NoDak Pharmacy

Volume 19, No. 5, September 2006

Compounding to Meet Patients Needs

October is National Pharmacist Month

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Mark Your Calendar

September Calendar Events

September 6
District 8 Meeting – Fargo

September 7
District 4 Meeting – Grand Forks

September 9 & 23
PQC Training: Bismarck & Fargo

September 15-16
NAPT-NDSHP Fall Seminar in Bismarck

September 15-18
APhA Legislative Conference

September 20
ND Opportunities Night at NDSU

September 21 - NDSU Career Fair

September 29 & 30
Immunization Training Program: Bismarck & Fargo

October Calendar Events

Legislative Breakfast Meetings during Pharmacy Month
October 3, Bismarck – Kelly Inn
October 17, Grand Forks – Hilton Garden Inn
October 19, Fargo – NDSU Alumni Center
October 24, Williston – El Rancho Motor Inn
October 26, Minot – Sleep Inn
October 31, Jamestown – Gladstone Inn

District Meeting
October 3 - District 6, Bismarck
October 23 - District 1, Williston
October 25 - District 2, Minot
October 30 - District 7, Jamestown

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OFFICERS

NDPHA Officers

President Dennis Johnson
Wall's Medicine Center
Work Ph: (701) 746-0497
Fax: (701) 746-7908
E-Mail: dennis.
johnson@nodakpharmacy.net
walls@wallsrx.com

President Elect Jerome Wahl
St Joseph's Hospital & HealthCenter Pharmacy
Work Ph: (701) 456-4388
Fax: (701) 456-4807
E-Mail: jerome.
wahl@nodakpharmacy.net
JerryWahl@catholichealth.net

Vice President Lance Mohl
KeyCare Pharmacy
Work Ph: (701) 857-7900
Fax: (701) 857-783
E-Mail: lance.
mohl@nodakpharmacy.net
Lance.Mohl@trinityhealth.org

Chairman of the Board
Timothy Carlson
White Drug #17
Work Ph: (701) 852-4181
Fax: (701) 839-6019
E-Mail:
timothy.carlson@nodakpharmacy.net
P017@thriftywhite.com
tcar@min.midco.net

NDSHP Officers

President Joel Aukes
SCCI Hospital – Fargo
Work Ph: (701) 241-9099
Fax: (701) 241-4351
E-Mail: joel.aukes@nodakpharmacy.net
JAukes@triumph-healthcare.com

President Elect John Savageau
Medcenter One Hospital Pharmacy
Work Ph: (701) 323-6186
Fax: (701) 323-6988
E-Mail: john.
savageau@nodakpharmacy.net
jsavageau@mohs.org

Secretary/Treasurer
Melanie Cairns
Altru Health System Pharmacy
Work Ph: (701) 780-5150
Fax: (701) 780-1486
E-mail: melaine.
cairns@nodakpharmacy.net
mcairns@altru.org

Immediate Past President
Joan Johnson
St. Alexius Medical Center Pharmacy
Work Ph: (701) 530-6924
Fax: (701) 530-6940
E-mail: joan.
johnson@nodakpharmacy.net
jjohnson@primecare.org

Member At Large Wendy Baisch
Mercy Hospital
Work Ph: (701) 774-7733
E-mail: wendy.
baisch@nodakpharmacy.net
wendyb@wil.midco.net

NDPSC Officers

President Dennis Johnson
Wall's Medicine Center
Work Ph: (701) 746-0497
Fax: (701) 746-7908
E-Mail: dennis.
johnson@nodakpharmacy.net
walls@wallsrx.com

Vice President David Olig
South Pointe Pharmacy
Work Ph: (701) 234-9912
Fax: (701) 297-0807
E-Mail: dolig@aol.com

Secretary/Treasurer Robert Treitline
ND Pharmacy
Work Ph: (701) 225-4434
Fax: (701) 225-0013
E-Mail: robert.
treitline@nodakpharmacy.net
ndpharmacy@ndsupernet.com

Executive Vice President
Dr. Patricia A. Hill
Website: nodakpharmacy.net
Phone: (701) 258-4968

NAPT Board Members

President Danika Braaten
Northland Community & Technical College
Work Ph: (218) 773-4523
Altru Health System Pharmacy
Work: (701) 780-5158
Fax: (701) 780-1486
E-Mail: danika.
bratten@nodakpharmacy.net
danikaj@hotmail.com

Vice-President Brittany Muchow
MeritCare Hospital Pharmacy
Work Ph: (701) 234-5603
Fax: (701) 234-5090

Treasurer Melissa Heley
Clinical Supplies Management, Inc.
Work Ph: (701) 235-8002
Fax: (701) 235-8014
E-Mail: mheley@csm-plus.com

Secretary Barb Kalloch
Mercy Hospital Pharmacy
Work Ph: (701) 774-7433
Fax: (701) 774-7688
E-Mail: ljkal@wil.midco.net

Members-At Large
To be announced

Past President Jeanette Bleecker
Clinical Supplies Management Inc
Work Ph: (701) 235-8002
Fax: (701) 235-8014
E-Mail: jeanette.
bleecker@nodakpharmacy.net
jbleecker@csm-plus.com

Parliamentarian Diane Halvorson
SCCI Fargo
Work Ph: (701) 241-4145 Ext 310
Fax: (701) 241-6641
E-Mail: diane.
halvorson@nodakpharmacy.net
dhalvo1034@cableone.net

Dennis Johnson, RPh

This is a time of ups and downs for pharmacy – wages are going up and reimbursements are going down, making the financial strain on all pharmacy practices pretty challenging. I think to myself (on a more regular basis) and I hear from my colleagues every week: "I'm just about ready to throw in the towel!"

In this atmosphere it is difficult to manage ANY pharmacy operation, whether you're in a health system setting or a community pharmacy. I have been trying to resolve staffing issues lately and came across this insight which I think could benefit others...

The 10 Things People Want Most In Their Jobs

By Joe Phelps, founder of California based The Phelps Group

With the free market determining the labor costs (salaries) in most products and services, the most important value-added component a company can offer its people increasingly will be job satisfaction.

Extensive research has been done on what's important to us in our jobs. The conclusions of most studies, and my personal observations, are that the following ten points are the main components of job satisfaction.

1. Recognition for a job well done

Mark Twain said he could live for two months on a good compliment. It is widely known that recognition is the number one motivator of people.

2. A healthy working environment

Clean, well-lit, adequate space; the proper equipment; and inhabited by people who care and who communicate in an honest, timely fashion. Some companies have workout rooms and bring in trainers to help their teams achieve optimum health.

3. Meaningful work

Trading your time in life to help achieve something worthwhile. This can be something within the company, the community or even global. Reminding your team that everything they do touches other people adds meaning to their lives and work.

4. Responsibility

People need to believe that they are responsible for their own actions, and that they are trusted. Self directed teams give people clear responsibility. They are also the ultimate delegation tool for busy executives.

5. Accountability

A feeling of ownership and of outcomes. It is a sense of the proverbial buck stopping with every single person and not in the lap of someone far down the line. People on self-directed teams willingly hold each other accountable as well as themselves. Accountability is the ability to follow through with your commitments.

6. Equitable compensation

Linked not to longevity or rank, but to performance; being treated like partners; possible equity in the business can be important. There are numerous ways to do this such as ESOP, phantom stock, etc. Talk with a compensation expert to find out what is best for your company, and then put the plan into action.

7. The chance to learn

Opportunities to grow into more significant positions with greater responsibility and ultimately, to increase one's value to the organization. Supporting the team members in getting advanced degrees or improving their skills through classes or conferences is a great way to open this door for them.

8. The chance to do great work

Not just work that meets minimum standards and expectations, but quality work: A+ work! Ask your team what it takes for them to do their job really well and ask if they'll commit to that standard.

9. Understanding

Knowing how the work relates to the realization of the overall goals of the business. Sharing the company goals, and getting input from your team at your annual meeting is a great tool for getting buy in and creating understanding.

10. The chance to work with interesting, motivated, responsible people

People whose personal and professional goals are in alignment with one's own. Encourage your team members to introduce great people to your company. You never know when you'll meet someone who is a great fit.

Dr. Patricia Hill

P_2A – An Essential Compound for Your Professional Survival!

Over the years pharmacy associations have tried various marketing ideas and messages to convey the important role that public policy debates and legislative initiatives play in the professional lives of pharmacists. For a majority of our pharmacy practitioners those messages have fallen on deaf ears.

It occurred to me that perhaps if we disguised the message as a chemical entity it would catch and hold your attention. Sooooo...introducing a new and essential compound for your profession survival – P_2A!

P_2A: Pharmacist Political Action

Generic Name: Lobbying (not a negative concept when practiced by pharmacists)

Description: Sharing your issues, concerns, solutions, and ideas with elected officials at the city, state, and national level.

Mechanism of Action: This can be accomplished by; a) volunteering or running for elected office at the city, state, and national level; b) actively supporting someone who is running for an elected position, (i.e. doorbelling, stuffing envelopes, putting up yard signs, fund raising etc. etc.); c) bringing your legislator to your pharmacy and visiting about key issues impacting patient access to care (such as reimbursement rates not covering your costs); d) making a contribution to the Pharmacy PAC Fund; e) encouraging a peer to make a contribution to the PAC; f) participating in statewide legislative breakfasts during Pharmacy Month in October; g) actively participating in NDPhA's annual Legislative Rally Day during the 2007 legislative session. (I think you get the picture.)

Indications: Necessary for the advancement of public health initiatives and the development of public health policies that improve patient health care outcomes. Also, indicated for the preservation of current pharmacy practice standards.

Dosage: For best results P_2A should be administered on a regular basis, both during the legislative session and during the interim between sessions. However, the legislative session is the most critical stage of the legislative cycle that may require intense off-label dosing for this very serious acute phase. Chronic long-term therapy during the interim session is the most effective way of building sustainable outcomes for the future.

Contraindications: None

Adverse Events: If administered in a combative or aggressive manner can result in door slammed in face. Best applied with honest intentions and willingness to compromise if needed.

Now that I have your attention let me share with you some thoughts and ideas on the upcoming elections and legislative session.

The NDPhA PAC Fund is in desperate need of your support. Today's health care crisis and the many political solutions that are being suggested to fix that crisis will require resources and expertise that we do not currently have. Soon you will receive a solicitation to send contributions to the NDPhA PAC fund – please take the time to become an active participant in this critical component of our lobby effort.

Unlike some other healthcare providers, North Dakota

pharmacists do not have a full time lobbyist. While I do my best to cover all the bases, it is not the same as having someone on staff who is constantly monitoring legislative initiatives during session as well as during the interim, developing legislative support for pharmacy initiatives, developing and updating a year round communication tool to inform members about current legislative and regulatory issues, and helping pharmacists who are interested in running for public office successfully achieve that goal.

This is an election year and a great time for individuals to get involved in a political campaign. Nothing opens doors as effectively, in both the state and federal legislative halls, as helping candidates get elected to office. There are many ways for you to get involved in the election process and I would urge you to contact the campaign office of your favorite candidate.

This is an important time for health care policy in general and in the practice of pharmacy in particular. I encourage you to increase your inventory of P_2A and administer it regularly in the coming months. We need your personal and financial commitment in the political arena to ensure our future and improve the health of the patients we serve.

Legislative Breakfast Meetings

October 3, Bismarck – Kelly Inn
October 17, Grand Forks – Hilton Garden Inn
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October 24, Williston – El Rancho Motor Inn
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October 31, Jamestown – Gladstone Inn

NDPhA – Finding better ways to keep you informed

The NDPhA e-mail database listserve is completed and ready for use! First of all, thank you to all members who responded to the mailings and provided us with your e-mail address. Having this listserve will keep us better connected and well informed on the important issues facing the pharmacy industry today.

The NDPhA will now be sending many informative pieces that normally would be postage mailed to you via e-mail, so take the time to check your e-mail and stay informed.

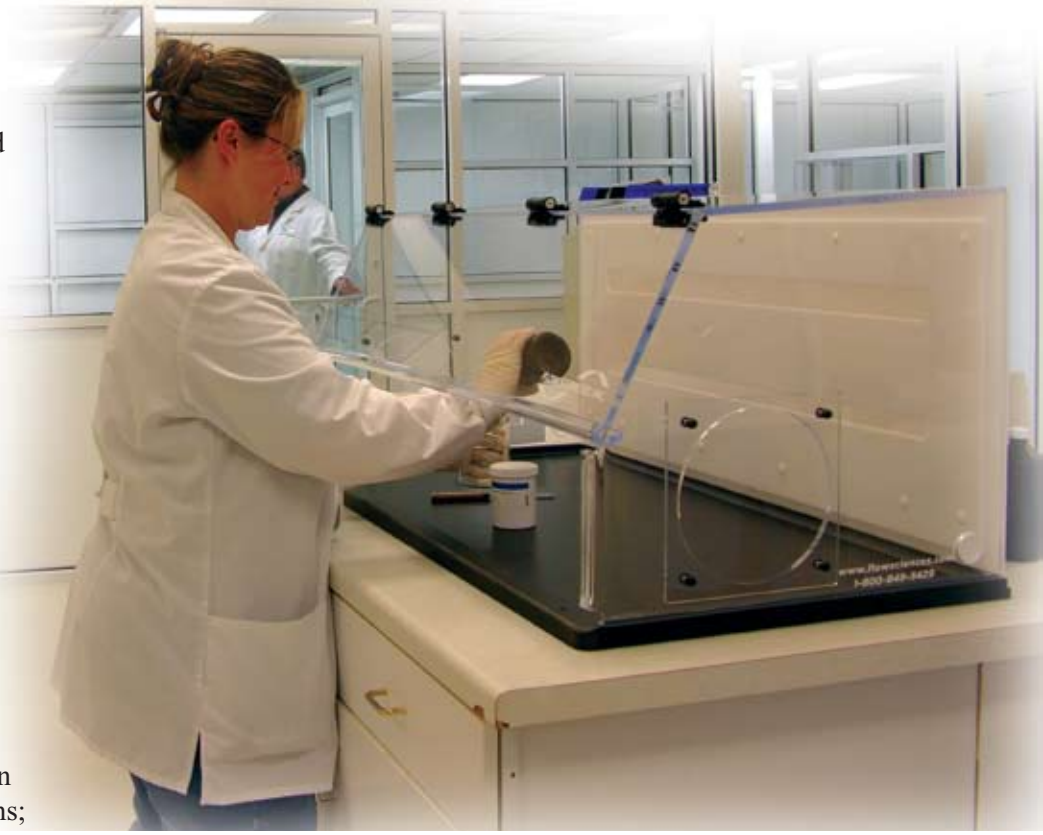
Again, we appreciate your participation in getting this listserve together. If you did not provide your e-mail address or have since updated your information, please contact the NDPhA at 701-258-4968 and we will gladly add you to the listserve.

Compounding to Meet Patient Needs

By Stacy Fiedler,
Clearwater Communications

Throughout the history of the profession, pharmacists have compounded medications. From ancient apothecaries to modern online pharmacies, compounding has been an integral part of the pharmacy profession. As pharmacies exist to meet the medical needs of the patient, compounding pharmacy is one of the greatest applications working to meet specific, individual patient needs.

In general, compounding is the customized preparation of a medication not otherwise commercially available. These medications are prescribed by a physician, veterinarian, or other prescribing practitioner and are compounded by a state-licensed pharmacist. Most often, medications are compounded to make them easier and safer for patients to use. Compounding can include: adding flavor to liquid medications; changing caplet forms of medication into drops or creams; removing dyes, preservatives, or binders; and tailoring dosage strengths to meet patient needs.



A pharmacy technician works in the new compounding lab at Dakota Pharmacy in Bismarck.

One of the key stipulations regarding compounding medication is that pharmacists may not compound medications that are already commercially available. Rather, there must be a specific patient need that is not being met by market drugs. Rick Detwiller, pharmacist at the Community Pharmacy in St. Alexius Medical Center and member of the North Dakota State Board of Pharmacy, says there is some gray area for pharmacists regarding what medications can be compounded. "There are several medications on the market that are similar to those often compounded, but not identical," says Detwiller. Pharmacists are left with the difficult decision of whether to compound these medications or use the very similar ones on the market."

North Dakota Pharmacists in Compounding

Pharmacy compounding requires a great deal of additional space, equipment, and time for research, yet many pharmacies and pharmacists in North Dakota practice compounding to serve the medical needs of their customers.

Heather Novak is a pharmacist and co-owner at PharmaCare in Fargo, the only pharmacy in North Dakota that distributes solely compounded medications. "As much as our pharmacy is like other facilities, it has different equipment and space," says Novak. "We need a lot of additional resources and spend a lot of time researching." As a compounding pharmacist, Novak is involved in compounding for adults, children, senior citizens, and even animals. She says a large portion of the compounding done at PharmaCare is for children. "It's rare to find pediatric medicine that doesn't have to be compounded to fit small children or to be more accessible to them," says Novak.

Other pharmacists in North Dakota also see compounding as a pharmacy niche that allows them to serve patients with special medication needs. The Meritcare Clinic Pharmacy in Fargo is one North Dakota pharmacy that specializes in specific compounding. Chip Storandt, pharmacist at Meritcare, says Meritcare has been at the forefront of the very complicated, intrathecal IV compounding. "I've given presentations across the country about intrathecal IV compounding," says Storandt. "In this area of compounding, we are something of a leader."

Intrathecal compounding involves altering pain medications to be used in an IV that is inserted directly

into a patient's spine. "By compounding the medication, we are able to use concentrated forms that aren't otherwise available for pain control," says Storandt. "The concentrated medication helps for much better pain management."

Other pharmacies across the state are involved in compounding at a variety of levels. From pharmacies such as PharmaCare that specialize in compounding, to smaller, rural pharmacies that compound only one or two medications each day, pharmacists compound to serve the needs of their customers.

Licensure and Regulation

Compounding pharmacies are licensed and regulated in all 50 states and the District of Columbia by their respective state boards of pharmacy. The National Association of the Boards of Pharmacy, the United States Pharmacopeia, and pharmaceutical manufacturers have established standards for compounding that are enforced by many states.

While compounding is regulated and governed by state boards of pharmacy, and all compounding pharmacists must be licensed pharmacists, there are no additional, required certifications or education necessary for compounding pharmacists, nor are there any written, national standards of practice.

According to Detwiller, there is a problem with not having standards for compounding. He says many pharmacists involved in compounding would like to have established guidelines and standardization for the practice. "The FDA has been looking at standards and creating more regulation, but it hasn't happened yet."

Compounding is changing and growing along with pharmacy technology. "It is stretching to include all sorts of new technologies, medications, and practices," says Detwiller. "As the technology increases, there is a greater need to have standards on the practice."

Pharmacy Accreditation

Dakota Pharmacy in Bismarck was, according to owner and pharmacist Kevin Oberlander, one of the first pharmacies in the region to have a compounding lab. As a pharmacist actively engaged in compounding, Oberlander is a member of the International Association of Compounding Pharmacists. As such, he's been closely monitoring recent efforts towards accreditation of compounding.

Within recent years, the Pharmacy Compounding Accreditation Board (PCAB) was formed by a multitude of pharmacy organizations that saw a need to develop and maintain principles, policies, and standards for the practice of pharmacy compounding. PCAB states, "Compounding pharmacists...are among the most dedicated. PCAB standards are another way of demonstrating their commitment."

Out of its mission and concern for standards of practice in the world of compound pharmacy, PCAB has developed an application and standard for accreditation. Pharmacies wanting to be accredited complete an application and submit to several rounds of on-site visits in order to meet accreditation standards. "Everything within the pharmacy is analyzed," says Oberlander. "There are staff, site, policy, equipment, and validation of process checks involved in the accreditation process."

To make accreditation more feasible for all compounding pharmacies, the level and cost of accreditation varies according to the level of involvement in compounding. Pharmacies that compound one to 15 medications per day pay $1,250 per year for accreditation, and go through a different accreditation process than those that compound more than 100 medications per day. These pharmacies pay $5,000 per year for accreditation.

As accreditation for compounding pharmacies becomes more prevalent, many pharmacists want to know the benefits of being accredited. Oberlander explains that as more pharmacies become accredited for compounding, insurers are beginning to look to PCAB to determine insurability. "As I see it, eventually it will be very difficult for pharmacies that are not accredited to do compounding, because it will be impossible to get liability insurance," says Oberlander.

Compounding, or tailoring medications specifically for the consumer is not only a convenience, but also a life-saving practice. "When medications are in a simpler, more patient-friendly form, patients are more likely to take them, thus increasing their effectiveness," says Detwiller. "By compounding medications, pharmacists are able to meet patients' needs that can't be met through ordinary market drugs. While compounding is a small portion of general pharmacy, is a very important service."

Understanding the Medicare Prescription Drug and Modernization Act of 2003

2007 Update on Medicare Modernization Act of 2003 presentation delivered through IVN network

Date: **Tuesday, September 12, 2006**

Time: **7:00 p.m. – 9:30 p.m.**

Target Audience: Any pharmacy personnel interested in and/or involved with Medicare part D

Where:

Bismarck- Bismarck State College
Bottineau- MiSU Bottineau
Devils Lake- LRSC
Fargo- NDSU
Grand Forks- UND
Jamestown- State Hospital
Mayville- Mayville State University
Minot- Minot State University
Oakes- SE Vocational Center
Valley City- Valley City State University
Wahpeton- ND State College of Science
Williston- Williston State College

Presenter: **Mark Hartman, R.Ph.,** Region VIII Pharmacist for Medicare and Medicaid Services

Objectives:

1. Discuss an overview of the implementation of the Medicare Modernization Act
2. Explain 2006 transition of beneficiaries to Medicare Prescription Drug Plans
3. Describe formulary issues and appeals/grievances process
4. Discuss and present topics specific to pharmacist and pharmacy operational activities for 2007

Disclosure: The presenter has no actual or potential conflict of interest in relation to this program

RSVP **By Thursday, September 7, 2006 to Carol at carol.jore@ndsu.edu**

(701)231-7589

Please include site you will be attending at.

Fee: $10.00 for continuing education request. This will be mailed to the College along with each individual's registration and evaluation form (available at presentation and required to receive credit).

A certificate of attendance will be mailed to those participating in the program. The College of Pharmacy at North Dakota State University is awarding 0.25 CEU's (2.5 hours) of Pharmacy Continuing Education Credit for the program.

North Dakota State University College of Pharmacy, Nursing, and Allied Sciences, is accredited by the Accreditation Council of Pharmacy Education as a provider of continuing pharmaceutical education.
ACPE approval number 047-000-06-135-L04

Howard C. Anderson, Jr. RPh
Executive Director

Guidelines Regarding Conscientious Objections

I have recently been asked if I would make some efforts to determine the stance of pharmacists practicing in North Dakota regarding conscientious objections, and to review all pertinent laws, rules/ regulations and guidelines of the State and the North Dakota State Board of Pharmacy, relating to the rights and responsibilities of a North Dakota Pharmacist, and to take appropriate action to ensure that all laws, rules/regulations and guidelines support the direction the pharmacists of our State wish to pursue.

This is a topic which has recently received considerable exposure in the press. In fact, several Governors have decreed that the pharmacists in their State MUST fill prescriptions for emergency contraception, when patients present those prescriptions.

Recently, there was a lawsuit when several Wal-Mart Pharmacies refused to stock certain medications, and in some cases chains have fired pharmacists for refusing to fill prescriptions in certain circumstances.

Religious overtones often get blamed for these controversies. Sometimes, religion is the genesis of a particular action. On other occasions, a particular drug may not be stocked for financial, utilization, or for reasons of risk avoidance. I can remember when most pharmacies did not stock Dilaudid® because they felt there was too much of a risk for theft if it was known that their pharmacy carried this controlled substance. We still have some pharmacies, in high-risk areas, not willing to stock certain Schedule II Controlled Substances. Certainly, some pharmacists may not wish to fill prescriptions for contraceptive medications, contraceptive devices or even have condoms in their pharmacies.

Here are some guidelines that I believe will help us address most of these issues, if we consider them in advance:

1. **Take care of care of the patient.**
   Pharmacists have a professional responsibility to act in the best interest of the patient. Each of us have had instances where we have counseled a patient to do certain things or not to do certain things when we felt that action was in their best interest. We should attempt to approach these issues with the focus that we are attempting to provide the patient with as much information as necessary, so they can make an informed choice about their healthcare.
2. **Pharmacists are employees at will.**
   This is a characteristic of employment law in North Dakota. Under the employment laws of North Dakota, as a professional, the pharmacist can quit anytime and they can be fired at anytime. There may be some contractual obligations, which have some financial consequences on one or the other of the parties, but both actions are legal.
3. **Talk to your employer or employees.**
   It should not come as a surprise to either the employee or employer if an individual has concerns about filling prescriptions for a drug or class of drugs. Certainly, for a pharmacist to order birth control pills in a hospital sponsored by an organization opposed to birth control, might not be appropriate. In turn, for an employer to expect an employee to take actions contrary to their own personal beliefs might also be inappropriate.
4. **Notify patients.**
   If our pharmacy has decided not to provide certain types of medical care, we should make some effort to notify potential patients of that decision. Consider placing signs where patients might be expected to see them with statements such as, “We Do Not Dispense Birth Control Pills.” Many pharmacies have signs which declare, “We Do Not Stock Oxycontin” or Dilaudid®, or some other drug. This gives patients notification so they may seek care in an alternate

setting. Sometimes notification is provided by a long-standing policy, which new employees should be informed about so they can/will continue the tradition of the business without confusion.

5. **Give the patient choices.**
   If you feel that you cannot care for the patient in a manner they expect, perhaps you should refer them to another professional who will provide that care. Very often this happens with physicians who either cannot or will not provide certain types of care, such as tubal ligations, hysterectomies, vasectomies or other procedures. They simply inform the patient of this and the patient can seek care in an alternate setting. If your beliefs are so strong that you cannot even discuss an issue with a patient, perhaps you are in the wrong profession. For example, a physician who does not believe in blood transfusions should not be the lone physician working in an emergency room.
6. **Have a fall-back procedure.**
   If an issue comes up that a pharmacist cannot or will not address, there should be a fall-back procedure, such as calling another pharmacist the boss. This should happen rarely if the employer and employees have talked over the issue and made an effort to notify their patients.
7. **Remember – always keep the patient in mind.**
   We are professionals. We have taken an oath to always do our best to take care of our patients. That care might take different forms and different directions. However, we should always treat our patients with respect. We should always remember that once they have received the benefit of our knowledge and expertise, they are the ones who are ultimately responsible for the making of the decisions for their own care.

OCTOBER IS NATIONAL PHARMACIST MONTH

Consumers with questions about their medications don't have to worry about where to get information. ***PHARMACISTS are their best and most accessible medication experts!***

A dialogue between the patient and pharmacist about any prescription and nonprescription medications being taken will ensure that health benefits are optimal and harmful side effects avoided.

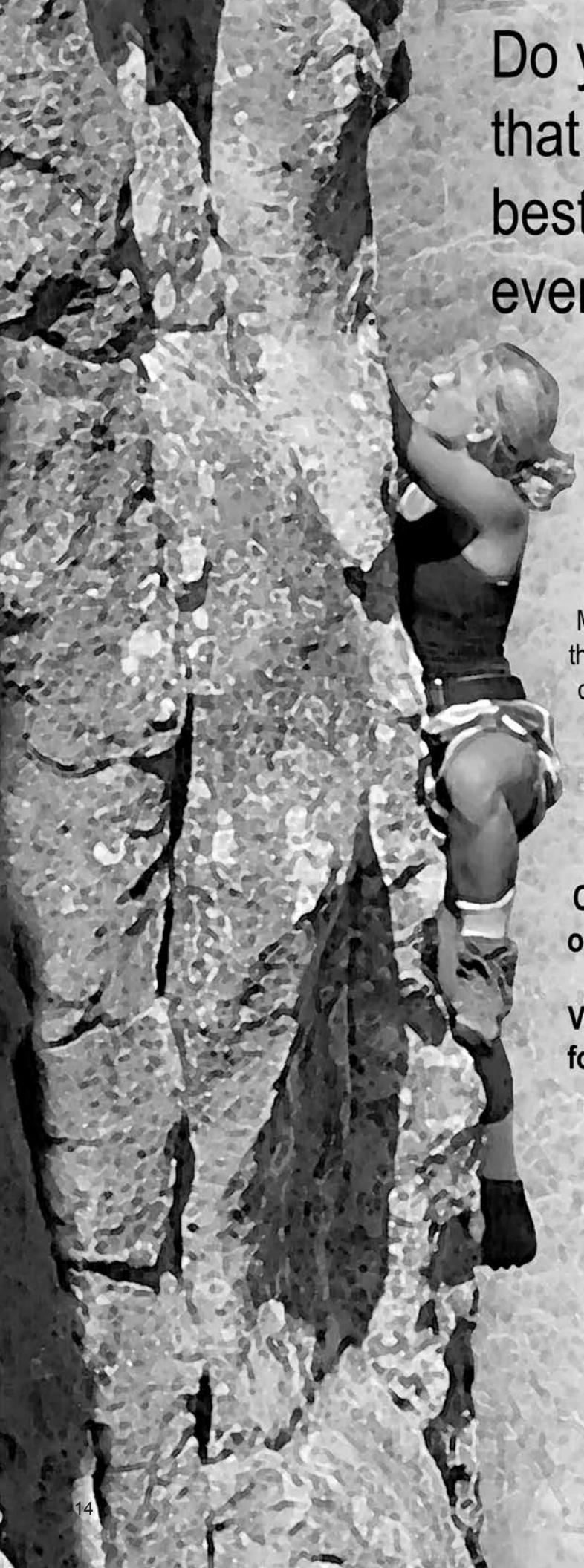
Pharmacists provide consumers with answers to questions that might arise from a variety of online health information. Your pharmacist knows about interactions with food, medicines, or dietary supplements that can effect how medicines work. Some interactions can be dangerous.

Following the pharmacist's advice can also save money for consumers and help lower the nation's health care bill by ensuring proper use of medication. Not following instructions or discontinuing use without consulting a health care provider can lead to more expensive treatment, including surgery or hospitalization.

Patients must keep their pharmacist up-to-date on all prescription and nonprescription medications being taken so the pharmacist can monitor the patient's treatment and help guarantee a healthy result.

The pharmacist is no longer simply a dispenser of drugs, and most pharmacies have become health care centers. Pharmacists are key health care professionals, who are actively changing their practices to meet the challenges of the health care system and their patient's needs and demands. Patients should choose a pharmacist they trust and build a partnership for good health!

Celebrate Pharmacists Month.... Go see your local pharmacist and say "thanks!"



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Good for your pharmacy and your profession.

Continuing Education for Pharmacists

Volume XXIV, No. 6

Management of Hypertension: Lifestyle Modifications and Drug Therapy

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 define hypertension, and discuss current management guidelines and reasons for non-compliance.

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

1. define hypertension and its prevalence;
2. list lifestyle modifications to reduce the risk of onset and maximize reduction of elevated blood pressure;
3. recognize appropriate drug therapy and monitoring parameters; and
4. identify barriers to patient adherence and reasons for noncompliance.

This continuing education activity is supported by an educational grant from GlaxoSmithKline.

gsk GlaxoSmithKline

Hypertension is the most common primary diagnosis in America. Approximately 50 million individuals in the United States (i.e., one in four adults) and one billion worldwide have elevated arterial pressures. Prevalence will increase further as the population ages unless widespread, effective preventive measures are implemented. At present, individuals with normal blood pressure at age 55 have a 90 percent lifetime risk for developing hypertension.

Hypertension is asymptomatic, readily detectable, and oftentimes manageable. Less than one-third of patients with hypertension, however, actually achieve optimal blood pressure control because of their non-adherence to lifestyle modification and/or drug therapy. Based on the National Health and Nutrition Examination Survey, the elderly have the poorest rates of achieving blood pressure control. This is especially problematic since high blood pressure can lead to other medical complications and may be fatal if not treated.

This lesson discusses current guidelines for therapy of hypertension based on the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7). It also lists barriers to patient adherence to lifestyle modifications and therapy.

Classification of Blood Pressure and Health Benefits of Reducing It

Table 1 summarizes blood pressure values for the normal state and various levels of pathology for persons 18 years and older, according to JNC 7. Classification is based on the average of two or more blood pressure readings, for each of two or more physician office visits. New to the current classification is a category designated *prehypertension*. Persons with prehypertension have an increased risk for advancement to clinical hypertension. Moreover, Stage 3 hypertension, from the previous classification system, has been combined with Stage 2 in the current classification. Individuals with blood pressure 130-139/80-89 mmHg are at twice the risk of developing hypertension as those with lower pressures.

The correlation between blood pressure and risk of adverse cardiovascular events continues throughout life. The higher the pressure, the greater the risk for developing heart failure, myocardial infarction (MI), stroke, and kidney disease. For individuals 40 to 70 years of age, each 20 mmHg increase in systolic or 10 mmHg in diastolic blood pressure doubles the risk of adverse cardiovascular events across the blood pressure range from 115/75 to 185/115 mmHg. The classification *prehypertension* acknowledges this correlation, thereby affirming the need for increased patient education by all members of the health care team.

Table 1
Classification of Blood Pressure for Adults ≥18 Years of Age*

Blood Pressure**	Systolic Pressure	Diastolic Pressure
Normal	<120 mmHg	and <80 mmHg
Prehypertension	120-139 mmHg	or 80-89 mmHg
Stage 1 hypertension	140-159 mmHg	or 90-99 mmHg
Stage 2 hypertension	≥160 mmHg	or ≥100 mmHg

*The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)
**When systolic and diastolic pressures fall into different categories, the higher category should be selected to classify the individual's blood pressure status.

Antihypertensive drug therapy (Table 2) has been demonstrated to reduce the incidence of MI by 20 to 25 percent, heart failure by >50 percent, and stroke by 35 to 40 percent. In patients with Stage 1 hypertension along with additional cardiovascular risk factors, blood pressure lowering of 12 mmHg systolic sustained over 10 years will prevent one death for every 11 patients treated.

Systolic Versus Diastolic Blood Pressures

Systolic blood pressure normally increases with age until the eighth or ninth decade of life. Diastolic pressure, in contrast, increases only until middle age and then either levels off or decreases slightly. The Framingham Heart Study showed that there was a gradual shift from diastolic to systolic blood pressure with increasing age as a predictor of cardiovascular risk. Diastolic pressure was a stronger predictor in patients <50 years of age; age 50 to 59 years was a transition period when both systolic and diastolic pressures were comparable predictors. From 60 years and over, however, coronary heart disease risk correlated positively with systolic pressure, more so than with diastolic pressure. Other studies have confirmed the greater reliability of systolic pressure over diastolic pressure as a predictor of cardiovascular morbidity and mortality.

Effective blood pressure control can be achieved in many hypertensive patients, but most will require two or more antihypertensive drugs to bring them to goal. Effective control requires adequate drug doses, appropriate drug combinations, and lifestyle modifications if blood pressure treatment goals are to be met.

Goals of Therapy

The ultimate goal of therapy is to reduce cardiovascular and renal morbidity and mortality. Most persons with hypertension, especially those ≥50 years of age, will reach diastolic pressure goals once systolic pressure is under control. Therefore, the primary day-by-day goal is to achieve the systolic pressure goal. Treating systolic pressure and diastolic pressure to targets suggested in Table 1 will result in fewer cardiovascular complications.

Lifestyle Modifications

The adoption of healthy lifestyles is critical for all persons in order to reduce the risk for onset of hypertension, as well as to maximize reduction of elevated pressure. Major lifestyle modifications known to lower blood pressure are summarized in Table 3. Lifestyle modifications lower blood pressure, enhance antihypertensive drug efficacy, and decrease the risk for adverse cardiovascular events. These include dietary restrictions with weight reduction in persons who are overweight or obese, cessation of smoking, moderation in alcohol consumption, and programmed physical activity. Restricting sodium intake to 1,600 mg/day or less, for example, is equivalent to single antihypertensive drug therapy. Combining two (or more) lifestyle modifications can achieve even better results.

Table 2
Antihypertensive Drug Classification*

Diuretics
- Thiazides (hydrochlorothiazide, etc.)
- Loop diuretics (furosemide, etc.)
- K^+-sparing diuretics (spironolactone, etc.)

Sympatholytics
- Beta-blockers (metoprolol, etc.)
- Alpha-blockers (doxazosin, etc.)
- Mixed adrenergic blockers (carvedilol, etc.)
- Centrally acting agents (methyldopa, etc.)
- Adrenergic neuron blocking agents (guanadrel, etc.)

Calcium Channel Blockers (nifedipine, etc.)
Angiotensin Converting Enzyme Inhibitors (lisinopril, etc.)
Angiotensin-II Receptor Antagonists (losartan, etc.)
Vasodilators
- Arterial (hydralazine, etc.)
- Arterial & venous (nitroprusside)

**The Pharmacological Basis of Therapeutics*, 11th edition

Approach to Drug Therapy

The aim of therapy is to use antihypertensive drugs, alone or in combination, to return arterial pressure to target levels with minimal adverse effects. Ideally, the drug would correct the underlying defect that causes the elevated pressure (e.g., use of spironolactone to treat primary aldosteronism). As knowledge of the underlying mechanisms in hypertension increases, specific drug programs to achieve this goal will be made available. Such programs presumably will result in normalization of blood pressure with fewer adverse effects. Meanwhile, an empirical approach to treatment is used, which takes into consideration efficacy, safety, impact on quality of life issues, compliance, ease of use, and economics. Most hypertensive patients will require multiple drugs to reach goal pressure. Drugs used in combination should be chosen from different classes.

Table 3
Lifestyle Modifications to Manage Hypertension*

Modification	Recommendation	Approximate SBP Reduction (Range)
Weight reduction	maintain normal body weight (body mass index 18.5-24.9 kg/m^2)	5-20 mmHg/10kg weight loss
DASH† eating plan	consume a diet rich in fruits, vegetables, and low fat dietary products with a reduced content of saturated and total fat	8-14 mmHg
Dietary sodium reduction	reduce dietary sodium intake to no more than 2.4 g Na or 6 g NaCl	2-8 mmHg
Physical activity	engage in regular aerobic physical activity such as brisk walking, at least 30 min/day, 5 to 6 days a week	4-9 mmHg
Moderation of alcohol consumption	limit consumption to no more than 2 drinks/day‡ in men, and 1 drink/day in women and persons of lighter weight	2-4 mmHg

*The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7). For overall cardiovascular risk reductions, stop smoking. Effects of implementing these modifications are dose and time dependent, and could be greater for some individuals.
†DASH, Dietary Approaches to Stop Hypertension
‡Two drinks = 1 oz or 30 mL ethanol; e.g., 24 oz beer, 10 oz wine, or 3 oz 80-proof whiskey

If low doses of two drugs do not achieve blood pressure control, the primary agent should be increased to full dose. If the goal pressure is still not attained, a search for a secondary cause of hypertension is indicated. If none is found, a detailed assessment of dietary habits may reveal an aggravating inciter, e.g., excessive sodium intake. In this case, if dietary modification with reduced sodium intake fails to lower the pressure, a third agent should be added.

If with addition of a third agent the pressure is controlled, a stepwise reduction in the dose and/or withdrawal of one or both of the previous drugs may be undertaken to determine the minimal drugs and doses to maintain blood pressure at goal values. More than 95 percent of patients should be adequately controlled at this point. For failures, a reason for the therapeutic failure (Table 4) should be sought. If none can be identified, an additional agent(s) should be added. When blood pressure is controlled, previous drugs may be withdrawn sequentially to determine the minimum number that will maintain a normal blood pressure.

Pharmacologic Treatment

If non-drug treatment is ineffective in reducing blood pressure, the choice of drug therapy is determined by its efficacy and safety. When efficacy and safety are equal, choice of pharmacotherapy should ideally be based on drugs with the lowest cost. JNC 7 recommends drug therapy at ≥140/90 mmHg for otherwise healthy patients and ≥130/80 mmHg for patients with heart and kidney disease or diabetes mellitus.

Thiazide diuretics have been the mainstay of antihypertensive therapy in most clinical trials to-date. In these trials, including the landmark Antihypertensive and Lipid Lowering Treatment to Prevent Heart Attack Trial (ALLHAT), diuretics have been unsurpassed in preventing onset of the adverse cardiovascular events associated with hypertension. Diuretics enhance the antihypertensive efficacy of multidrug regimens and are more affordable than many other antihypertensive agents. Their use today, in controlling hypertension is, however, underutilized.

Thiazide diuretics should be used as initial therapy for most patients with hypertension, either alone or in combination with one of the other antihypertensive drug classes. Table 5 lists specific indications that require use of alternative antihypertensive drugs as initial therapy due to the alternative drugs' demonstrated efficacy in those conditions. If a drug's adverse effects are excessive or a drug is contraindicated, one of the agents from an alternative class that is proven to reduce adverse cardiovascular events should be used instead.

As noted earlier, most hypertensive patients will require multiple antihypertensive medications to achieve their blood pressure goal. Blood pressure that is more than 20/10 mmHg above goal may be treated initially with two drugs, either as separate prescriptions or in fixed-dose combinations. Initiation of therapy with multiple drugs may increase the likelihood of achieving the goal pressure in a more timely fashion, but puts the patient at increased risk for adverse effects.

Follow-up

After antihypertensive drug therapy is initiated, follow-up with medication(s) adjustment is indicated for most patients at monthly intervals until the pressure goal is reached. Patients with Stage 2 hypertension and those with comorbid conditions should be evaluated more frequently until reduced pressures are stabilized.

Table 4
Reasons for Poor Therapeutic Response in Patients with Hypertension*

- Inadequate patient compliance
- Volume expansion, caused by
  - --excessive sodium
  - --nondiuretic antihypertensive drug
  - --renal damage
- Excessive weight gain
- Inadequate doses
- Drug antagonism
- Sympathomimetic drugs (e.g., cold remedies)
- Oral contraceptives (estrogens)
- Adrenal steroids
- Secondary forms of hypertension

**Principles of Internal Medicine*, 16th edition

Table 5
Compelling Indications for Individual Drug Classes*

	Recommended Drugs†					
Compelling Indication‡	**DIU**	**BAB**	**ACE**	**ARB**	**CCB**	**ANT**
Heart failure	X	X	X	X		X
Postmyocardial infarction		X	X			X
High coronary disease risk	X	X	X		X	
Diabetes	X	X	X	X	X	
Chronic kidney disease			X	X		
Recurrent stroke prevention	X		X			

*The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7).
†DIU = diuretic; BAB = beta-adrenergic blocker; ACE = angiotensin converting enzyme inhibitor; ARB = angiotensin receptor blocker; CCB = calcium channel blocker; ANT = aldosterone antagonist
‡Compelling indications for antihypertensive drugs are based on benefits from outcome studies or existing clinical guidelines; the compelling indication is managed in parallel with the blood pressure.

Serum potassium and creatinine should be monitored one to two times a year. When blood pressure reaches goal and is stable, follow-up visits at three- to six-month intervals should be adequate. Comorbidities increase the need for more frequent visits. Other cardiovascular risk factors should be treated to their respective goals, and smoking cessation should be vigorously promoted. Low-dose aspirin therapy can be considered, but only after blood pressure has been controlled, since aspirin increases the risk of hemorrhagic stroke in persons with uncontrolled hypertension.

Patient Adherence with Antihypertensive Drug Therapy

The most effective therapy will control hypertension only if the patient is motivated to comply with the physician's instructions including maintaining a healthy lifestyle. In studies of elderly hypertensive patients designed to assess adherence with antihypertensive drug therapy, the average patient failed to refill prescriptions more than 50 percent of the time. Moreover, only one patient in five exhibited compliance with physicians' instructions sufficient to achieve therapeutic benefit. Adherence decreased even more with multiple drug regimens and treatment periods extending beyond one year. Reasons why patients fail to comply with therapy include:

- increased misunderstanding of the condition or treatment;
- denial of illness due to lack of symptoms or perception of drugs as symbols of ill health;
- lack of patient involvement in the care plan;
- unexpected adverse effects of medications;
- cost of medications;
- complexity of care (i.e., transportation, patient difficulty with polypharmacy, difficulty in scheduling appointments, etc.); and
- life's competing demands.

Pharmacists need to be aware of opportunities for patient interventions, e.g., when patients seek OTC products that may interfere with blood pressure control. The pharmacist can encourage hypertensive patients to avoid adding any new OTC product(s) without first discussing it with their physician or pharmacist. For example, nonsteroidal anti-inflammatory drugs (NSAIDs) can cause salt retention or drug interactions. Thiazide diuretics, beta-blockers, ACE inhibitors, and alpha-blockers are less effective in some patients who use NSAIDs. Decongestants may elevate blood pressure.

Summary

Tight control of blood pressure at normal values is important to reduce the risk of adverse cardiovascular events. While control of blood pressure is often achieved with currently available antihypertensive therapies, too many patients fail to maintain lowered pressures. A major contributing reason is nonadherence with instructions.

JNC 7 guidelines indicate that the most effective therapy prescribed will control hypertension only if patients are motivated to follow instructions. Positive experiences with and trust in their health professionals have shown to improve patient motivation.

Continuing Education Quiz

Management of Hypertension: Lifestyle Modifications and Drug Therapy

1. It has been reported that the number of patients with hypertension who actually achieve optimal blood pressure control is less than which of the following?
   a. One-fourth c. One-eighth
   b. One-half d. One-third
2. The higher an individual's blood pressure, the greater the risk for developing which of the following conditions?
   a. Bronchial asthma c. Myocardial infarction
   b. Cirrhosis of the liver d. Varicose veins
3. The type of blood pressure that normally increases with age until the eighth or ninth decade of life is:
   a. diastolic b. systolic.
4. In the Framingham Heart Study, the type of blood pressure that was the stronger predictor of cardiovascular risk in patients <50 years of age was:
   a. diastolic b. systolic
5. According to the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), systolic and diastolic blood pressure readings for adults classified as Stage 1 hypertension are:
   a. 120-139 and <80 c. 140-159 or 90-99
   b. 120-139 or 80-89 d. 140-159 and >100
6. According to the JNC 7 report, the lifestyle modification with the greatest range of impact on reducing SBP was:
   a. dietary sodium restriction c. DASH eating plan
   b. weight reduction d. physical activity
7. The JNC 7 report recommends drug therapy for patients with heart and kidney disease or diabetes mellitus when their blood pressure reaches which of the following readings?
   a. 130/80 c. 140/80 b. 130/100 d. 140/100
8. The mainstay of antihypertensive therapy in most clinical trials to-date has been the:
   a. ACE inhibitors c. calcium channel blockers
   b. beta-blockers d. thiazide diuretics
9. According to the JNC 7 report in Table 5, the drug class with the greatest number of compelling indications for patients who are also being treated for hypertension is the:
   a. ACE inhibitors c. calcium channel blockers
   b. beta-blockers d. thiazide diuretics
10. Which of the following OTC products are especially important for hypertensive patients to discuss with their physician or pharmacist prior to initiating therapy?
    a. Antidiarrheals and laxatives
    b. Cough suppressants and antihistamines
    c. Decongestants and NSAIDs
    d. Expectorants and antacids

Management of Hypertension: Lifestyle Modifications and Drug Therapy

September 2006 ACPE # 129-047-06-006-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:

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Fargo, ND 58105

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

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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: 6-15-09

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

Rx And The Law

By Kerianne M. Hanson
& Don R. McGuire, Jr., R.Ph., J.D.

This series, **Pharmacy and the Law**, is presented by Pharmacists Mutual Insurance Company and your State Pharmacy Association through Pharmacy Marketing Group, Inc., a company dedicated to providing quality products and services to the pharmacy community.

Combat Methamphetamine Epidemic Act:
What This Act Means For Your Retail Setting

On March 9th, 2006, President Bush signed the Patriot Act, which includes a portion known as the Combat Methamphetamine Epidemic Act of 2005. In light of this law, the sale of pseudoephedrine-containing products across the nation is set up for big changes, and the responsibility of enforcing these changes has landed on the shoulders of licensed pharmacists in retail settings.

Pseudoephedrine is a decongestant found in multiple products used to treat symptoms associated with the common cold and seasonal allergies. It is also the primary ingredient needed to manufacture methamphetamine, an illicit drug that has rapidly gained popularity in the U.S. over the past few years. The new regulations regarding the sale of pseudoephedrine are intended to curb the manufacturing of methamphetamine by making it more difficult to accumulate large amounts of pseudoephedrine and by keeping a record of all pseudoephedrine purchases.

The Combat Methamphetamine Epidemic Act categorizes pseudoephedrine as a controlled substances and regulates, among other factors, the amount of pseudoephedrine sold to individuals. Although some states, particularly in the Midwest, have been regulating the sale of pseudoephedrine for over a year now, the Combat Methamphetamine Epidemic Act makes the regulations federal law. Beginning September 30, 2006, patients everywhere in the nation will need to visit a pharmacy in order to purchase pseudoephedrine-containing products.

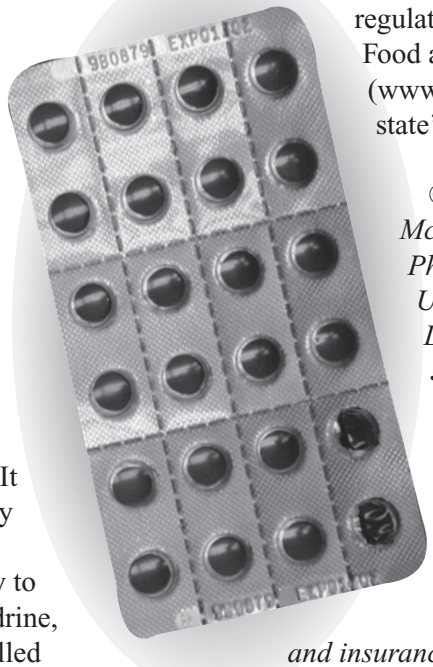
It is important to keep in mind that some of the specific regulations, such as who in the pharmacy is allowed to sell the products (i.e. pharmacists only, technicians, interns, etc.) and the number of boxes which can be sold in a single transaction, have been left up to the individual states. Pharmacists should check with their State Board of Pharmacy to ensure they are aware of state-specific regulations and train their pharmacy staff accordingly.

Some of the federal regulations regarding the sale of pseudoephedrine-containing products according to the Combat Methamphetamine Epidemic Act are summarized below:

- All pseudoephedrine-containing products must be kept behind the counter.
- An individual may purchase no more than 3.6 grams of pseudoephedrine in one day.
- An individual may purchase no more than 7.5 grams of pseudoephedrine in any 30-day period.
- The purchaser must present a State or Federal Government issued photo identification card at the time of purchase.
- Either a written or electronic logbook of all pseudoephedrine transactions must be kept by the pharmacy for a period not less than two years from the date of purchase.
- For each sale, information including the name and address of the purchaser, the name of the product, the quantity purchased, and the date and time of the transaction must be collected and entered into the logbook. Many states will also require additional information be collected, such as the purchaser's birthday or a driver's license number.
- Products packaged for individual sale that contain less than 60 milligrams of pseudoephedrine are exempt from the logbook requirements but must also be kept behind the counter.

- The pharmacist must confirm the information provided by the purchaser matches that provided on the identification card.
- The purchaser must provide a signature verifying the information provided is correct.

In response to the new regulations, and in an effort to further hinder methamphetamine production, many product manufacturers have voluntarily re-formulated their products to contain alternative decongestants such as Phenylephrine. These products, commonly identified by the letters PE (ex. Sudafed® PE), may offer alternatives to patients who need decongestant products on a daily basis. It is also important to recognize that the majority of the regulations established by the Combat Methamphetamine Epidemic Act do not apply to prescription products containing pseudoephedrine, but these products will be classified as controlled substances, and regulations set forth by the Controlled Substance Act 1970 are now applicable.



Complete information regarding the Combat Methamphetamine Epidemic Act and the regulations it sets forth are available on the Food and Drug Administration's website (www.fda.gov) and from each individual state's Board of Pharmacy.

 Kerrianne M. Hanson is a Pharm.D/MBA Candidate at the Drake University College of Pharmacy in Des Moines, Iowa. Don R. McGuire Jr., R.Ph., J.D. is Assistant General Counsel, at Pharmacists Mutual Insurance Company.

This article discusses general principles of law and risk management. It is not intended as legal advice. Pharmacists should consult their own attorneys and insurance companies for specific advice. Pharmacists should be familiar with policies and procedures of their employers and insurance companies, and act accordingly.

NDPhA To Provide New Member Service

Pharmacy Career Network begins September 1, 2006

A new career center will be available on the NDPhA web site on September 1st providing members with information on job opportunities that are specific to each member's needs. Unlike listings on job boards such as Monster, Job Target gives NDPhA members options to:

- Post a resume anonymously
- Keep you connected to the employment market while maintaining full control over the confidentiality of person information
- Save jobs searches
- Store jobs in your personal account
- Keep notes on job opportunities
- Communicate with employers using an internal messaging system

The new career center also benefits employers who will have access to al pharmacists in the database, providing unparalleled access to a highly qualified group of health care professionals. When individual members post their resume, it is sent in a broadcast e-mail to employers whose list of criteria matches the pharmacist's qualifications. Employers can create a free company profile, and members can access the details of each company's work environment.

If you have questions call NDPhA, or go online and simply follow the directions to register as a user of new career center.

Time to Begin Billing for Patient Care

Written by Jeff Roh, Director of Pharmacy Care, Washington State Pharmacy Association. Reprinted with permission from the WSPA, Washington Pharmacy Spring 2006 Journal.

Cognitive Services. Pharmaceutical Care. Medication Therapy Management. You can call it what you want. These terms are not new to pharmacists. Defining them may be a challenge but one thing is certain: they involve patient care in conjunction with medication therapy. Patient care is a valuable service that pharmacists have been providing free of charge. The tools are finally in place for pharmacists to bill for the patient care we provide.

Although the implementation of Medicare Part D has been extremely challenging, there is a silver lining to the cloud, Medication Therapy Management. Medication Therapy Management (MTM), as it is related to Medicare Part D, may currently seem like a moving target hiding within the smoke and mirrors. This elusiveness accompanied by all the additional work and confusion that Part D implementation has generated has caused more than a few pharmacists to shout, "Not right now!" I am going to tell you about four very important developments that have opened a window of opportunity to demonstrate the value of pharmacy based patient care.

The first development was the recognition by our federal government that medications do not manage themselves and reimbursement mechanisms are necessary to encourage healthcare providers to engage in MTM. This is something that healthcare provides have known for years, but third party payers have been dragging their feet on. Pharmacists have been unable to gain compensation for the services they provide, which has arguably pushed the pharmacy business model to focus on dispensing volume rather than patient care outcomes.

The second development was the National Provider Identifier number. Pharmacists have struggled with billing third party payers because they have not had the appropriate billing provider numbers. With the requirement of the NPI number, that problem is solved. Healthcare providers that are considered "covered health care providers" under HIPAA are required to obtain a NPI number. A covered healthcare provider transmits any heath information in electronic form between two parties to carry out financial or administrative activities related to health care. Pharmacists and pharmacies are included as healthcare providers and are eligible to apply for a NPI number. Pharmacies and pharmacists who transmit health information in an electronic format must obtain a NPI number. Covered healthcare providers must obtain a NPI number by May 23, 2007. To apply for your NPI, visit the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov/NPPES/.

The third development is the creation of Current

Procedural Terminology (CPT) codes that allow pharmacists to bill for medication therapy management. The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel approved three "temporary" CPT billing codes for pharmacists to use to bill third-party payers when providing Medication Therapy Management Services (MTMS), which became effective January 1, 2006. The codes are used to bill any health plan providing a benefit for MTMS, including but not limited to those covered under the new Medicare Part D Prescription Drug Benefit. Third-party payers will individually determine the reimbursement rates and criteria for MTMS. The "temporary" status of these codes means that their use is being monitored and CPT codes that go unused will be dropped from the system. MTMS may be initiated at the request of the patient and/or caregiver, payer, pharmacist and/or other healthcare provider, so we need to start billing for the services that we are providing!

The CPT billing codes used to bill third-party payers for MTMS performed face-to-face between a pharmacist and a patient:

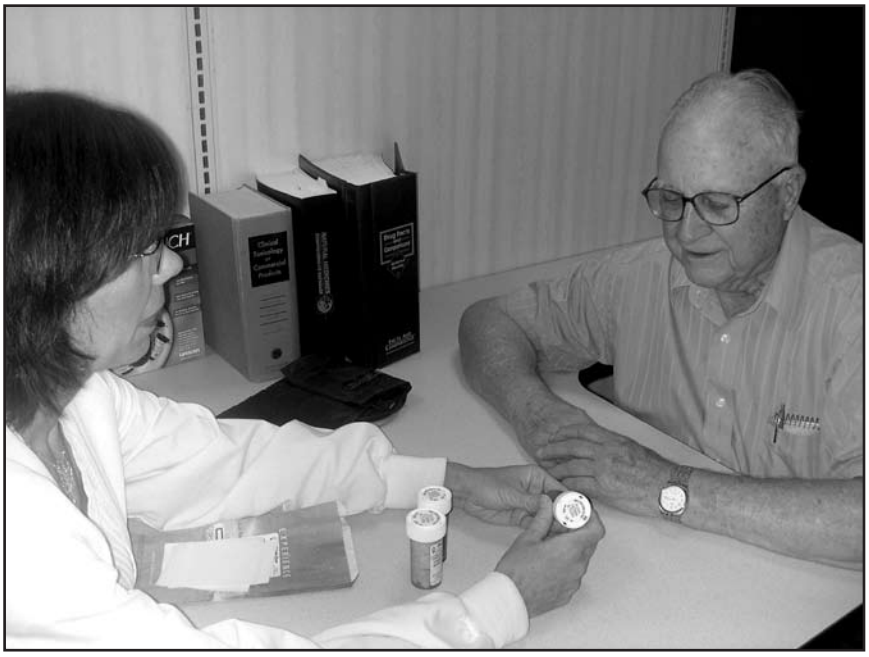
- Code 0115T: a first-encounter service performed face-to-face with a patient for up to 15 minutes.
- Code 0116T: used with the same patient for a time period up to 15 minutes for a subsequent or follow-up encounter.
- Code +0117T: add-on code which may be used to bill for additional increments of 15 minutes of time to either of the preceding codes.

A Place of Service (POS) code was also developed for services in a pharmacy setting. Beginning October 1, 2005, pharmacists may use POS code 01, "Pharmacy." This new code supplements other POS codes typically used by pharmacists such as Code 11, "Office," or 99, "Other Place of Service."

The codes are used in similar fashion to other CPT or billing codes. The MTMS codes are not to be used to describe the provision of product-specific information (e.g., patient medication leaflets) at the point of dispensing. Documentation requirements are similar to other healthcare providers. The elements required to verify the service provided dependent on the type and level of MTMS are: review of the pertinent patient medical history; complete medication profile; interventions and recommendations for optimizing medication therapy; referrals; treatment compliance; communications with other healthcare professionals; administrative functions (including patient and family communications) relative to the patient care; and/or follow-up care.

Lastly, the fourth development actually happened several years ago. In 1996, the Every Category of Provider law (RCS 48.43.045) was passed in Washington stating that every healthcare insurance plan delivered in Washington must permit every category of healthcare provider to provide health services or care for conditions included in the basic health plan services to the extent that (a) the provision of such health services or care is within the health care providers' permitted scope of practice; and (b) the providers agree to abide by standards related to: (i) provision, utilization review, and cost containment of health services; (ii) management and administrative procedures; and (iii) provision of cost-effective and clinically efficacious health services. This law states that health plans must compensate pharmacists that bill for patient care services that are within their scope of practice if they pay other healthcare providers to provide the same service.

The time is now. We need to utilize the new CPT billing codes, and the NPI numbers to bill for MTMS for all of our patients. Given the Every Category of Providers law, if we are denied reimbursement by a health plan and have the appropriate documentation of the services provided, we should have grounds for legal contention.



Joel Aukes, RPh
President, NDSHP

We Are All Together in the Profession of Pharmacy

In 2005, then NDPhA President Tim Carlson requested and received approval from the NDPhA Executive Board to form an Advisory Council. The goal of the Advisory Council was to explore the possibility of making a more unified state pharmacy organization and how that new organization may be structured and function. The Advisory Council is comprised of the executive boards of NDSHP, NDPhA, NAPT and representatives from the ND Board of Pharmacy and NDSU College of Pharmacy (faculty and students). The idea is that with more unification the Profession of Pharmacy (including technicians and students) can have a "stronger voice" when trying to improve mutually beneficial issues on a state and national level.

The Advisory Council had its first meeting in early 2005 and has since spent most of its time defining mutual concerns, shared visions and the possible structure of our state pharmacy organization. The result of these efforts was the rediscovery of the common ground held by all of those involved in the Profession of Pharmacy. Some of these pieces of common ground are concern for the welfare of our patients; desire to implement the best practices into our profession; support access to care; promotion of fair reimbursement; and a positive impact on policy at the state and national level. I thought that this process was beneficial in reminding us of the reasons why we went into the Profession of Pharmacy and what we all hope to have accomplished at the end of the workday.

The survey, which was mailed in July to all NDSHP members, showed that a majority of respondents were not aware of the Advisory Council and required more information before they could make a decision on pursuing a more unified state pharmacy organization. In an attempt to provide our membership with the desired information, I will be joining Dr. Hill and visiting each district to provide a short informational presentation on the Advisory Council recommendations and to answer questions. These district visits will be in conjunction with legislative breakfast meetings scheduled throughout October. I would urge all those in the Profession of Pharmacy to attend these sessions so that concerns, questions and comments can be voiced. The hope is that once the information has been disseminated our organization can make an informed decision whether to move forward with a new structure for our state's pharmacy organization.

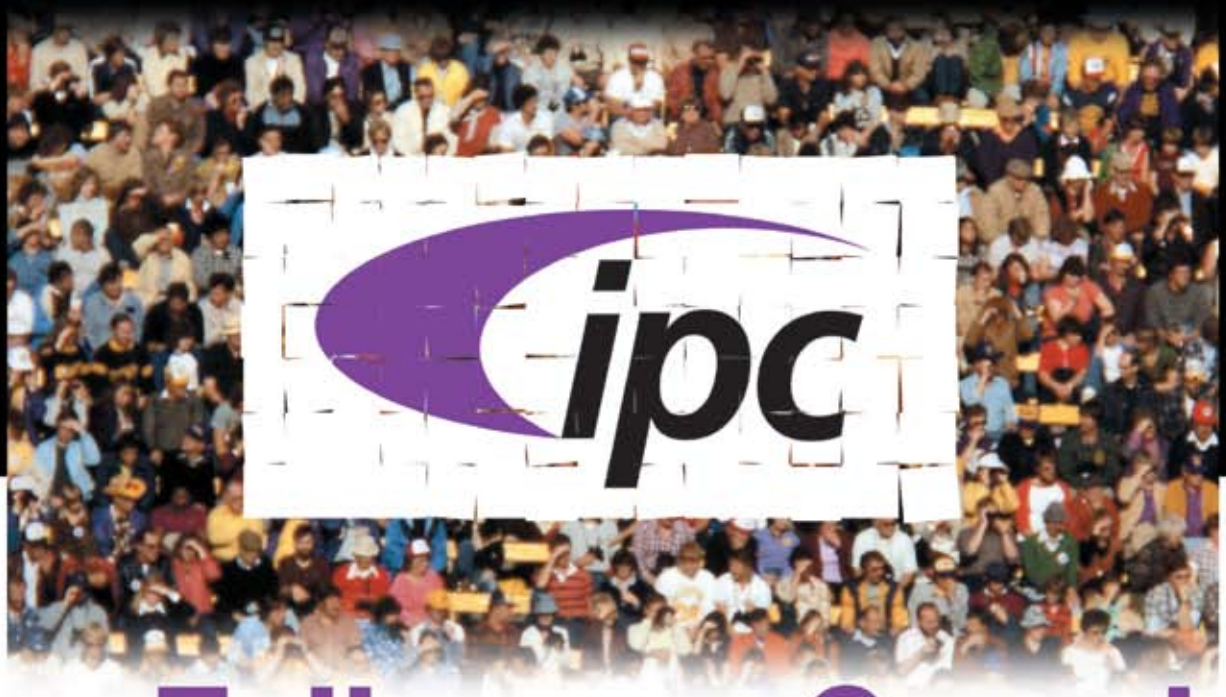
District Meetings

September 6 - District 8, Fargo
September 7 - District 4, Grand Forks
October 3 - District 6, Bismarck
October 23 - District 1, Williston
October 25 - District 2, Minot
October 30 - District 7, Jamestown

Legislative Breakfast Meetings are listed on page 3
Highlights of NDPhA Issues are listed on page 27

This year the Fall CE Conference will be held in Bismarck on September 15-16. This conference will be held in conjunction with NAPT and will offer a wide variety of topics. Brochures were mailed in August. Registration details on NDPhA web site. The conference is open to all pharmacists and technicians.

Sometimes it's OK



to Follow the Crowd

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NAPT Updates

By Danika Braaten - NAPT Presidnet

It's just around the corner, fall conference time again!! This year's fall conference will be in Bismarck on September 15-16 at the Doublewood Inn. The conference will be in conjunction with the NDSHP. The planning committee has done an awesome job and it should be a great conference. I hope to see everybody there.

This summer I had the opportunity to go to the Pharmacy Technician Educators Council annual conference in Pittsburgh, Pennsylvania. It was a great learning experience. This was a three-day conference and it covered many different issues, some including: herbal medications, diabetes, compounding, FDA regulations on herbal medications, and so much more. I will give a complete report at the general business meeting in Bismarck.

We will be holding our next general business meeting in Bismarck at the fall conference. This a great time to bring up any issues, concerns, or comments that you have and would liked discussed. If anybody has any issues that they would like to talk to a board member about, you can contact anyone on the NAPT board and we would be happy to help out in any way we can.

The summer has gone by quickly, but keeping up on issues that involve technicians in pharmacy is always an educational opportunity. I look forward to keeping up on these topics and informing you on the outcomes. I hope all has had a great summer!

Danika Braaten
NAPT Pharmacy

Meet Jeanette Bleecker
NAPT Past President

I am a 1995 graduate from the NDSCS Pharmacy Technician program. (This was the very first class in the program.) I receive my PTCB certification in the winter of 1995 and due to some technical difficulties (a name change) missed my re-certification date and was given to opportunity to take the test a second time in July of 2003. I began my career in pharmacy by working in Lisbon for about a year at the local retail pharmacy.

In 1997 I found myself packing up my things and moving to Fargo. I was hired at Southpointe Pharmacy and worked there for six years. During this working experience I also obtained a part-time invoicing job at CSM. I eagerly accepted the position and worked part-time there for about a year. I began working for CSM full time in December 2002.

Outside the work environment, I have been an active member on the NAPT board for several years serving as Member-at-Large, Treasurer, Parliamentarian and Vice President/President Elect and President. I have also been on several planning committees for the Fall Conferences and the AAPT Convention held in Fargo in 2003. In 2002, I received the NAPT Technician of the Year award.

I am the proud mother of 2 children. Brandon, 8 and Bailey, 5. They are the true reason for my existence. We reside in West Fargo. As a family we enjoy camping, traveling and almost anything that involves being outside.

I am extremely excited to serve another term on the NAPT Executive Board and look forward to another great year.

Meet Diane Halvorson
NAPT Parliamentarian

My name is Diane Halvorson. I am currently employed at SCCI Hospital Pharmacy of Fargo. As a mother, wife and full time worker, my schedule is often full and hectic. While I have had the privilege of representing Pharmacy Technicians in many different capacities on the Northland Association of Pharmacy Technicians (NAPT) Executive Board, I am currently serving as the parliamentarian.

It is my continued goal to promote the profession of Pharmacy and highlight the importance the Pharmacy Technician plays in the pharmacy. A pharmacy that utilizes pharmacy technicians to their full capacity is a pharmacy that can offer quality pharmaceutical care, while operating efficiently and cost effectively. Thank you for this opportunity to represent Pharmacy Technicians. I encourage those of you who are thinking of getting involved to contact President Braaten, to find out what NAPT is all about. It is exciting to see new faces!

Highlights of NDPhA Issues for Discussion at District Meetings

The information provided does not represent the details on each issue, rather this is an overview to re-acquaint members on funding issues and introduce the Advisory Council's work prior to the district meeting in your area.

Funding the Future of Pharmacy

The funding needs of NDPhA were discussed with members throughout 2005 and into 2006. Based on member comments of support, the ND State Board of Pharmacy increased the license renewal fee in 2006 to the maximum allowed by law - $200.

History: Beginning in 1989, when the integrated membership began, 50 percent of the license fee ($150) went to NDPhA for operations, as defined in statute. Of the $75 received by NDPhA, $25 (from each hospital pharmacist) was forwarded to the ND Society of Health-System Pharmacists (NDSHP) to help get their organization started.

In 2006, a formal process was incorporated into the license renewal and all NDPhA members were invited to officially join NDSHP. The transfer of $25/pharmacist continued under an agreement between the NDPhA and NDSHP Boards of Directors.

The funding received by NDPhA continues to be insufficient to cover the cost of operations. To address the funding challenge and other issues the NDPhA Board created an Advisory Council. The Council includes representatives of all pharmacy organizations in ND. They first met in May 2005, with their fourth meeting scheduled for September 23, 2006.

Advisory Council Update

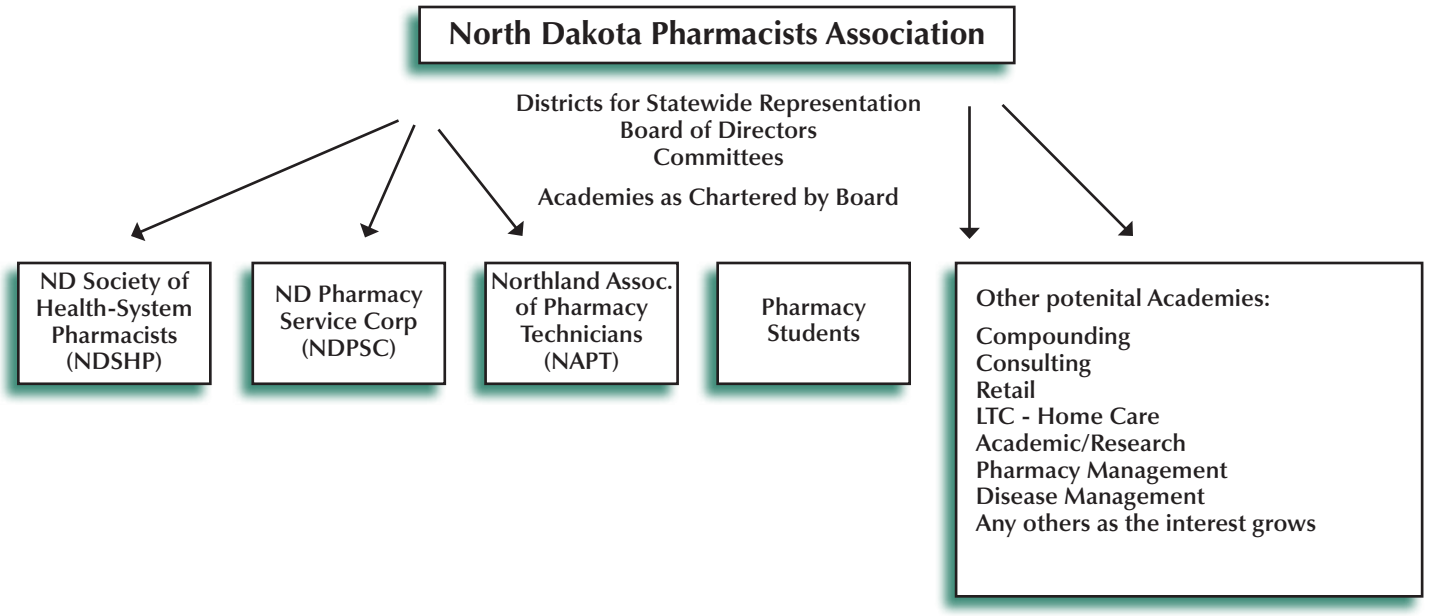
Key Issues

Funding:

- Deficit funding is at the heart of most issues
- The $200 license fee ($100 to NDPhA and a portion to NDSHP) does not alleviate the funding deficit
- $165/member is a target for adequate funding
- The Council supports model where all members pay equal amount to support NDPhA

Organizational Structure:

- Goal is to create model that will unite entire pharmacy profession in North Dakota
- Any new model must be inclusive, provide flexibility & reasonable autonomy for individual groups with a shared responsibility to NDPhA
- NDPhA Board of Directors will retain governance responsibility
- The Council is working on draft that considers an Academy model for NDPhA (diagram below)
- Academies could represent any practice setting, or other pharmacy affiliated group, that requests to become an academy under the umbrella of NDPhA...guidelines would be developed



Charles Peterson, Dean
NDSU College of Pharmacy

A Message from the Dean

ACPE Accreditation Report

We received the final reports (Evaluation Team and Board of Directors) in July from the Accreditation Council for Pharmacy Education (ACPE) regarding their on-site accreditation visit of our pharmacy program on April 11-13, 2006. The reports are very positive and encouraging and I am pleased to announce to you that we have received continued accreditation by the ACPE Board of Directors for another full six-year term (the maximum period which they allow by policy) without any need for interim site visits. The reports also lay out the future program needs and challenges to maintain a strong accreditation status with ACPE.

The evaluation team acknowledged the tremendous growth and development of the College (its people and programs) since the last accreditation visit in 1999 including the addition of nursing and allied sciences. It highlighted several strengths of the program including students, faculty, and preceptor support, expanded research program, and NDSU's innovation and leadership in developing the Thrifty White Concept Pharmacy and Telepharmacy. Future issues which will need to be addressed by the program to maintain a strong accreditation status include: adding additional administrative support, revising our strategic plan, addressing space needs to accommodate future growth of the program, hiring additional faculty, ensuring adequacy of financial resources to sustain the quality of the program, and completing a comprehensive curriculum re-evaluation to satisfy the new 2007 ACPE Accreditation Standards. Of particular importance will be for the College to incorporate an early practice experience (100 hours per year) for all 1st year, 2nd year, and 3rd year professional students to satisfy the new standards. This will require significant increases in preceptor and experiential site support to accomplish this new requirement. In addition, we have already begun the search process for a new Associate Dean for Academic Affairs for the College. The Search Committee is being chaired by Dr. Mary Margaret Mooney, chair of our nursing program.

I would personally like to thank everyone for the tremendous support you have given us in helping us through this very important accreditation process. It has been a very labor-intensive process for all, but the effort and the outcome were smashing successes! We greatly appreciate all your support and encouragement.

The College Has a New Name!

On May 17, 2006, the North Dakota State Board of Higher Education approved the College's name change. The College is now officially the "College of Pharmacy, Nursing, and Allied Sciences". The following is reprinted with permission from an article recently published in NDSU It's Happening at State.

The North Dakota State University College of Pharmacy has been renamed the College of Pharmacy, Nursing and Allied Sciences. The State Board of Higher Education approved the change at its May meeting.

"We're a different college today," explained dean Charles Peterson. "We wanted to grab on to all the changes, recognize them and designate a new name to celebrate all the additions, victories and successes that we have had as a college."

The college's history dates back more than a century, and it has established a tradition of excellence recognized

by the nation's pharmacy profession. Nursing was added to the college's program mix in 1986, when NDSU and Concordia College started a cooperative program through Tri-College. In 2002, NDSU hired a nursing chair and began the transition to NDSU having its own independent, fully accredited baccalaureate program. The nursing department received accreditation this past year from the Commission on Collegiate Nursing Education.

"Nursing has been here 20 years contributing to the mission and vision of the college. We felt it was important that everybody could visibly see and know without question that nursing is a part of this college," Peterson said.

In addition, the allied sciences of clinical laboratory science, radiologic sciences and respiratory care recently were moved from the biological sciences department to the college's program structure.

"Anytime you have more than one program under the same roof, you want everyone to feel equally recognized and valued for the contributions they make," Peterson said, noting that pharmacy professionals and NDSU alumni gave strong support for the name change. "It actually was the pharmacy faculty that came forward with the idea to consider a name change."

Peterson points out that the college has experienced dramatic growth, moving from 650 students a few years ago to about 1,500 today. In 2000, the college had 46 faculty and staff; that number has risen to 72.

He also said the Institute of Medicine has prepared a paper urging schools to conduct more inter-professional education. According to Peterson, successfully serving patients in the future will come through collaborative efforts – working as an interdisciplinary health care team.

"The college has the greatest opportunity that we have ever had to put into practice what the Institute of Medicine is asking of schools of health sciences across the nation," Peterson said. "We want to create an inter-professional education for our students. Students of pharmacy, nursing and the allied sciences will take classes together and earn each other's roles which will lead to better care for patients. We hope to be on the front line of establishing NDSU as a national model for inter-professional education that other schools can follow."

Story by Steve Bergeson, 07/19/06 issue of NDSU It's Happening at State

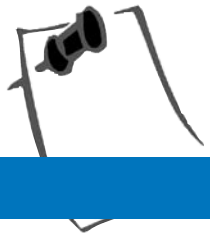
White Coat Ceremony

On Saturday, September 16, 86 students will take the oath of a pharmacist during the White Coat Ceremony at Bentson-Bunker Fieldhouse on the NDSU campus in Fargo, ND. Each student will receive a white coat symbolizing his or her duty to patients and colleagues as they enter the pharmacy profession.

The ceremony, sponsored by Walgreens, will feature speakers Dr. Charles D. Peterson, Dr. Kimberly Vess Halbur, and Howard Anderson, RPh will administer the Oath of a Pharmacist.

Our White Coat Ceremony is an opportunity to officially welcome our students into the profession of pharmacy and instill in their minds and hearts an attitude of professionalism including honesty, integrity, and good moral character.

Classifieds



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Pharmacist/Assistant Professor of Pharmacy Practice
The Department of Pharmacy Practice, North Dakota State University, is seeking a full time pharmacist to practice at the Student Health Center pharmacy on campus and share teaching students in its Concept Pharmacy. The successful candidate will be expected to be pharmacist-in-charge at the NDSU Student Health Center pharmacy, precept pharmacy students on site, assist in the Concept Laboratory, and do occasional classroom lectures. The position is non-tenure track. Applicants must have a Pharm.D, have at least two years of practice experience, be licensed in North Dakota, and have excellent interpersonal and communication skills. Preference will be given to candidates with teaching or precepting experience. Screening of applications will begin August 21, 2006 and continue until the position is filled. Applicants should submit a letter of interest with a statement of their career goals, a curriculum vitae, and three letters of reference to: Donald Miller, Pharm. D., Professor and Chair, Pharmacy Practice Department, College of Pharmacy, North Dakota State University, Box 5055, Fargo, ND 58105-5055. NDSU is an equal opportunity institution.

NDPhA To Provide New Member Service

Pharmacy Career Network begins September 1, 2006
A new career center will be available on the NDPhA website on September 1st providing members with information on job opportunities that are specific to each member's needs. Unlike listings on job boards such as Monster, Job Target gives NDPhA members the options to:

- Post a resume anonymously
- Keep you connected to the employment market while maintaining full control over the confidentiality of personal information
- Save job searches
- Store jobs in your personal account
- Keep notes on job opportunities
- Communicate with employers using an internal messaging system

The new career center also benefits employers who will have access to all pharmacists in the database, providing unparalleled access to a highly qualified group of healthcare professionals. When individual members post their resume, it is sent in a broadcast email to employers whose list of criteria matches the pharmacist's qualifications. Employers can create a free company profile, and members can access the details of each company's work environment.
If you have questions call NDPhA, or go online and simply follow the directions to register as a user of the new career center.

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