

PROCEEDINGS OF THE
ANNUAL MEETING OF THE
NATIONAL ASSOCIATION OF BOARDS OF PHARMACY
AND THE
AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY
OF THE THIRD DISTRICT

Charleston Place Hotel

Charleston, South Carolina

August 9-11, 1998

**CO-HOSTS: South Carolina Board of Pharmacy
Carol V. Bateman, President
and
University of South Carolina College of Pharmacy
Wayne E. Buff**

Edited by Samuel T. Coker
Published in Auburn, Alabama, 1999

Monday, August 10, 1998

- 7:30-9:00 am Registration
- 7:45-8:45 am Continental Breakfast
- 8:45-10:15 am Drug Preventing Medication Errors: Current Issues Effecting Accuracy of
Ordering, Dispensing, and Administration
Michael R. Cohen, RPh, MS, FASHP
Institute for Safe Medicine Practices
- 10:15-10:30 am Break
- 10:30-12:00 pm Current Issues Which Impact Accurate Pharmaceutical Dispensing
“Transition to outcome based Regulation- A Quality Improvement Approach”
John D. Taylor, RPh
Florida Board of Pharmacy
“Board Policy Regarding Pharmacists’ Work Loads”
David Work, RPh
North Carolina Board of Pharmacy
“The Chain Drug Perspective on Prescription Accuracy”
Tracy L. Baroni, RPh
National Association of Chain Drug Stores
- 12:00 pm Adjourn
- 12:30 pm Organized Afternoon Activities
Golf at Patriots Point
Tour of Middleton Place-Plantation and Gardens
- 5:45 pm Bus Transportation to Citadel Beach Club
- 6:15-11:00 pm Low Country Seafood Buffet and Beach Party

Tuesday, August 11, 1998

- 7:30-9:00 am Registration
- 7:45-8:45 am Continental Breakfast

8:00-11:00 am	Board Inspectors Program - The Inspection Process: Current and Future
8:00-11:00 am	Board Attorneys' Round table - Legal Issues and Solutions
8:45-10:00 am	Separate Sessions NABP - Business Session ACCP - Clerkships:Challenges in Moving to the All PharmD Curriculum
10:00-10:15 am	Break
10:15-10:30 am	Invitation by Hosts of 1999 NABP/ACCP District III Annual Meeting
10:30-11:15 am	Joint Session: Committees' Reports Presiding: Farid Sadik, Ph.D., Dean University of South Carolina
11:15-12:00 pm	"Open Mike Session" on Current Pharmacy Topics
12:00 am	Adjourn

ACKNOWLEDGEMENTS

For their financial support of the educational activities presented at the 1997 NABP/AACP District III Meeting, the National Association of Boards of Pharmacy and American Association of Colleges of Pharmacy express their sincere appreciation to the following:

*Barr Laboratories, Inc.
Novartis
South Carolina Association of Chain Drug Stores
Amersource
Genentech, Inc.
Glaxo Wellcome, Inc.
Hoeschst Marion Roussel
International Academy of Compounding Pharmacists
Janssen Pharmaceutica
PCS Health Systems
Pfizer
Smith Drug Company
Zeneca Pharmaceuticals
American Classic Tea
Bayer Corporation
Bristol Meyers Squibb
C. F. Sauer and Company
Cardinal Health, Inc.
Carolina Panthers
Capsugel
Drug Package Company, Inc.
Eli Lilly and Company
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Merck
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Pharmacia/Upjohn
Rhone-Poulenc Rorer
Schering/Key
South Carolina Parks, Recreation, and Tourism
South Carolina Peanut Board
South Carolina Pharmacy Association
South Carolina Soybean Board and Association
Wise Snack Foods
Wyeth-Ayerst*

**ROLL CALL OF DELEGATES OF BOARDS AND COLLEGES
AND REPRESENTATIVES OF INDUSTRY AND ORGANIZATIONS**

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Alabama Board of Pharmacy

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National Wholesale Druggist Association

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Barr Labs Inc.

Jim Crow
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Bob Dufour
Walmart

Gina Ford
Int'l Academy of Compounding Pharm

Mark Gregory
Kerr Drug, Inc

Jake Hansen
Barr Laboratory, Inc.

Phillip Hecht
Knoll Pharmaceutical Co..

Larry Hrvatin
Knoll Pharmaceutical Co

Jimmy Jackson
Eckerd Corporation

David Nelson
David Nelson & Associate

Karen Nishi
Cardinal Health

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Cathy Polley
Kmart Corporation

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Merck/Medco

Terry Short
CVS Pharmacy

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Joseph Valentino
USP

Don White
Knoll Pharmaceutical Co.

Lawrence Wise

Martin Wisse
Novartis Pharm. Corp.

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DISTRICT III NABP REPORT

Kevin E. Kinkade
President, NABP

Over the years, many of us have come to view our annual AACP/NABP district meeting as an opportunity to relax, to share our thoughts and experiences with our colleagues, to hear what the boards and colleges are doing, and to catch up with the latest trends and innovations impacting pharmacy practice. These are still good reasons for attending your district meeting, and those programs I have attended this year continue to meet those expectations. But in recent years, and particularly this year as the profession of pharmacy continues to reinvent itself to meet the challenges of the next century, the district meetings have become critical information links that connect the boards and colleges of pharmacy.

As we prepare for the future, our two great organizations continue to collaborate and interact on a number of projects and issues. It has been almost ten years since NABP and AACP initiated the Pharmacy Manpower Project. While the focus of the Project shifted from supply-side to demand-side once the baseline census of pharmacists had been determined, our commitment has never wavered. In other areas, NABP and AACP willingly share our knowledge and the expertise of our members to assist each other with the committee and project work that has been so helpful to the pharmacy community and the public.

This past spring the future moved a bit closer when the Mississippi State Board of Pharmacy applied for and received a Medicaid waiver from HCFA that would allow pharmacists to seek reimbursement for monitoring the progress of Medicaid patients suffering from asthma, diabetes, dyslipidemia, and anticoagulant problems. Representatives of the national pharmacy associations, chain pharmacy headquarters, software vendors and developers, third party payors, academia, and the state boards of pharmacy gathered in Jackson at the Board's invitation and agreed to cooperate in an unprecedented effort to develop the standards for disease state management examinations that would serve to credential Mississippi-licensed pharmacists in these diseases.

There was only one problem; we had just six short weeks to develop the standards and the item bank, and assemble the examination. Those of you who are familiar with NABP's painstaking examination development process will appreciate the enormity of this undertaking, and I'll admit there were a few anxious moments along the way. But thanks to the commitment and unflagging support we received from all areas of the profession, including the schools and colleges of pharmacy, we accomplished our goal of delivering valid, defensible examinations to the Mississippi Board in time for their July 8 and 9 administrations.

With the Mississippi project successfully behind us, NABP is seeking to extend the benefits of pharmacist provided disease management services to patients throughout the U.S. As you may already be aware, NABP has joined with NACDS and NCPA to form the National Institute for Standards in Pharmacist Credentialing to coordinate the development of standards and

competencies for pharmacists to provide disease management services. The work of the Institute will provide uniform, national standards that may be used to credential pharmacists in every U.S. jurisdiction and in a growing number of diseases.

This is not a closed shop. We have invited every pharmacy organization, including AACP, to join us in this tremendous undertaking. As charter members of the Institute's Standards Board, we will develop the standards necessary to credential pharmacists and extend the benefits of pharmaceutical care and disease state management to all segments of our communities. The dream that has sustained us for years is within reach. I encourage you to accept this heartfelt invitation and help us make pharmacy history.

As important as the disease state management project is, it is not the only noteworthy program occupying our attention. Beginning this fall, NABP's newest computerized examination, the Multi-State Pharmacy Jurisprudence Examination, or MPJE, will be administered at Cogent Testing Centers around the country. More than 30 states are planning to use the MPJE for their state law examination.

Last year, we told you about nabp.net, NABP's web site. In the second half of this year and continuing into 1999, we will continue to expand the site to include a number of new features. The Pharmacist and Pharmacy Achievement and Discipline database, or PPAD, which was introduced at NABP's Annual Meeting in May, will, in addition to state disciplinary actions, include the names of foreign educated pharmacists who have earned their FPGEC certification and pharmacists who are credentialed through the Disease State Management program. Also beginning next year, the NABP web site will allow pharmacists and other visitors to the site to electronically register for NABP meetings, apply for licensure transfer, and purchase Association publications.

These are exciting days for the profession of pharmacy. The new technologies that were viewed with some trepidation in their infancy have proved to be the catalyst that has freed pharmacists from the routine dispensing process and allowed them to fulfill the promise of their education and practice experience. In my opinion, AACP and the schools and colleges of pharmacy, and NABP and its member boards of pharmacy may take pride in the contributions we have made toward redefining and expanding the role of the pharmacist while continuing to safeguard the public health.

I thank you for inviting me to join you today, and on behalf of the Executive Committee and member boards of the National Association of Boards of Pharmacy, I wish you a very successful and productive district meeting.

DISTRICT III AACP REPORT

Jordan L. Cohen
President, AACP

On behalf of the members and Board of Directors of the American Association of Colleges of Pharmacy, I am pleased to be here to participate in this NABP district meeting and to provide you with this annual report of AACP activities. During 1997/98 AACP and NABP continued our mutual agenda of promoting pharmaceutical care and exploring issues of shared interest. It has been a very busy year, presenting both opportunities and challenges as we work together to serve our members, the profession, and the public. This report will touch on several of these initiatives.

NABP District Meetings -- AACP staff and/or presidential officers participated in all of the NABP district meetings last year, and we are continuing that activity because the opportunity for interaction and sharing of information is so valuable. You may be assured of the continuing commitment of the AACP Board of Directors to participate actively in these important forums.

Pharmacy Manpower Project, Inc. -- AACP and NABP continue to collaborate on this important project under the governance of a Board of Directors comprising representatives from 12 supporting national pharmacy and government organizations. As you are aware, the Pharmacy Manpower Project, Inc. (P.P.) has recently focused its attention on issues related to the future demand for pharmacist census and supply data. PMP, working with consultant Dr. Kathy Knapp of the University of Pacific, has worked during the past year to develop a fact sheet and policy paper on current issues related to demand for pharmacists' services in current and emerging practice settings to facilitate our ability to predict future demand trends as practice evolves. This year the P.P. is scheduled to complete a plan of work with NABP to utilize the comprehensive database developed by the organization and its member boards to assist in updating information, most recently published in 1972, on the number and key demographics of pharmacists in the U.S.

Importantly, the Bureau of Health Professions and the Bureau of Labor Statistics have recently communicated to the P.P. a renewed interest in workforce issues in pharmacy (and other health professions). The P.P. will actively cultivate this interest in an effort to further amplify both our data and our understanding of the complex issues impacting the size, nature, and emerging trends in the pharmacy workforce.

Curricular Change -- Ongoing and substantial curricular change (perhaps more accurately described as continuous evolution during these times of turmoil in health care) continues to dominate the daily lives of the faculty and administrators of the nation's schools and colleges of pharmacy. This is evidenced by the rapid movement of the majority of schools to a single degree program offering at the doctor of pharmacy level, now numbering more than 50 of the 79 programs with students currently enrolled.

Even more importantly, it is evidenced by the substantial commitment of time, people, and resources of our member schools to participate in our innovative AACP Institute initiative. During the past three years, including the 1998 Institute earlier this year, 56 schools of pharmacy will have sent five-member teams to a week long "experience" structured to assist them in fostering improvements in pedagogy, teaching methods, assessment of student learning, and other approaches that can enhance both the teaching and learning processes in the schools of pharmacy.

In support of this ongoing change process, AACP has this year reconvened its CAPE Educational Outcomes Advisory Panel to review and update the educational outcomes published by AACP in 1994 as a result of the work and recommendations of the Commission to Implement Change in Pharmaceutical Education. NABP past-president David R. Work serves on this important panel, whose work is scheduled for completion this fall as we continue to collaborate to provide valuable resource documents for curriculum improvement in our schools.

It is important to remind ourselves that these developments in curricular revision and educational innovation reflect not only the direction indicated by the newly adopted ACPE accreditation standards, but also by the realization that significant curricular evolution must occur almost continuously if our schools are to prepare caring and collaborative practitioners who will be capable of practicing and succeeding in a fully interdisciplinary and rapidly changing health care system.

Practitioner Education Issues -- Opportunities for practitioners to pursue the doctor of pharmacy degree via part-time and nontraditional educational pathways continue to expand, as evidenced by the availability of a wide range of such programs from more than 48 of the nation's schools and colleges of pharmacy this coming fall. In fall 1996, 1,778 practitioners were enrolled in nontraditional educational pathways leading to the doctor of pharmacy degree, a number that exceeds the number of students enrolled in traditional full- and part-time programs combined. Clearly a substantial number of colleagues have embraced this opportunity and mechanism to enhance their professional skills.

To assist practitioners and schools in this effort, AACP has recently issued requests for proposals to assist our CAPE initiative in developing instruments and processes that schools can use to assess practitioners' prior learning for the purpose of facilitating their advanced placement in nontraditional doctor of pharmacy programs. Once developed, these tools will be available for schools to use in assessing practitioner knowledge and skills in order that their educational program be, as much as possible, tailored individually to their needs and the educational outcomes designated for that specific Pharm.D. program. This initiative is being supported by a generous grant from Glaxo-Wellcome, Inc.

Many other pharmacists are choosing educational opportunities with focused knowledge and skill objectives that do not lead to the granting of a degree. The explosion within the profession of all manner of certificate programs presents both an opportunity for practitioners and a challenge for the profession as a whole. AACP, NABP, and other organizations are obviously actively interested and involved in this issue.

Consequently, the AACP Board of Directors earlier this year directed staff to convene a national invitational conference on certificate programs in pharmacy in collaboration with the American Council on Pharmaceutical Education. NABP representatives participated in the conference, held August 10-11, in Arlington, Virginia. Closely modeled after the initial conference on the topic, conducted in 1989, in which NABP was also an active participant, this conference hopefully will help guide the profession toward an enhanced understanding and use of certificate programs in the continuing professional development of practitioners.

Finally, it is appropriate as we begin this meeting to address the very recent developments surrounding the issue of post-licensure credentialing of pharmacists in disease state management. This issue has emerged as a critical one for all of us as a result of two events: (1) the important decision by the Mississippi Medicaid Program to amend its plan to allow for payment to appropriately credentialed pharmacists for certain disease management services; (2) the announcement by NABP, NACDS, and NCPA of the formation of the National Institute for Standards in Pharmacist Credentialing.

The rapid pace of developments in Mississippi's program made the lack of a national system for post-licensure credentialing in pharmacy readily apparent. Mississippi needed to move forward in the absence of a national system -- and did so. At the urging of the director of the Mississippi Medicaid Program, the Mississippi Board of Pharmacy was charged with assuring that practitioners seeking payment for such services were competent in disease management. The board of pharmacy in turn sought assistance from and worked with the University of Mississippi School of Pharmacy and NABP to develop standards and a process for credentialing pharmacists in four specific disease states. Both the school and NABP responded. This type of collaborative spirit between various components of the profession could form the basis for ongoing efforts to develop a uniform national system for post-licensure credentialing. But the work is just beginning.

At its recent meeting in Colorado, the AACP Board of Directors reviewed the previous work of the Joint Commission of Pharmacy Practitioners (JCPP) in dealing with national issues related to defining and assessing practitioner competence and processes for credentialing practitioners. In addition, the Board discussed the recent announcement that NABP, NACDS, and NCPA had formed the National Institute for Standards in Pharmacist Credentialing, and the request from NABP that AACP indicate its interest in joining in this effort. Because receipt of additional clarifying information requested of NABP by the AACP staff could not be provided in the short time between the announcement and the Board's meeting, the Board could make no decision with regard to the request at that time.

During the AACP Board of Directors discussion, several concerns relevant to the issue were expressed:

- postgraduate professional education and training, defining and assessing practitioner competence, and credentialing of practitioners are complex issues that deserve in-depth and broad dialogue within the profession in order that consensus be achieved;
- the prominent role of regulatory bodies and/or their trade associations in post-licensure credentialing is highly irregular in the health professions;
- the issue is loaded with intraprofessional politics;
- self-regulation is a hallmark within the professions -- credentialing by the profession is a major expression of self-regulation;
- since education is intimately involved in the preparation and assessment of practitioner competence, the AACP Board feels strongly that AACP and its member colleges have much to offer in defining outcome measures, and in offering the profession expertise in designing and evaluating educational programs as a part of any credentialing process.

The Board reviewed its long-standing position that post-licensure credentialing within the profession should be conducted by an independent agency or Consortium within the profession that is supported by and broadly representative of it. Based on the information available to the AACP Board during its meeting, the newly established Institute does not appear to fulfill that criterion. The Board believes that AACP must continue to work with all constituencies to develop nationally credible post-licensure credentialing processes.

This is an important issue for our two organizations -- indeed for all of us in pharmacy. We have an obligation to work through this issue constructively and effectively. If we're successful, we can develop programs and processes that facilitate and assure pharmacists' knowledge, skills, and abilities, both basic and advanced, throughout their careers. We look forward to working together, on behalf of our respective constituencies and our common interest, the public's health.

Best wishes for a most successful district meeting.

**DISTRICT III NABP/AACP
NECROLOGY REPORT**

Samuel T. Coker
Auburn University

According to the information provided to me by the Boards and Colleges of Pharmacy, the following faculty and board members have deceased since the 1997 meeting in Chattanooga:

Alabama Board of Pharmacy

George S. Hiller, Jr.

Florida Board of Pharmacy

Daniel R. Noble

Kentucky Board of Pharmacy

Ralph J. Schwartz

University of Florida

Dr. Perry A. Foote, Dean Emeritus
Dr. Koppaka V. Rao, Professor of Medicinal Chemistry

University of Georgia

Dr. Paul F. Parker, Professor Emeritus, Hospital Pharmacy

University of Mississippi

Dr. Coy W. Waller, Professor Emeritus of Pharmaceutics

University of North Carolina

Dr. Albert M. Mattocks, Professor Emeritus

Medical University of South Carolina

Dr. Alvin F. Dodds, Professor Emeritus

Are there others?

Please rise for a moment of silence in memory of our departed friends and colleagues. Dear Lord, we thank you for these lives who have served you and their communities through their profession. Amen.

DISTRICT III NABP/AACP COMMITTEE APPOINTMENTS

Time & Place Committee

Mark Conradi, Alabama Vice-Chairman
Dean Joseph Dean

NABP Resolutions Committee

Ronnie Cromer, South Carolina Board of Pharmacy - Chairman
Dianna Drake - Tennessee Board of Pharmacy
David Jaquith - Kentucky Board of Pharmacy
Jack Watts - North Carolina Board of Pharmacy

AACP Resolutions Committee

Michael McKenzie - University of Florida - Chairman
William Ozburn - University of Georgia
Ken Roberts - University of Mississippi
Glenn Farr - University of Tennessee

NABP Nominating Committee

Tom Alford - Alabama Board of Pharmacy - Chairman
Milagros Morales - Puerto Rico
Leonard Inge - Florida Board of Pharmacy
Harold Hodgson - Georgia Board of Pharmacy

Audit Committee

NABP:

Harold Stamps - Mississippi Board of Pharmacy
David Works - North Carolina Board of Pharmacy

AACP:

Johnnie Early - Medical University of South Carolina - Chairman
Stuart Feldman - University of Georgia

COMBINED SESSION

CONTEMPORARY PHARMACY COMPOUNDING: CURRENT LEGAL AND PROFESSIONAL ISSUES

Speakers: Gina Ford, RPh, FIACP
Executive Director, International Academy of Compounding Pharmacists

Tenny Moss, RPh
SC Board of Pharmacy

James B. Bobo, RPh
Owner, Prescription Center, Inc.

PROGRAM OVERVIEW:

With the resurgence of pharmaceutical compounding in the practice setting a variety of issues regarding such compounding have developed. This program will examine a number of these issues from the perspectives of a professional compounding organization, the FDA, a board of pharmacy member, and a practicing pharmacist.

PROGRAM OBJECTIVES:

- *Identify current compounding issues that challenge pharmacists
- *Describe the purpose of The International Academy of Compounding Pharmacists
- *Describe the FDA Modernization Act of 1997 and describe its application to pharmacy compounding practice
- *Understand the processes, procedures, and equipment of a contemporary pharmacy compounding practice
- *Identify pharmacy compounding issues from an FDA perspective
- *Identify pharmacy compounding issues from a board of pharmacy perspective
- *Identify pharmacy compounding issues from a practicing pharmacist's perspective

Contemporary Pharmacy Compounding: Current Legal and Professional Issues

Gina Ford, R.Ph. FIACP
Executive Director
International Academy of Compounding Pharmacists

(For Further Information on this topic contact Ms. Ford at the FIACP)

I. International Academy of Compounding Pharmacists

- A. Referral Source
- B. Literature Search and Distribution Service
- C. Publications
- D. www.iacprx.org
- E. Fellowship Honors

II. The Food and Drug Administration Modernization Act of 1997

- A. The Compounding Law
- B. Triad Relationship
- C. Bulk Drug Substitution
- D. Commercially Available Medications
- E. Interstate Distribution
- F. Advertising and Promotion
- G. The Implementation

III. The Contemporary Pharmacy Compounding Practice

- A. The challenges of 1998 vs. 1908
- B. The equipment of 1998 vs. 1908
- C. The resources of 1998 vs. 1908
- D. As it provides pharmacy care

CONTEMPORARY PHARMACY COMPOUNDING: CURRENT LEGAL AND PROFESSIONAL ISSUES. A BOARD MEMBER'S THOUGHTS

Robert T. (Tenny) Moss, Jr., RPh
South Carolina Board of Pharmacy

There are several items related to pharmacy compounding that I believe the various Board of Pharmacy needs to address. These are issues that the boards need to be involved in. The Boards should not wait for another state, NABP, nor the FDA to decide the outcome of these issues without the individual boards having a primary role in deciding the outcome and resultant policies - or regulations - or laws.

The FDA Modernization Act of 1997, as we all know, reaffirmed that pharmacy compounding is a legal aspect of pharmacy practice, regulated by the states thru the Boards, and not the federal government via the FDA. The Modernization Act specifically ensures that compounded drugs are available for individualized therapy when the traditional triad of the physician, patient, and pharmacist is intact. This law also helps enable the states to prevent manufacturing under the guise of compounding via an entity holding a pharmacy permit.

The Modernization Act provides for pharmacy compounding in a state that enters into a Memorandum of Understanding with the FDA that address specific issues required by the act. However, under this act, states may choose not to enter into a MOU if state guidelines limit pharmacies or physicians to distribution of compound products out of state in quantities not to exceed 5% of the total prescriptions distributed by such pharmacies and physicians.

The act states that NABP in conjunction with the FDA shall develop a standard MOU. The South Carolina Board feels this need for a MOU to be critical for the protection of the public and regulation of true compounding. We distributed our proposed MOU to the FDA at this past national meeting of NABP in May, 1998. To my knowledge, no response has come from the FDA. We believe our proposed MOU answers the requirements of the Modernization Act in a concise and enforceable manner for the State of South Carolina. Copies of our MOU are available for your review and comments.

Another issue resulting from the Modernization Act we must keep up with as regulatory bodies is the "Nominations for bulk drug substances to be used in pharmacy compounding." The FDA and the USP are required to develop an approved list of drugs. It would have been much easier to regulate if we had a list of unapproved drugs, but we will have to do it the hard way. The state Boards may also need to develop mechanisms for approving drug substances to use in compounding. The boards MUST assure that pharmacists have sources of high quality drug products to meet the medical needs of their patients.

I ask you to recall the Dietary Supplement Health and Education Act of 1994. This federal legislation allowed for the OTC sale of products such as vitamins, minerals, herbs, and amino acids intended to supplement the diet and required labeling with what is called "Supplement Facts." This legislation opened the way for OTC sale of DHEA and melatonin - products for oral administration.

As regulators we should be aware that certain entities are using the Dietary Supplement Act as justification for producing progesterone cream for resale in OTC transactions. Such products are being offered to pharmacies and retailers via direct solicitations from the producers of the products, and thru wholesalers. Last week, in a phone conversation with another pharmacist about OTC progesterone cream, he rattled off a list of 11 progesterone creams he know of being sold OTC.

I contacted Betty Hiner who put us in touch with Anne Scott and Roma Egll at FDA. They provided used with copies of the FEDERAL REGISTER/ Vol. 58, No. 173 that states progesterone at concentrations of 5mg/oz when used in an amount not exceeding 2 oz. Per month is safe for OTC use. Products exceeding this concentration are not approved for OTC sale.

I asked how the FDA could allow OTC sale of a product that I and other Board members have dispensed only by prescription for over 15 years. The answer is that the FDA does not allow it. They told me that by the time FDA could start enforcement actions, the companies would typically have sold hundreds of thousands - or more - dollars worth of product before being shut down. The companies might just be satisfied with what they had made, or move to another state and start over.

Our Board has taken the position that OTC progesterone sales are not safe for the public. Pharmacists may not compound for OTC sale progesterone at concentrations greater than 5mg/oz nor may entities offer for OTC sale such products in South Carolina. We have had our staff draft a notice to pharmacies and wholesalers in our state of the Board's decision. At our September meeting next month, we will implement policy to address this situation. We strongly feel the public should be protected from unsupervised and improper use of any drug product that should be restricted to prescription sale only. The South Carolina Board and the FDA are in agreement about this.

In a different arena, an unusual situation concerning compounded drugs in our state has been resolved. In South Carolina, prescriptions are exempt from state sales tax. The residents and the members of the General Assembly believe this is proper. About a year and one-half ago, the State Tax Commission decided that nuclear pharmacists' compounded PET products should be taxed. The nuclear pharmacists appealed to the Board for help. The Board issued a policy statement in a letter that compounded PET products are indeed compounded prescription drug products. The Tax Commission decided not to pursue instigating the new tax. Our declaration helped prevent the residents of our state from being improperly taxed for compounded drugs.

We have fought the good fight with our friends at the FDA, to assure for all time, that regulation of pharmacy compounding is within the purview of the state boards of pharmacy. We must be diligent and properly regulate compounding to assure that no entity manufactures behind a pharmacy permit or pharmacist's license. We must regulate in a manner to allow pharmacists to use new technologies, new drug substances, new science, and the traditional arts and skills of compounding to provide the best drug products possible. We need to regulate to assure pharmacists produce drug products that they are competent to compound. We must train our students in the use of modern technology. Sadly, many pharmacy schools are still using 19th century tools and equipment to train students, even as we approach the 21st century.

Our regulations, while protecting the public, must be enabling regulations that allow for state-of-the-art practice and science. It matters not whether we are talking about compounding, patient counseling, disease state management, or any other aspect of pharmacy.

March 18, 1998

Memorandum of Understanding:

The South Carolina Board of Pharmacy and the Food and
Drug Administration

Introduction

Pursuant to Section 127 "Pharmacy Compounding" of the Food and Drug Modernization Act of 1997, the South Carolina Board of Pharmacy (SCBOPh) has developed this memorandum of understanding (MOU) to address specific issues related to compounded drugs. The purpose of this MOU is to provide specific guidelines on the dispensing of compounded drug products.

I. Investigation of Complaints of Compounded Drugs Sent Out-of-State

In general, complaints about compounded drugs which are shipped out-of-state, will be investigated by the board of pharmacy in the state in which the compounding pharmacy is located. That board of pharmacy may obtain the assistance of the board of pharmacy which is located in the state where the compounded drug was shipped.

If the complaint involves a death or serious injury of a patient, either board of pharmacy (in the state where the compounded drug was shipped, or in the state where the compounding pharmacy is located) may initiate the investigation. A serious injury is defined as any experience that is fatal or life-threatening, is permanently disabling, requires impatient hospitalization, or results in a an overdose due to formulation. In a case involving a death or serious injury, the boards of pharmacy will coordinate to determine which board will investigate the complaint. The results of any investigation of a complaint will be shared with the other board.

II. Inordinate Distribution of Compounded Drugs Out-of-state

A pharmacy may dispense compounded drugs interstate in an amount greater than 5% of its total drugs dispensed or distributed, provided that the pharmacy notifies the state board of pharmacy with which it is registered and provides additional information that may be required by the state board of pharmacy. The SCBOPh shall develop procedures to implement this notification requirement. This notification shall not be in lieu of any other registration or licensure requirements that may be applicable to the pharmacy in the state into which it ships compounded medication.

In addition, pharmacies that dispense a majority of their total compounded prescriptions interstate, must provide counseling to patients and a toll free number, which is affixed to the label of the patient's medication. The pharmacy must be available at least forty hours and five days a week, unless state rules require greater access to counseling services from nonresident or mail order pharmacies.

III. Compounded Drugs For Office Use

A pharmacy may compound drugs for the use of a licensed prescriber who administers or dispenses the drugs, in accordance with state law, to patients in the prescriber's office. However, a pharmacy may not dispense compounded drugs to a prescriber for office use if the drug is resold to a patient. Compounded medication for office use must be prepared pursuant to an order by prescriber.

CONTEMPORARY PHARMACY COMPOUNDING A PRACTITIONER'S VIEW

James B. Bobo, RPh, FIACP
Prescription Center, Charleston, South Carolina

A. CHALLENGES OF INDEPENDENT PHARMACISTS

1. Managed Health Care
 - A. Caused increase in number of third party prescriptions
 - B. Reimbursement levels very low
2. Chain Pharmacies
 - A. Increasing numbers of chain pharmacies
 - B. Effecting independent pharmacies that remain dispensing pharmacy

B. RESURGENCE OF PHARMACEUTICAL COMPOUNDING IN THE PRACTICE SETTING

1. Legal considerations
 - A. Duplication of commercial products
 - B. Producing products for resale in other office settings
2. Professional acceptance
 - A. Veterinary markets
 - B. OB/GYN
 - C. Sports medicine markets

C. FORMATION OF PROFESSIONAL COMPANIES TO ASSIST PHARMACISTS

1. Product information, formulas and chemicals needed
 - A. Pharmaceutical Compounding Centers of America
 - B. International Academy of Compounding Pharmacists
 - C. Gallipot
 - D. Paddock Laboratories

D. SITE ACCOMMODATIONS

1. Compounding area in the pharmacy
 - A. Selection of appropriate area in pharmacy
 - B. Can site area be visible to client area
2. Remodeling requirements
 - A. Cost factors

E. DEVELOPING A COMPOUNDING PRACTICE

1. Training
2. Marketing
3. Product development
4. Quality assurance
5. Sterile product formulation
6. Installation of clean room (Laminar flow hood)

F. SUMMARY

1. Compounding pharmacists are able to realize improved profits
2. Possible reduction in third party plans
3. Offer additional services such as disease management, glucose monitoring, BP monitoring, cholesterol screening, etc.

DISEASE STATE MANAGEMENT CERTIFICATION: A CREDENTIALING PROCESS TO ACHIEVE THE PROFESSIONS'S POTENTIAL

Walter Morrison, Ph D.
Associate Dean, College of Pharmacy
University of Arkansas for Medical Services
Little Rock, Arkansas

PROGRAM OVERVIEW:

The ability of pharmacists to provide disease state management for their patients is an important component of pharmacy care services in the changing health care environment. Pharmacists currently receive training in such management from a variety of providers. This program will examine issues related to the credentialing of pharmacists for provision of consistent and effective disease state management services.

PROGRAM OBJECTIVES:

- *Identify barriers and limitations to the provision of pharmacy services in disease state management
- *List professional opportunities and responsibilities in disease state management
- *Outline a successful pharmacist credentialing process in disease state management

Editorial Comment: Dr. Morrison presented a very extensive slide program. Those desiring further information on his involvement in this rapidly developing field should contact him by phone at (501) 686-5557 or by FAX at (501) 686-8315.

Pharmacy Management Certification

Primary Topics

- Barriers and limitations to the provision of pharmacy services in disease state management
- Professional opportunities and responsibilities
- A successful pharmacist credentialing process

Walter J. Morrison, Ph.D.

Pharmacy Management Certification

Barriers and Limitations

- Lack of degree programs which assure competence
- Lack of certificate programs which assure competence
- Lack of certificate program accreditation process
- Lack of nationally recognized certification process
- Third party emphasis on drug distribution

Walter J. Morrison, Ph.D.

Pharmacy Management Certification

Barriers to Participation in Certificate Programs

- Time
- Cost
- Travel
- No commitment
- No confidence
- No perceived need
- Unwillingness to change practice
- Lack of ability to apply skills gained
- No tangible rewards
- Age/ally
- No Reimbursement

Source: Dr. Robert B. Spector, "Certificate Programs in Pharmacy (1991 ACP) Update Meeting"

Walter J. Morrison, Ph.D.

Pharmacy Management Certification

Certificate Programs

38 Certificate Programs involving 20 schools of pharmacy

- Pharmaceutical Care (6)
- Diabetes (4)
- Asthma (3)
- Geriatrics (3)
- Pharmacokinetics (3)
- Consulting Practice (2)
- Anticoagulation (2)
- Hypertension (2)
- Physical Assessment (2)

Source: Dr. Robert B. Spector, "Certificate Programs in Pharmacy (1991 ACP) Update Meeting"

Walter J. Morrison, Ph.D.

Pharmacy Management Certification

Lack of Nationally Recognized Credentialing Process

8. Third Party Prescription Drug Programs
 "APhA shall explore the development of a national credentialing process for pharmacies participating in various third party prescription drug programs." (1994 HOD by W. J. Morrison)
This proposal was referred to the Board of Trustees for further review and action as warranted.

Walter J. Morrison, Ph.D.

Pharmacy Management Certification

Professional Opportunities

- The Louisiana experience
- Patient's Choice
- Diabetes Legislation
- Mississippi Medicaid Program
- Needs of Pharmacy Benefit Managers

Walter J. Morrison, Ph.D.

Pharmacist Management Certification

Professional Responsibilities

- ◆ Enhance the quality of care
- ◆ Contain cost when it does not impact negatively on the quality of care

Pharmacist Management Certification

Pharmacist Management Certification

AACP/ACPE Conference on Certificate Programs

- ◆ Introduction
- ◆ Definition
- ◆ Certificate Programs and Certification
- ◆ Quality Assurance
- ◆ Accreditation

Surprise - Another such conference starts tomorrow

Pharmacist Management Certification

Pharmacist Management Certification

The Credentialing Process

NABP Resolution No. 93-5-97
Standardization of Qualifying Criteria for Certification Programs

Pharmacist Management Certification

Pharmacist Management Certification

The Credentialing Process

NABP Task Force on Certificate Program Standards and Accreditation
Recommendations 1-4

Pharmacist Management Certification

Pharmacist Management Certification

The Credentialing Process

- ◆ Competency Statements
- ◆ DSM Objectives/Standards
 - ◆ Asthma
 - ◆ Diabetes
 - ◆ Dyslipidemia

Pharmacist Management Certification

Pharmacist Management Certification

The Credentialing Process

The National Model and Process:
The National Institute for Standards in Pharmacist Credentialing

Developed by: NABP/NCPA/NACDS

Pharmacist Management Certification

Distance Management Certification 16

The Credentialing Process AACP Board Concerns

Postgraduate professional education and training, defining and assessing practitioner competence, and credentialing practitioners are complex issues that deserve in depth and broad dialogue within the profession in order that consensus be achieved.

Walter J. Morrison, Ph.D.

Distance Management Certification 17

The Credentialing Process AACP Board Concerns

The prominent role of regulatory bodies and/or their trade associations in post licensure credentialing is highly irregular in the health professions.

Walter J. Morrison, Ph.D.

Distance Management Certification 18

The Credentialing Process AACP Board Concerns

The issue is loaded with intraprofessional politics.

Walter J. Morrison, Ph.D.

Distance Management Certification 19

The Credentialing Process AACP Board Concerns

Self-regulation is a hallmark within the professions; credentialing by the profession is a major expression of self-regulation.

Walter J. Morrison, Ph.D.

Distance Management Certification 20

The Credentialing Process AACP Board Concerns

If education is involved, AACP and pharmaceutical education should be involved. Expertise in designing educational programs, measuring their outcomes, and assessing their quality resides within pharmaceutical education.

Walter J. Morrison, Ph.D.

Distance Management Certification 21

The Credentialing Process

As leaders in our profession,
success or failure is in your hands.
How do you plan to provide practitioners
the opportunity to realize their potential?
Should new graduates require CE?
Why not certification rather than CEUs?

Walter J. Morrison, Ph.D.

**PREVENTING MEDICATION ERRORS: CURRENT ISSUES
EFFECTING ACCURACY OF DRUG ORDERING,
DISPENSING, AND ADMINISTRATION**

Michael R. Cohen, MS, FASHP
President, Institute for Safe Medication Practices
Westminister, Pennsylvania

PROGRAM REVIEW:

Medication errors continue to be a concern for the pharmacy profession and the patients who are served; recent national media coverage has highlighted specific and tragic situations involving medication errors. This program will focus on a variety of issues involved in the prevention of medication errors in the pharmacy setting and beyond.

PROGRAM OBJECTIVES:

- *Discuss recent publicity concerning pharmacy dispensing errors
- *Identify the common causes of dispensing errors that occur in community practice settings
- *Discuss actual case studies of medication errors and how they could have been avoided
- *Examine the role of drug labeling, packaging, nomenclature, and environmental factors as contributors to dispensing errors.
- *Discuss practice issues that can affect the detection of medication errors, such as diagnosis on the prescription face
- *Describe procedures that can be incorporated into the pharmacy's dispensing process that can help to prevent dispensing errors
- *Describe procedures that can be incorporated into the pharmacy's risk management program to minimize error potential

EDITORIAL COMMENT:

The following is a copy of Mr. Michael R. Cohen's slide presentation. Please contact him at the above Institute for further information.

Medication Errors Reporting Program

*Operated by the
United States Pharmacopeia in cooperation
with the
Institute for Safe Medication Practices*

Report medication errors in confidence:
1 800 23 ERROR

Mission of ISMP

- Translate errors into education
- Encourage voluntary reporting
- Help prevent medication errors by productively interacting with:
 - Regulatory agencies
 - Professional organizations
 - Practitioners
 - Healthcare institutions
 - Pharmaceutical industry

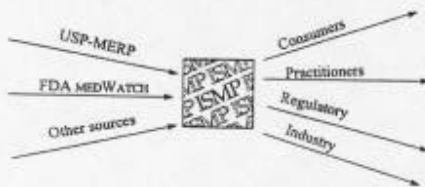
ISMP Publications

- *ISMP Medication Safety Alert!*
- *Journals and newsletters*
 - ASHP Newsletter, APhA Pharmacy Today, Nursing '98, Hospital Pharmacy, INS Newslite, Oncology Times, Internal Medicine News, Family Practice News, US Pharmacist, ASHP Homecare Newsletter, HomeHealth Insights
- *Internet World Wide Web Site*
 - (www.ismp.org)

Communication tools

- *ISMP Medication Safety Alert!* (all US hospitals) - retail pharmacies and long term care planned
- Professional journals (monthly features)
 - Medicine (400,000+ readers)
 - » Internal Medicine News, Family Practice News, OB-Gyne News, Oncology Times
 - Pharmacy (all US pharmacists)
 - » Hospital Pharmacy, ASHP Newsletter, APhA Pharmacy Today, ASHP Homecare News, US Pharmacist, Hospital Pharmacist Report
 - Nursing (1,000,000+ readers)
 - » Nursing 98, INS Newslite, Nursing 98 Home Care

Institute for Safe Medication Practices

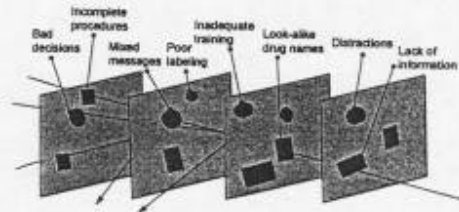


Other US Error Prevention Efforts

- National Coordinating Council on Medication Error Reporting and Prevention
 - Comprises 14 organizations including ISMP, FDA, USP, JCAHO, AMA, ANA, APhA, ASHP
- USP Advisory Panel on Medication Error Prevention

Medication safety systems

- Information about patient
- Knowledge and information about drug
- Communication
- Computer and order processing
- Labeling, packaging, drug nomenclature
- Drug distribution
- Formulary
- Drug compounding and manufacturing
- Environmental
- Drug administration
- Device acquisition and monitoring
- Quality assurance
- Patient education



Safety nets
(Professional, Institutional, Individual, Technological, etc.)

The latent failure model of complex system failure
(from James Reason, 1991, with permission)

Most frequent serious error types

- Insulin
- Free flow IV pumps
- PCA devices
- Parenteral narcotics
- Lidocaine
- Cancer chemotherapy
- Neuromuscular blockers
- Conscious sedation
- Concentrated electrolytes (potassium, magnesium, phosphate)

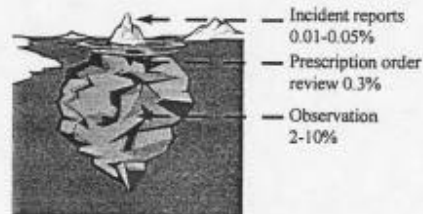
Failure Mode and Effects Analysis

- A systematic assessment of how and where pharmaceutical trademarks may be vulnerable to confusion
- Set up process flow diagram
- Determine failure modes
- Rank likelihood of occurrence, severity of outcome
- Where effects of errors are judged unacceptable, action may be taken to minimize potential for errors

Consider the process flow:

- Who purchases?
- Where stored?
- Who prescribes?
- Ordering process?
– handwritten, verbal, telephone, computer
- Where used?
- How does it get to site?
- Who administers?
- Who/how monitored?
- Who adjusts therapy?
- Recording of administration?
- Reordering?

Incident reports are the tip of the iceberg



MD handwriting study¹

<i>Category</i>	<i># MDs</i>	<i>%</i>
Totally illegible	8	17
Poor to difficult	8	17
Fair to average	9	19
Good to very good	16	34
Excellent	6	13

¹Arns. A study of physician handwriting as a time waster. JAMA 1979;242:2429-30.

Dangerous Abbreviations

Standardize order communication (cont'd)

- Use leading zero (0.1 mg not .1 mg)
- No trailing zeros (1 mg not 1.0 mg)
- Avoid nonstandard abbreviations ("U" for unit, q.d., drug name abbreviations such as "AZT")
- Never prescribe an entire course dose to be given over a range of dates (e.g., "4 g/m² x 4 days")
- Consider preprinted orders to help standardize prescribing methods

Verbal Orders

Standardize order communication

- Eliminate oral orders
- Use generic and brand names - no abbreviations
- Do not refer to drugs by class name (is "platinum" carboplatin or cisplatin?)
- Never prescribe by volume, # vials, amps, etc.
- Use standard units (is it mEq, mg, mOsmol?, etc.)
- Include body surface area with order and drug dose per m² or mg/Kg for independent check

Considerations when responding to disastrous errors

- Plan internal and external notification process in advance (health dept., coroner, manufacturer, USP MERP, FDA MEDWATCH, JCAHO, etc.)
- Approach to patient and family
- Confidentiality when dealing with media
- Psychological counseling and support of practitioner and associated staff
- Safeguard documents, containers and equipment
- Staff aware of need for patient confidentiality
- Contact with USP or ISMP to learn of similar experience, peer contacts

Considerations when responding to disastrous errors

- What immediate and long term remedial action is needed?
- Take steps to remove defective equipment, product labeling, packaging, redesign process, etc.
- Disciplinary action against employee? Action to take?
- Internal and external PR
- Press conferences
- Visits from regulatory agencies, JCAHO Accreditation Watch

Verifying the dose

- Dose verification process with independent checks
- Computer screening for maximum dose
- Calculations performed independently by at least three individuals
- Pharmacist access to lab and patient data
- Investigational doses verified by IRB protocol or two independent sources

Establish dose limits

- Maximum doses established and communicated during orientation
- Doses not exceeded without peer review process
- Install in computer and place on preprinted order sheets
- Limits for infusion duration and route
- Warning labels where appropriate

Errors with automated equipment

- Retrieving an incorrect medication due to misreading order and open access
- Wrong dose of medication or larger quantity than ordered
- Careless reading of labels of drugs removed from matrix pockets, slots or "pies"
 - "It's computerized so errors impossible"(people "lean" on automation)
 - "Pharmacy placed it there and they don't error"
 - "That drug was always in that very slot before"

Errors with automated equipment

- Taking more than one patient's medications at a time and somehow mixing them up (in envelope, pocket, zip lock bag)
- Items removed from equipment but not ordered for patient (1-2%)
- Items not returned to equipment
- Doses placed into wrong slot by pharmacy or doses that fall into wrong slot or are misplaced into wrong slot when returned

Educate healthcare providers

- Test based on published errors
- Certification to validate knowledge before practice
- Pharmacy provided checklist for all new drugs
- Educational sessions that describe problem situations and consequences

Read labels carefully - 3 times!

- When obtaining package
- When using package
- When discarding package or returning to storage

***DO NOT BE FOOLED BY SHELF
OR BIN OR CARTON LABELS -
RELY ONLY ON IMMEDIATE
CONTAINER LABEL***

Overcoming label problems

- Change printer ribbons
- Replace old printers
- Pharmacy name on bottom of label
- Make drug name most prominent
- Differentiate portions of label with fonts, boldface, etc.
- Commercial labels for repackaged drugs
- Two-sided labeling
- Label placed just beneath manufacturer's name
- Differentiate IV labels from irrigations, TPN from cardioplegia, etc.

Confirmation bias

Accept information that agrees with our hypothesis; reject information that does not

Environmental considerations

- Poor traffic patterns (people reaching over you, having to walk around objects, location of telephones, etc.)?
- Temperature conditions
- Workload
- Schedule/Shifts
 - Stress
 - Fatigue
- Routine

Environmental considerations

- Adequate lighting
- Clean work area
- Controlled access to hazardous substances
- Reduce distractions
 - Noise (page speaker, radio, excessive talking, etc)?
 - Telephone
 - Excessive interruptions of personnel

Improved communication between health professionals

- Many errors result from poor communication
- Peer review for doses that exceed predetermined limits
- Collaborative effort needed at each institution
- Assume errors will occur
- Emphasis on external errors

Risk management considerations

- Interdisciplinary activity
- Examine internal and external reports
- Classify by severity
- Brainstorm prevention methods
- Pharmacist must be aware of all ADEs within institution

Risk management considerations

- Reduce fear of reporting
- Systems and processes are the problem
- Collaborate on decisions
- Feedback to reporters when action taken
- Reward reporters

Working with drug manufacturers

- Report labeling, packaging and nomenclature errors or potential errors to USP-ISMP Medication Errors Reporting Program
- Communicate concerns to pharmacy and manufacturer

Patient education

- Inform patients of drug names, purpose, dose, side effects and management methods
- Suggest readings for patient
- Inform patient about right to ask questions and expect answers
- Listen to what patient is saying and provide follow up!

Nomenclature related problems

- Names with number prefixes:
 - 5-fluorouracil
 - 6-mercaptopurine
 - 6-thioguanine, etc
- Names that are abbreviated:
 - MTX, HN2, CDDP, AZT, FUDR, Ara-A, Ara-C

Nomenclature related problems

- Names that look or sound similar:
 - folic acid-folinic acid
 - cyclophosphamide-cyclosporine
 - floxuridine-fludarabine
 - daunorubicin-doxorubicin-idarubicin
 - Adriamycin-Idamycin
 - vincristine-vinblastine
 - carboplatin-cisplatin

Clinical screening needs for software

- Dose limits
 - single dose
 - total/24 hours
 - course of therapy
 - lifetime
 - by ingredients
- Allergic reactions and cross allergies
- Drug information
- Drug duplication
- Therapeutic duplication
- Contraindicated drugs
- Dose modifications
 - renal, liver, CHF, DM
- Drug interactions
- Quality assurance
 - justification of overrides
 - peer review

Computer system-related problems

- Standing orders that include common allergens
- Computers or printers that print incorrect characters
- Software that adds terminal zeros or fails to add leading zeros
- No link between IV system and other medication listings
- Generation of poorly designed MARs and 24-hr prescriber updates
- Not using features such as computer "flags," maximum dose fields, etc.
- Generation of hard to read labels
- Poorly designed mnemonics

Assign mnemonics carefully

- Mnemonics
 - confusing abbreviations (AZT 100)
 - do not assign to certain drugs or consider what may appear on same screen or if mistyped
 - mnemonics that are too similar (THI100, ANCE500 and ANEC500, BUS10, etc.)

Home care medication errors

- Inadequate patient/caregiver education
- Infusion pump programming problems
 - rate, concentration
- Infusion pump free-flow
- Time sequencing of antibiotics
- Drug storage improper
- Confusion between hospital and home care agency

Primary principles in error reduction

- Reduce possibility of errors
 - e.g., remove KCI from patient care areas
- Make errors visible
 - e.g., incompatible IV/NG tube fittings
- Minimize the consequence of errors
 - e.g., reduce amount available for hazardous drug

Concepts used in designing systems and processes

- Simplify - reduce steps and number of options
- Outsource or centralize error prone processes
- Differentiate items (appearance, location)
- Standardize (communication and dosing methods)
- Redundancy (double checks)
- Reminders (notes, auxiliary labels, protocols, checklists, warnings, visual and audible alarms)

Concepts used in designing systems and processes

- Improve access to information
- Constraints to limit access or use
- Forcing functions (e.g., form design, incompatible fittings)
- Modify default values
- Failsafes
- Tactile cues

Summary

- Errors can kill
- Voluntary reporting is critical
- Management of errors is good
- Anticipation of errors is better
- Prevention of errors is best

CURRENT ISSUES WHICH IMPACT ACCURATE PHARMACEUTICAL DISPENSING

Speakers: John D. Taylor, RPh.
Florida Board of Pharmacy

David Work, RPh
North Carolina Board of Pharmacy

Tracy L. Baroni, RPh, JD
National Association of Chain Drug Stores

PROGRAM OVERVIEW:

Even with the changing role of the pharmacist in a dynamic health care environment, the process of dispensing pharmaceuticals remains a critical portion of the pharmacy profession's responsibilities. This program will focus on issues of quality improvement, pharmacists' work loads, and dispensing accuracy.

PROGRAM OBJECTIVES:

"TRANSITION TO OUTCOME BASED REGULATION-A QUALITY IMPROVEMENT APPROACH"

- *Describe one state's efforts to move toward outcome based regulation
- *Discuss proposed regulations designed to reduce quality-related events in pharmacies

"BOARD POLICY REGARDING PHARMACISTS WORK LOADS"

- *List reasons for the introduction of pharmacists' work load guidelines
- *Describe one state's current policy regarding limitations on the work load threshold of pharmacists

"THE CHAIN DRUG PERSPECTIVE ON PRESCRIPTION ACCURACY"

- *Recognize the various aspects of pharmacy practice involved in dispensing errors
- *Identify steps taken in chain pharmacies to decrease errors
- *List benefits and problems related to mandatory quality assurance reporting

Transition to Outcome Based Regulation - A Quality Improvement Approach

John D. Taylor, RPh.
Florida Board of Pharmacy

I appreciate the opportunity to share with you some of the work of the Florida Board of Pharmacy to improve the health, safety and welfare of the residents of our state. I would like to give you a brief history of this project and conclude with a brief review of the proposal. I understand that there will be a time for questions after the other speakers have concluded. The work to move our regulatory process from one based less on structure and process to one with increased emphasis on outcome has been exciting and exhausting. It is certainly a work in progress, one we hope to implement, evaluate, and continue to revise and implement. Our work in this area would not be possible without the tireless efforts of Professor David Brushwood of the University of Florida College of Pharmacy and the support of Dean Riffie.

Let me take a few minutes to describe the beginnings of this project. The UF College of Pharmacy granted David a sabbatical during the 1996-97 academic year. During this year David worked with NABP to develop the concepts of outcome based regulation. David reported on his work at the NABP Annual Meeting in San Diego last year. That audience included some members of the FL BOP and MQA Division Director Gloria Henderson of the FL DOH. Mrs. Henderson is responsible for all the medical and health regulatory boards in Florida

An optional workshop was held in San Diego and David and I began a dialogue on how a state might implement outcome-based regulation.

With the blessing of the Chair of the Board of Pharmacy and Mrs. Henderson at the Department of Health, David and I began to work together to develop a proposal for Board consideration. One of the suggestions that I made during the San Diego workshop was for an incremental transition to regulations based on these concepts. I am not sure that I convinced David that this was the best implementation method, but I did convince him that incremental change had the best chance of success in Florida. The idea is to insert new outcome based regulations into the current code and then delete older structure and process regulations, as they become less meaningful.

We decided to begin with three of David's ten concepts; medication errors, performance evaluations, and consumer surveys. This morning we will focus on medication errors. We presented what was about our fifth draft to the Board in January 1998. We received a generally positive response from the Board, but they had a number of good suggestions for revisions. Around this same time we also shared an early draft with NABP's Task Force on Workload Systems, and received additional suggestions, many that have been incorporated in some form in subsequent drafts.

At our March meeting the Board made a few more suggestions and voted unanimously to proceed toward implementation of the first three proposals. This was not an adoption of final language, but an important statement of intent from the Board. . In June the Board voted to continue the rule development process.

The first of the three proposed rules addresses medication errors. As regulators we are often asked what are we doing about the medication error problem. In most cases our responses are limited to describing after-the-fact discipline taken. This assumes a complaint was filed and the Board felt that discipline was appropriate. Is this the most effective form of regulation? How much effect does a letter of guidance, or a fine, or any punitive sanction that you might impose have? I do not want to suggest that there is no effect, we use these methods in Florida, but would it not be better if as regulators we could do something proactively to reduce errors?

Lets look at the proposal being considered in Florida. There is a handout with proposed language.

The proposal begins with definitions:

(1) “Continuous Quality Improvement Program” means a system of standards and procedures to identify and evaluate quality-related events, and constantly enhance the efficiency and effectiveness of the structures and processes in a pharmacy system that determine the outcomes of medication use.

We have used the term “Quality Related Event” to describe what is basically a medication error.

(2) “Quality-Related Event” means any departure from the appropriate dispensing of a prescribed medication that is not corrected prior to the medication leaving the direct supervision of a pharmacist in the dispensing area of a pharmacy. The term includes variations from the specifications of a prescription, such as wrong drug, wrong strength, wrong directions, and wrong dosage form. The term also includes packaging or warnings that fail to meet recognized standards, the delivery of a medication to the wrong patient, and the failure to detect and appropriately manage a significant actual or potential problem with a patient’s drug therapy.

Key elements include: language describing when an error becomes an error, standard error descriptions, and other failures to meet recognized standards. There are certainly other ways to define medication errors. We believe this serves our purposes best.

The next section requires the establishment of a Continuous Quality Improvement Committee. It provides for membership and authority.

- (3) Each pharmacy shall establish a Continuous Quality Improvement Program. The program shall include a committee comprised of staff members of the pharmacy, including pharmacists, pharmacy interns, pharmacy technicians, clerical staff, and other personnel deemed necessary by the prescription department manager or the consultant of record. The prescription department manager or the consultant of record for the pharmacy shall serve as the chair of the committee. The program shall be described in a policy and procedures manual, and records shall be maintained of all activities undertaken as a part of the pharmacy's Continuous Quality Improvement Program.

Section 4 requires that a record must be kept when a "Quality-Related Event" is reported to the pharmacy. The pharmacist to whom it is described must record it on the day of the report. It must be described sufficiently to permit *categorization and analysis* of the event.

- (4)Each Quality-Related Event that occurs, or is alleged to have occurred, as the result of activities in a pharmacy, shall be documented in a written record or computer database created solely for that purpose. The Quality-Related Event shall be documented by the pharmacist to whom it is described, and it shall be recorded on the same day of its having been described to the pharmacist. Documentation of a Quality-Related Event shall include a description of the event that is sufficient to permit categorization and analysis of the event. Pharmacists shall maintain such records for at least two years from the date of their creation.

Section 5 requires that all reasonable steps necessary to mitigate the problem for the patient be taken, including a complete and truthful explanation and contact with the physician if the medication has been ingested.

- (5)As a component of its Continuous Quality Improvement Program, each pharmacy shall assure that, following a Quality-Related Event, all reasonably necessary steps have been taken to remedy any problem for the patient. Such steps shall include a complete and truthful explanation of the event to the patient or the patient's agent. If the patient has ingested the medication, such steps shall also include contact with the patient's physician, and a thorough investigation of the potential consequences of the event to the patient.

Records shall be maintained for two years of all remedial measures undertaken following a Quality-Related Event.

After these steps have been accomplished, the next section requires that the CQI Committee meet at least every other month to review and consider each and every QRE since the last CQI Committee meeting. At a minimum, the committee shall consider the effects on quality of the pharmacy system due to staffing levels, workflow, and technological support. Obviously, the goal is to reduce the number of QRE's that must be considered the following month.

(6) As a component of its Continuous Quality Improvement Program, each pharmacy shall assure that periodic meetings of the committee, established in subsection (3) of this section, are held to discuss quality improvement matters. Such a committee meeting shall be held at least bimonthly. The record of Quality-Related Events shall be reviewed at each committee meeting. Suggestions for improvement in the pharmacy system shall be solicited from all committee members. At a minimum, the committee shall consider the effects on quality of the pharmacy system due to staffing levels, workflow, and technological support. Records shall be maintained of committee discussions for a period of two years.

Before we look at the seventh section, I would like to discuss the board's disciplinary philosophy for this rule. For pharmacists and pharmacies complying with the requirements of this section, discipline for a QRE would be minimal, however QRE's resulting when these requirements have not been followed will lead to enhanced penalties. Most would agree that some errors may occur despite our best efforts to prevent them. Significant discipline is not appropriate in those instances. The work of CQI committees can probably reduce the occurrence of some errors; if those opportunities are ignored enhanced disciplinary penalties will be appropriate. This "carrot or stick" principle is fundamental to the proposal, and is the clear intent of the Board.

Finally it is the intent of the Board that the discussions of the CQI Committee be frank and useful. In this regard, it is further the intent of the Board that these discussions be protected from discovery in civil and administrative litigation. We tried to get this protection enacted in statute this past year but we were not successful. We are hopeful that we can get it done next year.

(7)Records maintained as a component of a pharmacy Continuous Quality Improvement Program are confidential under the provisions of sections 465.017, and 766.101, F.S. They are subject to review by the department as necessary to protect the public health. They are considered peer-review documents and are not subject to discovery in civil litigation brought against a licensee by a private party.

Board Policy Regarding Pharmacists' Work Load

David R Work
Executive Director, North Carolina Board of Pharmacy

It's a pleasure to be here to share with the Board members from the southeastern states the experience of the North Carolina Board of Pharmacy on pharmacist workload issues. The North Carolina Board first publicly expressed its concern in a resolution presented and adopted at the National Association of Boards of Pharmacy at their 90th Annual Meeting in 1994 in Portland, Oregon. This resolution states:

"WHEREAS the adoption by Boards of Pharmacy of patient counseling and drug utilization review following federal guidelines as a standard of practice has greatly increased the responsibilities and time demands on practicing pharmacists; and

WHEREAS the public safety may be jeopardized by excessive workload demands placed on pharmacists in complying with this and other rules; and

WHEREAS it is the responsibility of boards of pharmacy to protect the health and safety of the public in this matter;

THEREFORE BE IT RESOLVED that NABP commission a research project to determine the effect of pharmacists workload on the public health and safety, assessing such matters as prescriptions per time period, technician assistance, computer capabilities, patient counseling, drug utilization review, hours worked by pharmacy department employees, working conditions, scheduled breaks for food, and other matter necessary and report the results back to the Convention not later than 1996."

This resolution led directly to the creation of the National Coordinating Council on Medication Error Reporting and Prevention. This group consists of representatives from the National Association Boards of Pharmacy, the American Association of Retired Persons, the American Health Care Association, the American Hospital Association, the American Medical Association, the American Nurses Association, the American Pharmaceutical Association, the American Society of Consultant Pharmacists, the American Society for Health Care Risk Management, the American Society of Health System Pharmacists, the Food and Drug Administration, the Joint Commission on Accreditation of Health Care Organizations, the National Council of State Boards of

Nursing, the Pharmaceutical Research and Manufacturers of America and the United States Pharmacopoeia.

This group meets several times each year to consider issues surrounding medication errors and their prevention. The council has approved two sets of recommendations to help reduce the risk of medication errors due to labeling and packaging of drug products; one for health care organizations and one for health care professionals. They have also produced recommendation to change packaging and labeling for certain medical products as well as a set of simple recommendations that can dramatically reduce the potential for harmful medication errors in prescription orders. Specific recommendations or more information can be obtained from Diane Cousins at the United States Pharmacopeia, 1261 Twinbrook Parkway, Rockville, Maryland 20852-1790, phone 301-881-0666.

The concern expressed by Board members is a direct result of constant reports from pharmacists who feel they are overworked. These reports came both to Board members and inspectors, as well as letters to the Board office and many anonymous phone calls. A review of Board hearings in the recent past revealed two situations where one pharmacist was filling between 600 and 700 prescriptions per day with technician help. Obviously these pharmacists were unable to perform any kind of patient counseling or drug use review at these levels.

In response to these reports the Board proposed and adopted the following rule.

.1811 EXCESSIVE DISPENSING OF PRESCRIPTION DRUGS

Pharmacists shall not dispense and permit holders shall not allow a pharmacist to dispense prescription drugs at such a rate per hour or per day as to pose a danger to the public health or safety.

HISTORY NOTE: Statutory Authority G.S. 90-85.6;
 90-85.32
 Eff. July 1, 1996

The course of this rule through state government was uneventful. The proposed language was first published in November of 1995 and hearings were held in January and February of 1996. The Board approved the rule in March of that year and it was submitted to Rules Review Commission where the suggestion was made that one word be deleted and that did occur. The revised rule was approved by the Rules Review Commission in June for an effective date of July 1, 1996. What is most interesting is that there were no comments on the proposed rule.

The members requested that a notice be placed in the Board Newsletter on this issue and it was published in the October 1996 issue and the text follows.

“ITEM 895 - Prescription Load - As reported in the July Newsletter the Board recently adopted a rule which provides that pharmacists shall not dispense and a permit holder shall not allow a pharmacist to dispense prescription drugs at such a rate per hour or per day as to pose a danger to public health or safety.

The Board staff would very much appreciate hearing from pharmacists in writing, about what they believe to be an excessive number of prescriptions per hour or per day. Please direct all comments to NC Board of Pharmacy, PO Box 459, Carrboro, North Carolina 27510.”

Almost 40 responses were obtained from this item and the 150 prescriptions per day figure was often mentioned in these submissions. A few examples follow:

- ▶ “Concerning the number of prescriptions that a pharmacist can safely handle per hour

without a tech - 8 per hour maximum
with a tech - 12 per hour maximum

I've given this a great deal of thought and considering that in my store we must field five telephone lines, counsel while we run the cash register, answer patient questions on otc's, be responsible for certain managerial functions, public relations, morale booster for your support staff and whatever else is required just to keep the irate at peace, bill third party plans, keep sign-in logs for third parties, place orders, etc.

From time to time my partner has confided in me that she does not always feel in control and from time to time neither do I.”

- ▶ “In response to the latest Board of Pharmacy bulletin that asks pharmacists opinions of what is an excessive number of prescriptions per day or hour, I would have to say that for one pharmacist in retail - 150 prescriptions over a 12 hour day - 12.5 prescriptions per hour. (12.5 prescriptions per hour means

- ▶ about 5 minutes per prescription to perform DUR, enter patient information and prescription into computer, respond to any insurance problems, call doctor if needed, count and check medicine, counsel, patients, ring up at the register) Above this amount would be excessive if the pharmacist had only one technician and no allocated lunch break. A mandatory 15 minute break after 6 hours of work would also increase safety to the public in less dispensing errors.”
- ▶ “Given this information and my experience pharmacists should not feel more than 12 prescriptions per hour including refills. To do more than this would prevent the proper application of OBRA 90 regulations.

I thank the Board for taking up this issue for I do agree that in many practices it has become a crisis. I would hope that pharmacy would not be like many others industries where reform only occurs after someone is hurt or killed. Please act.”

The member considered this information when they adopted a policy at the March, 1997 meeting and it is reproduced below.

BOARD STATEMENT

3/26/97

“At the regular March meeting of the North Carolina Board of Pharmacy the members discussed its policy on dispensing errors in relation to pharmacist workload. By consensus the members instructed staff to handle prescription dispensing errors in the following manner.

Reports of prescription dispensing errors will be investigated in due course and, if probable cause is determined, a hearing or pre-hearing conference will be scheduled. If the error occurred at a location where more than 150 prescriptions per pharmacist per day were filled on the date of the error then both the pharmacist and the permit will be cited for the disciplinary proceeding. Each case would be considered individually on the facts involved. All should be aware that the Board would presume under these circumstances that, if a sanction is issued, both the pharmacist and the permit should receive the same penalty. For example if the Board issued a 7 day active suspension of the pharmacist’s license to practice then a 7 day suspension of the permit would also be issued.

In arriving at the 150 prescriptions per pharmacist per day threshold the Board used information presented at the NABP Health Law Officers Conference in Savannah in

November of 1996. Experts on this program gave a ranged of not more than 10 to 20 prescriptions per hour as established levels for safe dispensing. A vice president for one national chain store stated their standard was 5 minutes per prescription for technical functions only which did not include patient counseling and prospective drug utilization review. Their standard, then, would be something less than 12 prescriptions per hour.

Application of this data to work schedules leads to the derivation of the 150 prescription threshold. It is common for pharmacists to split a 12 hour schedule with one working 9 to 3 and another 3 to 9. This is a relatively short shift and using the lower number of 10 prescriptions per hour (6 hours x 10 Rx per hour) produces a 60 prescription figure. Some other pharmacists work a 12 hour shift and using the higher number of 20 prescriptions per hour (12 hours x 20 Rx per hour) yields a 240 prescription figure. Averaging these two results $(60 + 240) \div 2$ produces the 150 prescription threshold.

This further delineation of the Board's intent in adopting rule .1811 which states "Pharmacists shall not dispense and permit holders shall not allow a pharmacist to dispense prescription drugs at such a rate per hour or per day as to pose a danger to the public health or safety."

Permit holders should be on notice of this 150 per pharmacist threshold, It is not a limit or a quota. Pharmacists should not adopt the attitude that they will walk away from their responsibilities once this level is achieved. This policy is intended to address the health and safety issues inherent in high volume dispensing and to signal management to reexamine their situation as workloads increase. It also sends a message to ownership that they have a responsibility for reasonable scheduling of employees and can share in the consequences of high volume dispensing which produces errors."

Please note that this is a policy and not a rule. This is the Board's instruction to staff that the license of the individual pharmacist and the permit to operate the pharmacy should be brought to any hearing involving prescription errors where the workload was more than 150 prescriptions per pharmacist per day.

This policy has been applied three times since its adoption in the Spring of 19978. The first involved a Phar-Mor case where a relatively minor error occurred. In that case a prescription for cordran creams was filled with tablets for hypertension. This, however, was just one of a series of five recent errors which had occurred at that location. The case happened to arise as the first heard by the Board under the new policy. Board action with its new attitude was to issue an order suspending the pharmacy permit for seven days, stayed for three years under several conditions including the requirement that Phar-Mor adequately staff the pharmacy. This is the first Board order I could find in our 117 year history that specifically referred to adequate pharmacy coverage with the implied work load issue.

The second case involved a Revco pharmacy and a pharmacist who failed to catch a drug interaction and an adolescent patient expired. The patient, a 13 year old boy with

cerebral palsy received a prescription for Roxicodone 5 mg. per 5 milliliter, dispensed even though an allergy warning was in the patient's file. No offer to counsel occurred and no patient counseling was given. The patient expired shortly thereafter although we could not find any evidence that the error caused the patient's death. The Board issued a Reprimand, required reporting of prescription errors and that Revco make efforts to see that not more than 150 prescriptions per pharmacist per day are dispensed from the pharmacy. The Board's order was appealed but it appears we have settled the case and the final order would include the provision that management must make efforts to see that not more than 150 prescriptions per pharmacist per day are dispensed at the pharmacy.

The most recent case involved an Eckerd's pharmacy where an error was made when the pharmacist dispensed Amitryptiline instead of Lorazepam. The patient suffered the stress from withdrawal from Lorazepam and incurred considerable discomfort. The Board deferred a decision in the case to a later date and, during the interim, Eckerd's management took what we believe to be a proactive step and informed us of their plans to institute a program to provide an uninterrupted 30 minute meal break at their Wilmington, North Carolina stores. Please note that this is the first time that we are aware of that any large retail pharmacy organization has made a decision, absent a collective bargaining agreement, to give pharmacists breaks for meals and other purposes.

The next step taken by the Board of Pharmacy has just occurred with the publication of two proposed rules, one on working conditions and another on quality assurance.

.2506 PHARMACIST WORK CONDITIONS

A permit holder shall not require a pharmacist to work longer than 12 continuous hours per work day. A pharmacist working longer than 6 consecutive hours per work day shall be allowed during that time period to take a 30 minute meal break and one additional 15 minute break.

These are just two examples of a package of rules now being considered by the Board. We are seeking input from pharmacists from our web site [www.ncbop.org] through a survey on the issue of working conditions. If you'll bring up the web site you will see an invitation for participation which looks like this.

(ON THE HOME PAGE)

NEW SURVEY

We are polling interested parties for their opinion about the amount of time a pharmacist should work without the benefit of a rest or meal break. Please give us your opinion (just one vote per person, please). Voting is anonymous.

(Click on NEW SURVEY on the Home Page and it will bring up the survey)

SURVEY:

We are polling interested parties for their opinion about the amount of time a pharmacist should work without the benefit of a rest or meal break. Please give us your opinion. Voting is anonymous.

- ▶ A permit holder shall not require a pharmacist to work longer than _____ continuous hours in a single work day.
- ▶ A pharmacist working longer than _____ continuous hours shall be allowed to take at least a _____ minute break during that time period.
- ▶ A pharmacist working longer than _____ continuous hours shall be allowed to take a _____ minute meal break.

Although the Board has specific numbers in their proposal they are open to be influenced from what is produced by the survey on rest breaks and meal breaks.

The other proposed rule is intended to encourage the recognition of dispensing errors and provides an incentive for those pharmacists who wish to address and resolve these problems independent of any Board action. If a matter is serious enough to bring to the Board than an internal error reporting system will be considered a mitigating circumstance providing the store policy is followed

.2502 RESPONSIBILITIES OF PHARMACIST-MANAGER

(m) Dispensing errors which are not detected and corrected prior to the patient receiving the medication shall be documented and reported within a suitable time frame to the pharmacist-manager. Documentation shall include pertinent chronological information and appropriate forms including the identity of individual(s) responsible. These documents shall be archived in a readily retrievable manner and available for inspection by the Board for a period of three years. These documents shall not be discoverable or admissible into evidence or otherwise used in any civil action involving private parties as provided by G.S. 90-85.36.

(n) In any Board proceeding, the Board shall consider compliance with paragraph (k) and (m) of this Rule as a mitigating factor and noncompliance with Paragraphs (k) and (m) of this Rule as an aggravating factor.

All of this is to do the best job we can to protect the public from unnecessary dispensing errors.

The Chain Drug Perspective on Prescription Accuracy

Tracy L. Baroni, RPh, JD
Manager of State Pharmacy Affairs for the
National Association of Chain Drug Stores

EDITORIAL COMMENT:

The following is a copy of Ms. Tracy Baroni's slide presentation. Please contact her at the National Association of Chain Drug Stores for further information on her new location.

The Relationship Between Dispensing Errors and Workload

Actual or Perceived?

Prepared by NACDS, June 1996

When it Rains, it Pours

- Number One in Gallop Polls
- Countless Exposés and Articles

Prepared by NACDS, June 1996

Medication Errors

- 39% from physician ordering mistakes
- 38% from nurse administration mistakes
- 12% from pharmacy dispensing errors
- 11% from transcription errors

Prepared by NACDS, June 1996

IT CAN HAPPEN TO ANYONE

...

- 1% - 5% dispensing error rate, depending on study
- 28% of all Americans have been effected
- \$2.5 billion costs to hospitals annually, not including subtherapeutic dosing

Prepared by NACDS, June 1996

AND IT'S EVERYONE'S RESPONSIBILITY

- Pharmacist/Pharmacy
- Prescriber
- Patient
- Boards of Pharmacy

Prepared by NACDS, June 1996

State Boards Address Workload and Dispensing Errors

- North Carolina - 150 Rx/shift
- Georgia - Guidelines for Safe Pharmacy Practice

Prepared by NACDS, June 1996

Error Reporting

- South Carolina - "death or serious injury" - proposed and rejected
- Kansas - mandatory reporting of all "alleged or real errors" by the pharmacist, PIC responsible for the report

Prepared by NACDS, June 1994

What is an error?

- Incorrect drug, strength, dosage form?
- Incorrect quantity?
- Inappropriate drug?
- Incorrect prescriber?
- Failure to counsel?
- Incorrect/Inappropriate counseling?

Prepared by NACDS, June 1994

In Search of . . .

- Elizabeth Allan Flynn, Ph.D.
- Tony Grasha, Ph.D.

Prepared by NACDS, June 1994

Grasha's Numbers

- Controlled studies show an overall error rate of 3% - 5%
- 0.87% - 1.5% are considered potentially injurious to patients

Prepared by NACDS, June 1994

More Numbers

- 53% of pharmacists surveyed in San Antonio report making a potentially serious error within the past month

Prepared by NACDS, June 1994

Cognitive Components According to Grasha

- Sensory Registers
- Working Memory
- Long-term Memory

Prepared by NACDS, June 1994

As Workload Increases, Error Occurrence Levels Off, Maybe Even Decreases

- External Factors
- Internal Factors

Prepared by NACDS, June 1994

Workload and Prescription Errors - From All Sides

- Boards of Pharmacy need to feel as though they are addressing a consumer concern
- State pharmacy associations view this as a member service
- Pharmacies and pharmacists aim for 0% errors
- Consumers expect 0% errors

Prepared by NACDS, June 1994

Inflammatory Factors

- "I hate when that happens"
- "Oh, no - another mistake"
- Disinterest in the patient and the occurrence

Prepared by NACDS, June 1994

BOARD INSPECTORS PROGRAM - THE INSPECTION PROCESS: Current and Future

Moderator: Lee Ann F. Bundrick, RPh
South Carolina Board of Pharmacy

Panel: Cheryl A. Ruff, Rph
South Carolina Board of Pharmacy

Wilbur L. Harling, Rph
South Carolina DHEC

Susan Gagnon, Rph
South Carolina DHEC

Steve Hudson, B.S.
North Carolina Board of Pharmacy

C. Richard Allen
Georgia Drugs and Narcotics Agency

PROGRAM OVERVIEW:

This program will provide instruction to pharmacy inspectors and board of pharmacy staff members and will allow them to share information regarding the current pharmacy inspection process within District III and possible future changes in this process. The program will consist of a round table discussion dealing with various aspects of the pharmacy inspection process.

PROGRAM OBJECTIVES:

- *Describe techniques currently used for performing pharmacy inspections
- *Discuss issues related to staffing types
- *Review fee structures involved in the inspection process, if applicable
- *Discuss agency types involved in pharmacy inspections
- *Describe current investigational techniques employed by inspectors
- *Describe future developments and trends which will impact on the pharmacy inspection process

EDITORIAL COMMENT:

The Board Inspectors Program consisted of 50 pages. It was too voluminous to include in these proceedings. Contributions of various inspection forms, policies & procedures were made by panel members representing South Carolina, North Carolina and Georgia Boards. The above program overview and objectives will provide

additional information on content. Readers should contact Lee Ann F. Bundrick, Manager of Regulatory Compliance, South Carolina Board of Pharmacy, P.O. Box 11927, Columbia, SC 29211, telephone (803) 896-4700, Fax (803) 896-4596 for specific information. Also, each board of pharmacy in attendance should have a complete copy of the materials distributed.

BOARD ATTORNEYS' ROUND TABLE - LEGAL ISSUES AND SOLUTIONS

John F. Atkinson, JD
Dale J. Atkinson, JD
NABP Counsel
Counsel to the National Association of Boards of Pharmacy
Evanston, Illinois

Richard P. Wilson, JD
South Carolina - Department of LLR
Columbia, South Carolina

PROGRAM OVERVIEW:

This program will allow for the presentation and discussion of twelve topics of current interest to the attorneys who serve the pharmacy boards. Initial comments will outline the legal issues for each topic and time will be allotted for discussion of each topic by the presenters and participants.

PROGRAM OBJECTIVES:

- *Discuss pharmacy board legal issues regarding:
 - Licensure mobility
 - Multi-state practice
 - Confidentiality
 - Federal legislation affected boards
 - Examination as a disciplinary or reinstatement device
 - Specialization and licensure-unique problems
 - Continued competence
 - Recent court decisions and trends
 - Res judicata, collateral estoppel, and administrative hearings
 - Technical advancements, licensure, disciplinary hearings
 - Americans with Disabilities Act
 - Conflict of interest

EDITORIAL COMMENT:

The Board of Attorney's Round Table was very voluminous and could not be included in the proceedings. Each board of pharmacy member in attendance should have a copy of the materials distributed. The above program overview and objectives present the issues discussed. Readers should contact the above District III Boards of Pharmacy members for specific information.

SEPARATE SESSIONS

BOARDS BUSINESS SECTION

NO DOCUMENTATION WAS SUBMITTED FOR THESE PROCEEDINGS.

SEPARATE SESSIONS

SCHOOLS & COLLEGES

Challenges in Moving to the All PharmD Curriculum

EDITORIAL COMMENT:

An attempt was made to standardize materials to be submitted by each school/college on progress toward moving to the all PharmD curriculum. As can be seen from materials submitted, there is little uniformity.

Auburn University
School of Pharmacy

R. Lee Evans, Pharm.D., FASHP, BCPP, Dean

1. Practice Experiences in the Curriculum (Categorized Based on Terms used in New Accreditation Standards):
 - a. **Introductory Pharmacy Practice (PPEs): 96 weeks (3-4 hours per week)** {This program is longitudinal throughout the first three years of the curriculum and occurs solely in *Community Settings*}
 - b. **Advanced Practice Experiences (APEs) Required in the Entry-Level Pharm.D. Curriculum {Final year of Curriculum}: 10 months**
2. Characteristics of **Introductory Pharmacy Practice Experiences (PPEs)**:
 - a. The entire class is divided into Pharmaceutical Care Teams which meet weekly to discuss Service-Learning experiences, patient care responsibilities, and health and wellness projects. There are 2 Faculty Mentors per team.
 - b. Begins with *Service-Learning* where students are placed in community service settings. The emphasis during this time is on: 1) being responsible for a life-enhancing service that improves a patient's quality of life, 2) establishing a pharmacist-patient relationship, 3) patient caring skills, and 4) health and wellness promotion. Students learn to write SOAP notes documenting patient care interactions. Professionalism and self-learning abilities are also emphasized.
 - c. Second year responsibilities expand to include: 1) Development of a comprehensive patient database, 2) identification/prevention of drug-related problems, and 3) development of careplans. Second-year students serve as Peer Mentors to first-year students.
 - d. Third-year responsibilities expand to include: 1) Continual updating of patient databases, and careplans, 2) identification/prevention of drug-related problems, and 3) assessment of patient outcomes. Third-year students serve as Peer Mentors to first- and second-year students.
3. Characteristics of **APEs**:
 - a. Length - 1 month each (28-31 days)
 - b. Description:
 1. Internal Medicine/Medicine Speciality - 2 months
 2. Primary Care (settings are predominately ambulatory care outpatient clinic/family practice programs) - 3 months
 3. Drug Information - 1 month
 4. Community Pharmaceutical Care (provide pharmaceutical care in Community pharmacies) - 1 month
 5. Electives - 3 months (may repeat any of the required experiences 1 time, rural health care, managed care, ambulatory care specialty clinics, pediatrics, neonatology, surgery, public health service, geriatrics, psychiatry, pharmacy practices based in physician's offices, clinical administration, nutrition, etc.)

- c. Numbers of APEs Clerkships Available
 - 1. Students are assigned to one of five regions for APEs.
 - 2. As of May, 1998 - 771 clerkship blocks (goal for 2000/2001 is 950-1000)
- d. Administration and Coordination of Experiential Education Program
 - 1. Administrators & Staff:
 - (a) Director of Experiential Education (manages program and APEs) - Diane Beck, Pharm.D.
 - (b) Coordinator of PPEs - Janelle Krueger, M.S.
1 Full-time Staff member responsible for student scheduling, Day-to-day logistics
- e. Distance Clerkships
 - 1. Public Health Service/Indian Health Service
 - 2. Professional Organizations
- f. Efforts to Develop Community/Clerkship Sites
 - 1. Steering Committee comprised of community pharmacy leaders in the state who are providing Pharmaceutical Care
 - 2. Working with individual pharmacists whose practices are evolving into pharmaceutical care experiences.
- g. Policy of Payment of Preceptors/Sites:
 - 1. Limited to just a few sites (Both Auburn and Samford have agreed on a rate of \$350/rotation.

Projected Sites for 2000/2001 - May, 1998

Rotation Type	Total from Other Than Regional Sites	Number of Rotations Needed by Region/ Projected Number Available as of May, 1998					
		Huntsville/ Decatur/ NE Ala.	Birmingham/ Tuscaloosa	Auburn/ Montgomery	Columbus	Mobile	Total
Drug Info (1)		16/16	25/25	32/32 (10 of Auburn will be for Mobile Students)	20/20	10 from Auburn	93/93
Primary Care/ Amb.Care (3)	4	48/31	75/32	66/48	60/47	30/16	279/174
Int. Med./ Medicine Specialties	16	32/30	50/49	44/58	40/71	20/52	186/260
Electives (3)	25	48/38	75/54	66/50	60/46	30/26	279/214
Community (1)		16/10 (Bishop)	25/0	22/10	20/0	10/10* Thomasville	93/30
	Total=45						930/771

Campbell University School of Pharmacy
Experiential Program

I. Current Size of the Program

Class Of	Number of Students	Minimum Number of Rotation Months	Total Number of Rotation Months Scheduled
1999	91	8	728
2000	78	2	156
2001	81	1	81
		Total Number Of Rotations For 1998-1999	965

II. Program Description

<u>FIRST YEAR</u>	<u>HOURS</u>	<u>CREDIT HOURS</u>
Shadow Program	32	1
Top 100 Exam	----	----
<u>SECOND YEAR</u>		
Community Pharmacy	160	1
<u>THIRD YEAR</u>		
Community Pharmacy	160	1
Hospital Pharmacy	160	1
Externship Exam	----	1
<u>FOURTH YEAR</u>		
Advanced Community Ambulatory	160	4
	160	4

III. Preceptor Requirements

- a. Maintain professional competency by fulfilling continuing requirements as determined by the appropriate State Board of Pharmacy and be in good standing with the Board.
- b. Provide professional clinical services and exercise patient care responsibilities
- c. Participate in activities of local, state, and/or national professional organizations
- d. Assure that the minimum training time of 160 hours and other experiential requirements are fulfilled during the rotation time period.
- e. Supervise the student and review, in detail, expectations for the student with respect to appearance, attitude, site specific processes of prescription-processing, and patient-care responsibilities. (The primary preceptor may delegate some of these responsibilities, to other qualified persons).
- f. Allow adequate time for communication and be willing to discuss all aspects of professional practice in accordance with ethnical, moral, and legal standards.
- g. Provide necessary support systems to allow atmosphere of maximal/optimal learning for the student.
- h. Offer constructive criticism in a professional manner as well as praise for outstanding achievements (mid-rotation evaluations are mandatory by all preceptors).
- i. Not enter into any personal or professional relationship with a student that would jeopardize or interfere with objectivity or effective teaching. Not reimburse the student for services rendered, either, directly or indirectly.
- j. Observe the law, uphold the dignity and honor of the professional, and accept its moral and ethical principles.
- k. Complete the student evaluation forms, review them with the student, and submit to the Director of Experiential Programs in a timely manner (within 7 days following completion of the rotation).

IV. Clerkship Electives:

Advanced Internal Medicine
Advanced Drug Information
Advanced Pharmacokinetics
Ambulatory Care Elective
Anesthesiology
Bone Marrow Transplant
Cardiology
Community Elective
Emergency Medicine
Geriatric Elective
Home Healthcare
Hospice Care
Industrial Pharmacy
Infectious Disease

Intensive Care Medicine
Medical Mission
Neonatology
Neurology
Nuclear Pharmacy
Nutritional Support
Oncology
Pediatrics
Pharmacy Administration
Psychotherapy
Pulmonary Medicine
Renal Medicine
Special Elective
Substance Abuse Education

Surgical Medicine
Poison Control
Veterinary Medicine

UNIVERSITY OF FLORIDA

College of Pharmacy
Department of Pharmacy Practice
Office of Experiential Programs

Health Science Center
PO Box 100846
Gainesville, FL 32610-0486
Tel: (352) 392-5964
Fax: (352) 846-

0162

July 31, 1998

Dr. Wayne E. Buff
College of Pharmacy
University of South Carolina
Columbia, SC 29208

Dear Dr. Buff:

I apologize that this information is late in getting to you. I have been out of town extensively over the past few weeks, and have just received your request.

The University of Florida College of Pharmacy is currently in the transition stage of our new curriculum which began last year. For the next couple of years, we will be finishing students who had enrolled under the old curriculum. However, for your purposes, I will provide the "new curriculum" information.

- a) We have gone to an all Pharm.D. program and enroll between 110-115 each year.
- b) Students are required to complete eleven clerkship rotations that are each four weeks in length, except for Ambulatory Care and Internal Medicine which are eight weeks in length. Some rotations are required: (Drug Information, Pediatrics, Ambulatory Care, and Internal Medicine). The remaining clerkships will be student electives.
- c) Types of clerkships available: Administrative, Ambulatory Care, Cardiology, Community Pharmacy Practice, Critical Care, Drug Information, Emergency Medicine, Home Health Care, Immunology, Infectious Diseases, Internal medicine, Long Term Care, Managed Care, Neonatology, Nuclear Pharmacy, Oncology, Pain Management, Pediatrics, Pediatrics Hem/Onc, Pharmacokinetics, Clinical Pharmacy Research, Psychiatry, Pulmonology, Surgery, Nutrition, Toxicology, and Veterinary Medicine. Additionally, students in the dual Pharm.D./MBA curriculum are eligible to complete Industry clerkships.
- d) Clerkship coordination is done through the office of Experiential Programs in the Department of Pharmacy Practice. Each fall we send out to all preceptors and "availability sign-up sheet" giving them the months of clerkship for the following year, and asking them to tell us which months they are available.

- e) Students in the Gainesville program are required to be on-site at the institutions where scheduled. Students in the Working Professional Pharm.D. Program offered by the University of Florida work through a competency based clerkship curriculum.
- f) Preceptors are required to be licensed and practicing for at least two years. They are also required to submit a syllabus of for rotations they would like to offer. Additionally, they are appointed as external faculty of the University of Florida.
- g) Innovative Methods for Developing Clerkships: Innovative is in the eyes of the beholder! We are not sure that we're doing more or less than other schools. Our graduates however, are eager to become clerkship preceptors following graduation. We have to make them wait at least two years before allowing them to become preceptors.
- h) Development of Community Clerkship Sites: We currently have four to five community clerkship sites that emphasize clinical skills in a community setting.
- i) Payment for Clerkships: Currently the University of Florida College of Pharmacy provides a stipend of \$200 per clerkship month to institutions. We have been at this level for the past 3 years. Institutions can receive funds directly or they can leave the funds here at the College and spend for travel, books, software, etc. The second method is provided to some of our pharmacy facilities that do not have control over their own funds.

In closing, I hope I have provided the information that will be beneficial to your report. Please contact me if I can be of more help.

Sincerely,

Randell E. Doty, Pharm. D.
Director of Experiential Programs

1998 District III NABP/AACP Meeting
University of Georgia
Pharm.D. Clerkship Program

4th Year Pharm.D. Class Size

1998-1999: 61
1999-2000 87
2000-2001 95 (Projected)
2001-2002 100 (1st Year All-Entry Level Graduating Class)

Number of Clerkships: 11 (9 Patient Care; 1 Hospital Dispensing; 1 Retail Dispensing)

Clerkship Length: 4 weeks
**Alternative formats are being investigated, such as block rotations in which students are assigned to a site for a longer time period for several rotations. Activities from various rotations can be integrated over the time period - i.e. Internal Medicine with Assigned Clinics and/or Hospital Dispensing and/or Drug Information/MUE.

Clerkship Coordination: (1) Coordinators are identified at each site.
(2) Regional Coordinators are being established in various areas around Georgia to assist with coordination of traditional and Non-Traditional Pharm.D. students.
(3) Regional Coordinators will act as a liaison between students, preceptors, and the Office of Experience Programs.

Distance Learning Clerkships: None Developed Yet

Preceptor Requirements: Not well developed - Will formalize during 1998-99 academic year.
Pharmacist in good standing with the Georgia Board of Pharmacy (unless with a Federal Facility)
Site/Rotation has been assessed by members of the UGA College of Pharmacy

Innovative Methods for Clerkship Development: Block rotation format
Partnerships with Government Agencies
Partnerships with Chain Pharmacies

Community Clerkships: Attempting to form partnerships with various chain pharmacies. Have developed an 8 week experience with Drug Emporium in which students are implementing a stroke prevention/education

Payment: \$300.00 per Pharm.D. clerkship (pay institution NOT individual)
Problems: Excessive \$\$\$\$\$
Paying Federal Facilities with State Dollars

Clerkship Information University of Kentucky College of Pharmacy

Each student is required to do 10 one month clerkships between May (following the end of the 3rd professional year) and the end of April of the 4th professional year.

Required types of clerkships

Students are required to complete one clerkship for each of the following types of sites:

- Pharmaceutical Care Clerkship - Community Pharmacy
- Pharmaceutical Care Clerkship - Community Hospital
- General Medicine Acute Care Selective
- Ambulatory Care Selective
- Specialty Population Selective

The Specialty Population rotation include selection from pediatrics, geriatrics, long term care, home health care, hospice, prison population and others.

The remaining 5 clerkships are elective and can be selected from the above types of sites if available (e.g. a student may want to do a second Pharmaceutical Care Clerkship in a Community Pharmacy) as well as a group of elective clerkship experiences that include:

Infectious disease/antimicrobial management, drug information, pharmacokinetics, nutrition, oncology, bone marrow transplant, pharmacoeconomics, managed care, clinical research, administration, nuclear pharmacy, continuing education, service learning, board of pharmacy, and public mental health outcomes. Students are also able to arrange rotations with pharmaceutical companies and the Indian Health Service.

Two of the ten clerkships should relate to the student's elective course pathway (e.g. geriatrics, community practice). Either required or elective clerkships can meet this requirement.

Education Center (AHEC) areas that includes most of the state except Lexington and surrounding counties, most of Louisville and Northern Kentucky (this latter area is being added to the AHEC system).

Assignment and Coordination Process

An Experiential Education Oversight Committee provides overall direction on policies for students, preceptors and sites. The Committee makes recommendations to the Pharmacy practice Division for discussion, modification, and approval.

For the assignment process, students are permitted to submit a list of preferences for the clerkship experiences/sites desired. Students can indicate which two months they prefer to be "off rotation". A matching process occurs and assignment is done centrally by the clerkship coordinator on campus for the period of the clerkship year. The clerkship coordinator collects information from preceptors regarding availability during the year and provides the annual schedule and communicates the changes that need to be made. Monthly communications and grading forms are sent to preceptors who have students assigned as well as monthly communications to students who have clerkship assignments. Students are permitted one "swap" period in August to request changes in the schedule for the remainder of the year.

CLERKSHIP OUTCOMES

At the end of clerkship rotations, the student will be able to:

1. dispense and compound prescriptions in accordance with all legal, ethical and patient care 'good practices'
2. prepare IVS and other sterile products in accordance with accepted standard of practice
3. apply case management skills alone or as a care team member to drug therapy selection, monitoring and assessment
4. plan for continuity of care of patients across multiple care sites for drug therapy either alone or as part of health care team
5. formulate, implement, and document pharmaceutical care plans that manage patient care needs using drug monitoring and physical assessment skills for:
 - a. common chronic disease states
 - b. common acute episodes of common diseases
 - c. common disease states in special patient populations: e.g. pediatrics, OB/GYN, geriatrics, terminally ill and critically ill
6. identify barriers and propose solutions to manage common disease states in traditionally underserved populations such as the indigent or those with little or no access to the health care system
7. use strategies to improve patient compliance with drug therapy regimens to enhance outcomes
8. develop practice management skills relating to documentation and compensation issues, managed care, supervision of technical personnel, and administrative matters related to operations and patient outcomes
9. demonstrate the ability to integrate distributive and clinical skills in providing pharmaceutical care
10. actively participate in clinical process improvement activities and population based therapeutic drug decision making for targeted populations or groups of patients

University of Kentucky
PHARM.D. PROGRAM
Experiential Course Faculty Requirements - Clerkships

Experiential Course Faculty should:

1. Have a formalized relationship with the College of Pharmacy through the submission and approval of documents for an appointment in the College.
2. Have a comprehensive patient-focused professional practice.
3. Be a licensed or registered health care practitioner in good standing with his/her respective state board of practice and/or be certified by his/her board if there is such a process in his/her profession.
4. Possess a high degree of professional competency and motivation, common sense, good judgment, and an unquestionable standard of ethics.
5. Reflect an attitude, professional stature, and character that is suitable in serving as a role model for students.
6. Exhibit primary concern for the health of his/her patients. Professional ethics should operate to ensure the best possible health care for the patient.
7. Be responsible for patient care including the provision of effective instruction and information to the patient in order to ensure the safe and appropriate use of prescribed medications.
8. Be receptive to new ideas for the provision of patient care services.
9. Possess the qualities of a teacher, particularly the ability to motivate and communicate with students.
10. Demonstrate good professional relationships with other health professionals.
11. Communicate at regular intervals with other community- and campus-based faculty and the experiential course coordinators to exchange teaching experiences and to discuss, design, and implement ways to improve the learning experiences of students.
12. Continue the active pursuit of new knowledge, attitudes, and skills related to enhancing professional practice.

Development of Community Clerkship Sites

During the past year, two faculty members were able to devote a portion of their effort to developing clerkship sites. One person, who also works in our continuing education program and has a strong background in ambulatory care and community pharmacy has focused primarily on community pharmacy sites to develop clerkship experiences. This effort has generally been state-wide. The second individual has focused more in a couple of areas of the state and worked with a few community sites as well as hospitals.

One of the ways that potential sites were identified was through the work done on developing the early pharmacy practice experience which is a month long experience at the end of the first professional year. When the early experience was developed about three years ago faculty traveled around the state and talked with practitioners about this new approach to distinguish it from the externship that was most familiar. Through that process and from the sites used for externship, good potential sites were identified for the early experience. Several of those sites had activities and qualities suitable for clerkship development.

Having started many new sites this year, emphasis during the next year will be on helping those sites to continue to develop as well as adding several new sites.

Benefits for Preceptors/Clerkship Sites

The Medical Center has developed a community-Based Faculty (CBF) initiative. Preceptors outside the regular University appointment process receive an appointment to the community-Based Faculty. Along with the appointment, they receive some benefits such as discounts at the University bookstores, UK computer stores, and lodging in some state hotels. Internet access is provided at reduced fees. Access is available for various University facilities such as sports complexes and parks. Pins and/or certificates are periodically provided.

The community-Based Faculty Initiative also provides one annual conference per year for CBF faculty in all the Medical Center Colleges. This conference focuses on helping them be better preceptors and provides a forum for communication with the individual colleges. In the last year, two regional programs have been provided to reach more preceptors and this effort will continue.

From the College level, work focuses on developing partnerships with clerkships sites to assure appropriate assistance in preceptor educational expertise and to provide assistance in practice management where applicable on an individual case by case.

SUMMARY REPORT OF ADVANCE PRACTICE EXPERIENCES
AT
MERCER UNIVERSITY SOUTHERN SCHOOL OF PHARMACY

1) Number and length of Advanced Practice Experiences (APEs) that students are required to take and the type of APEs available. Each fourth year student is required to complete six experiences lasting five weeks each. Please find attached listing of required experiences and the types available.

2) APE Coordination at Mercer involves Dr. Bill Hopkins and Dr. April Adams. These individuals devote approximately 35 hours each week to this responsibility. This involves a variety of activities including scheduling, site visits, site development, preceptor training, dealing with constant student issues, grading, syllabus development, manual development, etc. Note: a student worker/secretary is also utilized approximately eight hours each week as well.

3) Distance Education APEs (Out of town experiences). Mercer has approximately ten sites outside the Atlanta area in Georgia, four in Tennessee and four in Florida. In addition we have sites with the U.S. Public Health Service and international experiences in approximately six countries.

4) Preceptor Requirements - A pharmacist who enjoys students and has the time/dedication to devote to being a preceptor is a key consideration. Preceptors are expected to attend several training programs each year. The preceptors are also evaluated by each student. These evaluations as well as our annual visit to the site provide information useful to our system.

5) Experience Development - There are several different methods by which we develop new experiences for the students.

- a) Follow up on alumni who call the school requesting to be preceptors.
- b) Pay attention to alumni who are loyal to the school (contribute monetarily, attend alumni functions, etc..) and where they are currently practicing.
- c) We have found it to be best if the program coordinator is an alumnus of the school and also be exposed to the students in some teaching capacity early in the curriculum.

6) Community Experiences - We have developed Advanced Community Experiences. These are sites where the student is exposed to more than basic pharmacy practices. Our introductory experiences to community deal with the mechanics of the practice, whereas the advanced community is more concerned with delivery of pharmaceutical care (diabetes, immunizations, asthma counseling, etc.) The key is hiring faculty to develop these programs. Mercer has three faculty members who have residencies in community practice developing and organizing this endeavor.

7) Payment - \$300/five week/student. Not all preceptors receive this, because some institutions are not allowed to receive payment. This payment is pretty much restricted to institutional sites for internal medicine and medicine subspecialties.

**District III NAPB/AACP
College of Pharmacy
Nova Southeastern University
August 9, 1998
Charleston, S.C.**

Clerkship Requirements:

The College of Pharmacy requires eight clerkships; each are four weeks in duration. In addition, each student must complete eight weeks of community externship and eight weeks of institutional externship.

The four required clerkships are:

Internal Medicine
Ambulatory Care
Drug Information
Geriatrics

The list of elective clerkships available is extensive but the ones with the highest enrollments are:

Infectious Diseases
Advanced Infectious Diseases
Native American
Administration
Kinetics
Oncology
Operating Room
Nutritional Support
Pediatrics
QA-DUE
Critical Care
Psychiatry
Clinical Research
Nutrition/Surgery
HIV/AIDS
ER/Toxicology
Dermatology
Home Infusion
Hematology/Oncology
Investigational Drugs
Indigent Care
Managed Care
Cardiology

Association Management
Poison Information/Toxicology
Immunology
Neonatology
Pediatric Critical Care
Pediatric Oncology
Pharmacy Informatics

Clerkship Coordination:

Clerkships are under the Department Head of Pharmacy Practice. Two coordinators orient and schedule students, maintain all required paperwork, and review new as well as existing sites.

Sites are located throughout central and south Florida in such cities as Fort Myers, Sarasota, Tampa, Orlando and West Palm Beach.

All sites, whether geographically close or distant, are given expected outcomes and assessment documents. If a site is able to meet the objectives, and after interviews are approved. All sites are monitored after a rotation has been completed to determine whether objectives are met.

Preceptor Requirements:

The Department of Pharmacy Practice reviews all preceptor applications and recommends appointments to the Dean. Decisions are based on education, training, experience, and practice site.

Community Clerkship Site:

The two pharmacies under the direction of the College of Pharmacy are serving as the prototype for community clerkships. Two additional sites are under early development at this time.

Payment:

Where students are assigned to the College faculty (20) for clerkships, there is no payment. Payment of \$278 per student rotation is made to sites which are adjunct faculty.

District III NABP/AACP Survey on Clerkships-Response Form

School of Pharmacy, University of North Carolina
Chapel Hill, North Carolina

1. Number of clerkships required in entry-level Pharm.D. curriculum:

10 clerkships

2. Description, length, distribution, other characteristics of clerkship requirement:

One calendar month for each clerkship

One clerkship required between first and second professional year

One clerkship required between second and third professional year

Of the eight clerkships required in last professional year:

One clerkship must be advanced community/hospital

One clerkship inpatient general medicine

One clerkship selected inpatient medicine

One clerkship ambulatory care

3. Types and numbers of clerkships available:

300 clerkships of all types

Community pharmacy practice clerkships to traditional clinical clerkships

FDA

Pharmaceutical industry

IHS, etc.

4. Administration and coordination of clerkships:

Under review

5. Distance clerkships (i.e., out-of-state or international sites offered, use of information technology, etc.):

We offer both out of state and international clerkships;

Students have access to Site Data Base to prioritize clerkships.

6. Efforts to develop community' clerkship sites:

We have been actively developing these sites and hope to encourage more.

7. Policy of payment of preceptors/sites:

\$500 per clerkship

District III NABP/AACP Survey on Clerkships
University of South Carolina College of Pharmacy
August 1998

Clerkship Requirements and Characteristics

There are eight clerkships required in the entry level Doctor of Pharmacy curriculum. Each clerkship in the traditional Doctor of Pharmacy program is four credit hours. Students are required to complete four/forty hour weeks for each rotation. The majority of traditional students take clerkships in the state of South Carolina; however, students are allowed to take clerkships in adjoining states. Students must complete four core rotations: medicine, family medicine, family medicine, drug and poison information, and either pediatrics or long term care. Four elective rotations are also required. Please refer to the table below for the types and numbers of clerkships.

University of South Carolina College of Pharmacy Clerkship Offerings

Designated Course Prefix	Basic Course Number	Advanced Course Number	Title of Clerkship
PHRM	677	686	Drug and Poison Information
PHRM	678	687	Medicine
PHRM	679	688	Family Medicine
PHRM	680	689	Psychotherapy
PHRM	681	690	Pediatric
PHRM	682	691	Long Term Care
PHRM	683		Pharmacokinetics
PHRM	684		Nuclear Medicine
PHRM	685		Clinical Oncology
PHRM	692		Critical Care
PHRM	693		Surgery/Nutrition
PHRM	694		Clinical Research
PHRM	694		Advanced Specialty
PHRM	696		Community Practice
PHRM	697		Institutional Practice

Clerkships are coordinated by the Clinical Clerkship Coordinator. Preceptors receive an availability and information update to assess type of clerkship offered, dates available, and updates in basic information. The Clinical Coordinator then tabulates

the data and presents it to students taking rotations the next academic year.

Nontraditional Clerkships

Distance education students are required to take eight clerkships as well. Core rotation requirements must be completed. These students may select the same four week rotations as traditional students or opt for six week rotations (twenty hours per week). Several modes of clerkships are offered in the nontraditional program. Out of state clerkship sites are identified through discussions with the local College of Pharmacy, AHECs, or students. Two case-based rotations are offered: medicine and family medicine. USC College of Pharmacy faculty precept nontraditional students in these clerkships. Communication through telephone, computer, and fax facilitates completion of these rotations. Students may take a maximum of two rotations in this manner. Students may opt for two rotations through credit by examination. Students solicit the Coordinator for clerkship offerings. After submission of a portfolio to the review committee, students are then notified whether they have received clearance to take the written and oral exam. Distance students have a total of five years to complete the didactic and clerkship portion of the program.

Community Clerkship Development

Due to the number of students in the program, every effort is being made to develop clerkship sites. Proposals are in progress to develop more community based clerkships.

Reimbursement Policy

The current reimbursement is \$250.00 per student per rotation. Preexisting contracts are being updated to account for the recent change in payment. Reimbursement is issued at the end of the semester.

DOCTOR OF PHARMACY CURRICULUM
ENTRY-LEVEL PHARM.D. PROGRAM

COLLEGE OF PHARMACY
MEDICAL UNIVERSITY OF SOUTH CAROLINA
CHARLESTON, SOUTH CAROLINA

<u>SUMMER SEMESTER (1ST YEAR [3 WEEKS])</u>	<u>Credit Hrs</u>
PHAPR-300 Introduction to Pharmacy	2
PHAPR-305 Pharmaceutical Calculations/ Medical Technology	3
	5
<u>FALL SEMESTER (1ST YEAR)</u>	
PHAPR-400 Health Care Delivery Systems	2
PHAPR-310 Pharmacy Care Unit I	1
PHAPR-315 Introduction to Drug Information	2
PHAPR-320 Pharmacy Law/Ethics	3
PHASC-300 Pharmaceutics	3
PHASC-300L Pharmaceutics Laboratory	1
GENSC-300 Anatomy	4
GENSC-305 Biochemistry	3
	19
<u>SPRING SEMESTER (1st YEAR)</u>	
PHAPR-410 Pharmacy Care Unit II	1
*PHAPR-411 Professional Expeiene Unit I	*1
PHASC-400 Pharmaceutical Biotechnology/Immunology	3
PHASC-405 Medicinal Chemistry I	3
PHASC-410 Drug Delivery Systems	3
PHASC-410L Drug Delivery Systems Laboratory	1
GENSC-400 Pathophysiology	7
	19
<u>SUMMER SEMESTER (2ND YEAR [4 WEEKS])</u>	
*PHAPR-415 Community or	*4
*PHAPR-420 Hospital Externship	*4
<u>FALL SEMESTER (2ND YEAR)</u>	
PHAPR-500 Ambulatory & Self-Care Therapeutics	3
PHAPR-505 Disease Processes & Therapeutics I Introduction to DPT	4
*PHAPR-510 Professional Experience Unit II	*1
PHASC-500 Biopharmaceutics/Pharmacokinetics	3
PHASC-505 Medicinal Chemistry II	3
GENSC-500 Pharmacology I	4
Elective	<u>0-2</u>
	18-20

SPRING SEMESTER (2ND YEAR)

PHAPR-600	Ambulatory & Self-care Therapeutics II	3
PHAPR-605	Disease Processes & Therapeutics II	2
PHAPR-610	Pharmacy Care Unit III	1
PHASC-600	Clinical Pharmacokinetics	3
PHASC-605	Medicinal Chemistry III	3
GENSC-600	Pharmacology II	4
GENSC-605	Biostatistics	2
	Elective*	<u>0-2</u>
		18-20

SUMMER SEMESTER (2ND YEAR [4 WEEKS])

*PHAPR-615	Community or	*4
*PHAPR-620	Hospital Externship	*4

FALL SEMESTER (2ND YEAR)

PHAPR-750	Disease Processes & Therapeutics III	2+1
PHAPR-755	Disease Processes & Therapeutics IV	2+1
PHAPR-760	Disease Processes & Therapeutics V	3+1
PHAPR-765	Personnel Management	2
PHAPR-770	Pharmacy Care Unit V	1
PHAPR-775	Pharmacy Systems Management	2
	Elective*	<u>3-5</u>
		18-20

SPRING SEMESTER (3RD YEAR)

PHAPR-800	Disease Processes & Therapeutics VI	2+1
PHAPR-805	Disease Processes & Therapeutics VII	2+1
PHAPR-810	Disease Processes & Therapeutics VIII	2+1
PHAPR-815	Advance Drug Information	2+1
PHAPR-820	Pharmacy Care Systems	2
PHAPR-825	Pharmacy Care Unit VI	1
	Elective*	<u>3-5</u>
		18-20

SUMMER, FALL & SPRING SEMESTER (4TH YEAR)

*Rotations (11 x 4 weeks, 4.4 credit hours each)

Required:

Acute Care	(2 Rotations)
Community Pharm	(2 Rotations)
Ambulatory	(2 consecutive rotations at same site)
Drug Information	(1 rotations)
Hospital Pharmacy	(1 rotations)
Elective Rotations	(3 rotations)

Ground Rounds	1 Hr
---------------	------

July 20, 1998
Dr. Wayne Buff
College of Pharmacy
University of South Carolina
Columbia, SC 29208

Dear Dr. Buff,

This is in response to Farid's letter of July 8, 1998. The answers to the questions that you asked, are as follows:

1. Number of required clerkships. There are two one-month clerkships required in the P-2 and P-3 year and ten one-month clerkships required in the P-4 year. The clerkships in the fourth professional year include a core of five required, three that are selective and two that are elective for a total of ten one-month rotations.
2. All clerkship experiences begin on the first day of the month and end on the last day of the month, with a minimum of twenty days being spent on rotation for it to be completed.
3. The clerkships that are available are listed in the enclosed handout.
4. Clerkship coordination is handled through the director of the Experiential Education Program, Dr. Greta Gourley. Dr. Emmett Manley has served as the PEP director for the past twelve years and will be retiring in June, 1999. We have changed the name of the program from the PEP program to the EEP program. The job description for that position is attached.
5. You requested information on distance education clerkships and I am not sure what you want in that regard, so I have not answered that question.
6. Preceptor requirements - guidelines are being revised.
7. Payment for clerkships - please see attached article which describes our payment schedule.

We have community pharmacy clerkship sites across the state as well as other types of clerkships. I hope that you find this information of assistance.

Dick R. Gourley, Pharm.D. Professor and Dean

EDITORIAL NOTE: Please contact Dr. Greta Gourley, Director of Experiential Education Program for information on available clerkships, job description for the the clerkship coordinator position and the clerkship payment schedule)

NABP-AACP JOINT Business SESSION
Committees' Reports

Presiding: Farid Sadik, Ph.D.
Dean, University of South Carolina

NOMINATIONS

NABP-AACP Chairpersons to the 1999 meeting in Sandestin

Mark Conradi
Alabama Board of Pharmacy

Dean Joseph Dean
Samford University

Secretary-Treasurer

Samuel T. Coker, Auburn University

Nominating Committee - NABP

Delegate - Sonya King, Tennessee Board of Pharmacy
Alternate - Tom Alford, Alabama Board of Pharmacy

Resolutions Committee - NABP

Delegate - Frank Landrum, Georgia Board of Pharmacy
Alternate - Alan Corley, Tennessee Board of Pharmacy

Respectfully submitted,

Tom Alford - Alabama Board of Pharmacy - Chairman
Harold Hodgson - Georgia Board of Pharmacy
Leonard Inge - Florida Board of Pharmacy
Milagros Morales - Puerto Rico Board of Pharmacy

NABP BOARD RESOLUTIONS

Resolution A.

Whereas, the value of the 1998 NABP District III/AACP meeting provides a forum for the exchange of ideas and the diffusion of professional and social interactions, and

Whereas, the value of the 1998 NABP District III/AACP meeting has far exceeded the attainment of the stated educational objectives, and

Whereas, the 1998 NABP District III/AACP meeting exhibited exceptional planning and execution,

Be it resolved that appreciation be extended to Carol V. Bateman, Wayne Buff, Dean Farid Sadik, Cheryl A. Ruff, their families and staff for their dedication and hospitality.

Resolution B.

Whereas, the excellence of the 1998 NABP District III/AACP meeting could not have been achieved without the generous support contributors,

Be it resolved that the following organizations be recognized and gratitude expressed and extended to:

Barr Laboratories, Inc.
Novartis
South Carolina Association of Chain Drug Stores
Amersource
Genentech, Inc.
Glaxo Wellcome, Inc.
Hoeschst Marion Roussel
International Academy of Compounding Pharmacists
Janssen Pharmaceutica
PCS Health Systems
Pfizer
Smith Drug Company
Zeneca Pharmaceuticals
American Classic Tea
Bayer Corporation
Bristol Meyers Squibb
C. F. Sauer and Company
Cardinal Health, Inc.
Carolina Panthers
Capsugel
Drug Package Company, Inc.
Eli Lilly and Company
Fuji
Johnson & Johnson
Knoll/BASF
Merck
Parke-Davis
Pharmacia/Upjohn

Rhone-Poulenc Rorer
Schering/Key
South Carolina Parks, Recreation, and Tourism
South Carolina Peanut Board
South Carolina Pharmacy Association
South Carolina Soybean Board and Association
Wise Snack Foods
Wyeth-Ayerst

Resolution C.

Whereas, the Food and Drug Administration Modernization Act has dictated that a memorandum of understanding be written by each state board of pharmacy to Food and Drug Administration and approved by Food and Drug Administration, and

Whereas, the memorandum of understanding is to be place by November 1998, and

Whereas, the South Carolina Board of Pharmacy has adopted a Memorandum of Understanding which encompasses all facets of the Food and Drug Administration's instructions and does so in a very concise manner,

Be it resolved that District III, NABP submit to the Food and Drug Administration a copy of the South Carolina proposed memorandum of understanding for approval, and that a response be given by the Food and Drug Administration by the end of September in order for all states to meet the November deadline. (THE ABOVE HAS BEEN SUBMITTED TO FDA).

The Committee moves the adoption of the aforementioned resolutions, that they be made a part of the proceedings of this meeting, and that they be referred to NABP where appropriate.

Ronnie W. Cromer, South Carolina
Dianna Drake, Tennessee
David L. Jaquith, Kentucky
Jack G. Watts, North Carolina, Chairman

March 18, 1998

Memorandum of Understanding:

The South Carolina Board of Pharmacy and the Food and
Drug Administration

Introduction

Pursuant to Section 127 "Pharmacy Compounding" of the Food and Drug Modernization Act of 1997, the South Carolina Board of Pharmacy (SCBOPh) has developed this memorandum of understanding (MOU) to address specific issues related to compounded drugs. The purpose of this MOU is to provide specific guidelines on the dispensing of compounded drug products.

I. Investigation of Complaints of Compounded Drugs Sent Out-of-State

In general, complaints about compounded drugs which are shipped out-of-state, will be investigated by the board of pharmacy in the state in which the compounding pharmacy is located. That board of pharmacy may obtain the assistance of the board of pharmacy which is located in the state where the compounded drug was shipped.

If the complaint involves a death or serious injury of a patient, either board of pharmacy (in the state where the compounded drug was shipped, or in the state where the compounding pharmacy is located) may initiate the investigation. A serious injury is defined as any experience that is fatal or life-threatening, is permanently disabling, requires impatient hospitalization, or results in a an overdose due to formulation. In a case involving a death or serious injury, the boards of pharmacy will coordinate to determine which board will investigate the complaint. The results of any investigation of a complaint will be shared with the other board.

II. Inordinate Distribution of Compounded Drugs Out-of-state

A pharmacy may dispense compounded drugs interstate in an amount greater than 5% of its total drugs dispensed or distributed, provided that the pharmacy notifies the state board of pharmacy with which it is registered and provides additional information that may be required by the state board of pharmacy. The SCBOPh shall develop procedures to implement this notification requirement. This notification shall not be in lieu of any other registration or licensure requirements that may be applicable to the pharmacy in the state into which it ships compounded medication.

In addition, pharmacies that dispense a majority of their total compounded prescriptions interstate, must provide counseling to patients and a toll free number, which is affixed to the label of the patient's medication. The pharmacy must be available at least forty hours and five days a week, unless state rules require greater access to counseling services from nonresident or mail order pharmacies.

III. Compounded Drugs For Office Use

A pharmacy may compound drugs for the use of a licensed prescriber who administers or dispenses the drugs, in accordance with state law, to patients in the prescriber's office. However, a pharmacy may not dispense compounded drugs to a prescriber for office use if the drug is resold to a patient. Compounded medication for office use must be prepared pursuant to an order by prescriber.

SCHOOLS AND COLLEGES RESOLUTIONS

The Resolution Committee of the schools and colleges of pharmacy of the NABP-AACP District III met and discussed some issues that emerged from this meeting which was held in Charleston, South Carolina. Committee members were Dr. William Osborne from the University of Georgia, Dr. Ken Roberts from the University of Mississippi, Dr. Glenn Farr from the University of Tennessee, and Dr. Michael McKenzie from the University of Florida. The following resolutions were submitted and passed.

I. WHEREAS, the professional program in Charleston for the NABP-AACP District III annual meeting was informative and timely;

WHEREAS, the speakers were enthusiastic and instructive;

WHEREAS, the hospitality has been genuine and the accommodations and facilities were comfortable, and the social activities outstanding;

THEREFORE BE IT RESOLVED that the representatives assembled here compliment the outstanding work conducted on our behalf by the South Carolina Board of Pharmacy and its Executive Director, Cheryl Ruff, the University of South Carolina College of Pharmacy and its dean, Dr. Farid Sadik, and the Co-Chairs and staffs for the NABP/AACP District III annual meeting, Carol Bateman and Wayne Buff.

II. WHEREAS, numerous agencies desire a standardized approach for credentialing pharmacists providing disease state management services;

WHEREAS, the NABP, NACDS, and NCPA have formed the National Institute for Standards in Pharmacist Credentialing;

WHEREAS, the AACP and ACPE have convened a national conference on certification;

THEREFORE BE IT RESOLVED that pharmacy organizations work together to focus on a uniform and unified system (a national template) for certification/credentialing of pharmacists for disease state management competencies.

III. WHEREAS, many pharmacists are opting to implement the pharmaceutical care practice model;

WHEREAS, numerous agencies, adopting reimbursement for disease state management services, desire credentialing of pharmacists to provide pharmaceutical care services for multiple chronic diseases ;

WHEREAS, these pharmacists are requesting additional education and clinical training;

THEREFORE BE IT RESOLVED that school/colleges of pharmacy will continue to offer many mechanisms to provide curriculum-based continuing education for pharmacists to improve their skills and knowledge (e.g., certification programs for disease management, nontraditional Doctor of Pharmacy degree programs, and traditional post-baccalaureate Doctor of Pharmacy degree programs on their campuses).

IV. WHEREAS, medication errors and adverse drug events continue to be a major health concern in the United States;

WHEREAS, pharmacists are instrumental in the medication use process;

THEREFORE BE IT RESOLVED that schools/colleges of pharmacy insure that curricula include educational outcome statements that assure pharmacy graduates demonstrate abilities to institute systems that prevent medication errors and organize quality assessment programs that rectify adverse medication events.

Respectfully submitted,

Michael McKenzie, Chair
Resolution Committee
Schools and Colleges of Pharmacy
NABP-AACP District III

Time and Place Committee - 1999

The time and place committee for 1999 is pleased to report that the meeting of District III NABP/AACP will be held August 7-10 at the Sandestin Beach Hilton, Sandestin, Florida.

Respectfully submitted,

Mark Conradi, Alabama Board of Pharmacy
Dean Joseph Dean - Samford University

AUDIT

The Audit Committee reviewed the financial statements, expenditures, income and supporting documents for the period of July 1, 1997 - August 1, 1998. We are pleased to report that all accounts and expenditures are in order and recommend approval of the report. We recommend that the honorarium for the Secretary-Treasurer be continued with the usual convention expenses.

Respectfully submitted,

Harold Stamps, Mississippi Board of Pharmacy
David Work, North Carolina Board of Pharmacy
Stuart Feldman, University of Georgia
Johnnie Early, MUSC, Chairman

REPORT OF THE SECRETARY-TREASURER
DISTRICT THREE NABP/AACP

Samuel T. Coker
School of Pharmacy
Auburn University

This report covers the period of August 1, 1997 - July 18, 1998. Dues were received from all 24 boards and colleges for 1998. Dues from 2 members were received during the 1997-98 budget period.

The financial statement for the 1997 District III meeting is attached. The District III treasury advanced the Tennessee Convention account \$4,379.69 so the Marriott account could be closed. The central treasury received \$3,958.98 when the 1997 convention account was closed. Expenses exceeded income by \$420.71. This represents the difference between the amount advanced and the amount received. The small deficit represents a misunderstanding in the amount of support expected for a speaker. The Treasury is sound financially and I anticipate moving about \$5,000.00 from checking to the CD after audit of the financial statement.

The Office of the Secretary-Treasurer greatly appreciates your continued cooperation and support. It has been a pleasure serving the District another year.

**REPORT OF THE TREASURER
DISTRICT THREE NABP/AACP**

**Financial Report
August 1, 1997**

Checking and Savings Account

July 18, 1997 Checking Account Balance	\$ 8,700.25	
Interest on Checking	\$ 143.59	
Certificate of Deposit in Colonial Bank Auburn, Alabama -- Maturity date 9/20/98	<u>\$14,060.78</u>	
Anticipated interest -- \$808.49		
Balance in Checking/Savings		\$22,904.62

1997-1998 Receipts

24 -- 1998 Boards and Colleges Dues at \$100	\$2,400.00	
2 -- 1997 dues received in 1997-98 budget year	\$ 200.00	
Income from the Tennessee Convention Account	<u>\$3,958.98</u>	
Total Receipts		<u>\$ 6,558.98</u>
Grand Total Receipts and Assets		\$29,463.60

1997-1998 Disbursements

Expenses for the Secretary-Treasurer as approved by the 1997 convention.

Mileage to & from Chattanooga (550 miles at \$.30/mile)	\$ 165.00	
Meals not covered by registration	\$ 28.94	
Parking at Marriott for 3 days @ \$6.50/day	\$ 19.50	
District office expenses at home	\$ 9.90	
Honorarium as approved by the 1997 audit report	<u>\$1,500.00</u>	
	\$1,723.34	
Secretarial expenses -- typing proceedings, correspondence, and other office expenses	\$ 500.00	
Printing and binding of 150 copies of the 1996 Proceedings	\$ 500.24	
1998 Convention Deposit	\$ 500.00	
Advance on payment of the Marriott bill	\$4,379.69	
Reimbursement to the Department of Pharmacal Sciences for postage, telephone, fax, and office supplies for the period of 1996 through June, 1998.	<u>\$ 490.00</u>	
Total Disbursements		\$ 8,143.27
Net Total Assets (Grand Total Receipts & Assets minus Total Disbursements)		\$21,320.33
Colonial Bank CD # 195145		\$14,060.78
July 18, 1998 balance in Checking Account		<u>\$ 7,259.55</u>
Net Total Assets July 18, 1997		\$21,320.33

**1997 District III NABP/AACP Meeting
Marriott Hotel, Chattanooga, Tennessee
August 10-12, 1997**

Financial Statement

INCOME

Contributions

Schering	100
Knoll	500
Wyeth-Ayerst	1,000
Hoechst Marion Roussel	2,250
Rhone Poulenc Rorer	500
Bristol-Meyers Squibb	500
Searle	500
SmithKline Beecham	500
Pyxis/Cardinal Health	750
Parke-Davis	100
Glaxo-Wellcome	500
Astra Merck	500
Eli Lilly	500
Pfizer (Theracom)	6,000
Total Contributions	\$14,200.00
Total Registration	\$14,975.00
Total Income	<u>\$29,175.00</u>

**1997 District III NABP/AACP Meeting
Marriott Hotel, Chattanooga, Tennessee
August 10-12, 1997**

Financial Statement (page 2)

Expenses

Honoraria and Speaker Travel Expenses

Cronan	569.60
Helling	2590.46
Dillabough	642.04
Ober	2241.00
Atkinson	862.00

Total Speaker Expenses **\$6,905.10**

Marriott Hotel **\$14,379.69**

Other Expenses

Check printing and service charges	78.62
Headliner Entertainment	3,200.00
Rafting (Cripple Creek)	2,382.00
Transportation for rafting (Choo-Choo Express)	850.00
Golf	384.00
Brochure printing	765.00
Miscellaneous	256.30
Refunds	395.00

Total Other Expenses **\$8,310.92**

Total Expenses **\$29,595.71**

NET: **(\$420.71)**

Total Attendance: **198**

DISTRICT III
 NATIONAL ASSOCIATION OF BOARDS OF PHARMACY
 AND
 AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY

YEAR	PLACE	CHAIRMAN OF BOARDS	CHAIRMAN OF SCHOOLS AND COLLEGES	SECRETARY TREASURER
1936	Charleston, S.C.	Bd. Mbr. From Charleston	William A. Prout	----
1937	----	----	----	-----
1938	Augusta, GA	Lew Wallace	Robert C. Wilson	Robert T. Walker
1939	Memphis, TN	Paul Molyneux	R.L. Crowe	Robert T. Walker
1940	Biloxi, MS			
1941	Miami, FL	E.L. Hammond	----	Robert T. Walker
1942	Charleston, SC	R.Q. Richards	Perry A. Foote	Paul Molyneux
1943	No meeting-voted no	Robert T. Walker	Robert C. Wilson	R.D. Rainey
1944	Atlanta, GA	Robert T. Walker	Robert C. Wilson	R.D. Rainey
1945	----	----	----	----
1946	Birmingham, AL	Lehman M. Alley	L.S. Blake	E. W. Gibbs
1947	Jacksonville, FL	K. J. Attwood	E.L. Hammond	H.C. McAllister
1948	Chapel Hill, NC	R. A. McDuffie	Perry A. Foote	H. C. McAllister
1949	Charleston, SC	Robert T. Walker	M.L. Jacobs	H.C. McAllister
1950	Atlanta, GA	Robert T. Walker	Kenneth L. Waters	H.C. McAllister
1951	Biloxi, MS	George Roberts	E. L. Hammong	Kenneth L. Waters
1952	Gatlinburg, TN	R. L. Yeargan	E. A. Brecht	Kenneth L. Waters
1953	Charleston, SC	Tom Wyatt	Karl Goldner	Kenneth L. Waters
1954	Mobile, AL	Floy Macon	George Hargreaves	Kenneth L. Waters
1955	Asheville, NC	H.C. McAllister	E.A. Brecht	Kenneth L. Waters
1956	Pensacola, FL	Dewey Johnson	Perry A. Foote	Kenneth L. Waters
1957	Savannah, GA	Homer Avera	Melvin Chambers	Kenneth L. Waters
1958	Biloxi, MS	Chester E. Jones	Lewis Nobles	Kenneth L. Waters
1959	Gatlinburg, TN	Tom Lemond	Bill Prout	Lewis Nobles
1960	Columbia, SC	Horace McAlliis	Robert Morrison	Lewis Nobles
1961	Mobile, AL	Lester Haggard	Samuel T. Coker	Lewis Nobles
1962	Asheville, NC	Roger McDuffie	E.A. Brecht	Lewis Nobles
1963	Daytona Beach, FL	John Stadnick	Charles Haupt	Lewis Nobles
1964	Jekyl Island, GA	Mills Harrison	Kenneth L. Waters	Lewis Nobles
1965	Biloxi, MS	E.E. Cammack	Charles W. Hartman	Lewis Nobles
1966	Memphis, TN	R.C. Hoskins	Seldon D. Feurt	Lewis Nobles
1967	Myrtle Beach, SC	Ed Walsh	R.W. Morrison	Lewis Nobles
1968	Point Clear, AL	Dan Dennis	Woodrow Byrum	Lewis Nobles
1969	Wrightsville Beach, NC	H.C. McAllister	George Hager	William B. Swafford

DISTRICT III
 NATIONAL ASSOCIATION OF BOARDS OF PHARMACY
 AND
 AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY

YEAR	PLACE	CHAIRMAN OF BOARDS	CHAIRMAN OF SCHOOLS AND COLLEGES	SECRETARY TREASURER
1970	Cocoa Beach, FL	H.F. Bevis	Kenneth Finger	William B. Swafford
1971	Jekyll Island, GA	N.W. Chism	Oliver Littlejohn	William B. Swafford
1972	Biloxi, MS	Robert H. Read	Joe B. McCaskill	William B. Swafford
1973	Knoxville, TN	Drew Haskins, Jr.	Seldon D. Feurt	William B. Swafford
1974	Myrtle Beach, SC	Stokes Alexander	William H. Golod	William B. Swafford
1975	Gulf Shores, AL	Mahlon Turner	Ben F. Cooper	William B. Swafford
1976	Wrightsville Beach, NC	Jesse M. Pike, Sr.	Seymour Blaug*	William B. Swafford
1977	Clear Water Beach, FL	H.F. Bevis	Charles Walker	William B. Swafford
1978	Savannah, GA	William A. Atkins	Howard Ansel	William B. Swafford
1979	Biloxi, MS	H.W. Holleman	Wallace L. Guess	Samuel T. Coker
1980	Gatlinburg, TN	Norval Webb	John Autian	Samuel T. Coker
1981	Charleston, SC	Howard Sudit	Julian H. Fincher	Samuel T. Coker
1982	Gulf Shores, AL	George S. Hiller	John E. Winter	Samuel T. Coker
1983	Wrightsville Beach, NC	William R. Adams, Jr.	Tom S. Miya	Samuel T. Coker
1984	San Juan, PR	Pedro J. Vanga	Victor D. Warner	Samuel T. Coker
1985	Howey-in-the-Hills, FL	Monroe Mack	Michael A. Schwartz	Samuel T. Coker
1986	Savannah, GA	George D. McFarland	Dick R. Gourley	Samuel T. Coker
1987	Biloxi, MS	H.W. Holleman	Wallace L. Guess	Samuel T. Coker
1988	Gatlinburg, TN	J. Floyd Ferrell, Jr.	Michael R. Ryan	Samuel T. Coker
1989	Charleston, SC	Terry B. Netherton	William F. Golod	Samuel T. Coker
1990	Orange Beach, AL	Clemont Carpenter	William H. Campbell	Samuel T. Coker
1991	Ashville, NC	Jack G. Watts	Ronald W. Maddox	Samuel T. Coker
1992	Orlando, FL	T. Ray Lowe	William O. Hardigan	Samuel T. Coker
1993	Lexington, KY	Glenn L. Watson	Jordan L. Cohen	Samuel T. Coker
1994	St. Simons Island, Ga	Joseph Whaley	Stewart Feldman	Samuel T. Coker
1995	Biloxi, MS	William Jackie Thompson	Kenneth B. Roberts	Samuel T. Coker
1996	San Juan, PR	Arnaldo LaLuz	Ilia Oquendo	Samuel T. Coker
1997	Chattanooga, TN	John M. Smith	Dick Gourley	Samuel T. Coker
1998	Charleston, SC	Carol Bateman	Wayne Buff	Samuel T. Coker