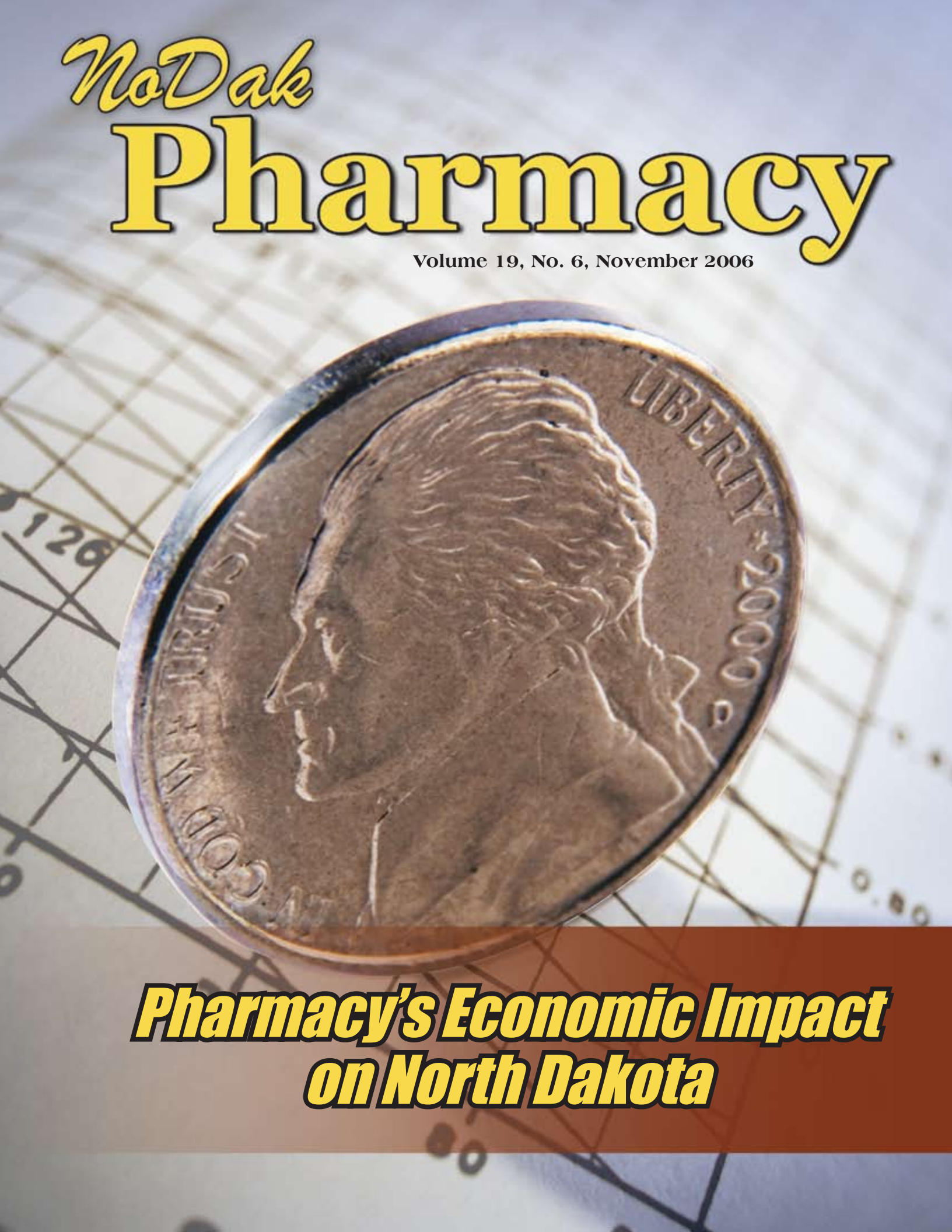
NoDak Pharmacy

Volume 19, No. 6, November 2006



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Mark Your Calendar

November Calendar Events

November 9
District 4 Meeting – Grand Forks

November 18
PPTCB Exam

November 23
Thanksgiving

November 24
NDPhA Office Closed

December Calendar Events

December 3
ASHP Clinical Midyear

December 4
Legislative Organizational Session

December 25
Christmas

January Calendar Events

January 3
Legislative Session Begins

January 16
Pharmacy Rally at State Capitol

January 28
NDPhA Board of Directors Meeting

March Calendar Events

January 16
APhA Annual Meeting in Atlanta

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Dennis Johnson, RPh

Whatever Happened to Competition?

Is competition good or something to be avoided? Competition has been a driving force in my life, and I am sure in yours too. I remember competing against other students for grades, honors, and in sports. Every coach I had required competition in order to make the varsity football or basketball team.

Current, popular "reality" tv shows pit individuals in direct competition with each other, and we enjoy watching them compete every week. In work and play, competition is good – it builds character, maturity, and stamina.

What has happened to competition in business? I'm talking about healthy competition between "like" businesses. In recent times, there has been a concerted effort to eliminate competition in the business world.

Over the years we've seen the mergers of banks, department store chains, restaurants, gas and oil companies. So today we go to a cookie-cutter bank, restaurant, gas station, department store, etc., and have access to the "most common" items that sell and have a quick turnaround. Often the clerks can't even make change or carry on a conversation. If you're lucky you have some specialty shops or boutiques. We've lost a lot of individualization and competition between similar businesses.

Consider what has happened in the pharmaceutical industry. It wasn't too hard to predict years ago what was happening with all the mergers and elimination of competition. Now they set their own prices and there's little we can do about it! The knee-jerk reaction is to let the government step in and fix it, but that's not the answer. Government-approved mergers, corporate acquisitions, politics, and government programs encourage consolidation of activities and entities that work directly with government agencies – just like Medicare Part D.

So, now we have a problem; now, what are we going to do about it? What would happen if we started paying for only "catastrophic insurance" instead of "colds, warts, and sniffles insurance" for which we pay plenty? What if individuals had to pay for their medications for minor illnesses and only had insurance for major illnesses like cancer or heart attacks? This would put pharmacies in a position to handle cash rather than waiting on the 'handout' from insurance companies.

I think families could save thousands of dollars annually under this plan. If one spends $500 to $1000 per month for health insurance, catastrophic insurance should be much less and allow sufficient funds to cover minor ailments and still have money left over. Not only that, but hospitals, physicians, pharmacies, etc. would be working with the patient/consumer, not with some cyberspace intermediary; isn't that a novel thought? This would put the pharmaceutical industry back in the mode of competing for and servicing pharmacies instead of servicing primarily PBMs and seemingly not really caring about pharmacists.

I'm afraid that if we don't take a hard look at the loss of competition that we now have, we are going to see more and more monopolies in the business world and loss of control of our future! Think about this as you go by the bank for a loan to fill up your gas tank.

(Reprinted excerpts from the International Journal of Pharmaceutical Compounding, Loyd V. Allen, Jr, PhD, RPh., August 2006)

Dr. Patricia Hill

The Promise versus The Task

If you ever attend a Disney Management Institute seminar a significant portion of the program is dedicated to the topic of customer loyalty. To improve customer loyalty your employees must understand the importance of not only providing great customer service but also delivering on the promise. For Disney the promise is - *Disney, the happiest place on earth!* The tasks required to keep that promise are cleanliness, friendliness, safety, and so forth.

To illustrate delivery of Disney's "promise" consider an elderly couple who brought their five year old granddaughter to Disney World and bought her an ice cream cone. As the little girl is walking down Main Street and licking the cone she pushes too hard and the ice cream falls out of the cone and onto the street. The little girl's upper lip begins to quiver as she fights back her tears while the grandparents try to console her, wondering if they can afford another $21.00 ice cream cone. A Disney employee who has witnessed the event intervenes.

Scenario number one: The empathetic employee rushes over and provides wet wipes to clean the front of the little girl's dress. Quickly and efficiently scoops up the offending pile of ice cream and deposits it the nearest trash can. Sprays the area with cleaning and disinfectant solution, wipes up the mess, then smiles and says, "Have a magical day.", and goes about her business.

Scenario number two: The employee rushes over and provides the same empathy and hygiene benefits, then takes the little girl by the hand, walks her back to the ice cream parlor, gets her another ice cream cone for free, and then says, "Have a magical day!"

Both employees provided the appropriate amount of empathy and service, but employee number 2 remembered the promise – *"Disney, the happiest place on earth!"*

It occurred to me as I listened to this concept of "promise versus tasks" that some pharmacy professionals may have forgotten the promise – to provide CARE. Whether you ask a seasoned pharmacist veteran of 20 years on the bench or a newly accepted pharmacy student about why they got into pharmacy they will tell you it was to provide care. Oh, they may couch that in terms of wanting to help people or to improve their health outcomes, but regardless of the phrase it's about providing care.

Unfortunately, the various tasks required to provide that care have become the central focus in a majority of practices – almost to the point of distraction! Yes, I know that the distributive function is an important central service for patients. Yes, I know that the current reimbursement system is (often) not even sufficient to cover costs! But if we don't begin to focus on providing the "promise of pharmacy" - the CARE, which then translates into value – the patients and payers will find alternative delivery options that are cheaper, faster, and safer.

If we agree that the future for the profession is delivering patient care, then the fundamental question is - how do we make this transition from provider of product to provider of care? I would suggest that it begin with a patient centric approach.

The cornerstone of the pharmacy Promise of Care is the establishment of a relationship with the patient. The easiest way to begin that process is to introduce yourself to your patient, yet a recent survey by APhA indicated that only 28% of patients knew their pharmacist's name. In a related question, patients were asked to rate their personal relationship on a scale of 1 to 5 with one being no relationship and five being on a first name basis. Looking

at just those professions that scored a rating of 5 were:

Hairdressers (60%)	Doctor (50%)
Dentist (46%)	Auto Mechanic (37%)
Attorney (31%)	Veterinarian (27%)
Banker (26%)	**Pharmacists (20%)**

What wrong with this picture? Is it any wonder that we have a difficult time convincing patients and payers to pay more for the product we provide much less pay us for providing care?

We can fix this! It won't happen through legislative or regulatory efforts and it won't happen through national and state association policy or advocacy efforts, but rather one patient at a time across your pharmacy counter or at the bedside within your health system. It will be incumbent upon each pharmacist to make a personal commitment to change our practice focus.

What are the steps we must to take to change public perception? Let's start with making a commitment that every patient that comes into your pharmacy will know your name. Ask what their individual health related goals are and what can you do to help them achieve those goals. Use your medication expertise to become the patient educators, enablers and advocates that you were trained to be and your patients need.

In the next few months there will be opportunities for you to get involved with various medication therapy management programs. Currently, CCRx has over 400 patients who have been identified in North Dakota as having one or more medication therapy issues that need to addressed by a pharmacist. Those patients have been assigned to specific pharmacies and it is up to the pharmacy to set up appointments with those patients. If you have not looked to see if your pharmacy has any of these opportunities please contact Community Care Rx to review the list of patients.

More opportunities are on the horizon for ND pharmacists; take an active role in your future.

Remember, people don't care how much you know, they want to know how much you care!

Dear NDPhA Members,

It has been a pleasure and privilege to serve as your Executive for more than 2 1/2 years! Thank you for the opportunity to work with you to build a stronger future for the profession of pharmacy in North Dakota.

Near the end of November, I will be leaving NDPhA for new professional adventure that has significant personal and professional advantages. As I revert back to my role as patient/consumer, now armed with a plethora of knowledge about pharmacy issues and the direct relation to patient care, I hope you will call upon me if you need an consumer advocate in support of your efforts.

I appreciate the support you have given to me, and hope you share the pride I have in our numerous accomplishments. Be assured any progress achieved was the direct results of united, focused efforts by all of us and I hope you continue to use that approach. Also, you can be certain that your commitment and dedication to quality patient care…no matter where you practice…is the defining characteristic that sets you apart (and above) all others. I was proud to represent you, and wish you all God speed.

Patricia A. Hill, PhD, Executive Vice President

Pharmacy's Economic Impact on North Dakota

By Stacy Fielder

"While the use of pharmaceutical drugs has been rapidly increasing in recent years, the businesses that dispense those prescriptions to consumers have not necessarily reaped the benefits of increased consumption and face numerous challenges (Wirtz 2006). A pharmacist shortage, mail and internet competition, thinning margins, and third-party payer issues are just some of the issues challenging pharmacies. Those challenges have raised concerns about the long-term viability of independent community pharmacies, especially those in rural areas (Wirtz 2006). The importance of pharmacies in terms of the delivery of prescription drugs is fairly straight forward. However, community pharmacies also play an important role in the state and local economies. Community pharmacies, ('drug stores') are a business type that has consistently been classified as a business that provides "essential services." Businesses that provide essential services are critical for communities that desire to maintain a viable business and service sector." - Executive Summary of Findings, *Contribution of North Dakota's Pharmacies to the State's Economy*, Hodur and Leistritz, 2006

In an effort to quantify the economic contribution that pharmacies make in North Dakota, the North Dakota Pharmacists Association contracted with economists at NDSU to conduct an economic impact study. The study, conducted by F. Larry Liestritz and Nancy M. Hodur, surveyed community pharmacies throughout the state and examined business characteristics, services provided, and demographic characteristics.

Study Methods

The methods, survey, and parameters used by Leistritz and Hodur in their study followed a similar study of the economic contribution of hospitals in North Dakota. This study estimates all relevant expenditures and returns,

including cost of goods sold, payroll and other business expenses. An input-output analysis was used to estimate secondary economic impact and employment. To gather initial data, a questionnaire was sent to 128 community pharmacies throughout the state. This survey asked for expenditure data and information about workforce, business characteristics and relevant business issues, and was returned at a rate of 53 percent.

Demographics and Services

Respondents to the survey were predominately male (82 percent) with an average age of 50 years, and have owned and operated a pharmacy for an average of 17 years. Fifty-eight percent of respondents plan to sell their pharmacy in the next ten years, yet most (69 percent) have not identified a buyer.

On average, pharmacies in North Dakota reported employing 7.8 individuals, making the total employment for all community pharmacies an estimated 1,057 employees. These employees of community pharmacies are helping to dispense more than 107,000 refill and new prescriptions per week (total throughout the state).

Community pharmacy creates over 10,000 full time jobs and contributes $907 million to the state's economy.

The study noted that 63 percent of pharmacies in North Dakota are in rural areas compared to 37 percent in urban areas. As the vitality of rural pharmacies becomes more threatened due to lower reimbursement rates and declining populations, the likelihood of North Dakota losing a great number of its pharmacies becomes more and more plausible. This is particularly worrisome when considering rural pharmacies in North Dakota employ roughly 620 people and provide vital services to other healthcare facilities. According to the study, ninety-two percent of rural pharmacies provide services for long-term care facilities and two-thirds provide services to assisted living facilities.

Economic Contribution

To gauge the economic contribution of community pharmacies, the study defined economic contribution as an estimate of all relevant expenditures and returns associated with the industry. The study examined both direct and secondary impacts with regard to community pharmacies.

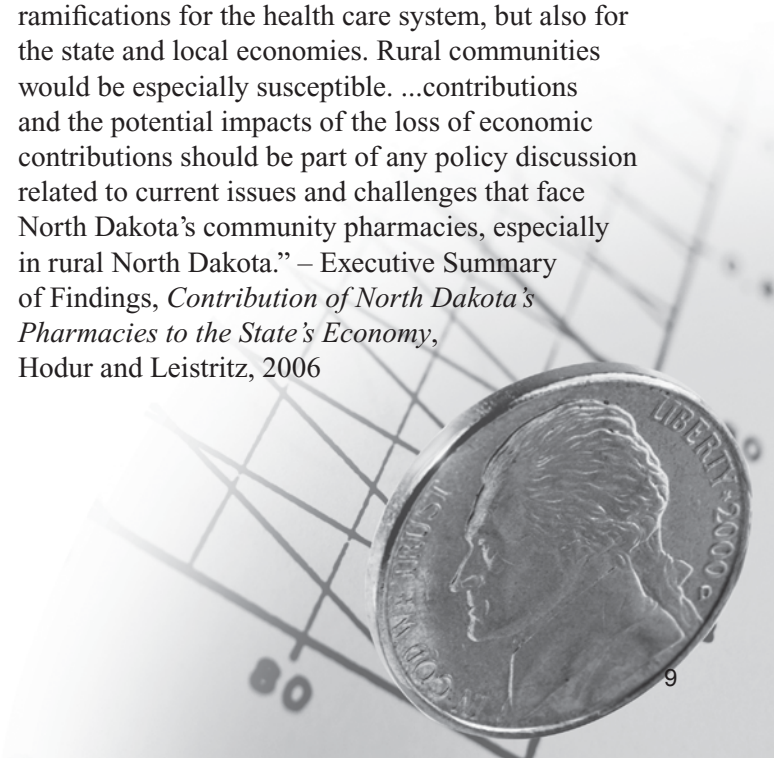
Total direct expenditures (average) for North Dakota community pharmacies were estimated to be $224 million annually. These direct expenditures were broken into categories of expenses, with the greatest expenditures in the categories of "Wholesale and Manufacturing" and "Households." This is expected considering the "wholesale and manufacturing" sector includes the cost of goods sold and the "household" sector includes salary and wages.

The average direct impacts of in-state expenditures per pharmacy were estimated to be roughly $2.3 million annually. Given this data, and the level of economic activity generated by community pharmacies, it is estimated that pharmacies support 10,158 full-time equivalent jobs in various sectors of the area economy.

Conclusions and Implications

According to the study by Liestritz and Hodur, North Dakota community pharmacies have a critical role in the health care delivery system. Community pharmacies, particularly those in rural areas, provide vital services to other health care providers including hospitals, long-term care facilities, and assisted living facilities.

"Community pharmacies directly contribute nearly $224 million annually to the state's economy. Direct and secondary impacts total $907 million annually. Community pharmacies directly employ over 1,000 individuals, and the economic activity generated by pharmacies supports secondary employment of over 10,000 jobs. Clearly, if the challenges that community pharmacies face today lead to numerous business closures or substantive modifications in how prescription drugs are dispensed, not only would there be ramifications for the health care system, but also for the state and local economies. Rural communities would be especially susceptible. ...contributions and the potential impacts of the loss of economic contributions should be part of any policy discussion related to current issues and challenges that face North Dakota's community pharmacies, especially in rural North Dakota." – Executive Summary of Findings, *Contribution of North Dakota's Pharmacies to the State's Economy*, Hodur and Leistritz, 2006



Howard C. Anderson, Jr. RPh
Executive Director

Plan B In North Dakota Pharmacies

The recent approval by the FDA to market Plan B over-the-counter through pharmacies is both a challenge and an opportunity for our Pharmacists.

Many of you have been serving patients for many years, with Plan B or ®Preven as trademark products available on prescription. Many years ago, physicians began prescribing the ingredients in these medications for the prevention of pregnancy by utilizing either compounded products or other medications, which were available and prescribed for off-label use.

This product is being approved for sale over-the-counter, but, only in pharmacies. This could be looked at as either a blessing or a curse. It might be the only current representative of the third class of drugs, which pharmacists have long sought. It might also be a source of controversy for some pharmacists, or some angst about whether one advocacy group or another might camp out on your front sidewalk. Each pharmacy and pharmacist must make their own decision as to whether they are stocking the product, just like they do with every other product that is available on the market. Many pharmacies have had Plan B in stock until it went outdated and then returned it to the manufacturer and discontinued stocking it, because it was never used.

The requirement that over-the- counter sales be restricted to patients eighteen years and older is one that pharmacist will be expected to enforce. My personal recommendation, is that the pharmacist make Plan B part of the prescription profile of the patient. This ensures that the pharmacist will check each prescription that you issue and the date of birth of that person.

There is also another opportunity connected with this drug approval. Should you have a physician or clinic nearby who believes that Plan B could be made available for patients younger than eighteen, under some defined circumstances, a pharmacist can seek a collaborative agreement with that physician. Of course all collaborative agreements must be approved by the Board of Pharmacy and Board of Medical Examiners.

Whatever you decide to do relative to Plan B, please make an effort to keep your local hospital emergency room, as well as the physicians you work with on a regular basis, informed of your decision, whether it be, yes you will stock it or no, you will not stock it. They may have their own opinions about whether they would use or prescribe Plan B, but, knowing your stance and the availability of the product in advance will help them care for their patients.

If the pharmacy in a small community chooses not to stock it, the emergency room may choose to make it available through their emergency physicians.

On the other hand, this over-the- counter approval should remove some of the angst, which governors and legislators have had and the propensity to adopt laws requiring pharmacists to dispense a prescription. Obviously, it would not be to interested in requiring that one business stock a particular product. However, the issue has not entirely gone away, since you may still receive prescriptions for those patients under the age of eighteen.

UPDATE TO THE MEMBERSHIP

"Draft" Recommendations from the Advisory Council to the NDPhA Board of Directors

Since May 2004 the Advisory Council (AC) has met four times in response to their directive from the NDPhA Board to investigate potential models that would unify the pharmacy profession in North Dakota and create more stabilized funding for the association's future. The AC includes representatives from both colleges, the state board of pharmacy, students, as well as the executive committee members of all pharmacy organizations (technicians, health systems, community pharmacy, and the NDPhA board).

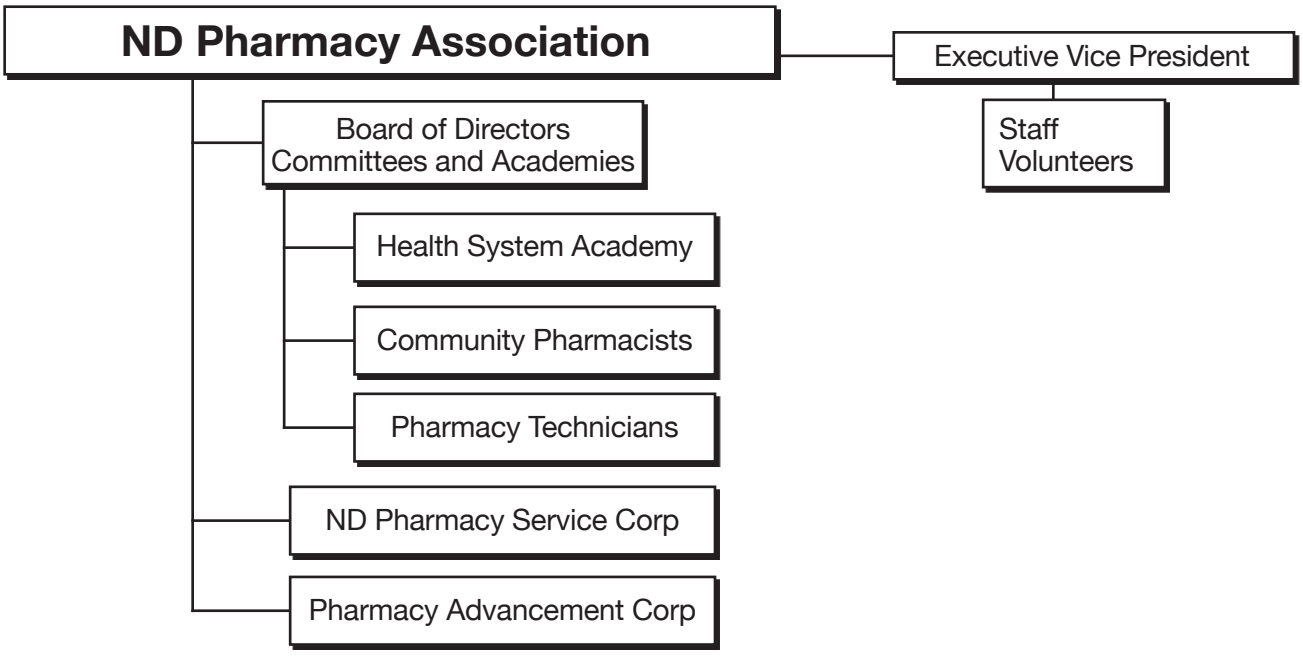
At the September 2006 meeting, the AC reviewed various organizational models from others states that are unified associations. One of these state models served as a point of reference with a few adjustments that would better serve North Dakota, as the AC finalized a set of recommendations. Those recommendations were presented to the NDPhA Board for review and discussion at their October 17th meeting. The Board approved the recommendations, which now go to subcommittees for more details and definition, and then back to the Board in January for further discussion. If approved, the draft will then be presented to the full membership for feedback and modification, including presentation at the 2007 convention in Fargo. The final step would be a vote of the full membership, possibly during the Summer 2007.

The Advisory Council received the Board's heartfelt thanks for their countless volunteer hours of research, meetings, and consensus building to identify the draft recommendations. Special thanks was extended to Tim Carlson for his leadership of the Council. The AC has been directed to move forward and bring more clarity to the following draft changes in a potentially new Association model:

- ND Pharmacists Association would be structured with the NDPhA as the "umbrella" organization representing the entire profession of pharmacy; all pharmacy organizations united with one voice and sharing resources
  - o Model will include the current committees identified in the bylaws
  - o Three "Academies" will be incorporated into the structure, representing Pharmacy Technicians, Health System Pharmacists, and Community Pharmacists
  - o A process will be designed for any future Academies that desire to be chartered
- The ND Pharmacy Service Corporation and Pharmacy Advancement Corporation will exist as totally separate entities, not Academies, and will not be represented in NDPhA governance

Governance

- The board of directors will be comprised of the current executive committee and eight district



representatives as identified in the bylaws, as well as the current ex officio (non voting) members. Additional representatives will include voting members from each of three academies and a pharmacy student. NDPhA Board retains full governance authority on behalf of members as outlined in bylaws.
- Pharmacy technicians will be considered full members
- Each Academy will have bylaws to govern their processes, including designation of officers
- District bylaws will be updated to represent more uniform participation statewide
- NDPhA Board will identify "core services" provided to members by the association
- The Board can designate "additional services" available through the Association for a fee
- The Board can call upon Academies to help with the work of the Association
- EVP reports to the NDPhA Board; EVP responsibilities, goals and objectives will coincide with the priorities set by the Board during the annual budgeting process

Financial

- All members will contribute to the financial viability of the Association
- Membership includes participation in Academies as preferred and selected by each member
- Annual budgeting process will include opportunity for Academies to request funding support for specific activities (such as sending reps to annual meetings or other activities)
- Academies can raise additional funds if necessary to meet their goals/objectives (such as charging additional dues, or sponsoring conferences)

FAQs

What is the Pharmacy Advancement Corporation (PhAC)?

The PhAC is a nonprofit organization, setup to accept financial contributions and grants. To date, the PhAC has received and distributed the funds raised at the annual convention auction and given as scholarships to NDSU pharmacy students. Six $1500 scholarships are given annually by NDPhA through the PhAC. The PhAC has its own board of directors and bylaws.

What is the ND Pharmacy Service Corporation?

The NDPSC is a for-profit organization, funded by annual dues paid by individual community pharmacy owners ($1250/year). Approximately 120 community pharmacies are current members. The NDPSC, a LLC, is a subsidiary of the NDPhA – the 500 shares of stock are owned by the NDPhA, purchased with funds provided by Dakota Drug, Inc. (a ND wholesaler). The NDPSC has its own bylaws and board, elected from dues-paying members.

The NDPSC is totally self-supporting and has never used any funds from the Association. The NDPSC has provided significant funding to the NDPhA, including substantial support for employee compensation and general operations. In addition, most of the external funds received by the NDPhA are directly related to the medication and supply purchases made by the community pharmacies.

Under the new structure, the NDPSC board has the option to contract for services from NDPhA, including the time and skills of the EVP and Assistant. At this time it appears the NDPSC would need fewer services than in the past, which would require additional funds from the NDPhA to cover the two staff positions. Future negotiations would have to determine the appropriate share of general operational costs for the NDPSC, of which they currently pay at least half.

What is the ND Society of Health-System Pharmacists (NDSHP)?

The NDSHP began in 1989 when NDPhA implemented an integrated membership under state law. Those members of NDPhA who practiced in a hospital were counted as members of NDSHP and $25 of their license fee was given to support NDSHP activities. This arrangement provided the opportunity for NDSHP to get started.

In the new model, all pharmacist-members pay an equal amount to support the NDPhA, and the exchange of funds is replaced with the annual budgeting process that includes the opportunity for the Health-System Academy to submit a budget request and receive funds for their activities.

NDSHP is the only pharmacy group with an "affiliation" to their national association – ASHP – and this draft model has been approved to meet ASHP guidelines in other states. Since there are health-system pharmacists who prefer to keep the affiliation with ASHP, Joel Aukes - NDSHP President, has been working in concert with the Council activities to maintain the ASHP affiliation while unifying the pharmacy profession in North Dakota.

Continuing Education for Pharmacists

Volume XXIV, No. 8

Acute Viral Hepatitis: Immunization and Hepatitis Vaccines

Thomas A. Gossel, R.Ph., Ph.D.
Professor Emeritus
Ohio Northern University
Ada, Ohio

and

J. Richard Wuest, R.Ph., Pharm.D.
Professor Emeritus
University of Cincinnati
Cincinnati, Ohio


Gossel


Wuest

Goals. The goals of this lesson are to discuss the hepatitis vaccines and recommendations for their use in prevention of acute viral hepatitis.

Objectives. At the conclusion of this lesson, successful participants should be able to:

1. list the goals of immunization with hepatitis vaccines;
2. identify the hepatitis vaccines and state their indications, usefulness, efficacy, safety profile, and recommendations for use; and
3. choose from a list important points to convey to hepatitis vaccine recipients and their caregivers.

Acute viral hepatitis is a systemic infection that has high affinity (i.e., is hepatotropic) for the liver. The World Health Organization estimates that more than 500 million people (i.e., approximately one-sixth of the population) worldwide are infected with hepatitis B or C. This includes nearly five million people in the United States.

This lesson provides a brief review of acute viral hepatitis infection and discusses experiences with hepatitis A and B vaccines that have resulted in a substantial reduction in the incidence of HAV- and HBV-related infection and disease. It describes the vaccines' immunogenicity and benefits.

Acute Viral Hepatitis: Epidemiology and Pathogenesis

Most clinical cases of hepatitis are caused by one of five viruses: hepatitis A virus (HAV), hepatitis B virus (HBV), hepatitis C virus (HCV), the HBV-associated hepatitis D virus (HDV), and hepatitis E virus (HEV). Other hepatitis viruses have been identified, but do not cause clinical hepatitis. Hepatitis A, B, and C are the most important types in the U.S.

Hepatitis A. HAV is highly contagious and causes human infection worldwide, particularly in developing countries. Transmission is achieved primarily through the fecal-oral route. Geographic areas include the Caribbean, Middle East, Eastern Europe, Southeast Asia, Central and South America, and Mexico. Areas in the United States with poor sanitation facilities have high HAV infection rates. The course of HAV is variable; most infections in children are asymptomatic, whereas most adult infections are symptomatic. Approximately 100 people in the United States die each year as a result of HAV infection.

Hepatitis B. HBV is part of a family of genetically related DNA viruses (in contrast to all other known hepatitis viruses which are RNA viruses). The highest concentrations of infectious HBV are found in blood. Other fluids, including semen, vaginal secretions, and saliva, are also infectious. HBV can remain contagious in the environment for at least seven days. Approximately 50,000 new cases of HBV infection are reported in the United States each year; the number of unreported cases may be 10 times higher.

Transmission is accomplished via contact with contaminated body secretions, percutaneously (usually through accidental needlesticks or by sharing needles and/or syringes with infected people), or by maternal-neonatal transfer. Transmission of HBV can also occur during close contact with an infected person. Persons at risk of HBV infection include spouses of acutely infected persons and sexually promiscuous individuals (especially promiscuous men who have sex with men). Health care workers exposed to blood, persons who require repeated transfusions especially with pooled blood product concentrates, residents and staff of custodial institutions for the developmentally handicapped, prisoners, and family members of chronically infected patients are also at risk. Infection via HBV blood transfusion is now rare in the United States due to

routine screening of blood donors and their donated blood.

Hepatitis C. The most common chronic bloodborne infection in the United States, which accounts for an estimated 8000 to 10,000 deaths annually, is caused by HCV. Approximately four million persons in the United States have been infected; three million have chronic HCV infection. Hepatitis C is a progressing disease that may advance gradually over two to four decades.

Individuals who encounter infected blood or instruments or needles, such as users of illicit injection drugs, health care workers or public safety workers, are at risk of acquiring the virus. Intranasal cocaine use, tattooing and body piercing are other potential risks. People who live with HCV-infected individuals should not share personal items such as razors, toothbrushes, and nail clippers to reduce the risk of exposure to infected blood. Approximately 5 percent of infants born to HCV-infected females may be infected.

Hepatitis D. HDV has a worldwide distribution. In nonendemic areas such as the United States, HDV infection is confined to persons exposed frequently to blood and blood products such as users of illicit injection drugs and hemophiliacs. Globally, HDV infection is on the decline.

Pathogenesis. The hepatitis viruses are not directly cytopathic to hepatocytes. The clinical manifestations following acute hepatic damage associated with viral hepatitis are determined by the immunologic response of the host. Persons with defective cellular immune competence are more likely to remain chronically infected rather than to clear the virus from the body.

Immunization with Hepatitis Vaccines

Primer on Terminology. The terms vaccination and immunization are often used interchangeably even though they have distinctly different meanings. *Vaccination* denotes only the administration of a vaccine to achieve immunity. *Immunization* describes the process of inducing or providing immunity by any means, whether active or passive. Thus, vaccination does not assure immunization. *Active immunization* refers to the initiation of immune defenses (e.g., antibodies) by the administration of an appropriate antigen. *Passive immunization* provides temporary protection to a disease state by the administration of exogenously produced substances (e.g., immune globulin). A *vaccine* is a product of attenuated live, or killed, microorganisms that contains the antigenic portion(s) of these agents used to induce immunity and prevent disease in a host recipient. An *immune globulin* is the protein fraction of an antibody derived from human plasma that is used primarily to maintain the immunity status of persons with immunodeficiency disorders or for passive immunization when active immunization is unpredictable or not possible.

The adage: *an ounce of prevention is worth a pound of cure* is relevant for the hepatitis viruses. Although antiviral therapy is approved in the United States for treatment of HBV and HCV infections, the drugs are effective in only a portion of patients. The drugs are also associated with considerable adverse effects, drug interactions, and high cost. Moreover, there is no approved treatment for HAV infection. Emphasis, therefore, is on prevention of viral hepatitis through immunization.

Efforts to describe, delineate, prevent, and control hepatitis A and B have resulted in enormous challenges to the health care delivery system. A major advancement was achieved when the epidemiologic features of "infectious" hepatitis (hepatitis A) and "serum" hepatitis (hepatitis B) were delineated in the 1940s. This achievement was further advanced with provision of serologic tests in the 1970s to more clearly delineate each virus.

Hepatitis Vaccines

Hepatitis B. The first HBV vaccine was derived from human plasma and licensed in the United States in 1982. It is no longer available in this country. A recombinant HBV vaccine produced in the yeast *Saccharomyces cerevisiae* was licensed in the United States in 1986 (Engerix-B), followed closely by another vaccine in 1989 (Recombivax HB).

Following harvesting and purification of the antigenic component, it is adsorbed onto an aluminum salt. The vaccine contains >95 percent antigenic protein and <5 percent yeast-derived protein. No yeast DNA is detectable in the vaccine. Recombivax HB formulations and pediatric/adolescent and adult formulations of Engerix-B are preservative free.

Hepatitis A. The first HAV vaccine was licensed in the United States in 1995 (Havrix), followed by approval of a second vaccine in 1996 (Vaqta). Both vaccines are inactivated whole-virus vaccines that have demonstrated safety and efficacy in preventing HAV infection.

Antibodies that develop in response to HAV infection confer lifelong immunity. Hepatitis A vaccines are produced from a cell-culture-adapted virus that is grown in human fibroblasts, purified, inactivated with formalin, and adsorbed onto an aluminum salt. Vaqta is preservative free. Havrix contains 2-phenoxyethanol as a preservative.

Combined HAV/HBV. A combined HAV/HBV vaccine (Twinrix) was approved for use in the United States in 2001. The bivalent vaccine is intended for use in persons ≥18 years of age to provide protection against both HAV and HBV. It is administered on a 0-, 1-, and 6-month schedule. The hepatitis A

Table 1
Recommendations for Hepatitis A and B Vaccines

Vaccine	Age (Years)	Dose[†]	Volume (mL)	Dosing Schedule (month)*
Hepatitis A				
Havrix[ä]	1-18	720 El.U.	0.5	0, 6-12
	>18	1440 El.U.	1.0	0, 6-12
Vaqta[â]	1-18	~25 U	0.5	0, 6-18
	>18	~50 U	1.0	0, 6-18
Hepatitis B				
Engerix-B[ä]	<11[±]	10 µg	0.5	0, 1, 6
	11-19	10 µg	0.5	0, 1, 6
	≥20	20 µg	1.0	0, 1, 6
	dialysis[‡]	40 µg	2.0	0, 1, 2, 6
Recombivax HB[â]	<11[±]	5 µg	0.5	0, 1, 6
	11-19	5 µg	0.5	0, 1, 6
	≥20	10 µg	1.0	0, 1, 6
	predialysis/ dialysis[§]	40 µg	1.0	0, 1, 6

[†]El.U. = ELISA (enzyme-linked immunosorbent assay) Units; U = Units; µg = microgram
*0 represents timing of the initial dose; subsequent numbers represent months after the initial dose.
[ä]GlaxoSmithKline, Research Triangle Park, NC
[â]Merck & Co., Inc., Whitehouse Station, NJ
[±]Infants whose mothers are hepatitis B surface antigen-positive should also receive hepatitis B immune globulin at birth.
[‡]Two 1.0 mL doses given at one site
[§]Special formulation for patients on dialysis

vaccine component is equivalent to the pediatric dose of Havrix; the hepatitis B vaccine component is equivalent to the adult dose of Engerix-B.

Hepatitis D and C. There is no vaccine to prevent HDV specifically. Hepatitis D infection can be effectively prevented by vaccinating susceptible persons with hepatitis B vaccine. Likewise, there is no vaccine to immunize against HCV. Prevention of infection is best achieved by screening donor blood, excluding blood donors in high-risk situations, and use of highly sensitive serologic screening tests for HCV infection.

Vaccine Immunogenicity and Efficacy

Hepatitis B. Protection conferred with hepatitis B vaccine correlates with the number of doses received in the recommended schedule. Among infants, antibody response ranges from 16 to 40 percent following the first dose, 80 to 95 percent following the second dose, and 98 to 100 percent following the third dose. Reported ranges in antibody response for teenagers and adults are 20 to 30 percent following the first dose, 75 to 80 percent following the second dose, and 90 to 95 percent after the third dose. Factors that may lower the response include age >40 years, male gender, obesity, immune deficiency, and smoking. In general, efficacy to hepatitis B vaccine is typically 95 percent with a range in efficacy of 80 to 100 percent among individuals who receive all recommended doses. Chronic infection is rare among persons who demonstrate an immunologic response to the vaccine.

Hepatitis A. Hepatitis A vaccines are highly immunogenic and provide protection against hepatitis A infection in persons who receive all recommended doses. Antibody titers are higher following a single dose of vaccine than those produced by immune globulin, but lower than levels produced following natural infection. Within one month of the first dose, >97 percent of children and adolescents, and >95 percent of adults will have developed protective levels of antibodies. Within one month of the second dose, essentially 100 percent of recipients will have responded to form protective antibody levels. Mathematical models show that antibodies formed in response to a second dose of vaccine administered six to 12

months after the initial dose should persist for 24 to 47 years.

Combined HAV/HBV. Among healthy individuals, immunogenicity for each component of the bivalent vaccine is at least as effective as that for each single-antigen vaccine administered separately. Combination vaccines provide for fewer injections while maintaining immunogenicity and safety comparable to separately administered vaccines. The Advisory Committee on Immunization Practices (the committee that advises the CDC on vaccines), American Academy of Pediatrics, and American Academy of Family Physicians recommend that combination vaccines be used when any single component of the vaccine is indicated and there are no contraindications to the other component(s).

Vaccine Safety

All hepatitis vaccines are safe. The most common adverse reaction is irritation at the injection site, reported in less than 10 percent of injections. Systemic reactions include fatigue, weakness, headache, nausea and vomiting, and fever. Health care professionals who administer hepatitis vaccines are advised to keep epinephrine injection and other appropriate agents readily available to control immediate allergic reactions should an anaphylactic reaction occur.

Vaccine Dosage and Administration

Table 1 summarizes dosage recommendations for hepatitis A and B vaccines. Alternate dosing schedules may benefit specific populations. Product Information Leaflets should be reviewed prior to use.

All hepatitis vaccines are injected intramuscularly into the deltoid muscle (adults) or anterolateral thigh (infants and small children), not into the gluteal region (buttocks) due to suboptimal response from this site. Intravenous, intradermal and subcutaneous injection should be avoided. In persons with clotting factor disorders who are at risk for hemorrhage (e.g., hemophiliacs) subcutaneous injection is indicated for hepatitis B vaccines. The benefit versus risk of intramuscular injection of hepatitis A vaccines in these individuals must be carefully considered when contemplating immunization. If the decision is made to administer hepatitis A vaccine intramuscularly, it should be given with steps taken to avoid the risk of hematomas following injection.

Patient Advice

Despite the significant decline in HAV- and HBV-related morbidity that has occurred as a result of widespread use of HAV and HBV vaccines, significant morbidity still occurs that could be prevented with proper use of the vaccines. Individuals at risk and those who plan to travel to areas where the viruses are found are, therefore, urged to speak with their physician about immunization to protect against hepatitis. Persons who engaged in high-risk endeavors in the past, including illicit injectable drug use or promiscuous sexual activity, should be urged to be tested for HCV.

Health care professionals should inform patients, parents or guardians of potential benefits and risks of the vaccine. The vaccine recipient, parent or guardian should be questioned concerning appearance of signs and/or symptoms of an adverse reaction following a previous dose of hepatitis vaccine, advised of the potential for adverse reactions that have been associated with the vaccine, and told to report severe or unusual adverse events to the physician or clinic where the vaccine was administered. The patient, parent or guardian should be given a copy of the current Vaccine Information Statement (VIS) prior to immunization. Vaccine Information Statements can be downloaded for printing from the CDC website (www.cdc.gov/nip).

Overview and Summary

Approximately one-sixth of the world's population is believed to be infected with hepatitis B or C virus. This demonstrates the clinical importance of having safe and effective vaccines to protect non-infected individuals. Vaccines for hepatitis A and B, but not C, are available and recommended. Their use has had a substantial impact on reducing the incidence of HAV and HBV infections and their related morbidity and mortality.

It is important that immunization with the vaccines start early in life, especially for individuals at high risk for acquiring hepatitis A or B. The time of exposure to these viruses is unpredictable; therefore, early vaccination improves the chance for successful immunization. Moreover, immunity conferred by each of these vaccines may continue for many years, if not a lifetime.

Continuing Education Quiz

Acute Viral Hepatitis: Immunization and Hepatitis Vaccines

1. Acute viral hepatitis is hepatotropic which means it:
   a. stimulates the function of the liver.
   b. is toxic to the liver cells.
   c. has high affinity for the liver.
   d. mimics the action of liver cells.
2. Which of the following is LEAST likely to cause clinical hepatitis?
   a. HAV c. HCV
   b. HBV d. HDV
3. Which of the following is part of a family of genetically-related DNA viruses, not RNA viruses?
   a. HAV c. HCV
   b. HBV d. HDV
4. Which of the following viruses causes the most common chronic bloodborne infection in the U.S.?
   a. HAV c. HCV
   b. HBV d. HDV
5. Which of the following statements is true?
   a. Vaccination assures immunization.
   b. Vaccination does not assure immunization.
6. There is no approved treatment for an infection caused by which of the following viruses?
   a. HAV
   b. HBV
   c. HCV
7. Twinrix is a bivalent vaccine approved for use to provide protection against which of the following viruses?
   a. HAV and HCV
   b. HBV and HCV
   c. HAV and HBV
   d. HBV and HDV
8. Essentially 100 percent of recipients of HAV vaccine will have responded to form protective antibody levels within which of the following time periods?
   a. Almost immediately
   b. Within one day of the first dose
   c. Within one week of the second dose
   d. Within one month of the second dose
9. The most common adverse reaction to hepatitis vaccine is:
   a. dizziness/vertigo.
   b. injection site irritation.
   c. low grade fever.
   d. runny nose.
10. All hepatitis vaccines are to be injected:
    a. subcutaneously.
    b. intravenously.
    c. intramuscularly.
    d. intradermally.

Acute Viral Hepatitis: Immunization and Hepatitis Vaccines

November 2006 ACPE # **129-047-06-008-H01**

The Ohio Pharmacists Foundation Inc and NDSU College of Pharmacy are approved by ACPE as providers of continuing pharmaceutical education. To receive 1 1⁄2 hours (0.15 CEUs) of continuing education credit, complete the following and mail with $10.00 to:

Continuing Pharmacy Education Office
Department of Pharmacy Practice
North Dakota State University
123 Sudro Hall - P.O. Box 5055
Fargo ND 58105-5055

Note: Answer sheet may be copied as needed but original answers are required on each.

Name _____

Social Security Number (SSN) XXX-XX- __ __ __ __

Address _____

City_____State _____

Zip_____

Your SSN will be used to maintain a permanent record of the courses you have taken. Your SSN will be kept confidential and will be used ONLY to identify you at NDSU.

COURSE EVALUATION

Evaluation Must Be Completed To Obtain Credit

How much time did this lesson require? _____

Today's Date_____

EXPIRATION DATE: 8-15-09

Learning objectives on first page were addressed.

1 Disagree - 5 Agree

Objective 1	1	2	3	4	5
Objective 2	1	2	3	4	5
Objective 3	1	2	3	4	5
Material was well organized and clear.	1	2	3	4	5
Content sufficiently covered the topic.	1	2	3	4	5
Material was non-commercial in nature.	1	2	3	4	5

Answer Sheet:

1.	a	b	c	d	6.	a	b	c	
2.	a	b	c	d	7.	a	b	c	d
3.	a	b	c	d	8.	a	b	c	d
4.	a	b	c	d	9.	a	b	c	d
5.	a	b			10.	a	b	c	d

2007 Award Nominations

Fax nominations by January 5, 2007 to: (701) 258-9312 or e-mail to: ndpha@nodakpharmacy.net

The NDPhA is accepting nominations for awards to be presented at the 2007 Convention in Fargo. Nominations should be submitted **along with biographical information**. The following awards will be presented.

Wyeth Bowl of Hygeia

The recipient must: be a pharmacist licensed to practice in North Dakota; be living (not presented posthumously); not be a previous recipient of the award; not be currently serving, nor have served within the immediate past two years as an officer of the association in other than an ex-officio capacity or its awards committee; have compiled outstanding record of community service which reflects well on the profession.

Nominee: _____ Submitted by _____

Al Doerr Service Award

The recipient must: be a pharmacist licensed to practice in North Dakota; be living (not presented posthumously); not have been a previous recipient of the award; has compiled an outstanding record for community and pharmacy service.

Nominee: _____ Submitted by _____

Elan Innovative Pharmacy Practice

The recipient should be a practicing pharmacist within North Dakota and a member of NDPhA who has demonstrated Innovative Pharmacy Practice resulting in improved patient care.

Nominee: _____ Submitted by _____

Pharmacist Mutual Distinguished Young Pharmacist

The recipient must: have received his/her entry degree in pharmacy less than nine years ago; be a pharmacist licensed to practice in North Dakota; have practiced retail, hospital, or consulting pharmacy in the year selected; have participated in national pharmacy associations, professional programs and/or community service.

Nominee: _____ Submitted by _____

Pfizer Health-System Pharmacist of the Year

The NDSHP is accepting nominations for the Pfizer Health-System Pharmacist of the Year Award. Recipients are to be pharmacists practicing in a health-system setting and who have contributed to the practice of pharmacy either within the system or to the profession as a whole.

Nominee: _____ Submitted by _____

ND Pharmacy Association Vice President

Nominee: _____ Submitted by _____

ND Society of Health System Pharmacists President Elect

Nominee: _____ Submitted by _____

Past Award Recipients

Wyeth Bowl of Hygeia

1959	FOSS, PALMER L., VALLEY CITY
1960	HALBEISEN, J.G., FARGO
1961	TROM, ORDNER S., LISBON
1962	SUCKERMAN, ANSUL, DICKINSON
1963	FOSS, ALDEN L., VALLEY CITY
1964	MOORE, JAMES W., BISMARCK
1965	DOERR, ALBERT, BISMARCK
1966	BAILLIE, DANRUGBY
1967	WAGNER, VERNON E., BISMARCK
1968	SCHULD, JOHN F., DICKINSON
1969	SHELVER, GLEN D., DUNSEITH
1970	CHASE, EARL W., WASHBURN
1971	WALTER, ANTHONY M., BISMARCK
1972	RODENHIZER, BRUCE G., STANLEY
1973	DEHLIN, GLENN R., MINOT
1974	SOUTHAM, CLAIR O., MOHALL
1975	GROSZ, WILLIAM J., WAHPETON
1976	KROHN, ODELL Q., HARVEY
1977	JACOBSEN, JOHN L., BISMARCK
1978	PLOWMAN, EDWARD DEAN, KILLDEER
1979	HAAKENSON, PHILIP N., FARGO
1980	IRGENS, JIM, WILLISTON
1981	ANDERSON, JR., HOWARD C., TURTLE LAKE
1982	KRAMER, JR., JOHN H., GRAND FORKS
1983	JOHNSON, GERALD R., FESSENDEN
1984	SOUTHAM, JOHN E., MOHALL
1985	SWINLAND, THOMAS L., DEVILS LAKE
1986	LeDOSQUET, JOHN J., WILLISTON
1987	LEGRID, DONALD A., NEW ROCKFORD
1988	ROGERS, RILEY H., VALLEY CITY
1989	MAYER, GORDEN L., HARVEY
1990	RONHOLM, ROY J., JAMESTOWN
1991	WELDER, ANTON P., BISMARCK
1992	HUBER, ARTHUR P., VALLEY CITY
1993	MALMBERG, MARVIN M., FARGO
1994	OLIG, J. HERMAN, HANKINSON
1995	DEWHIRST, GARY, HETTINGER
1996	SCHWINDT, ALVIN, BISMARCK
1997	IRSFELD, JAMES H., DICKINSON
1998	HERBEL, ELROY, ELGIN
1999	TOKACH, MARV, JAMESTOWN
2000	ZUEGER, EMIL, NEW ENGLAND
2001	KRUGER, RUSSEL C, MANDAN
2002	BAILLIE, FREDERICK D, RUGBY
2003	SILKEY, RICHARD B, DICKINSON
2004	WAHL, JEROME J, DICKINSON
2005	THOM, BONNIE J, VELVA
2006	TRETLINE, ROBERT L, DICKINSON

Al Doerr Service Award Past Recipients

1977	DOERR, AL, BISMARCK
1978	GROSZ, WM. J., WAHPETON
1979	FORBES, DAVID, FARGO
1980	MAYER, GORDON, HARVEY
1981	BERNARDY, JACK, FARGO
1982	SCHULD, JOHN F., DICKINSON
1983	LEE, JOHN, FORMAN
1984	KROHN, ODELL, HARVEY
1985	ROGERS, RILEY, VALLEY CITY
1986	HAAKENSON, PHIL, FARGO
1987	WELDER, ANTON, BISMARCK
1988	OLIG, HERMAN, HANKINSON
1989	IRSFELD, JAMES, DICKINSON
1990	GEORGE, CLARENCE T., WAHPETON
1991	LINK, RAYMOND, BISMARCK
1992	SCHLITTENHARD, DuWAYNE, FARGO
1993	OLIG, DAVID J., FARGO
1994	ZUEGER, JR., EMIL E., NEW ENGLAND
1995	ANDERSON, JR., HOWARD C., TURTLE LAKE
1996	AIPPERSPACH, LORETTA, JAMESTOWN
1997	DEWHIRST, GARY W., HETTINGER
1998	HAROLDSON, LAUREL, JAMESTOWN
1999	TREITLINE, BOB, DICKINSON
2000	THARALDSON, TOM, FARGO
2001	BILDEN, PAUL, NORTHWOOD
2002	BIRKMAIER, GEORGE (SKIP), GRAND FORKS
2003	ABRAHAMSON, EARL, DICKINSON
2004	OBERLANDER, KEVIN, BISMARCK
2005	BUCHHOLZ, DENNIS, LISBON
2006	CHURCHILL, PATRICIA, BISMARCK

Past Award Recipients

Pfizer Health-System Pharmacist of the Year

1978	RILEY ROGERS, VALLEY CITY
1979	NO NOMINATIONS – NO RECIPIENT
1980	NO MINUTES
1981	NONE LISTED IN MINUTES
1982	NO MINUTES
1983	NO MINUTES
1984	NONE LISTED IN MINUTES
1985	NONE LISTED IN MINUTES
1986	ROBERT BIBERDORF, FARGO
1987	JAMES CARLSON, FARGO
1988	CAMILLE WISSMAN
1989	HOWARD C. ANDERSON, JR, TURTLE LAKE
1990	TOM SIMMER, BISMARCK
1991	JERRY DUFAULT, GRAND FORKS
1992	AL SCHWINDT, BISMARCK
1993	DENNIS DELABARRE, BISMARCK
1994	HARVEY HANEL, FARGO
1995	WILLIAM STEFFEN
1996	GAYLE ZIEGLER, FARGO
1997	DEBRA MCPHERSON, BISMARCK
1998	CYNTHIA NAUGHTON, FARGO
1999	DOROTHY SANDER, BISMARCK
2000	KAREN FINCK, JAMESTOWN
2001	JEFFREY ZAK, GRAND FORKS
2002	JOHN SAVEGEAU, BISMARCK
2003	ROB NELSON, FARGO
2004	CARRIE SORENSON , BISMARCK
2005	JILL MCRITCHIE, LISBON
2006	JOAN JOHNSON, MANDAN

Pharmacist Mutual Distinguished Young Pharmacist

1987	ZEIGLER, GAYLE D., FARGO
1988	CARLSON, TIMOTHY S., MINOT
1989	OBERLANDER, KEVIN, BISMARCK
1990	OLIG, JOLETTE M., FARGO
1991	BILDEN, WADE, NORTHWOOD
1992	HANEL, HARVEY J., DICKINSON
1993	IRSFELD, STEVEN P., FARGO
1994	FINCK, KAREN M., JAMESTOWN
1995	MEESE, MARTIN G., BISMARCK
1996	BEISWANGER, DOREEN M., VALLEY CITY
1997	CLARENS, MARY LEE, FARGO
1998	SCHNASE, SUSAN M., FARGO
1999	HORNER, KEITH, BISMARCK
2000	WENTZ, MELISSA, MANDAN
2001	JONES, PAULA, MINOT
2002	TREITLINE, DAWN, DICKINSON
2003	NELSON, ROBERT, FARGO
2004	ALTRINGER, TERRY, MINOT
2005	GRONNEBERG, DAWN, BISMARCK
2006	NOESKE, AMY, VALLEY CITY

Elan Innovative Pharmacy Practice

1996	SCHLITTENHARD, DEWEY, FARGO
1997	TREITLINE, ROBERT L., DICKINSON
1998	OBERLANDER, KEVIN, BISMARCK
1999	DAVIS, THOMAS D., BISMARCK
2000	STORANDT, HARRISON (CHIP), FARGO
2001	IRSFELD, STEVEN, DICKINSON
2002	FINCK, KAREN, JAMESTOWN
2003	DOE, JODY, KILLDEER
2004	MCGARVEY, CURTIS, BISMARCK
2005	CHRISTENSON, ERIK, RUGBY
2006	GODFREY, ANTHONY, FARGO

Dear Pharmacy Provider:

The National Council of Prescription Drug Programs (NCPDP) is an authorized Electronic File Interchange Organization ("EFIO") for pharmacies who need to obtain their National Provider Identifier (NPI). NCPDP has earned a reputation as being a capable pharmacy enumerator since 1981, during which time NCPDP has provided pharmacies with NCPDP Pharmacy ID numbers (formerly known as NABP numbers).

In addition to enumeration, NCPDP maintains the NCPDP Pharmacy Database. The Database contains information on pharmacy demographics and hours of operation, pharmacy payment center information, state license numbers and other relationships and affiliations including your relationships with other entities. Industry uses this database for claims processing, direct mailings of product recalls and publications, network development, health plan directories and rebate information.

By May 23, 2007, the NPI will be the single national provider identifier (including pharmacies) replacing the NCPDP Pharmacy ID currently required by health plans, Medicaid/Medicare and PBMs. By taking on the role of an EFIO and submitting electronic files of new pharmacies and changed information on behalf of your pharmacy, you can be assured our industry will experience minimal disruption as we move from using the NCPDP Pharmacy ID number on a pharmacy claim to using the NPI.

Under NCPDP's guidance, the pharmacy industry has developed a transition plan to occur over the next nine months. NCPDP has begun enumerating pharmacies and is accepting paper NCPDP/NPI applications or standard Excel Input Spreadsheets from pharmacies to update the database and submit information to obtain your NPI. CMS requires that you certify that your data is correct and has been undated within the past 12 months. The Application Form can be found at http://www.ncpdp.org/frame_news_npi-info.htm along with other important information.

NCPDP requests that you authorize NCPDP to enumerate your pharmacy with CMS on your behalf by checking the box in Section 11 of the Application Form. Doing so will help insure your NPI as well as your current NCPDP Pharmacy ID number will be more easily distributed, that your claims are more likely to process normally, and that industry is minimally disrupted. NCPDP will not charge any fees for its EFI activities on your behalf. Please fax the Application/Update Form or letter to NCPDP at 480-767-1043. Once your NPI has been assigned, NCPDP will notify your pharmacy's contact person of your NPI in writing.

If you have already obtained your NPI, please fill out the Application/Update Form and include your NPI on the Form and attach a copy of your NPPES NPI notification. This insures NCPDP will update NPPES regarding all future changes to your data when you update us and your NPI will be on the NCPDP Database for industry along with your NCPDP Provider ID. If you do not wish to use NCPDP to update NPPES in the future, sign the "Authorization to Distribute" letter found on this CD.

If you have any additional questions or concerns, please call Jeannine Deese at 480-477-1000, ext. 116. Thank you for your consideration.

National Council for Prescription Drug Programs
NCPDP

Search Committee For New Executive VP

Jerry Wahl, Dickinson, Chair
Joel Aukes, Fargo, NDSHP
Dennis Johnson, Grand Forks, NDPhA
Bonnie Thom, Velva, NDSBOP
Dave Olig, NDPSC
Diane Halvorson, NAPT
Matt Paulson, Carrington
Carla Aipperspach, Wishek
Larry Larsen, Watford City
Terry Altringer, Minot
Lorri Giddings, Bismarck
Mark Hardy, NDSU Student Rep
Charles Peterson, NDSU College of Pharmacy
Barb Lacher, NDSCS Pharmacy Technician Program

Election results for Vice-President: Earl Abrahamson, R.Ph.

The following names will be forwarded to the Governor for consideration to appointment to the ND State Board of Pharmacy: *Rick Detwiller, R.Ph., Bob Treitline, R. Ph., Gayle Ziegler, R.Ph.*

Joel Aukes, RPh
President, NDSHP

Member Involvement Ensures a Successful Organization

The success of any organization depends on the involvement of its members. This is especially true for volunteer organizations like NDSHP. However, in our daily attempts to balance out professional and personal lives, it's hard to imagine that we could find the time to be on a board of directors or an organizational committee. What a lot of members don't realize is that there are other ways to become involved with minimal time commitment, yet this involvement is still essential to the viability of the organization.

One way to be involved is to become aware of the current activities of the organization both at the district and state level. This can be accomplished through the attendance of your district meetings. The district meetings can and often do have a member of NDSHP in attendance who can give an update. Another way to stay current is to read the NoDak Pharmacy journal and other mailings from NDPhA and NDSHP.

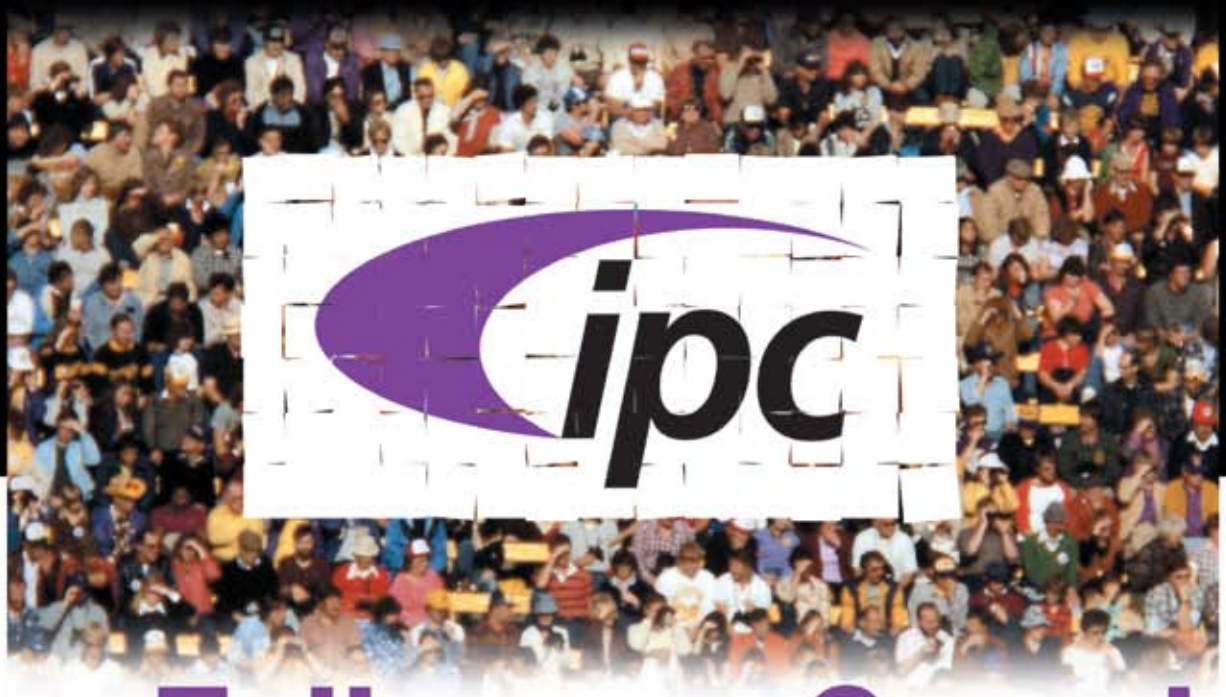
Another form of involvement is the completion and returning of the ballots and surveys from your organization. Even though this probably takes the least amount of time commitment it is by far the most critical form of involvement in any organization. It is the results of these ballots and surveys that establish a direction for the Board of Directors. Without such feedback, the Board of Directors has difficulties in determining organizational priorities and a delay in the advancement of the organization.

While requiring more initiative by a member, contacting and providing direct input to your representatives or board members is also an important form of involvement. In this case constructive criticism and disagreement is welcome, but equally important is letting them know when you agree with their direction and actions.

As you can see involvement in an organization takes many forms and the examples which I have listed require only a small amount of time. I hope that I have also illustrated that the most important reason to become involved is to ensure your views are heard.

In closing I'd like to thank all of the members who attended the legislative meetings through out the state in September and October. I was glad to hear your input on the Advisory Council update; this was exactly the interaction I had hoped for when the meetings were scheduled.

Sometimes it's OK



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NAPT Updates

By Danika Braaten - NAPT Presidnet

Where does the time go? It seems like it was just yesterday I was getting ready for the Fall Conference, that's come and gone and I'm already getting excited for the 2007 NDPHA Convention. Speaking of Fall Conference, it was another stellar line up. The Conference started on Friday with Medication Errors and ended with "Depression and Suicide facts, Meds& Uncertainties. Saturday continued with topics that included: Drug Abuse, Drug Trends, Home Infusion, Technology and the Technician, Occupational Therapy, and the Future of Pharmacy. Kudos to the planning committee. In addition to the Fall conference, NAPT held their general business meeting, discussed here were:

- Advisory Council- Diane Halvorson, Barb Lacher , and Jeanette Bleaker will continue to represent NAPT on the advisory council. The last meeting was held on Saturday, September 23, 2006 which was attended by these individuals and will be giving a full report at our next meeting.
- E-mailing list- NAPT has created an emailing list for the registered technicians. To get your name added to this listing, please send an email to rphtechnd@yahoo.com. If you do not have access to email you may contact any member of the NAPT Executive Board and provide them with your name and address. This information (email address or mailing address) will be used to provide time sensitive information pertaining to the Pharmacy profession as well as any other important issues that may affect you.
- Traveling meetings- The NAPT executive board will be traveling to all 8 districts to have district meeting and provide a CE. Look for this in the spring. If anyone is interested in assisting in the setting up these meetings in your district, please contact any member of the board.
- Technician of the year- 2007 NAPT Technician of the year. This award is given annually to a NAPT member who has been an outstanding achiever in the practice of pharmacy as a Pharmacy Technician. Nomination may be submitted by either a Pharmacist or Pharmacy Technician. Some guidelines to keep in mind are:
  - o Each nominee shall be an active member of NAPT
  - o No nominee shall be a member of the Selection Committee which includes the Vice President of NAPT, past recipients of this award and one additional NAPT member selected by the NAPT President.
  - o Each nominee shall be an outstanding achiever in the Pharmacy Technician profession.

Nominations must be submitted via a formal memo and must be signed by the nominator. If your nominee is selected to be the recipient of this award, it will be your option to either let the individual know ahead of time or surprise them at the awards ceremony (if a surprise it will be the nominators responsibility to ensure the recipient will be at the awards ceremony). The letter of nomination will be read at the time of presenting the award. If the nominator wishes to remain anonymous, please indicate this on the memo. **Nominations for this award will be accepted from December 1, 2006 through February 15, 2007.**

Please contact any member of the board if you have any questions about Tech of the year.

NAPT Pharmacy Technician of the Year Award Past Years Recipients

1996-Kathy Kochevar
1997-Robin Nelson
1998-Barbara Lacher
1999-Kim Durben
2000-Becky Prodzinski
2001-Diane Halvorson
2002-Jeanette Bleecker
2003-Sarah Meyer
2004-Denise Arends
2005 – Brittany Coughlin
2006 – Marisa Dolbeare

National Pharmacy week was Oct 22-28. I hope all you enjoyed it. Pharmacy couldn't be where it is today, without all you did yesterday. As always if anyone has any issues they would like to discuss, the board is always open for your comments. I hope everyone enjoys the holidays!

Congratulations

New Technicians

Renita C. Ba West Fargo
Beverly L. Brackeen Grand Forks AFB
Kimberly D. Froemke Fargo
Derrick R. Brown Fargo
Judy A. Leslie Fargo
Tessa E. Waxweiler Mantador
Chelsey A. Vinger Bismarck
Amanda J. Teigen Grand Forks
Sari J. Thomas Rock Lake
Mandi J. Aamold Hatton
Jesse L. Trottier Grand Forks
Claudia M. Deery Gardner
Dane R. Molde Grafton
Jason E. Narveson Grand Forks
Stacey L. Hughes Minot
Amanda L. Hoppe Bismarck
Jenny L. Tofte Williston
Megan E. Odermann Des Lacs
Jodi L. Schwehr Bismarck
Josie R. Schwab Fingal
Jana E. Kapaun Casselton
Alana M. Malaterre Rolla
Denise R. Alexander Mohall
April D. Keplin Grand Forks
Tiffany Huynh Fargo
Lori R. Loff Wahpeton
Derek D. Gietzen Minot
Jamie L. Johnson Valley City
Kristen M. Bonness Fargo
Christina M. Ridley-Kadrmas Dickinson
Amanda K. Willprecht Wahpeton
Darcy M. Fitzgerald Bismarck
Ginger M. Anderson Grand Forks

Advisory Council of NDPHA Impacting the Pharmacy Technician

Submitted by Diane Halvorson, RPhTech

At the NDPHA Convention in 2004, a new direction was explored and an Advisory Council was implemented. The purpose of this committee was to take all the entities of Pharmacy in North Dakota and see if we could work together to form a uniform Association to best represent the Profession of Pharmacy. Such representatives included Executive Members from the following Boards; NDPhA, NDSHP, NAPT and representatives from the ND Board of Pharmacy, NDSU College of Pharmacy (faculty and students)and NDSCS.

Jeanette Bleecker and myself represent the Northland Association of Pharmacy Technicians (NAPT) on this Advisory Council. Barb Lacher represents the North Dakota State School of Science, Pharmacy Technician program as well representing NAPT.

Throughout this process, the Advisory Council has worked diligently to dissect the needs of all entities brought to the table. The ultimate goal is to have a viable organization that represents Pharmacy as a whole.

One might ask how this restructuring would affect each of us as a pharmacy technician. NAPT has been in existence for several years, functioning efficiently on a volunteer basis as an association for pharmacy technicians run by pharmacy technicians. It is clear with the change of times, it would be a great opportunity to unify with the pharmacists as we work so well together in the work place, the dynamics seem rather simple that we would also work well together in a unified association. As we struggle on a year basis to find those who wish to commit to the NAPT Executive Board, reason being it is such a huge time commitment. By becoming a part of one organization, we would then be able to utilize the resources offered by the Executive Director of NDPhA as well as the resources of the office. Such opportunities gained would be beneficial to everyone.

As we continue to work together to determine the best for all groups, we will do our best to disseminate the information to our members. Truly the fate of our organization rests in the direction our members feel would be most beneficial for our association as well as for our profession. We encourage each of you to not hesitate to contact us should you have any comments, questions or concerns regarding this issue.

Charles Peterson, Dean
NDSU College of Pharmacy

A Message from the Dean

The following is the annual report for the North Dakota Institute for Pharmaceutical Care which was recently submitted to me by Dr. David Scott, Director of NIPC which summarizes the Institute's goals, priorities, and accomplishments for the 2005-06 academic year.

North Dakota Institute for Pharmaceutical Care (NIPC)

The College hired a new director (Dr. David Scott) for the NIPC in 2003. Dr. Shamima Khan was hired in 2005 and her expertise in pharmacoeconomics has strengthened the Institute's economic assessment capabilities. In 2004 the mission statement and actions plan steps were revised.

Mission Statement

The North Dakota State University's (NDSU) College of Pharmacy serves the state and region through its programs in pharmaceutical education, research, patient care, and public services. The North Dakota Institute for Pharmaceutical Care is an outreach arm of the College of Pharmacy. Initiated in 1996 and reorganized in 2003, the Institute exists for the purpose of helping pharmacists improve their practice and providing them with a ready source of health and drug information and assessment skills. Dr. David Scott is the director.

For drug information questions, contact Donald.Miller@ndsu.edu, phone 701-231-7941.

For assessment questions, contact David.Scott@ndsu.edu, phone 701-231-5867.

Action Plan Steps: The status of each action step follows.

1. Assess the current level of pharmaceutical care and technician use in ND
   a. Assess the need for pharmaceutical care and training areas in ND
   b. Compare rural vs. urban areas
   c. Identify high performance pharmaceutical care sites
   d. Compare telepharmacy and non-telepharmacy project sites

Status. In 2005, a $4,375 grant was funded by the North Dakota Board of Pharmacy to pay for the cost of survey mailing and data entry. The **ND Pharmaceutical Care Survey** was mailed to 686 pharmacists registered and living in North Dakota. A postcard reminder was mailed 2 weeks and 8 weeks, and a repeat second and third survey mailing was sent at 6 and 10 weeks to non respondents. Of the 686 surveys mailed, 412 (60.0%) surveys were returned. All surveys were entered. The data is being analyzed, and a report will be submitted to address the Action Steps 1a-d listed above.

On a second project to measure the current level of technician use in ND (Action Step 1a), the director has worked with the Northland Pharmacy Technician Association (NPTA) to conduct the **ND Pharmacy Technician Wage, Benefits and Responsibilities Survey.** Dr. John Schommer's survey with the Midwest Pharmacist Workforce Research Consortium (Minnesota Pharmacist, 2002, 56:3:29-32.) on wages and benefits has been modified, and pharmacy technician responsibilities were added to the survey instrument. Pharmacy technicians registered with the North Dakota Board of Pharmacy were surveyed. The response rate was 56.1% (251/451). Preliminary results were presented at the NPTA Fall meeting in Grand Forks (9-17-05), and final results were presented at the NDPhA Annual meeting in Dickinson (4-22-06). A technical report will be submitted to the NPTA and a manuscript will be submitted to ND Pharmacists Association Journal.

On a third project, the director is conducting the **ND Pharmacist Salary and Workforce Survey.** Dr. John Schommer's survey on wages and benefits and Dr. Caroline Gaither's 2004 National Workforce Survey (tasks, stress, and job satisfaction) have been modified. The survey will compare pharmacy

settings on pharmacist wages, benefits and workload indicators. A $3,000 grant (3-1-06) from NDSU Department of Pharmacy Practice Research Grant Program and a $2,500 grant (7-1-06) from the North Dakota Board of Pharmacy were obtained to fund this project.

2. Respond to the needs of practicing pharmacists in North Dakota by working with them to upgrade their knowledge, skills, and practices through the Institute's outreach programs.
   a. Identify existing national and regional training programs that meet pharmacists' needs (i.e., asthma, diabetes).

Status: Ongoing process – National training programs have been identified and pharmacists are referred to them, unless there is a substantial group to train.

   b. Develop and implement disease state management certificate programs in areas where there is a significant number of pharmacists with a need, or in areas where programs are not yet developed.

Status: Pharmacist's needs are being assessed by the Pharmaceutical Care Survey described in Action Step 1a. The director worked on the NDPERS Project with Dr. Patricia Hill (NDPhA) and a planning group to develop and assess a certificate training program in diabetes/asthma. Unfortunately, this project was not implemented by NDPERS.

On a second project, the College received a HRSA grant for a **Geriatric Education Consortium** where medicine, nursing and pharmacy will be training health professionals to work together to provide medication therapy management (MTM). Due to Congressional budget cutbacks, this project has been scaled back and with the remaining funds will conduct a pilot MTM project.

On a third project, Dr. William Doucette from the University of Iowa received a $92,000 grant (March 1, 2006) from the National Community Pharmacy Foundation to establish a **Midwest Region Medication Therapy Management Project.** The director and Dr. Patricia Hill are working with Dr. Doucette on this project.

   c. Assess the impact of the ND pharmaceutical care activities through the ECHO (economic, clinical, humanistic outcomes) model approach.

1. Economic outcomes
   a. Assist development of business plans
   b. Reimbursement for pharmaceutical care

Status: Pharmacist's level of reimbursement is being assessed by the Pharmaceutical Care Survey described in Action Step 1b. Dr. Khan is also conducting a study to develop a **business plan to assess telepharmacy services.** The financial statements for 2002-04 were obtained from Jody Doe at the Killdeer Pharmacy. Since the information was not sorted by the three pharmacies, Dr. Khan received assistance from Jody Doe's accountant to sort the data by the three pharmacies, so appropriate analysis could be done. Currently, the financial statements are in an Excel spreadsheet and some of the financial ratio analysis has been completed and compared to national standards. A technical report on the business case will be submitted.

2. Clinical outcomes
   a. Medication Dispensing Error Study. To measure medication dispensing accuracy rates in remote telepharmacy sites and compare to pharmacies in a comparison group

Status: Conducting the **Medication Dispensing Error Study** in conjunction with the North Dakota Telepharmacy Project. Currently has 30 pharmacies enrolled (8 central, 14 remote and 8 comparison pharmacies) and pharmacists and technicians were trained in 2004. A poster paper was presented at the 2006 APhA Annual Meeting. A presentation was given at the NDPhA Annual Meeting on "Reducing Medication Errors" in April 2006. In 2006, the Project will be expanded to 17 new Telepharmacy pharmacies (9 central and 8 remote). Hands-on training will be conducted in Bismarck (9-09-06) and Fargo (9-23-06). Comparison of error rates will continue through the next 24 months.

3. Humanistic outcomes

Status: Director is conducting a **Patient Satisfaction Survey with the North Dakota Telepharmacy Project.** The study was pilot-tested and protocol was approved by the IRB based upon receipt of letters of cooperation from participating telepharmacy sites (n=2). Two central pharmacies each with four remote Telepharmacy sites have administered the satisfaction survey (50/site) to patients who received one or more prescriptions at their sites to evaluate the quality of pharmacy services. Overall, 111 of 400 surveys (27.8% response rate) were obtained. Data has been entered and analysis is underway.

Pharmacy News Briefs

Medicare Part D Update

CMS announced the final Medicare Part D prescription drug plans approved for 2007. Most states will have MORE plan options, rather than less (which is what was requested because of the confusion this year.) There are 17 national plans (up from 9 this year). The complete list of plans is available on the Medicare website. Open enrollment begins November 15 and runs through December 31. CMS is strongly encouraging seniors to sign up by early December to ensure a smooth transition on January 1, 2007.

Seniors can go to www.medicare.gov RIGHT NOW to take advantage of new enhancements that make it easier for them to get personalized information on what the plans are offering...thus helping them decide which plan to sign up for (or switch to). Many will not need to make any changes.

Low income beneficiaries (not dual eligibles, but those in the lower income category) may have to switch plans in order to remain in a subsidized plan because the premiums for LLIS (low income subsidy) are lower in 2007 than they were this year. Those who choose to stay in a plan with a premium above the low-income benchmark for 2007 will be responsible for paying the difference. All LIS beneficiaries who might fall into this category were contacted by CMS in October 2006.

Importation News

Just prior to the pre-election break, Congress passed the 2007 Department of Homeland Security Appropriations Act which does not legalize importation of drugs but does permit individuals to import (transport on their own person) a 90-day supply of an FDA-approved drug from Canada (with the exclusion of controlled substances and biologies). This action reverts importation enforcement back to the FDA.

After the enactment of this law, the Custom & Border Protection agency decided to end its policy of stopping imported drugs from crossing the border through the mail. Now when shipments are stopped (at a central site), Customs will only focus on a select group of drugs and ignore others. This renews the concerns over patients potentially receiving counterfeit drugs and not realizing the difference or consequences.

Apparently, Canadian sources have noted their continuing concern about the drug supply and their capacity to care for patients in both Canada and the USA.

TRICARE Passes Without Mandated Mail Order

After extensive negotiation, Congress passed the National Defense Authorization Act for Fiscal Year 2007, including a provision provisions for TRICARE – the health care program for active duty military, active duty service families, retirees and their families. This includes more than 9 million people worldwide.

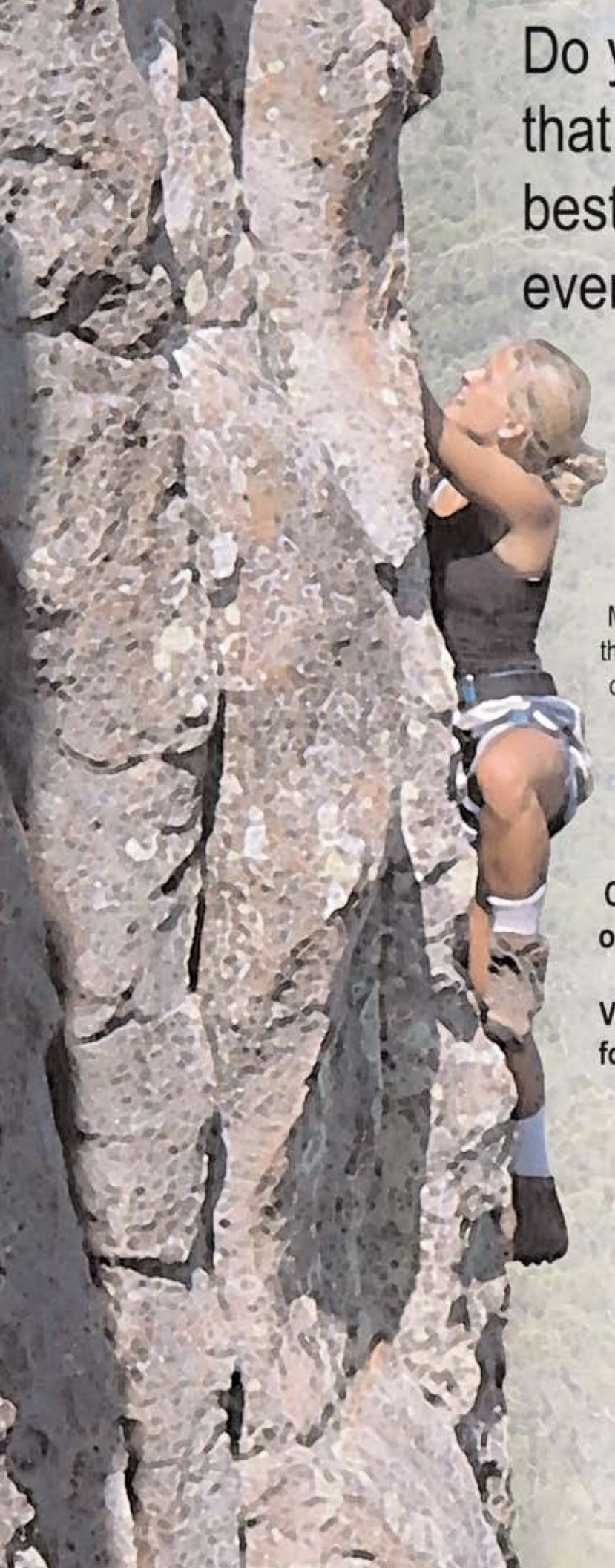
In the final bill TRICARE patients can continue to go to their local pharmacist to get prescription medications, and will not be forced to use mail order. Co payments will not be raised for patients who use their local pharmacy. Congress also agreed that discount prices currently provided by drug manufacturers only to TRICARE patients at military treatment facilities and through mail order, should also be available to a retail pharmacy (under the new law).

MEDCO Agrees to Another Fraud Settlement

October 25, 2006 -- US Department of Justice announced that Medco Health Solutions, the giant pharmacy benefit manager (PBM), agreed to pay the US government $155 million plus interest to settle allegations that the company submitted false claims to the government, solicited and accepted kickbacks from drug manufacturers to favor their drugs, and paid kickbacks to health plans to obtain business.

"This settlement confirms what we have been saying for years," said Bruce Roberts, RPh. And CEO of NCPA. "The business model for the giant PBMs is subterfuge, false claims and kickbacks, and has nothing to do with the health and well-being of patients."

Medco settled a separate lawsuit with the US Attorneys office in Philadelphia, and an Ohio jury found Medco guilty of defrauding the State Teachers Retirement System in 2005. Medco paid $7.8 million in that suit. Additional lawsuits are ongoing by state attorney generals in dozens of states who are looking into the business practices of Medco and other PBMs.



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