda.gov/ora/fed_state/DFSR_Activities/sail/Default.htm.

In what may be record speed, the Arizona State Board of Pharmacy (ASBP) recently responded to an urgent request for assistance from the Los Angeles FDA office. On July 19, 2001, the ASBP received a call from the Compliance Section at the Los Angeles FDA office, which was seeking the Board’s assistance in placing an embargo on a quantity of adulterated small volume parenteral products being held in a facility in Scottsdale, Ariz, in violation of a previous FDA quarantine in Florida. Following multiple phone calls between the two agencies and after receiving the documentation necessary for the ASBP to place an embargo at noon on July 20, 2001, two members of the ASBP compliance staff and two representatives of the Phoenix FDA staff served notice on the firm of an embargo being placed. By late afternoon on July 20, the paperwork was completed, the items were “embargoed”; the FDA obtained samples of material for their purposes, and the public was protected from the possibility of an illegal “dumping” of the products or the possibility of further illegal distribution of the items. ASBP Executive Director Llyn A. Lloyd says “This is an example of a state and federal agency working swiftly to protect the public from a clear and present danger. It is gratifying when all the elements fall into place like we think they should.”

The Academic Perspective (continued from page 143)

...tory issues for opioid products, there was concern that the sales force did not always appreciate this focus. The recommendation was that sales personnel be trained to be as aggressive with their diversion prevention message as with their pain relief message and that the company monitor to ensure that both messages were being conveyed to health care providers.

■ The Pharmacy Solution

Perhaps the least controversial suggestion from a pharmacy perspective would be to forbid physician offices from dispensing opioid analgesics. Apparently, one significant source of diversion is from practices where physicians do not write prescriptions, but, instead, dispense directly to patients, some of whom are not actually patients. By requiring that a prescription be written instead, the pharmacist would serve as a buffer against outright fraud in a medical practice.

Nobody is naïve enough to think that these solutions will rid society of the problem of drug abuse. Drug abuse has been with us for centuries and will continue to be with us in the foreseeable future until significant changes are made in the way drug abuse is managed. The minor tinkering that these solutions represent is intended to address the immediate problem faced by the law enforcement community and its need to work with health regulators to better protect the public.

Attorney David Brushwood is a professor at the University of Florida College of Pharmacy. He holds degrees from the University of Kansas, Schools of Pharmacy and Law.
NABP is seeking two volunteers to serve on its Advisory Committee on Examinations (ACE), which oversees the development and administration of all Association examination programs. The Committee also considers policy matters, develops long-range planning strategies, and recommends appropriate action on specific issues to NABP’s Executive Committee.

Interested individuals should submit a written statement of interest and a current resume or curriculum vitae to NABP Executive Director/Secretary Carmen A. Catizone at NABP headquarters no later than December 28, 2001.

NABP Now Accepting Nominations for Awards

Nominations for NABP’s 2002-2003 Honorary President, the Lester E. Hosto Distinguished Service Award, and the Fred T. Mahaffey Award must be received by Carmen A. Catizone, NABP’s executive director/secretary at Association headquarters no later than December 31, 2001. The awards will be presented during NABP’s 98th Annual Meeting in Phoenix, Ariz, May 18-22, 2002.

The letters of nomination, along with a brief biography or current curriculum vitae of the nominee, must be accompanied by a narrative explaining why the nominee should be considered for an award. When nominating a colleague or state board of pharmacy, please consider the following criteria.

**Honorary President**

Nominees for Honorary President should have served on one or more of NABP’s committees or task forces and have participated in district and annual meetings. In general, nominees must have demonstrated a strong commitment to NABP, the mission of the Association, and the profession of pharmacy.

**Lester E. Hosto Distinguished Service Award**

The Distinguished Service Award (DSA), named in memory of NABP’s 1990-1991 President Lester E. Hosto, is the highest honor bestowed by the Association. The DSA plaque and pin are awarded to those individuals who, through their endeavors, best exemplify the mission and objectives of NABP, regardless of their affiliation with the Association.

**Fred T. Mahaffey Award**

Presented by NABP’s past presidents and named in honor of NABP’s executive director emeritus, the Fred T. Mahaffey Award recognizes a member board of pharmacy that has made significant contributions to the profession during the past year. Specifically, the nominated board’s efforts must have contributed to the protection of the public health and welfare through the enforcement of state and federal laws, regulations, and the advancement of NABP’s goals and objectives as specified in the Constitution and Bylaws.

Nominations will be reviewed by the NABP Executive Committee, which will select the Honorary President and award recipients.

The 2002-2003 Honorary President will be announced during the 98th Annual Meeting’s Third Business Session on Tuesday afternoon, May 21. Later that evening, during NABP’s annual Awards Dinner, the Lester E. Hosto Distinguished Service Award and the Fred T. Mahaffey Award presentations will be made. NABP’s 2002 Honorary President, Joseph A. Whaley, Jr, will also be honored at that time.

For more information regarding the nominating process or the awards, please call NABP headquarters at 847/698-6227.
2001-2002 Committee and Task Force Appointments

NABP President Richard K. “Mick” Markuson has appointed the following individuals to serve as members of the Association’s 2001-2002 committees and task forces. Every effort has been made to accommodate individual requests to serve on a committee or task force and to ensure uniform representation from all regional districts.

Executive Committee
Honorary President ........... Joseph A. Whaley, Jr, Georgia
Chairman ......................... Jerry Moore, Alabama State Board of Pharmacy
President ..................... Richard K. “Mick” Markuson, Idaho Board of Pharmacy
President-elect .............. John A. Fiacco, New York Board of Pharmacy
Treasurer ......................... Donna S. Wall, Indiana Board of Pharmacy
Member ..................... Howard C. Anderson, Jr, North Dakota State Board of Pharmacy
Member ...................... B. Belaire Bourg, Jr, Louisiana Board of Pharmacy
Member ..................... Donna M. Horn, Massachusetts Board of Registration in Pharmacy
Member ...................... Dennis K. McAllister, Arizona State Board of Pharmacy
Member ..................... S. Patricia “Tris” McSherry, New Mexico Board of Pharmacy
Member ..................... William T. Winsley, Ohio State Board of Pharmacy
Ex-officio .................... Carmen A. Catizone, Executive Director/Secretary NABP

Committee on Constitution and Bylaws
Chair ......................... Charles R. Young, Massachusetts Board of Registration in Pharmacy
Member ..................... Wiki Erickson, Texas State Board of Pharmacy
Member ..................... Jack Stites, Illinois Department of Professional Regulation
Member ..................... C. A. “Leon” Alzola, Washington State Board of Pharmacy
Member ..................... Elizabeth Scott Russell, Virginia Board of Pharmacy
EC Liaison .................... Donna M. Horn, Massachusetts Board of Registration in Pharmacy
Alternate ................. Larry Griffin, New Mexico Board of Pharmacy
Alternate ................ Sophie Heymann, New Jersey State Board of Pharmacy
Alternate ................ Paula B. Hinson, Tennessee Board of Pharmacy

Committee on Law Enforcement/Legislation
Chair ......................... Timothy J. Benedict, Ohio State Board of Pharmacy
Member ..................... Dennis M. Jones, South Dakota State Board of Pharmacy
Member ..................... William T. Douglass, Jr, West Virginia Board of Pharmacy
Member ..................... Marilyn M. Silcock, Idaho Board of Pharmacy
Member ..................... Edith G. Goodmaster, Connecticut Commission of Pharmacy
Member ..................... Stephen R. Statz, South Dakota State Board of Pharmacy
Member ..................... Anthony W. Alexander, Jr, New Jersey State Board of Pharmacy
Member ..................... D. Frank Landrum, Georgia State Board of Pharmacy
Member ..................... Clayton O. Wilson, Alabama State Board of Pharmacy
EC Liaison .................... B. Belaire Bourg, Jr, Louisiana Board of Pharmacy
Alternate ................ Samuel M. Costello, Alabama State Board of Pharmacy
Alternate ................ Michael L. McGee, Georgia State Board of Pharmacy
Alternate ................ James E. Turner, Ohio State Board of Pharmacy
Task Force on Electronic Transmission of Prescriptions

Chair ............................... Matthew C. Osterhaus, Iowa Board of Pharmacy Examiners
Member .............................. Susan L. Warren, Colorado State Board of Pharmacy
Member .............................. C. Richard Allen, Georgia State Board of Pharmacy
Member .............................. Richard R. Smiga, Pennsylvania State Board of Pharmacy
Member .............................. Kim A. Caldwell, Texas State Board of Pharmacy
Member .............................. Donna Dockter, Washington State Board of Pharmacy
Member ......................... Suzanne R. Eastman, Ohio State Board of Pharmacy
Member .............................. Martin H. Michel, Missouri Board of Pharmacy
Member .............................. James T. Carder, Wyoming State Board of Pharmacy
EC Liaison ............................. John A. Fiacco, New York Board of Pharmacy
Alternate ............................ Susan Ksiazek, New York Board of Pharmacy
Alternate ............................. Karen Ryle, Massachusetts Board of Registration in Pharmacy
Alternate ............................. Lydia Main, West Virginia Board of Pharmacy

Task Force on Privacy and Confidentiality

Chair ............................. Gay Dodson, Texas State Board of Pharmacy
Member ............................. Patricia F. Donato, New York Board of Pharmacy
Member ............................. Robert P. Giacalone, Ohio State Board of Pharmacy
Member ............................. Michael Patrick, Oregon State Board of Pharmacy
Member ............................. Michael A. Moné, Kentucky Board of Pharmacy
Member ............................. Wallace E. Nelson, North Carolina Board of Pharmacy
Member ............................. A. Jeffrey Newell, Rhode Island Board of Pharmacy
Member ............................. Richard A. Palombo, New Jersey State Board of Pharmacy
Member ............................. John D. Taylor, Florida Board of Pharmacy
EC Liaison ............................. Donna S. Wall, Indiana Board of Pharmacy
Alternate ............................. Richard J. Oubre, Louisiana Board of Pharmacy
Alternate ............................. Thomas F. Dudley, Oklahoma State Board of Pharmacy
Alternate ............................. Byron T. Alford, Alabama State Board of Pharmacy

Advisory Committee on Examinations

Chair ............................... Lawrence H. Mokhiber, New York Board of Pharmacy
Member ............................. Harold B. Sparr, Massachusetts Board of Registration in Pharmacy
Member ............................. Donald H. Williams, Washington State Board of Pharmacy
Member ............................. Jeff Lurey, Georgia State Board of Pharmacy
Member ............................. Susan Lutz, Iowa Board of Pharmacy Examiners
Member ............................. Bryan H. Potter, Oklahoma State Board of Pharmacy
Member ............................. Carl W. Aron, Louisiana Board of Pharmacy
EC Liaison ............................. Howard C. Anderson, Jr, North Dakota State Board of Pharmacy
NABP Meeting Dates

**Thursday-Saturday, November 1-3, 2001**
NABP/AACP District I & II Meeting,
Otesaga Hotel & Resort, Cooperstown, NY

**Friday-Sunday, November 9-11, 2001**
NABP/AACP District IV Meeting,
Concourse Hotel, Madison, Wis

**Saturday-Tuesday, November 10-13, 2001**
Executive Officers Conference, Hyatt Regency
Monterey, Monterey, Calif

**Tuesday-Wednesday, November 13-14, 2001**
Executive Committee Meeting, Hyatt Regency
Monterey, Monterey, Calif

**Thursday-Friday, November 29-30, 2001**
Task Force on Electronic Transmission of Prescriptions, Marriott Suites O'Hare, Rosemont, Ill

**Thursday-Friday, November 29-30, 2001**
Task Force on Privacy and Confidentiality, Marriott Suites O'Hare, Rosemont, Ill

**Thursday-Friday, January 24-25, 2002**
Committee on Law Enforcement/Legislation, Marriott Suites O'Hare, Rosemont, Ill