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+ *A Taxing Issue*

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The Drug Quality and Security Act (DQSA) was signed into law by President Obama on November 27, 2013. Title II of DQSA, The Drug Supply Chain Security Act (DSCSA) specifically outlines steps to trace Drugs as they are distributed throughout the United States and is designed to ensure the safety, quality and security of these drugs. DSCSA has specific requirements that impact pharmacies including those processes pharmacies and employees must follow as part of the supply chain.

Parts of this act will be implemented over the next 10 years; however there are certain aspects of this act that are now in effect.

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- *Written agreements with Third-parties*
- *Returns*
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contents

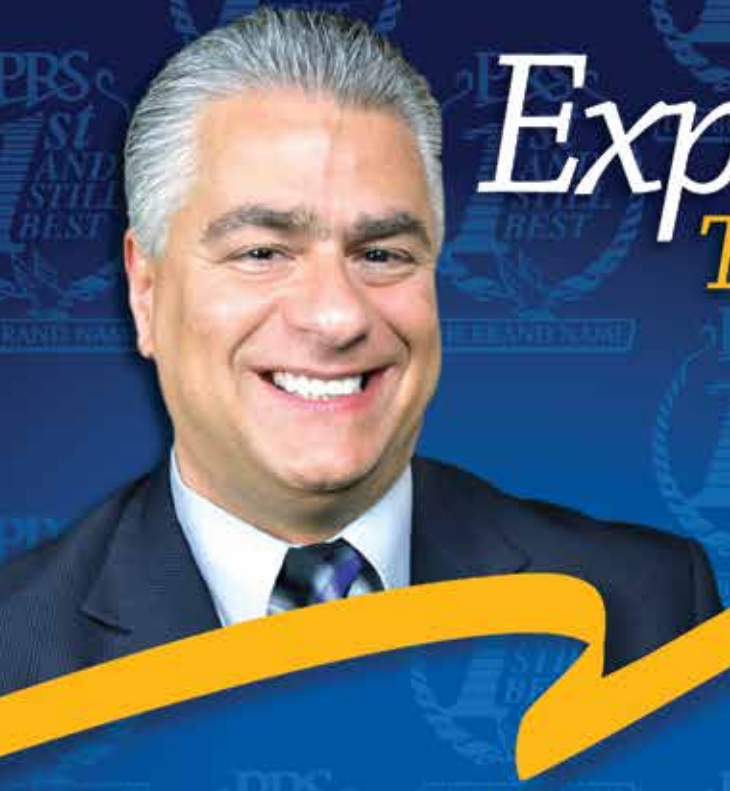
Letters to the editor—If you would like to comment on an article, email NCPA at info@ncpanet.org. Your letter may be posted on the NCPA website and edited for length and clarity.

FEATURES

THIS MONTH'S *cover* FEATURE

Caption: In sports, there's a saying that "quitters never win." Of course, when it comes to smoking cessation, giving up is always a winning strategy for improved health. When Caitlin Bertrand, PharmD, started a year-long post-graduate community practice residency at Barney's Pharmacy in Augusta, Ga., in 2014, she was asked what type of clinical service might interest her. She chose smoking cessation. "I think it's really needed in the community," she says. "And the reason why is that my grandmother passed away from lung cancer right before I moved here. So it's something I very much believe in, and I can relate to patients through that, after watching the effects of somebody smoking for several years."

DEPARTMENTS



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56

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Ask Your Family Pharmacist®

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The National Community Pharmacists Association (NCPA®) represents the interests of America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $81.4 billion health care marketplace and employ more than 314,000 individuals on a full or part-time basis. To learn more, go to www.ncpanet.org, visit facebook.com/commpharmacy, or follow NCPA on Twitter @Commpharmacy.

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Telling Congress How Unregulated PBMs Are Dominating the Pharmacy Landscape

It was a bit intimidating but quite thought provoking to be invited to testify before Congress barely a month into my term as NCPA president. Small community pharmacies like yours and mine are faced on a daily basis with the impact of PBM corporations' disproportionate market power, as I told the House Judiciary Committee Subcommittee on Regulatory Reform, Commercial and Antitrust Law in November.

Even so, as busy front-line practioners we sometimes forget how broad that impact is. In preparing my testimony with NCPA staff, we identified seven areas where the power of PBMs has an undue influence on patients, health plan sponsors, and pharmacies. This power and undue influence will only grow with the proliferation of mergers, such as Walgreens buying Rite Aid for $17.2 billion, and CVS snapping up Omnicare for $12.7 billion.

I tried to focus my testimony—speaking for you—on how the largely unregulated PBMs are allowed to dominate the pharmacy landscape. I included the following points for the subcommittee members who largely are unschooled in PBM-pharmacy relations:

- The concentrated PBM marketplace has Express Scripts, CVS Health, and OptumRx covering about 78 percent of patients who have their benefits managed by PBMs.
- When it comes to large-scale prescription drug plans, such as those provided through the federal government, the Big Three are currently the only practicable option, so choice is severely limited.
- Community pharmacies lack leverage and are saddled with "take it or leave it" contracts that include onerous terms that can threaten their financial viability.
- The criteria PBMs use to determine multi-source generic drug MAC reimbursements are unknown, which means that for approximately 86 percent of the prescriptions small community pharmacies dispense, we are unable to make informed business decisions on fundamental matters such as expected cash flow and drug inventory.
- The acquisition costs for generics are subject to dramatic prices spikes, yet PBM corporations lag in updating MAC reimbursements, triggering huge, unsustainable losses on those prescriptions.
- PBMs have inherent conflicts of interest by owning mail order and specialty pharmacies, often incentivizing or requiring patients to use such pharmacies when many prefer to use a community pharmacy.
- While there are industry-wide regulations for commercial health insurers, PBM corporations have largely escaped federal regulations.

I told the subcommittee that as a small business owner and health care provider, the current situation and overall business climate that exists in which market power is increasingly concentrated in an ever-shrinking number of corporations makes me apprehensive about what is around the bend.

I concluded by urging support of H.R. 244, which would require the same timely updates to MAC pricing lists in the Federal Health Benefit Program and the military's TRICARE program that are now required in Medicare Part D. I also asked the lawmakers to support H.R. 793, which would allow any pharmacy located in a health care shortage or medically underserved area to participate in any preferred pharmacy network if they are willing to meet comparable terms and conditions. ■

Best,

Bradley J. Arthur
NCPA President 2015-16

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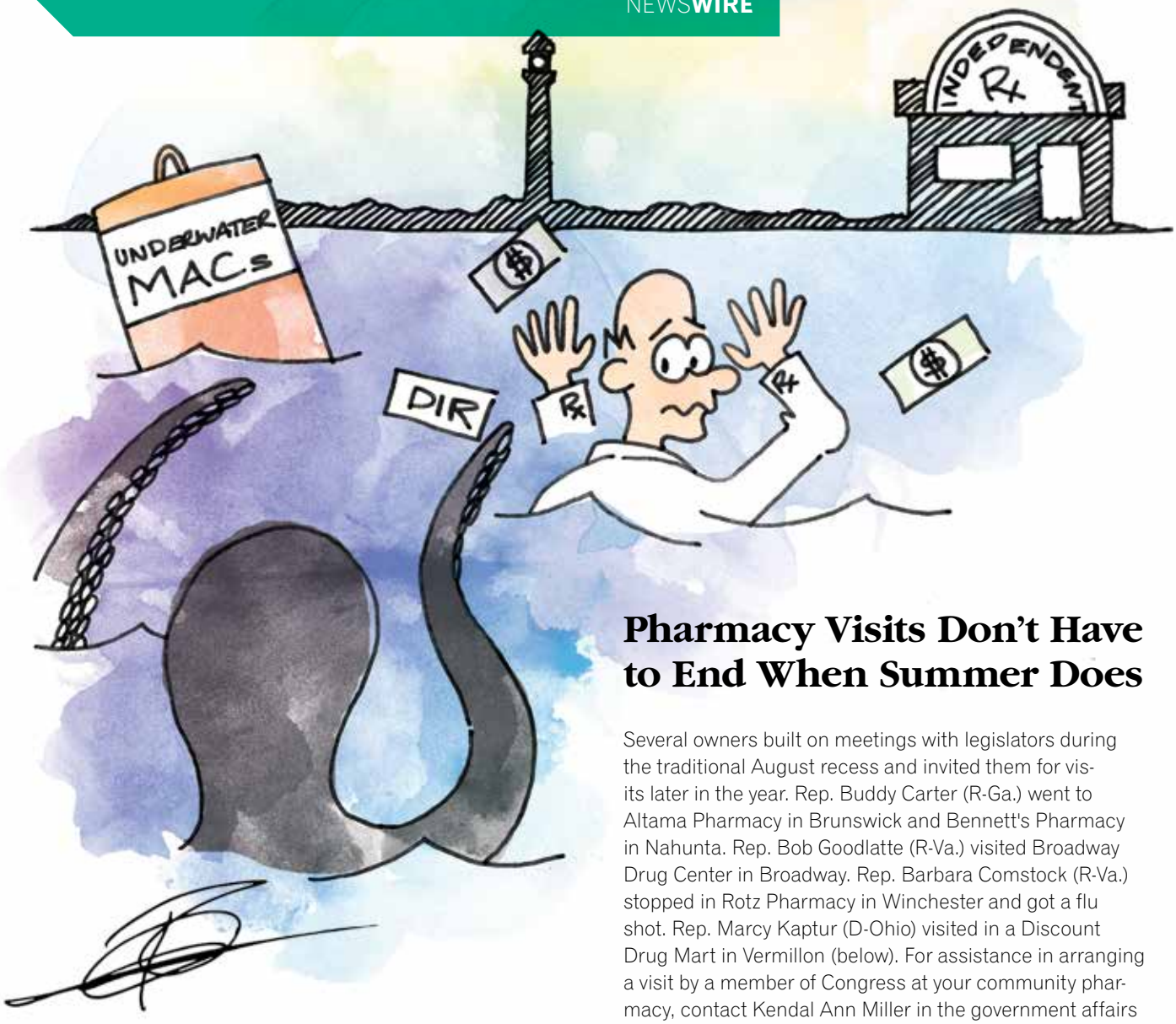


Pharmacy Visits Don't Have to End When Summer Does

Several owners built on meetings with legislators during the traditional August recess and invited them for visits later in the year. Rep. Buddy Carter (R-Ga.) went to Altama Pharmacy in Brunswick and Bennett's Pharmacy in Nahunta. Rep. Bob Goodlatte (R-Va.) visited Broadway Drug Center in Broadway. Rep. Barbara Comstock (R-Va.) stopped in Rotz Pharmacy in Winchester and got a flu shot. Rep. Marcy Kaptur (D-Ohio) visited in a Discount Drug Mart in Vermillon (below). For assistance in arranging a visit by a member of Congress at your community pharmacy, contact Kendal Ann Miller in the government affairs department at governmentaffairs@ncpanet.org.

Independent Pharmacy Today

Emerging Models: High Performance Pharmacies
Access to electronic medical records—23%
Collaborative drug therapy agreements—17%
Conduct patient education classes—16%
Transition of care program—6%
Implemented convenient care clinic—2%

Source: 2015 *NCPA Digest*, sponsored by Cardinal Health

THE AUDIT ADVISOR

Desk Audits—Do You Know What to Send?

Q: Our pharmacy received a desk audit notice from SCIO Health Analytics for OptumRx, and we're not sure what documentation they want us to send.

A: PAAS has recently seen an increase in the number of desk audits, and some of the notices have unclear instructions. This has led to much confusion and frustration about what documents to actually collect, copy, and send for the response.

A particularly confusing notice has been sent out by SCIO Health Analytics on behalf of Catamaran and OptumRx. Please see the sample language for what they are asking, shown below:

1. Photocopies—FRONT AND BACK—of original hard-copy prescriptions/physician order sheets (including back-slaps or any computer-generated stickers).
2. Computerized dispensing records, including refill records.
3. Supporting documentation necessary to support the appropriateness and accuracy of the billing.

We have clarified item No. 2 with SCIO staff, who have confirmed that they are looking for a printout showing all of the fill dates and they are NOT requesting signature logs as proof of dispensing. Item No. 3 means clinical documentation supporting the prescription (such as notes clarifying DAW code, use as directed instructions or vacation overrides).

By Mark Jacobs, RPh, PAAS National, (the Pharmacy Audit Assistance Service). For more information, call 888-870-7227 toll-free, or visit www.paasnational.com.

ADVOCACY ALERT

Pharmacy champion Rep. Doug Collins (R-Ga.) blasted PBMs in a speech in the House chamber. Collins, pictured here at a committee hearing, challenged his colleagues to "stand up" for community pharmacists "against the anticompetitive tactics of PBMs and the bullying behavior that has to stop." He decried the putative audits that pharmacists fear for speaking out against shady PBM tactics and declared, "I will continue this fight because they can't audit me." In the Dec. 8, 2015 speech, he also called for more lawmakers to support his PBM transparency bill H.R. 244, which now has 32 cosponsors.

Breathing Easy and It Feels So Good: Adhering to a Smoking Cessation Program

by Elisabeth Wygant

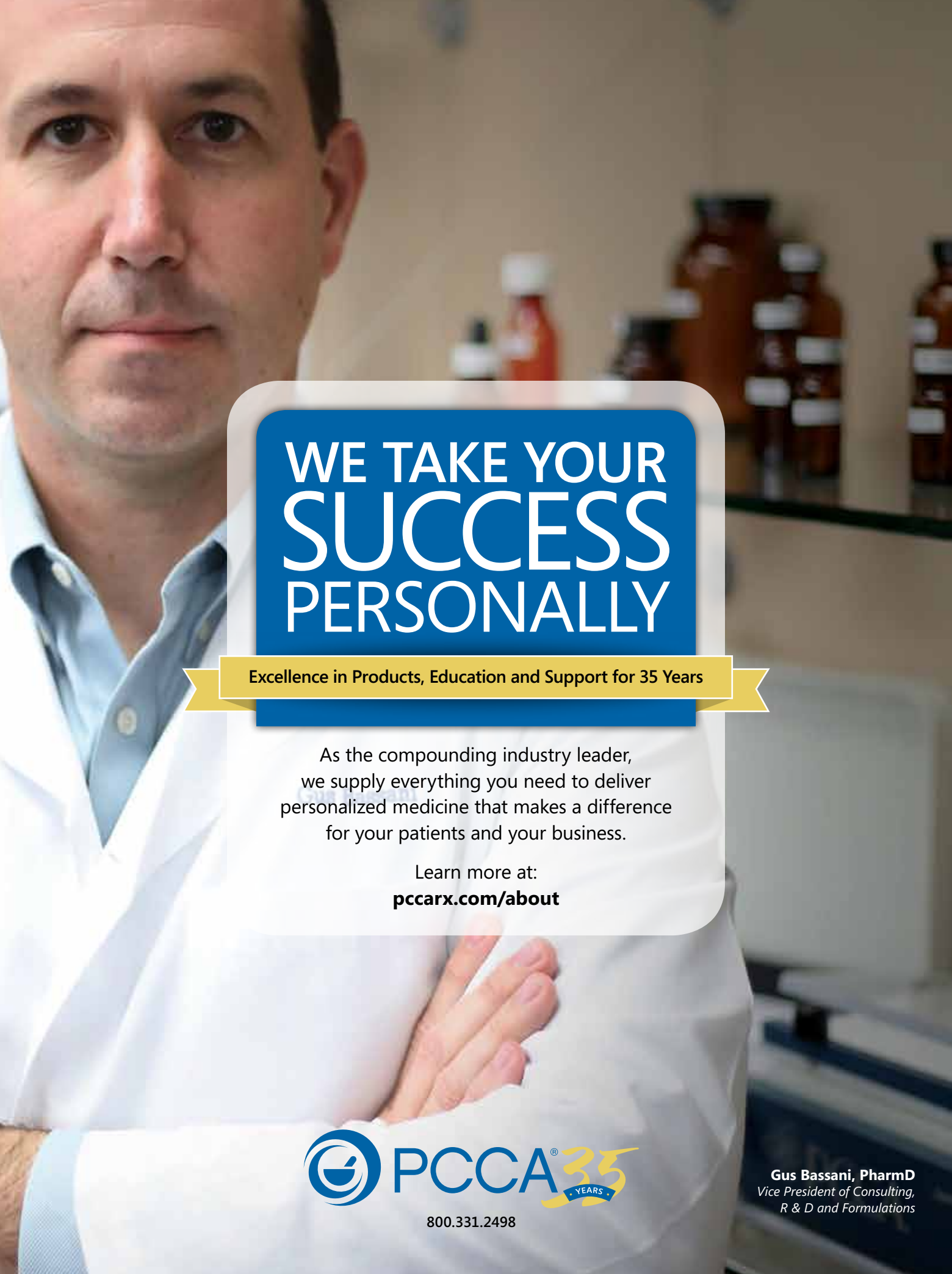
More than 480,000 deaths every year can be attributed to cigarette smoking in the United States, making it the leading cause of preventable disease and death in the country. Shockingly, 16 million Americans live with a disease that is caused by cigarette smoking, and 42.1 million adults in the U.S. are continuing this detrimental habit. Countless studies show that smoking significantly impacts health and health care costs. Now, the question that pharmacists must ask themselves is, "What can I do as a health care professional to reverse the mindset of patients who are current smokers?" The answer to this question comes with a series of steps that the pharmacist and patient must embark on together.

The first advancement in aiding with smoking cessation is to analyze the five A's, which are: ask, advise, assess, assist, and arrange. It is important to identify whether or not a patient smokes cigarettes or uses tobacco products. This is done so by asking the patient directly. To continue the dialog, the pharmacist should advise and inform patients of the benefits of quitting, and also the risks that they are taking if they continue to use tobacco products. From this point, an assessment must be made to determine if they are willing to try and quit, and allow the pharmacist to assist in the quit attempt. This is where pharmaceutical care truly comes into play. After making a recommendation for the patient, it is then crucial to schedule a follow-up appointment. This final step helps to build trust between the pharmacist and the patient because it promotes open communication within the relationship.

Whether the decision is made to try nicotine replacement therapy (NRT) or if a prescription medication is recommended, a pharmacist is readily available for each facet of the cessation process. Adhering to the smoking cessation therapy chosen by the patient and/or doctor is essential to their overall well-being. This can be distinguished by the fact that within a few weeks after quitting, the patient's circulation will be improved and coughing or wheezing will not occur as often. After one to five years, the risk of fatality from heart disease is reduced by half. More importantly, after 10 years of being tobacco-free, the risk of becoming diagnosed with lung cancer decreases to almost the same rate as that of a nonsmoker.

Adherence to a smoking cessation regimen is one that promotes a healthy lifestyle for the patient and reduces the inevitable risks associated with using tobacco products. By utilizing the five A's model, a pharmacist can be the first line of offense aiding in this beneficial lifestyle modification. Pharmacists are the most accessible health care providers for patients, and it is this responsibility that helps to encourage patients to seek their advice on matters involving their well-being. ■

Elisabeth Wygant is a 2016 PharmD candidate at the Lloyd L. Gregory School of Pharmacy.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Building Partnerships for a Stong Foundation

by Donnie Calhoun, PD

> ***Maintaining current funding relationships and developing new program partnerships are essential to helping the NCPA Foundation prosper***

You may recall from the December 2015 issue that my "In List" for this year included partnerships, commitment, prudence, and makeovers. During my tenure as president of the National Community Pharmacists Association Foundation, I would like to increase the number of companies, associations, foundations, and government agencies that have an alliance with the NCPA Foundation. Maintaining current funding relationships and developing new program partnerships are essential to helping the NCPA Foundation prosper and meet the needs of NCPA, its members, and the public.

Successfully achieving goals requires teamwork. The NCPA Foundation is always seeking partners to establish initiatives that offer NCPA members an opportunity to creatively highlight their value to the communities they serve and to support programs that encourage independent ownership. Please contact the NCPA Foundation if you are interested in supporting the programs highlighted below or to discuss a new public outreach initiative that may be of significance to independent pharmacists.

Bone Marrow Donor Drive: More than 1,000 individuals have been added to the national bone marrow registry as a result of donor drives conducted at independent pharmacies across the nation throughout the year. To inquire about sponsoring this program, please contact ncpaF@ncpanet.org.

Disaster Relief: The main components of the NCPA Foundation's disaster aid program are the Disaster Relief Fund, which provides immediate cash aid to independents recovering from calamity; the Pharmacy Disaster Support Center at www.rxdisaster.com; and programming at the NCPA Annual Convention related to preparedness, response, and recovery. To learn about funding opportunities, email ncpaF@ncpanet.org.

Dispose My Meds™: This is a turnkey public safety and environmental program that educates the public and provides resources to help communities and independent pharmacies promote responsible and safe medication disposal. More than 1,600 NCPA member pharmacies are participating in this popular outreach program, and so far they have collected more than 200,000 pounds of unused and expired medications. Email ncpaF@ncpanet.org to learn about sponsorship opportunities.

Health Awareness Campaigns: Sponsoring a health campaign is an effective way to engage community residents, promote your company, garner media attention, and edu-

Continued on page 55 ▶

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Who We Are

The National Community Pharmacists Association Foundation is a nonprofit, philanthropic 501(c)(3) organization established in 1953. The NCPA Foundation preserves the legacy of independent pharmacy through programs that improve the success of independent pharmacy and enhance patient care, community outreach initiatives, scholarships to NCPA student members, and disaster aid and resources to independent pharmacy owners.

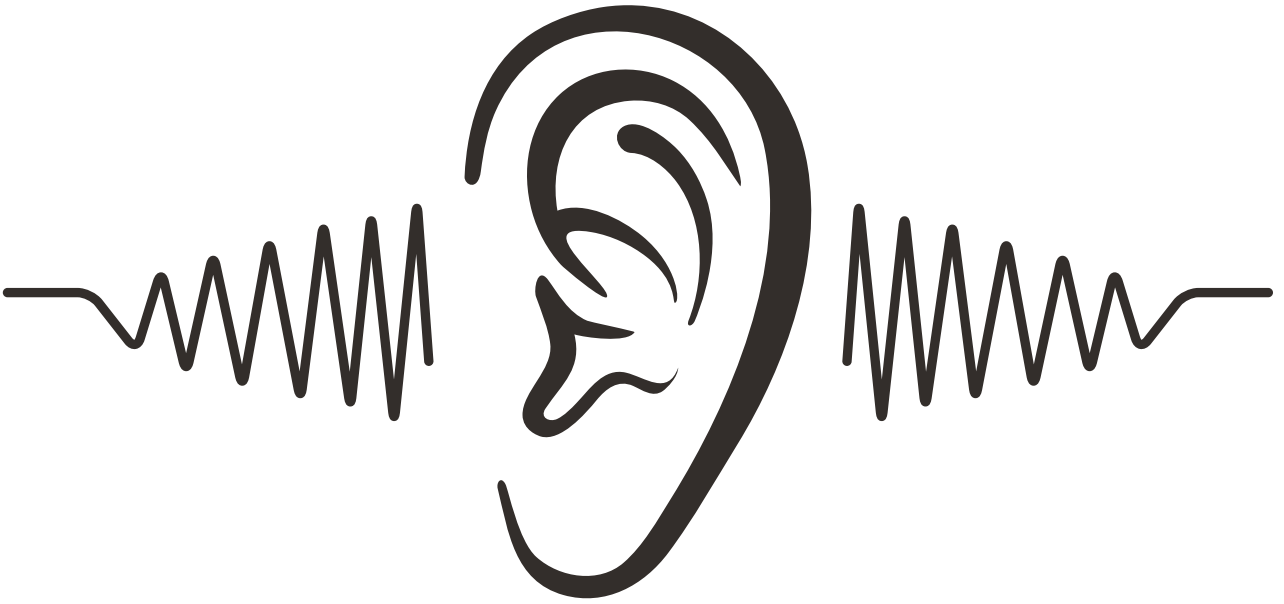
Partnership Opportunities

Please contact ncpaF@ncpanet.org today for information about national corporate sponsor opportunities, which include:

- Awards program
- Bone marrow donor drive
- Dispose My Meds™ program
- Fundraising auction
- General support
- Health awareness campaigns
- NCPDP—enhancing independent community pharmacist involvement
- Scholarship program

The NCPA Foundation

Established in 1953 in honor of John W. Dargavel



What the Rx Name Sounds Like May Not Be What It Is

A nurse from a physician's office called in a prescription to an outpatient pharmacy for PREVPAC (lansoprazole, amoxicillin, clarithromycin) for 14 days and asked the pharmacist if he could "make it" for the patient since it would be less expensive than using a manufacturer's combination "pack." However, the pharmacist misheard the nurse and thought the doctor had prescribed a "Pred-Pak," or a predniSONE "dose pack" with tapered dosing. Although the nurse had not specified a starting dose, the pharmacist filled the prescription beginning with a typical 30 mg dose (divided into three 10 mg doses on day 1), with tapering doses so therapy would be complete after 14 days. Since the pharmacist was asked to "make it" rather than dispense the prepackaged drug, he did not question the 14-day therapy instead of the usual 6- or 12-day schedules. The pharmacist had rarely dispensed Prevpac but had been dispensing predniSONE regularly. This is why he thought he heard "Pred-Pak" rather than "Prevpac." Fortunately, the patient read the leaflet about the newly dispensed medication and then called her doctor to ask why she was receiving a steroid to treat her duodenal ulcer and *Helicobacter pylori* (H. pylori) infection. The next day, the prescriber called the pharmacy to clarify the order.

These look- and sound-alike names, Prevpac and "Pred-Pak," demonstrate why telephone orders must be transcribed and read (and spelled) back. This includes the product name, dose, route, and directions for use. Unfortunately, in this case, the names are so close that, even with read back, the error might not have been detected unless the interpretation of "Pred-Pak" (predniSONE dose pack) was included in the read back process. The atypical duration of therapy and the absence of a starting dose should have prompted the pharmacist to verify the order. However, the pharmacist was uncomfortable "bothering" the physician, as he had been difficult to deal with many times in the past. While this can be a powerful disincentive to speak up, it is paramount to ask questions when the safety or quality of drug therapy is uncertain. Providing an indication with the prescription also could have helped to prevent an error, and patient counseling before leaving the pharmacy might have as well.

FARXIGA AND FETZIMA MIX-UPS

The Food and Drug Administration is aware of several reported mix-ups due to name confusion between FARXIGA (dapagliflozin) and FETZIMA (levomilnacipran). Farxiga was approved in January 2014 to lower blood glucose levels in adults with type 2 diabetes when used along with diet and exercise. It is available in 5 and 10 mg tablets. Fetzima was approved in July 2013. It is a selective norepinephrine and serotonin reuptake inhibitor for major depressive disorder.

Continued on page 55 ▶

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Marketing Health Can Make Your Pharmacy Healthier

by Liz Tiefenthaler

It is clear that the traditional model of a retail pharmacy that just dispenses prescriptions is not a formula for financial success. Today's successful independent identifies niche markets and value-add services to differentiate its pharmacy from others in a crowded marketplace.

For example, some of you offer compounding, which can be a great differentiator and is successful with niche markets such as veterinarians and BHRT where prescribers understand the benefits. Yet other pharmacies differentiate themselves through adherence offerings—multi-dose packaging, synchronization programs, and reminder software—which is worthy and important work. But what was once territory owned by independents is now getting some challenges from the chains. Whether or not they do compliance packaging as well as you do is not really the issue. It is another reason that you need to market your pharmacy and to constantly be evolving to stay ahead of your competition.

I often talk to independents about the importance of being disruptive in the marketplace. When we look at other industries, you will see that it is not just independent pharmacy that has to deal with change. Even the big guys find themselves being disrupted by newer and bigger ideas, like iTunes does with Pandora and Spotify. We saw the travel industry upended years ago by the Internet. It adapted and came up with easy-to-book online websites and competitive pricing. Yet, once again they are being disrupted by the new kids on the block, such as AirBnB and VRBO. No more middle man means savings for consumers and an opportunity for entrepreneurs to make money. As this column is being written, my son and his wife are staying with a family in Istanbul in a fabulous private apartment for much less than the cost of a hotel. Watch out, Marriott!!

What does this have to do with marketing health and wellness in your pharmacy? Health and wellness offerings can be the new marketplace disruptor. Along with fitting in with most pharmacies' mission of caring for patients and their families, it positions you as a health care provider and takes the insurance companies out of the equation. Now that sounds good, doesn't it?

Continued on page 55 ▶

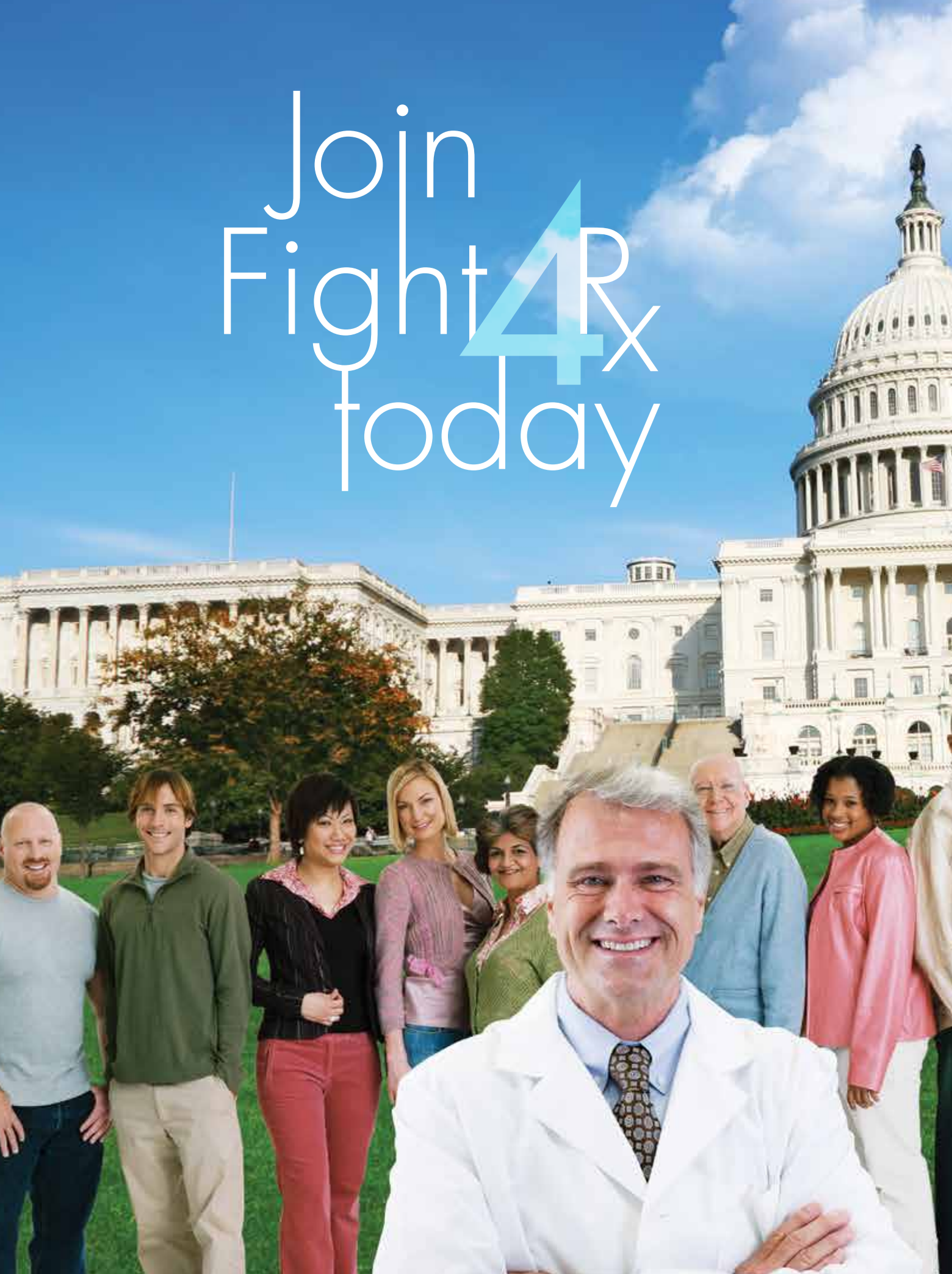
Sydney Kutter
PharmD Candidate 2017
Texas Tech University Health Sciences Center

"As the health care field continues to advance, pharmacists must constantly be searching for additional avenues to provide health care services as well as filling prescriptions. Upon graduation, my goal is to work in an independent pharmacy where I can serve as a clinical pharmacist, reaching out to the community by offering vaccine clinics, health screenings, and medication management.

Not only does the Partners in Pharmacy scholarship alleviate my loan burdens upon graduation, but it also encourages me to know there is an organization that believes in my future career in the pharmacy profession and the difference I will make."

The National Community Pharmacists Association Foundation preserves the legacy of independent pharmacy through scholarships to NCPA student members, programs that encourage independent pharmacy ownership, research that enhances patient care, community health awareness programs, and disaster aid to community pharmacy owners. The Foundation was established in 1953 and is a non-profit 501(c)(3) organization. The ***McKesson Foundation*** *supports the NCPA Foundation's scholarship program.*

The NCPA Foundation
Established in 1953 in honor of John W. Dargavel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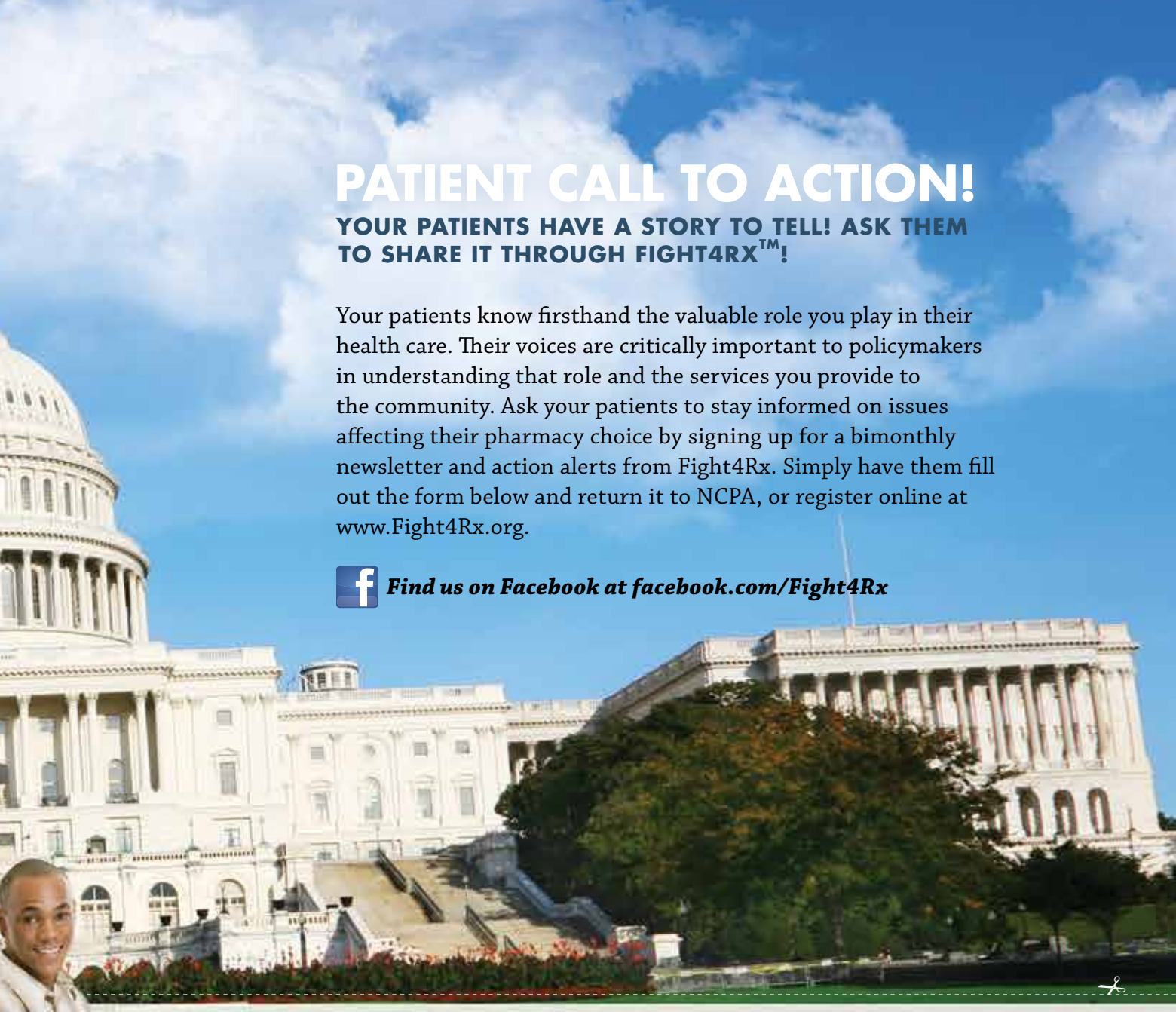

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Winners *Always* QUIT

…and quitters always win—with the right smoking cessation program

by Chris Linville

When Caitlin Bertrand, PharmD, started a year-long post-graduate community practice residency at Barney's Pharmacy, Inc., (www.barneysrx.com) in Augusta, Ga., in 2014, she was asked what type of clinical service might interest her. For Bertrand, a 2014 graduate of the University of Louisiana at Monroe, her choice carried a personal meaning.

"I said I would like to do smoking cessation. I think it's really needed in the community," she says. "And the reason why is that my grandmother passed away from lung cancer right before I moved there. So it's something I very much believe in, and I can relate to patients through that, after watching the effects of somebody smoking for several years. You always hear people saying, 'Oh my gosh, I really want to quit smoking, but I don't have the motivation or I just don't know what to do.' So that's kind of why I wanted to start it."

Bertrand's residency ended last June, and she now works as a community pharmacist in Reyna, La., where she hopes to eventually implement similar programs. However, smoking cessation services at Barney's continues. Building on the foundation Bertrand established, the program is now led by pharmacist Katie Bastug. She has contacted about 50 patients, with 25 expressing interest in the program. Barney's says that 15 patients have successfully completed the program and have remained non-smokers. The program is also staffed by student pharmacists on rotation in the counseling sessions as well.

BENEFITS OF QUITTING

In sports, there's a saying that "quitters never win." Of course, when it comes to smoking cessation, giving up is always a winning strategy for improved health. According to the Centers for Disease Control and Prevention (bit.ly/cdcquitsmoking), smoking remains the leading cause of preventable death and disease in the United States, killing more than 480,000 Americans each year. Smoking causes immediate damage to the body, which can lead to long-term health problems. For every smoking-related death, at least 30 Americans live with a smoking-related illness.

But the CDC also points out that a person's risk for a heart attack drops sharply just one year after quitting smoking. After 2-5 years, the odds for a stroke could fall to about the same as a nonsmoker's. And within five years of quitting, the risks for cancer of the mouth, throat, esophagus, and bladder is cut in half.

Looking back at her residency, those were the points Bertrand was trying to make with her smoking cessation efforts.

"A lot of people don't realize that once you quit smoking, the body immediately starts to heal," she says. "A lot of people just don't realize that and then think it's too late. Where I come in is to try and tell them it's not too late. I need to stress that because someone might say, 'I've been smoking for 50 years; it's too late for me.' No it's not. Smokers tend to live 10 years less than non-smokers. I try to bring those numbers to the patient."

Barney's has established a tradition of education and support services for patients dealing with a variety of health concerns, such as breast cancer, ostomy care, and diabetes, so smoking cessation seemed to be a natural fit. Bertrand started meeting with patients in November 2014,

with a mix of both group sessions and individual meetings. She met with more than 40 patients.

To help get a sense of her patients' health issues, Bertrand says that she created intake/assessment forms for their history, such as how long they have been smoking, how many cigarettes they smoke per day, and if they are taking any other medications.

"The reason I did this was to help me decide if they were a candidate for therapy – if there were any medication options, both prescription and over the counter, as there are several contraindications with them. If the patient is only smoking a few cigarettes per day, they probably wouldn't really benefit from something over the counter," she says. "It takes a bit more time to put all of that together, but it does help me to have that information."

During individual sessions, Bertrand says she would try to find out what triggers were in play that made patients smoke. She could also dig a bit deeper and find out if there were other obstacles that she might not have been aware of initially.

"For example, if they have tried OTC products in the past, we would go over how they used it," she says. "A lot of times you learn that they have used it incorrectly, so that might be a reason the product didn't work, or maybe they were experiencing side effects they weren't expecting and quit taking the medication, especially the prescription products for smoking cessation."

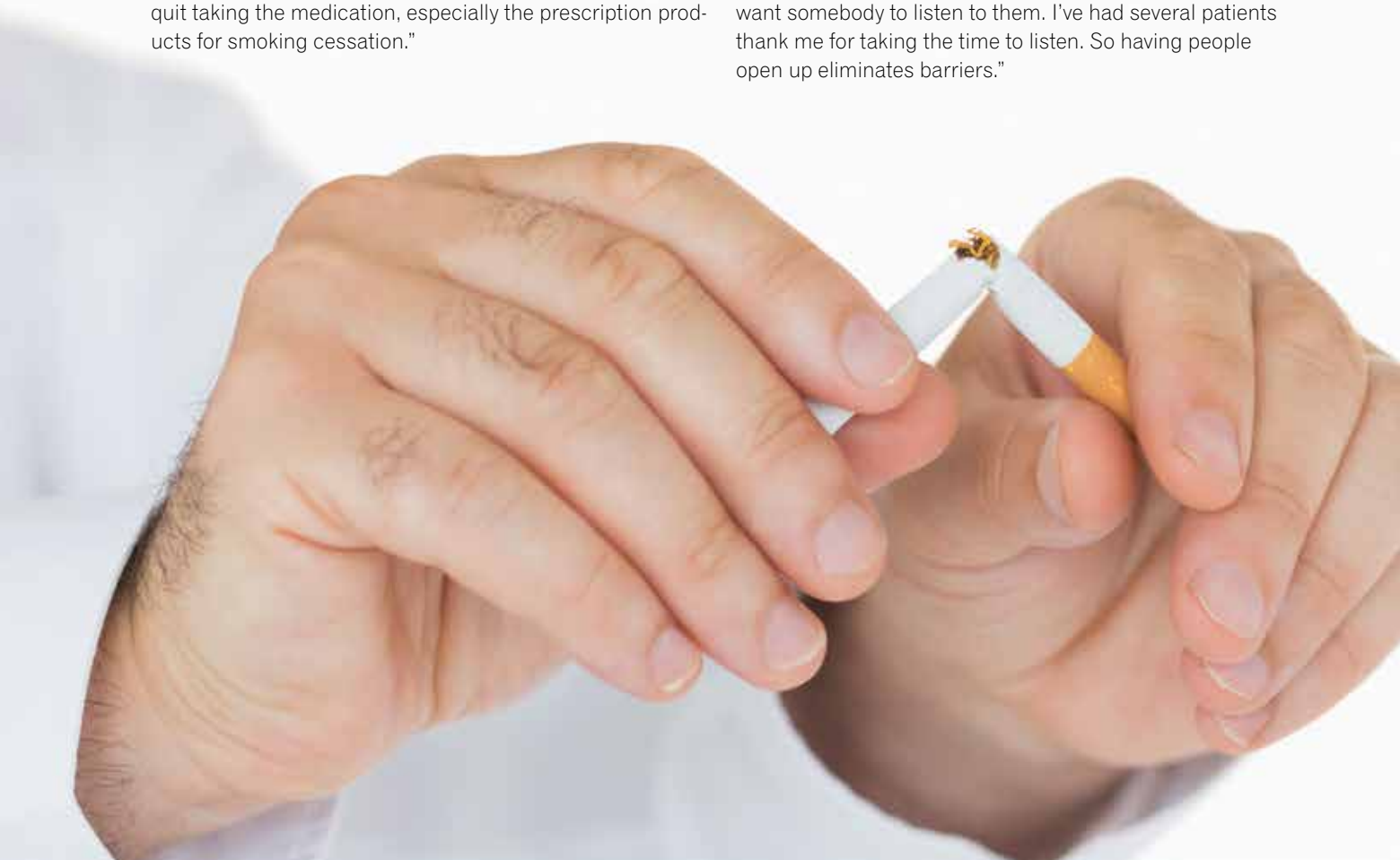
When interacting with patients, Bertrand believed it was important to point out what smokers are putting into their body when they light up. The American Lung Association says that there are approximately 600 ingredients in cigarettes. When burned, they create more than 6,000 chemicals. At least 69 of these chemicals are known to cause cancer, and many are poisonous.

"I liked to bring that awareness to the patient," she says. "It's important to be able to provide that education, and also discuss what diseases can be caused or affected by smoking. A lot of people might just think lung cancer or heart attacks might be the only things caused by it, when in reality smoking affects every part of your body, or potentially can do so."

SUPPORTIVE APPROACH

Bertrand says that she tried to avoid lecturing when interacting with patients, believing that a one-sided conversation can discourage discussion and an open flow of ideas and feedback.

"I try to use a conversational tone," she says "I think that when you provide a supportive tone or encouraging voice, it's better than just lecturing. I think it's beneficial to include them in the conversation. I like to share personal examples that I have had, watching someone go through the effects of smoking. I have found that a lot of people just want somebody to listen to them. I've had several patients thank me for taking the time to listen. So having people open up eliminates barriers."



Some of the frustration Bertrand would see from patients was due to them trying to quit cold turkey, which isn't the most effective or realistic approach.

"It's kind of related to trying to change your diet," she says. "It's not going to happen in one day. It's something that's very gradual, and something that you really have to work at."

With that in mind, Bertrand would initially try getting patients to reduce their frequency of smoking.

"With a lot of people I might say, why not try smoking 1-2 fewer cigarettes per day and see how that works," says. "It's all about encouraging them along the way to make these small changes, that it can really make a difference, and you'll have a much better success rate if you do these methods as opposed to trying to quit cold turkey."

Bertrand recalled a particular patient who found success following this strategy. She had talked to the patient previously and was able to follow up when the patient came into the pharmacy a few weeks later.

"I had suggested she leave the cigarettes at home [not bringing them to the car at all] and see how that worked for her," Bertrand says. "And she told me she was doing really well with that. So just having those small breakthroughs with patients, they are very excited to tell you about their achievements. And that was exciting."

FILLING THE GAP

Bertrand says a majority of the program participants were existing Barney's customers. She says many of them had filled a prescription there before, or their doctor had called in a medication for smoking cessation and they had never filled it.

> ***"A lot of people don't realize that once you quit smoking, the body immediately starts to heal."***

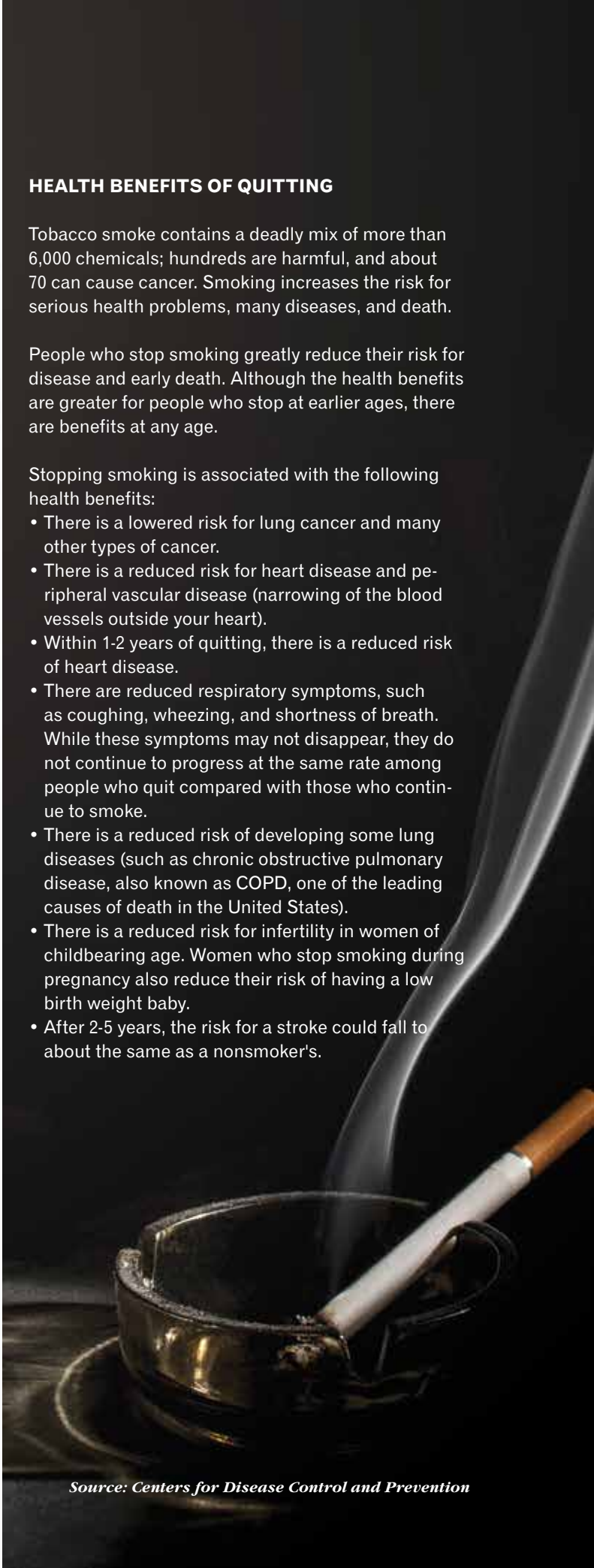
HEALTH BENEFITS OF QUITTING

Tobacco smoke contains a deadly mix of more than 6,000 chemicals; hundreds are harmful, and about 70 can cause cancer. Smoking increases the risk for serious health problems, many diseases, and death.

People who stop smoking greatly reduce their risk for disease and early death. Although the health benefits are greater for people who stop at earlier ages, there are benefits at any age.

Stopping smoking is associated with the following health benefits:

- There is a lowered risk for lung cancer and many other types of cancer.
- There is a reduced risk for heart disease and peripheral vascular disease (narrowing of the blood vessels outside your heart).
- Within 1-2 years of quitting, there is a reduced risk of heart disease.
- There are reduced respiratory symptoms, such as coughing, wheezing, and shortness of breath. While these symptoms may not disappear, they do not continue to progress at the same rate among people who quit compared with those who continue to smoke.
- There is a reduced risk of developing some lung diseases (such as chronic obstructive pulmonary disease, also known as COPD, one of the leading causes of death in the United States).
- There is a reduced risk for infertility in women of childbearing age. Women who stop smoking during pregnancy also reduce their risk of having a low birth weight baby.
- After 2-5 years, the risk for a stroke could fall to about the same as a nonsmoker's.



Source: Centers for Disease Control and Prevention

"That's where I came in." Bertrand says, "I would call patients to see why they had not gotten it, to assess the situation and see what was going on."

There is no fee for the smoking cessation program, she says, pointing out that all of Barney's educational activities at the pharmacy are at no cost to patients. Bertrand says it's an ideal way to provide a service and see if it actually works before making the patient pay for anything.

"There's definitely going to be an opportunity in the future when pharmacists are able to bill for these services," she says. "I know that Georgia Medicaid is actually wanting patients to undergo face-to-face counseling for smoking cessation to be able to bill for it. There are some states where you can bill it under the doctor, for example if you are in a clinic."

As for the return on investment for the pharmacy, Bertrand says, "A lot of these patients ended up getting a prescription filled for smoking cessation or bought an OTC product. So when you look at it, there is some revenue coming into the pharmacy."

When it comes to specific therapies, Bertrand says "It's definitely a case-by-case basis." She says there were some instances where patients wanted to try Chantix (varenicline) or Zyban (bupropion), so she called their physicians to find out if they were okay with writing prescriptions for those. Bertrand says she was extremely careful regarding some OTC products with patients who had hypertension, especially if it was uncontrolled.

Speaking of physicians, Bertrand says she had a positive working relationship with them. "In all of the calls that I made to request a prescription, I did not encounter any problems."

However, as physicians are not always readily accessible, Bertrand says smoking cessation is an area where pharmacists can provide support and give a boost.

"So many patients go to their doctor and they get that encouragement, but it just stops there," she says. "The doctor stresses the need to stop smoking, but then the patient leaves and they [physicians] don't think about it again. So I think a collaboration between pharmacists and doctors is a good thing. If the patient is advised by the doctor to quit smoking, and if the doctor knew of a place where the patient could receive counseling, it would be an easy referral. That's another reason pharmacies should look into doing things like this. It could definitely bring more business."

STANDING OUT

A common (and perhaps essential) line of thinking is that independent pharmacies need to find ways to stand out, especially in the face of chain competition. Bertrand certainly agrees with that sentiment.

"You really have to make yourself marketable, and providing the different services really does that for you" she says. "The thing about Barney's is that they do offer a lot of unique services that not a lot of others provide."

Bertrand realizes many pharmacies say they don't have time to implement various programs, and she acknowledges that she was able to devote more time as part of her resident responsibilities compared to a full-time pharmacist who must oversee all aspects of the business. Still, she says it can be done, and it doesn't necessarily demand a large time commitment.

"If you are counseling on other products (like cold and allergy), and you have a couple of minutes to spend with the patient on that, you can use that time on a smoking cessation patient," she says. "A successful session or conversation with a patient can happen in a couple of minutes. It's just asking simple questions like you would when counseling on any OTC product. I really think you can be effective, even in a short period of time. That's why I would encourage pharmacies to incorporate this into their practice."

Bertrand says that while she was at Barney's, she did a lot of informal counseling.

"There were several times where a prescription was coming through for a nicotine patch and somebody would ask if I would mind going and speaking to the patient," she says. "I remember one time, a patient's wife was picking up his prescription. I didn't think they originally were going to get the prescription for patches because initially they decided they didn't want it. But by talking to them they realized the importance of quitting, and I actually followed up with him a couple of times. It can make a difference if you interact with patients when they are looking at some of the nicotine products, and having a conversation with them about the products. It's better than just having them buy a product and potentially failing with it because they didn't receive proper counseling."

As far as promoting smoking cessation, Barney's does several newspaper advertisements monthly, and Bertrand included program information with the ads. She said one person came into a counseling session who had never been to the pharmacy before, "but she saw the ad and wanted to see what it was about."

Caitlin Bertrand, PharmD, who created the smoking cessation program at Barney's Pharmacy, says a conversational approach yields the most productive results when meeting with patients.

REWARDS

Bertrand says that perhaps the biggest reward she received for her efforts in smoking cessation are the stories where she was able to play a role in a patient moving toward improved health.

"I did a group session with about five patients," she says, "and a couple of days later one of the patients called me and said, 'Thank you, I just had to call you, and say thanks for really changing my life. The education you provided just did something for me and I haven't touched a cigarette since.'

"That just really kind of touched me because just by providing that education and encouraging somebody, that's just what he needed. He needed to quit, and he just needed that push in the right direction. I followed up with him a couple of times after that, and he was still smoke-free. That was a really good experience."

Emphasizing the impact that pharmacists can have, Bertrand says, "It's so important for us to encourage patients and take an active role in their health care. I think by doing this patients will appreciate us more and have loyalty to the pharmacy and all of its benefits." ■

Chris Linville is managing editor of *America's Pharmacist*.

Building *a* Career *Path*

University of North Carolina residency program helps pharmacists find their way toward ownership

by Patrick Brown, PharmD

Community pharmacy residency programs have been in existence for 30 years, and their numbers have been increasing in the past decade. During this time, programs have also expanded their number of sites. One of the first accredited programs was established at the UNC Eshelman School of Pharmacy at the University of North Carolina at Chapel Hill. The school will enroll its 17th class in 2016, representing 10 community residents in nine pharmacies. During its 16 years, there have been 79 graduating residents who have entered into a variety of career paths, including pharmacy management, clinical service development, ambulatory care, academics, and pharmacy ownership.

Drugco Discount Pharmacy, Roanoke Rapids, N.C.

ACCREDITATION IS KEY

A key to the successful expansion of community pharmacy residency training has been the development of accreditation standards for programs. These standards, maintained cooperatively by the American Pharmacists Association and American Society of Health-System Pharmacists, apply to 121 programs across the United States. A major point of emphasis for current accreditation standards is that residents spend greater than 50 percent of their time involved in the provision of direct patient care. While these accreditation standards ensure that residents are adequately prepared for patient care roles, they may not be ideal for all community pharmacy career paths. One area in which this dynamic is apparent is independent pharmacy ownership. Pharmacists who wish to become independent pharmacy owners stand to benefit from a training program with patient care experiences, but also need business training that is not always available under the current residency accreditation standards. With this educational need in mind, the UNC Eshelman School of Pharmacy and Mutual Drug Co., a cooperative drug wholesaler for independent pharmacy, are collaborating to develop a new residency training model that will focus on innovation and entrepreneurship, with the ultimate goal of training the next generation of independent pharmacy owners.

The independent pharmacy ownership residency program will begin in July 2016 with two residents. Each resident will be placed at one of two independently owned community pharmacies in North Carolina: Drugco Discount Pharmacy in Roanoke Rapids, and Central Pharmacy in Durham. These organizations both have multiple locations, are leaders in North Carolina pharmacy, and are known for their innovative patient care services and successful business models. Though unique in regard to their professional services and communities that they serve, each site will offer residents a wealth of experiences adequate to kick start a career as a successful pharmacy owner.

REAL WORLD AND SUPPLEMENTAL LEARNING

Along with real world business and patient care experiences, residents will complete a variety of programs that will supplement their practice-based learning. The UNC Kenan Flagler Business School offers a Business Essentials Certificate that will provide residents with foundational business content. NCPA conducts pharmacy ownership workshops that allow residents to take a deep dive into all aspects of pharmacy ownership, and an innovation, transformation, and pharmacy practice seminar will expose residents to contemporary topics in health care that will prepare them for success in an evolving health care marketplace. Residents will also spend time at Mutual Drug Co.'s headquarters, learning about the roles that the cooperative wholesaler plays in the independent pharmacy business model through supply chain management, political advocacy, professional education, and clinical service development.

Though the primary focus of the program is to meet the educational and experiential needs for aspiring pharmacy owners, it will also help to fill a need in the marketplace. Many pharmacy owners are approaching retirement age and are evaluating succession plans. These plans often hit snags as owners have trouble identifying a successor. This is especially apparent for Mutual Drug, which currently represents nearly 600 member pharmacies in North Carolina, South Carolina, and Virginia. A significant number of these member stores are considering plans for expansion or ownership transition, and need to be able to identify well trained and enthusiastic future owners. The successful expansion of this residency training model within the Mutual Drug footprint will create a pipeline of talented pharmacists who will help continue the tradition of innovative pharmacy business models for these stores.

Darius Russell, PharmD, and Jennifer Burch, PharmD, are preceptors for Central Pharmacy, Durham, N.C.

The need for more pharmacists interested in ownership is not exclusive to North Carolina or Mutual Drug. Pharmacy owners across the U.S. are experiencing similar challenges in expansion or transition of ownership. When scaling from the nearly 600 Mutual stores to the 22,000 independent pharmacies nationally, it is clear that expansion of this program can help to meet a national need. Successful collaboration between pharmacists who complete PGY1 community pharmacy residencies and independent pharmacy ownership residencies will build teams of pharmacy leaders that will become the future champions of community pharmacy practice. ■

Patrick Brown, PharmD, is a post-doctoral research associate, practice innovations, at the UNC Eshelman School of Pharmacy Department of Practice Advancement and Clinical Education.

Quality Measurement in the Health Insurance Marketplace

by Taylor Hightower

The Affordable Care Act called for the creation of what is now known as the Health Insurance Marketplace (sometimes also referred to as the "Health Insurance Exchange" or "Obamacare") within each state. Through the Marketplace, individuals and small businesses are able to select and enroll in private health plans. The Department of Health & Human Services (HHS) is primarily responsible for establishing the standards and guidelines for the Exchanges. Health plans must meet certain standards to be certified as a qualified health plan (QHP) and be offered through the Marketplace. Every health plan sold in the Marketplace must offer at least 10 essential health benefits.

The HHS has developed the Quality Rating System (QRS), which is similar to the Five Star Quality Rating System used by the Centers for Medicare & Medicaid Services (CMS) to rate Medicare Prescription Drug Plans (PDPs) and Medicare Advantage (MA-PD) plans. The QRS provides information so that consumers may compare plans and make an informed choice as well as to facilitate with regulatory oversight of the health plans.

Essential Health Benefits in the Health Insurance Marketplace

1. Outpatient care
2. Emergency room visits
3. Inpatient care
4. Prenatal and postpartum care
5. Mental health and substance use disorder services (including behavioral health treatment, counseling, and psychotherapy)
6. Prescription drugs
7. Services and devices related to injury or disability (including physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, and more)
8. Lab tests
9. Preventative services (including counseling, screenings, and vaccines) and care for managing chronic disease
10. Pediatric services (including dental and vision care)

The QHP ratings are based on health care quality and outcomes, consumer experience, and cost. There are 43 quality measures, of which 29 were implemented in 2015, with the remaining 14 to be implemented in 2016 and 2017. Altogether there are 14 measures that relate to pharmacy practice.

DEFINITION OF PHARMACY QRS MEASURES

- **Adult BMI Assessment (ABA):** the percentage of members 18-74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.
- **Antidepressant Medication Management (AMM):** the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment for at least 84 days during the effective acute phase of treatment and at least 180 days in the effective continuation phase treatment.
- **Aspirin Use and Discussion (ASD):** the percentage of members who are currently taking aspirin and the percentage of members who discussed the risks and benefits of using aspiring with a doctor or other health provider.
- **Childhood Immunization Status (CIS):** the percentage of children 2 years of age who have received the following vaccinations by their second birthday: four diphtheria, tetanus, and acellular pertussis (DTaP); one measles, mumps, and rubella (MMR); three hepatitis B (HepB); three hae-

2015 QRS Measures	2016 & 2017 QRS Measures
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Adult BMI Assessment
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Antidepressant Medication Management
Controlling High Blood Pressure	Childhood Immunization Status
Proportion of Days Covered	Follow-Up Care for Children Prescribed ADHD Medication
Flu Vaccinations for Adults Ages 18-64	Human Papillomavirus Vaccination for Female Adolescents
	Immunizations for Adolescents
	Medication Management for People with Asthma (75% of Treatment Period)
	Aspirin Use and Discussion
	Medical Assistance with Smoking and Tobacco Use Cessation

mophilus influenza type B (HiB), one chicken pox (VZV); and four pneumococcal conjugate (PCV).

- **Comprehensive Diabetes Care (CDC)—HbA1c Control:** the percentage of members 18-75 years with diabetes (type 1 and 2) whose most recent HbA1c was <8 percent.
- **Comprehensive Diabetes Care (CDC)—HbA1c Testing:** the percentage of member 18-75 years with diabetes (type 1 and 2) who had an HbA1c test performed during the measurement year.
- **Controlling High Blood Pressure (CBP):** the percentage of members 18-85 years who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria:
  - Members 18-59 whose BP was <140/90 mmHg
  - Members 60-85 with diabetes whose BP was <140/90 mmHg
  - Members 60-85 without diabetes whose BP was <150/90 mmHg.
- **Flu Vaccinations for Adults Ages 18-64 (FVA):** the percentage of members 18-64 years of age who received a flu vaccination between July 1 of the measurement year and the date when the QHP Enrollee Survey was completed.
- **Follow-Up Care for Children Prescribed ADHD Medication (ADD):** the percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.
- **Human Papillomavirus Vaccine for Female Adolescents (HPV):** the percentage of female adolescents 13 years of age who had three doses of the HPV vaccine by their 13th birthday.
- **Immunizations for Adolescents (IMA):** the percentage of adolescents 13 years of age who meet the criteria for combo 1: one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
- **Medical Assistance with Smoking and Tobacco Use Cessation (MSC):** the percentage of members 18 years or older who were current smokers and received advice to quit during the measurement year, who discussed or were recommended cessation medications during the measurement year, or who discussed or were provided cessation methods or strategies during the measurement year.
- **Medication Management for People with Asthma (MMA):** the percentage of members 5-64 years of age who were identified as having persistent asthma and who remained on an asthma controller medication for at least 75 percent of their treatment period.
- **Proportion of Days Covered (PDC):** the percentage of patients 18 years and older who met the PDC threshold of 80 percent during the measurement period for each of the following:
  - Renin angiotensin system (RAS) antagonists
  - Diabetes all class
  - Statins

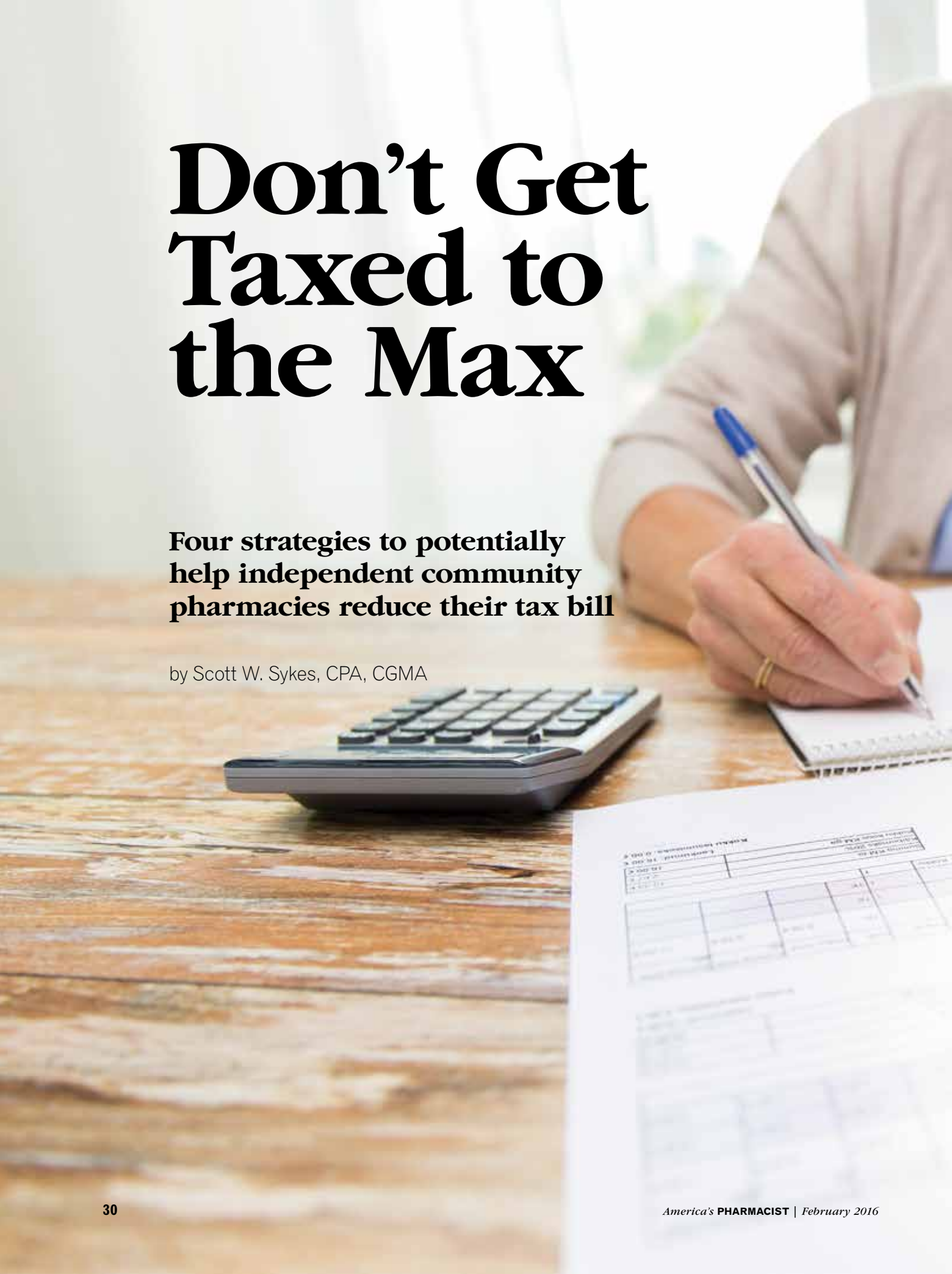
Now that purchasing health insurance is mandated by federal law, it only makes sense that health insurance plans have certain essential health benefits in common and that there is oversight to ensure the quality of the health insurance benefits. The incorporation of several measurements related to pharmacy underscore the role a pharmacist has in team-based patient care. The quality rating system summarized here is an important tool for health insurance purchasers who want to make informed decisions during the annual open enrollment period. ■

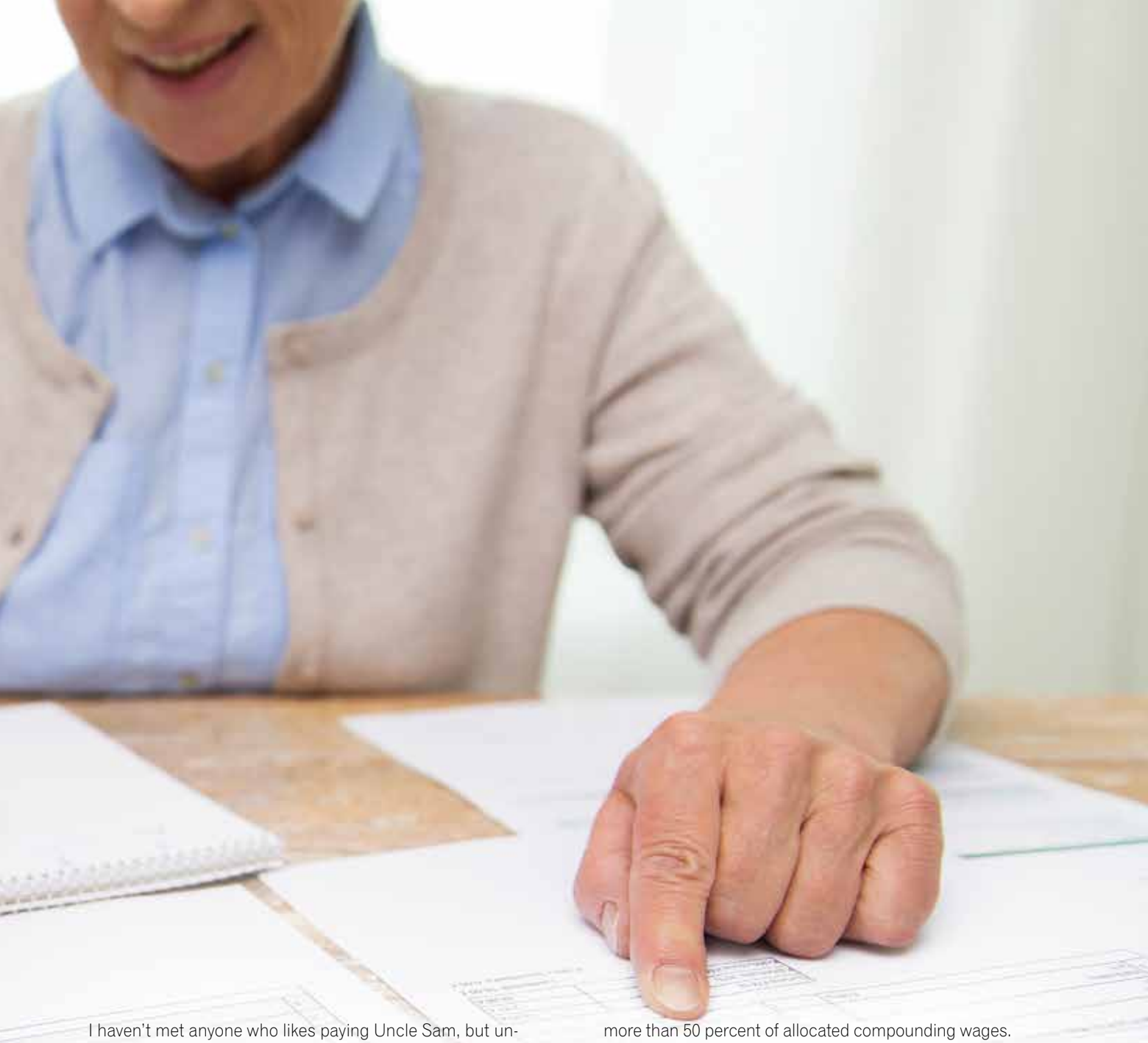
Taylor Hightower is a 2016 PharmD candidate at the McWhorter School of Pharmacy at Samford University.

Don't Get Taxed to the Max

Four strategies to potentially help independent community pharmacies reduce their tax bill

by Scott W. Sykes, CPA, CGMA





I haven't met anyone who likes paying Uncle Sam, but unfortunately many pharmacy owners pay more than they are legally required to do. If you're like most pharmacy owners, you fall into the top tax rates of 39 percent plus state tax rates. With cash flow tight in many pharmacies, these four strategies may improve your situation. You may not qualify or they may not fit your goals, but they're worth discussing with your advisors.

- Domestic Production Deduction. The Internal Revenue Code (IRC) Section 199 covers the domestic production deduction, which applies to U.S.-based manufacturers. Under current law, pharmacies that produce revenues from compounding services may qualify for this deduction. Although complex to calculate, the deduction can be as much as 9 percent of qualified production activities income or your adjusted gross income, not to exceed more than 50 percent of allocated compounding wages. It is imperative the correct accounting foundation is in place to maximize your benefit from this deduction.

- Section 179 Depreciation. Waiting until the very last minute of 2015, lawmakers passed the Protecting Americans from Tax Hikes (PATH) Act of 2015. The PATH Act retroactively restored for 2015 and 2016 the $500,000 Section 179 depreciation deduction and extended it permanently. Section 179 provides a current "expensing" deduction for qualified business property placed in service during the year. This is particularly important if you are in need of some technology updates in your pharmacy. For example, a $250,000 robot put in place and in use in 2015 or 2016 would be able to be written off, which will save you about 40 percent in taxes, or $100,000. Keep in mind however, the deduction cannot

exceed the net taxable income from all the businesses actively operated by the taxpayer, it must be in "use" before the end of the year and new equipment purchases are phased out at $2 million, indexed for inflation.

- Conservation Easements. Conservation easements provide limits on how land is used, for purposes such as wildlife preservation. They are a one-time charitable deduction and are currently limited to 50 percent of your adjusted gross income (AGI) with any excess allowed to carry forward. A taxpayer can invest in one of these easement entities and they usually get about a four or five to one deduction for the year, depending on the appraisal. This is a highly complex area of the tax law, but one that can provide benefits to the taxpayer that is considerable. In some cases this may greatly reduce or eliminate your tax bill for the year. Conservation easement investments usually carry high setup expenses and are not for every taxpayer, but they do offer an alternative.

- Various Retirement Options. Older pharmacy owners with limited debt and a plan in place to retire in the next 5-10 years should inquire about a more powerful retirement plan such as a cash-balance option. Although there can be higher in fees to set up and manage, the benefits of stashing away thousands of dollars into a tax deferred account far outweigh the fees. Some plans, when put into place, can completely wipe out all taxable income with most of the contributions going to the pharmacy owners and family members employed by the pharmacy.

As with any tax strategy, perform your due diligence and discuss these options with your CPA or advisor before making any decisions, as strategies mentioned above are subject to change with Congressional action. It is also imperative that the pharmacy has a solid accounting foundation in place. Without that, you may be missing basic strategies.

You can think of a well-tuned accounting foundation as working like a high end sports car. Its precision steering and power allows you to take control of your destiny with proactive tax planning and management decisions. And that speeds you down the road to fulfilling your goals, needs and desires. ■

Scott W. Sykes, CPA, CGMA is with Sykes & Company, P.A., working directly with pharmacy owners, assisting with day to day accounting and tax compliance issues. He is also active in year-end payroll preparation, tax planning, individual tax preparation and corporate tax preparation for pharmacy owners and businesses.

Time to Reinvent in a Changing Profession

by Corey Marin

For Charles Savage, taking advantage of opportunities is essential.

Charles "Chuck" Savage is no stranger to the practice of pharmacy—it has been a part of his life since a young age. He started out by working in an independent pharmacy, and realized it was ultimately what he wanted to do. After graduating from the St. Louis College of Pharmacy in 1973, he began practicing at a small independent pharmacy in southeast Illinois. From there, he moved to Jacksonville, Ill., where he worked for Osco Drug for nine years.

STARTING A DREAM

Savage's dream of owning his own pharmacy became a reality when a friend spoke about the opportunities and benefits of purchasing his own franchise through the Medicine Shoppe. Savage spoke to their representatives, and in 1984 the Medicine Shoppe in Jacksonville, Ill., opened for business. At the time, there were nine other pharmacies in the town, including other independents and chains, but he knew that he could offer more and had the ability to sell himself to the patients.

When Savage became owner, the pharmacy had a simple model—most of the business was retail pharmacy, with limited front-end merchandise and free delivery. Charge accounts were not offered, and credit cards were not accepted. However, as with all businesses, to stay successful you must adapt to the changing market. With the acquisition of another local independent pharmacy, business began to increase due to drug packaging needs. It was at this time that Savage realized that to continue, change was needed beyond offering all of the options that weren't initially available. That change came in the form of a brand new store.

BUILDING THE DREAM PHARMACY

With plans for the new store finished and construction underway, business at the old store continued as usual. In 2008, Savage and his staff moved from behind trees and houses to the main strip in Jacksonville, on Morton Ave.

Continued on page 35 ▶

Editor's Note: *"Profit Pearls" is an occasional series of articles focusing on pharmacies who have successfully used innovation, expanded offerings and outstanding customer service to become staples of their community.*

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BEFORE

AFTER

In 2008 Savage moved out of his old location (top photo, above) and into a brand new store he built from the ground up.

▶ *Continued from page 33*

What made this new store enticing? Namely, it was the outward appearance. No longer did he have a small corner business store, but a store to rival any pharmacy in town. There were two drive-thrus, more front-end merchandise, private immunization rooms, more workspace, a break room, offices, and room for expansion, if necessary. Also, the addition of services such as charge accounts and free delivery were enticing to those in the community. Customers walking to the front of the store are greeted by double glass doors and large, multi-leveled windows to ensure the pharmacy store is illuminated with sunlight. Of course, as in any independent pharmacy, entering customers are always greeted with a booming "hello" and a big smile from every employee.

NEVER SAYING 'NO' TO AN OPPORTUNITY

We have all heard the saying, "When opportunity comes knocking, it is wise to answer the door," and that is how Savage ran his pharmacy. If there was a need, there was a way to provide that need to the entire community. At the time, the pharmacy did limited medication packing, servicing only 20-30 patients. However, opportunity came knocking when the old heat-sealed bubble packing began to cause medication errors at nursing homes, which brought the need for something new. Savage, if he could find a way, was offered a contract to fill medication packages for all of the patients at the nearby nursing home in Springfield, Ill. After looking at the different technological options available and crunching the numbers, Savage selected pouch packing to provide this need. Obviously there was a learning curve, as with any new technology, but the value this type of packaging offered to elderly patients was tremendous. This service allows more of them to be independent and stay at home. It is a rewarding feeling to give people back their independence.

Besides adding pouch packaging to the pharmacy services, small non-sterile compounding was added because, again, an opportunity came knocking, and the void needed to be filled by someone in town. This was a service that no one else could offer and has been successful ever since for both patients and pets.

Continued on page 36 ▶

▶ *Continued from page 35*

> ***"If your heart is not in what you are doing and there is no passion, then it is not worth starting."***

Savage says "If your heart is not in what you are doing and there is no passion, then it is not worth starting. There was not a day where I was not thinking about how to practice at the top of my license and how things could be changed to allow me to sell myself."

These are only a few of the additions that have been added over time, but his business has always had the same motif: if there's an opportunity or need, Savage's pharmacy will meet and exceed the need, which in turn increases satisfaction and profit.

Savage says the No. 1 mistake owners make is letting emotion get in the way after seeing the reimbursement on only one prescription. Yes, you could lose money on one, he says, but you could be making more than expected on another. The key is to look at the whole aspect of your business because at the end of the day, it is the dollars that are put into the bank account, not the percentages.

A CHANGING TIME – REINVENTING PRACTICE

In recent years, there has been a shift in pharmacy practice, with more focus on clinical aspects. Savage recognized this, and knew that to continue providing the best service to patients, it would be necessary to reinvent himself. He began to look at the business numbers and realized that volume was up and employees were working smarter, but in order to increase profits, business would have to increase.

As the saying goes, "Behind every man there is an equally strong significant other." This is certainly true for Savage. His wife Diane, who also graduated from St. Louis College of Pharmacy, was instrumental in working the back office of their pharmacy. When it came time to consider selling the pharmacy, they carefully considered all of their offers. One thing they knew for certain: they wanted to sell the business to someone who would keep the store open. Ultimately, they sold the business to Beaux Cole, the owner of the Medicine Shoppe franchise in nearby Springfield, Ill.

NEW FACE, SAME FEEL

Cole graduated from Creighton University in 2005. After graduation, he started working for a retail chain and realized that he wanted to work in the community, just not for a chain. After considering his options, he eventually purchased the Medicine Shoppe franchise in Springfield in 2011. Knowing Cole's success in Springfield, Savage contacted him about potentially selling him his franchise. Cole admitted he was skeptical at first, but stated that life changes, and after talking things over with his wife, Carrie, he realized that owning the two stores was going to create a nice symbiotic relationship. As his Springfield franchise is mainly a compounding center performing both sterile and non-sterile compounding for patients and their pets, owning both pharmacies allows Cole to gain access to a customer base throughout central Illinois that was previously unavailable when both stores were separate entities.

Cole is active with the Illinois Pharmacist's Association, helping with programs such as the Patient Self-Management Program. Based off the Ten Cities Challenge, this study showed the health care savings by having a one-on-one conversation between patients and pharmacists. "The best thing a young pharmacist can do is to be politically active and involved. Owning your own pharmacy is the most rewarding thing you can do in your life," Cole said.

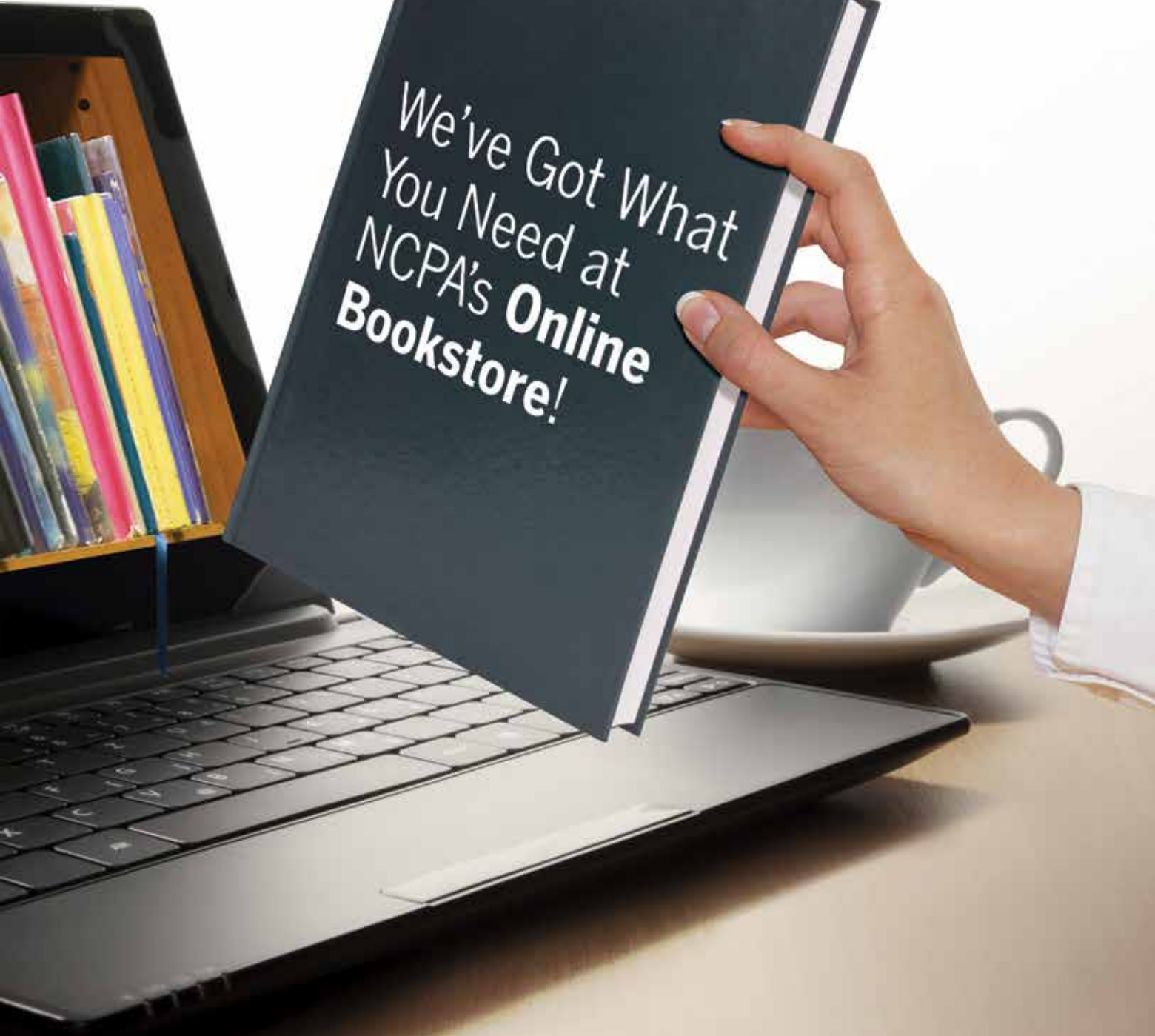
ADVICE FOR FUTURE OWNERS

Savage, who now does some consulting, says the best advice he can give is a quote from one of his business professors from pharmacy school.

"The best thing you can do is learn someone's name." he says. "When you own your own pharmacy, the goal is to sell yourself. I always made sure that I knew everyone's name and it came to the point where it was expected of me."

Savage also advises that pharmacy owners embrace technology and utilize the skills of people whose jobs involve other aspects of business. Back office work can be the bane of independent pharmacists because there is so much to do and learn. Therefore, he says, let others assist with that aspect of the business, freeing you to be the face of your pharmacy. ■

Corey Marin is a 2016 PharmD candidate at the University of Iowa College of Pharmacy.



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The Pharmacist's Role in Tobacco Cessation

by Jamie L. McConaha, PharmD,
and Lauren Elizabeth Wolfe, PharmD

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Upon successful completion of this article, the pharmacist should be able to:

1. Describe the current status of tobacco use patterns within the United States.
2. Review the key components and spirit of motivational interviewing techniques.
3. Demonstrate the assessment techniques involved in tobacco cessation counseling appropriate for each of the stages of change.
4. Select appropriate pharmacologic tobacco cessation aids based on patient-specific factors.
5. Apply practical counseling skills through recommendation of lifestyle changes to manage nicotine withdrawal symptoms.

Upon successful completion of this article, the pharmacy technician should be able to:

1. Describe the current status of tobacco use patterns within the United States.
2. Review the key components and spirit of motivational interviewing techniques.
3. List each of the stages of change and identify pharmacy patients who are likely to be interested in tobacco cessation counseling.

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INTRODUCTION

More than 50 years have passed since the landmark release of the 1964 report of the Surgeon General's Advisory Committee on smoking and health. Since that time, the detrimental effects of tobacco use have become public knowledge. While this information contributed to a decline in cigarette smoking from 42 percent in 1965 to 18 percent in 2012, more than 42 million Americans still smoke. For the first time in U.S. history, however, former smokers outnumber current smokers. Unfortunately, the decline in smoking prevalence has slowed in recent years, and the burden of smoking-attributable mortality is expected to remain high for decades to come.

Health care professional involvement is vital to successful smoking cessation and treatment of tobacco use. Pharmacists are accessible in all fields of practice to educate patients on the long-term risks of smoking and to encourage them to avoid tobacco use initially or pursue cessation. Pharmacists are capable of developing cessation plans and providing recommendations for lifestyle changes and pharmacologic therapies. The Surgeon General's Report also identified key target populations for prevention of nicotine use initiation. First use of cigarettes occurs in 87 percent of tobacco users by age 18, and 98 percent of people by age 26. Preventing initiation of these behaviors through targeted education of youth and young adults is therefore essential.

With the positive decline in cigarette use comes a changing pattern of tobacco use that warrants attention. Following the availability of electronic cigarettes in the United States in 2007, their use has steadily increased in current and former cigarette users. Nearly 500 brands and 7,700 flavors of electronic cigarettes are available for purchasing, all without regulation from the Food and Drug Administration (FDA). As electronic cigarettes have been available for fewer than 10 years, the long-term safety data is unknown. With a lack of safety data and lack of regulation from the FDA, neither the FDA nor the American Lung Association (ALA) advocate for the use of electronic cigarettes as smoking cessation aids.

Despite the abundant evidence in support of the deleterious effects of tobacco, its use continues to be the greatest cause of preventable death in the world. Tobacco kills more than half of its users, equating to approximately 6 million people annually. While most of the tobacco-related deaths are due to its direct use, more than 600,000 of the deaths are caused by secondhand smoke exposure. Recognizing the importance of tobacco cessation on health, three of the Healthy People 2020 objectives address tobacco use in adults. Specifically, the objectives are to reduce tobacco use by adults (from 18.1 percent to 12 percent for cigarette smoking, from 2.3 percent to 0.3 percent for smokeless tobacco products, and from 5.4 percent to 0.2 percent for cigar use), increase smoking cessation attempts from 48.3 percent to 80 percent, and increase smoking cessation success from 6 percent to 8 percent.

In the most recent Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) on quitting smoking among adults, 68.8 percent of cigarette smokers expressed a desire to quit. However, only 48.3 percent of smokers interested in quitting received advice to quit smoking from a health care provider in the past year. This statistic points toward the need for increased training of health care professionals to assist patients with tobacco cessation attempts. The following sections of this article offer strategies and methods to incorporate when addressing the presence of tobacco use and formulating a patient-specific plan for cessation.

MOTIVATIONAL INTERVIEWING

Example scenario from practice

A patient presents to your pharmacy with instructions from his physician to start a nicotine replacement patch. He asks for your help with selecting the cheapest option and purchases a two-week supply. You provide counseling points for proper administration and use of the patch. When you ask the patient if he has any questions, he says "no" and thanks you for your help.

One month later, the same patient returns to your pharmacy for refills on his prescriptions. You remember your previous encounter with him, and ask how his cessation attempt has been going. The patient replies that he never started the patch because he "just isn't ready to quit." He says he knows the risks of smoking and the benefits of quitting, but feels overwhelmed by the thought of eliminating smoking from his life.

Recommendation

Offer to discuss the smoking cessation attempt with the patient if he has time, or schedule a time in the future. This patient has given thought to quitting, but still has personal concerns that need addressed. Utilizing the motivational interviewing techniques and core components detailed below, work with the patient to identify his personal motivators for quitting.

Explanation

"Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change."

A significant portion of health care professionals' time is devoted to conversations about behavior and lifestyle change. While these conversations often begin with the best of intentions, the manner in which they are conducted may not result in optimal outcomes. Motivational interviewing (MI) is a technique that serves as a constructive way to handle conversations involving the decisions, attitudes, and emotions that affect clinical issues. The essential goal of MI is to allow for change through tailoring the conversation to enable the patient to use his/her own values and interests to initiate and maintain the process.

Returning to the example scenario, this patient is in a state of ambivalence toward change. He is aware of the risks of continuing his behavior, as well as the benefits of quitting. However, he is struggling with losing a significant aspect of his lifestyle. Taking the time to explore this patient's thoughts and concerns for tobacco cessation may allow him to strengthen his self-perspective and motivations for behavior implementation. The interaction should be focused on the patient and his motivations for change. Implementation of the following strategies can be applied to MI encounters: expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy. Each of these five skills is described in more detail in Table 1.

Distinct from the common lecturing or monologue style found in many health care encounters, MI is a guided conversation that allows the patient to discuss and explore further his/her own motivation for change. Effective use of MI requires not only techniques to evoke change, but also encompassing the spirit of MI, which includes partnership, acceptance, compassion, and evocation. Partnership requires deviation from the traditional model of passive information being provided to the recipient from the expert, which is a common scenario in the health care setting. MI is done "for" and "with" the patient, as opposed to "to" or "on" the patient. Involving the patient as an active participant in the tobacco cessation discussion activates his/her motivation and resources for change, versus tricking the patient into change. The key to partnership in MI is to allow the patient to speak more than giving information or asking questions. This allows for the patient's full story and viewpoints to be expressed, versus superimposing the practitioner's viewpoints. Acceptance does not imply an approval of a patient's actions, but does involve a lack of judgment portrayal. This involves respect for the patient and active interest in understanding his/her perspectives and ultimate autonomy to make decisions. The compassion component of the spirit of MI involves advocating for the patient's well-being and prioritizing his/her own needs.

Table 1: Motivational Interviewing Principles

Skill	Example	Explanation
Express Empathy	"It sounds like you are very devoted to your marriage and children. How do you think your smoking is affecting your family?"	As part of expressing empathy, the pharmacist should ask open-ended questions to explore the importance of smoking to the patient as well as his/her concerns with quitting. Then, the pharmacist should employ reflective listening skills to seek a shared understanding with the patient. The example to the left illustrates a summarizing statement of what the pharmacist learned through his/her conversation with the patient.
Develop Discrepancy	"What I have heard so far is that smoking is something you enjoy. On the other hand, your wife hates your smoking and is worried about your health."	Highlight the difference between present behavior and desired lifestyle change. Patients are more motivated to change when they see that what they are doing will lead them to a future goal.
Avoid Argumentation	"I agree that quitting smoking is going to make your life more stressful."	Gently diffuse patient defensiveness. If you try to argue with a patient's point, it may create hostility. The goal of MI is to "walk" with the patient, not "drag" him/her.
Roll with Resistance	"You can see that there are some real problems here, but you're not willing to think about quitting altogether."	Rather than viewing resistance as a form of defiance, the pharmacist should consider resistance as the patient viewing the situation differently. Encountering resistance is a signal to the pharmacist to change direction or listen more carefully. Reframe the patient's thinking; invite him/her to examine new perspectives.
Support Self-Efficacy	"So you were fairly successful the last time you tried to quit."	Help the patient to identify and build on past successes. Provide hope and increase his/her self-confidence.

Evocation diverges from the standard education approach, which assumes knowledge or personal deficits that can be addressed through providing additional information. Evocation takes on the perspective that the patient has the knowledge, skills, and personal experiences to make the change, and that these inherent qualities need to be brought to attention. These four qualities encompass the spirit of MI and allow for achievement of the overall goal, which is identifying patients' pre-existing motivators for instituting the change process.

In summary, MI involves collaboration between a practitioner and patient to establish goals and identify individual motivators for change. When done correctly, MI should allow for strengthening of a patient's personal motivators for change, exploration of reasons for change, and development of commitment toward specific goals.

ASKING PATIENTS ABOUT THEIR SMOKING STATUS

Example scenario from practice

You are a pharmacist working within a primary care practice. Prior to an appointment for medication therapy management with an established patient of the practice, you review his past medical history, risk factors, and current medication regimen. You notice the patient has a problem of "tobacco dependence" listed in his chart; however, there does not seem to be a documented discussion of his use in previous office visits. When you discuss this with one of the physicians, he recalls that the patient has "smoked like a chimney for years" and is "a lost cause."

Recommendation

Patients may make the decision to quit using tobacco at any time, and having this topic addressed by all health care professionals can contribute to the discussion and potentially result in motivation to quit. Using MI techniques in coordination with questions about tobacco use can open discussion with this patient and may lead to positive lifestyle changes in the future.

TOBACCO CESSATION COUNSELING

Along with motivation interviewing tactics, an appropriate plan is also necessary for assisting patients with tobacco cessation attempts. Once the patient has identified his/her key motivators for quitting, development of a tailored, individualized plan is essential for cessation success and maintenance.

While the tendency at this point of the conversation for the health care professional may be to dive into a monologue detailing the detrimental health risk of tobacco use and treatment options, the likeliness of success will be increased by maintaining the key principles of motivational interviewing throughout the conversation. The two discussion techniques discussed below are tactics to address key areas in plan development while involving the patient actively in its design.

ASK, ADVISE, REFER (AAR)

The AAR process may be appropriate in situations with limited time or for patients who are not yet ready to fully discuss cessation. Step one of the three-step AAR model involves asking the patient about his or her smoking status. Some examples for opening this dialogue include:

"Please tell me about your tobacco use history."
"Do you ever smoke or use any forms of tobacco products?"

When a patient's response to the second question is "no," encouragement of continued abstinence is warranted. Another potential response could be a history of tobacco use, with current cessation. In this situation, it is important to identify the length of cessation. Patients that have been tobacco-free for less than six months are still in the "action" phase of their quit attempt and may need continued assistance to prevent relapse. For quit attempts that have continued for six months or longer, relapse prevention may still be warranted to ensure patients stay in the maintenance phase. Relapse prevention may not be required for patients who have been tobacco-free for many years.

If the patient answers positively for current tobacco use, utilization of open-ended questions can allow for additional information to be gained about smoking patterns, preferred product, and duration of tobacco use. At this point, it is appropriate to also ask if the patient has given any thought to tobacco cessation. If applicable, the discussion of worsening of current medical conditions or development of new conditions may also be relevant. An example of incorporating these discussion points in the conversation includes:

"High blood pressure is often caused or worsened by smoking. Have you given thought to quitting in the past?"

As a health care professional, the next step should involve advising the patient to quit. This information may or may not be something the patient is receptive to hearing. Examples of handling this next step in an attempt to avoid leading the patient to shut down or close the door to conversation include:

"I know you are aware of the health risks associated with smoking. Even occasional smoking can still be harmful. The best thing you can do for your health is to stop use of tobacco entirely. I am here to assist you now or in the future if you are ready to quit."

"Quitting smoking can be a difficult process; however, it is really the best thing you can do for your health and the health of those around you. If you are ready to quit, I am available to help you arrange a plan that works best for you."

If the patient is open to discussion at this point and time allows, a full discussion and design of treatment plan as appropriate can occur at this time. However, if time is limited or if the patient is unwilling to discuss cessation, referral to additional resources for the future is the next step. Referrals can be made to additional health care professionals for counseling services, community pharmacists for over-the-counter cessation aides, or to a behavior change program such as "1-800-QUIT-NOW." It may also be appropriate at this time to schedule a follow-up appointment with the patient to discuss cessation at a later date. Some examples to navigate this discussion piece include:

"It sounds like you have a busy schedule with the holidays coming up, and now may not be the best time for you to discuss a quit attempt. Would you be willing to discuss this further at an appointment in the next few months?"

"I know you have a busy schedule with working the night shift and that making appointments can be difficult. I am going to provide you with a national, toll-free quit line phone number if you decide this is something you would like to discuss on your own time in the future."

Following a referral recommendation, it is important to follow up with the patient to determine if he/she was able to take the next steps toward pursuing cessation. This may be completed through a telephone call or at subsequent appointments. The decision to quit may be made at any time, and addressing a patient's tobacco use is vital to increasing the likeliness of positive tobacco cessation outcomes.

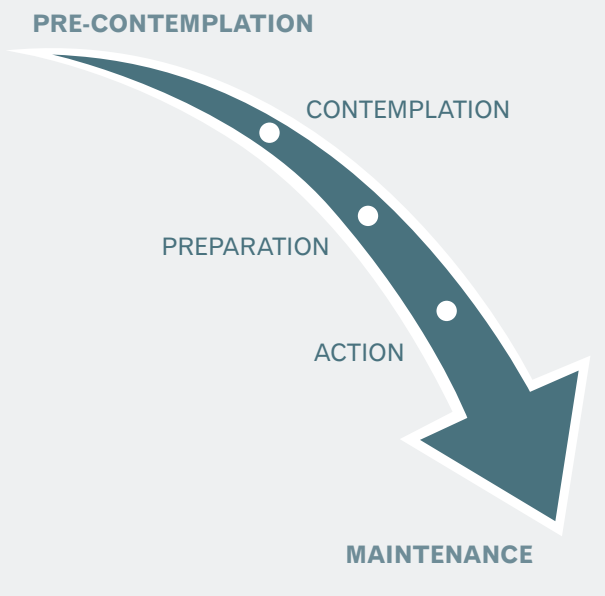
ASK, ADVISE, ASSESS, ASSIST, ARRANGE ("FIVE A'S")

If time allows during a patient encounter and the patient is open to discussing a cessation attempt, a more comprehensive approach may be taken to the discussion. The "Five A's" is a structured approach to tobacco cessation dialogue that includes the following elements: ask, advise, assess, assist, and arrange. The initial elements, "ask and advise," are also included in the AAR approach, and are addressed in the above section.

Once the initial steps of asking a patient about tobacco use and advising to pursue cessation are completed, assessing the patient's readiness to quit allows for proper guidance for the remainder of the conversation. During a smoking cessation attempt, or any type of change, it is essential to determine the stage of change a patient is in. The Transtheoretical Model (TTM) (Figure 1) integrates the stages of change with readiness to act toward a new behavior. Depending on the stage of change a patient is in, certain counseling approaches may or may not be appropriate to utilize.

Questioning the patient's readiness to quit within the next 30 days or next six months can provide information as to the current stage of change. For instance, if a patient is considering quitting tobacco use but is not ready to take action in the next 30 days or even in six months, the patient is still in a state of pre-contemplation. Pre-contemplation is categorized by the viewpoint that pros of continued tobacco use outweigh the cons of continued use. Patients may be aware of the health risks associated with tobacco use, but are not ready to think about quitting in the next six months. Patients who can see themselves quitting within the next six months but not as soon as 30 days are in the contemplation phase of change. Contemplation involves ambivalence, which is a simultaneous desire for two incompatible things. The contemplation stage is a common place for patients to remain in the change cycle. Patients in this phase know the benefits of tobacco cessation very well, but remain resistant to change due to various reasons, including fear of past failures, desire to keep things the same, or lack of confidence in their ability change. Motivational interviewing techniques are beneficial at both the pre-contemplation and contemplation stages and may be employed to progress patients toward readiness to quit.

Figure 1. Transtheoretical Model of Change



Example scenario from practice

(Part 1 of 2) You are a pharmacist conducting group tobacco cessation classes, which consist of five one-hour long sessions occurring once weekly. All members of the group enrolled voluntarily in response to an advertisement for the class except for one participant, Kevin Smith, who came to the class with his wife. The initial session of your course involves an introductory portion where each participant introduces him/herself and his/her reason for attending the class. All of the participants, not including the aforementioned man, express a desire to quit for various reasons. He states that he is attending the class because "his wife drug him here."

Recommendation

This patient is most likely in the pre-contemplation stage of change. Asking him about his readiness to quit in the next six months may provide a more accurate assessment of his current stage of change. If he is not ready to quit within the next 30 days and is truly just present because of his wife, he may still benefit from motivational interviewing techniques to explore his personal motivators toward quitting in the future. It would not be appropriate at this point to develop a cessation plan, as the patient needs to have a personal desire to quit.

Explanation

The goal for any stage of change a patient may be in is for progression to the final stage, maintenance, which involves

Table 2. Strategies for Stage of Change Progression

Stage	Do	Do not
Pre-contemplation	Strongly advise to quit Provide information Identify reasons for tobacco use Raise awareness of health consequences Demonstrate empathy Leave decision to patient	Persuade patient toward change "Cheerlead" Inform patient of detrimental effects in a judgmental manner Provide a treatment plan
Contemplation	Strongly advise to quit Provide information Identify reasons for tobacco use Demonstrate empathy and enhance motivation Encourage re-evaluation of concerns Offer encouragement	Persuade patient toward change "Cheerlead" Inform patient of detrimental effects in a judgmental manner Provide a treatment plan
Preparation	Discuss key issues Review methods for quitting Set a quit date Implement a tobacco use log Discuss coping strategies Offer assistance for quit attempt Congratulate patient	Fail to create a treatment plan Utilize a monologue approach to design of plan
Action	Evaluate the quit attempt • Slips or relapses • Support system • Triggers and withdrawal • Treatment utilized Encourage continued abstinence Congratulate successes	Convey judgment for slips or relapses Fail to follow up with patient
Maintenance	Evaluate status of quit attempt Assess medication adherence and determine a termination plan as necessary Continue to review relapse prevention and healthy lifestyle alternatives Congratulate successes	Assume a lack of risk for relapse Fail to address plan for medication discontinuation

permanent avoidance of the adverse health behavior. For our patient in the pre-contemplation phase, the goal is to use motivational interviewing techniques to assist him with identifying and exploring his personal motivators for cessation. Strongly advising him to quit is still appropriate, as is providing information that may be applicable to the patient, such as concurrent disease states that may be worsened by tobacco use. Opening the lines of communication through displaying empathy and providing contact information for referral if the patient becomes ready to quit can be useful if he decides to quit in the future. However, the choice is optimally up to the patient. Developing treatment plans, persuasion, or judgmental statements may turn him away from considering smoking cessation and make him less likely to utilize you as a resource in the future. Table 2 provides additional recommendations for progressing patients to the next stage of change.

Patients who can visualize themselves quitting within the next 30 days are said to be in the "preparation" phase of change. If a patient has expressed a readiness to quit in the near future, assisting with the quit attempt through the development of a treatment plan is critical to cessation success. At this stage, it is also important to address concerns the patient has for the upcoming quit attempt, such as weight gain and withdrawal symptoms. Non-pharmacologic coping strategies may be employed for use in development of the treatment plan, which will be discussed later in this article. Pertinent information to obtain from the patient includes current type(s) of tobacco product, amount of tobacco product, duration of use, and past quit attempts. Quantity of nicotine derived from the tobacco product currently in use is necessary to determine appropriate strengths and time of administration for nicotine replacement therapy (NRT), which will be discussed later in this article. Obtaining this information in advance can allow for optimal therapeutic decision making and preventing of suboptimal dosing, which is a frequent cause of treatment failure.

Information derived from past cessation attempts may also be useful to designing the treatment plan. Find out if past therapies have or have not been tolerated or successful for the patient. For treatment therapies that were not effective in the past, questions concerning the administration, dosing, and use of medication may allow for identification of inappropriate treatment use. Pertinent questions to ask in relation to past quit attempts may include number of quit attempts, most recent quit attempt, duration of attempts, and previous methods used. Pharmacologic and non-pharmacologic treatment options and strategies will be reviewed in this article.

Evaluation of a patient's quit attempt through follow-up allows for enhanced success rates over time. Patients who have been tobacco-free for less than six months are considered to be in the "action" stage of change, and are at risk for returning to tobacco use. An important discussion to have prior to and during the quit attempt as appropriate is the difference between a slip and a relapse. A slip is defined as a temporary return to a behavior, such as tobacco use. Having a slip may be a normal part of the quitting process, and does not imply that the individual has failed. Discussing the importance of not returning to the behavior following a slip may prevent a relapse, which involves a full return to the previous behavior.

A plan for follow-up that is convenient for the patient should be established during the "assist" phase and carried out during the final stage, "arrange." The ideal contact modality for follow-up may be unique to each patient and should be identified to allow for continuous and efficacious follow-up as necessary. Patient progress should be monitored during the first week of a quit attempt, as well as a second follow-up attempt within the first month. Patients are most at risk for slips and relapses during the first two weeks following a quit attempt due to heightened withdrawal symptoms. Having a support system in place and a plan to handle withdrawal symptoms may prevent a full relapse and increase the likelihood of success. For patients who have continued success with the attempt, congratulations are warranted and can contribute to sustained motivation to quit.

It is important to note that an individual can transition to any stage at any time. For instance, following a failed quit attempt (action), a patient may regress to contemplation or even pre-contemplation due to feelings of discouragement. The ultimate goal of a cessation attempt is to progress to and stay in the "maintenance" stage of change, which is defined as cessation from tobacco for six months or greater.

PHARMACOLOGY

Example scenario from practice

Mr. Jones, a 55-year-old male, is a patient of your pharmacy. He underwent stent placement for his coronary artery disease, and is coming to your pharmacy today to pick up his medication refills. You know that Mr. Jones quit smoking after his surgery, which was nearly three months ago, so you ask him today how it has been going. Mr. Jones responds with, "Awful! The patches didn't work at all, and I was completely miserable. I'm back to my old ways." He continues to tell you that he is currently smoking at least 25 cigarettes a day, and he smokes his first cigarette within the first 10 minutes of waking up. During his last quit attempt, he used 14 mg nicotine patches daily. Despite his failed attempt, Mr. Jones states that he is ready to quit again, but that he needs a "stronger" medication.

Recommendation

Nicotine replacement therapy patches 21 mg applied daily beginning on his quit date with nicotine replacement therapy gum 2 mg as needed to control cravings. In addition, recommend support for Mr. Jones during his quit attempt in the form of a smoking cessation group, telephone quit line, or other trained smoking cessation specialist.

Explanation

Evidence shows that a multicomponent approach of pharmacotherapy plus counseling is more effective than either alone in terms of long-term tobacco abstinence. Therefore, when appropriate, encourage all patients to utilize a form of pharmacotherapy in combination with counseling when quitting smoking. Pharmacotherapy is appropriate in most individuals; however, when selecting an agent, individual patient characteristics, such as preference, cost, and prior success should all play a role. Additionally, the pharmacist must also consider the patient's current smoking status (number of cigarettes, time to first cigarette upon waking, form of tobacco use), concomitant medications, and co-morbid medical conditions. Based on Mr. Jones' description of his quit attempt, it is clear that the 14 mg patches were inadequate in controlling his nicotine cravings. Mr. Jones can be categorized as a highly dependent smoker given that he smokes more than one pack per day (PPD) and smokes his first cigarette within 30 minutes of waking. At a minimum, he should have been using the 21 mg patches instead of the 14 mg patches.

The U.S. Public Health Service (USPHS) Clinical Practice Guidelines for Treating Tobacco Use and Dependence identify seven first-line medications for tobacco cessation. First-line medications are those that have been found to be safe and effective for tobacco dependence treatment and have been approved by the FDA for this use. These include five "nicotine medications" (gum, patch, lozenge, nasal spray, and inhaler) and two non-nicotine products, bupropion (Zyban) and varenicline (Chantix).

Nicotine replacement therapy (NRT) is the most widely used pharmacologic therapy for smoking cessation. The FDA first approved nicotine gum and patches as prescription products between 1984 and 1992, which were subsequently transitioned to over-the-counter (OTC) status between 1996 and 2002 based on research showing that they were safe for use without a prescription. The nicotine lozenge and mini-lozenge were approved directly for OTC use in 2002 and 2009, respectively. As the name suggests, these forms of therapy partially replace the nicotine formally obtained from smoking, with the intention to reduce the physiological and psychomotor withdrawal symptoms associated with smoking cessation. While most sources estimate that NRT roughly doubles the quitting success rate, one meta-analysis indicated that the long-term benefit of NRT may be modest, and that tobacco dependence should be viewed as a chronic, relapsing disorder requiring repeated episodes of treatment. Nicotine undergoes first-pass metabolism in the liver. As such, NRT products are formulated to be absorbed through the oral (gum, lozenge, inhaler) or nasal (nasal spray) mucosa, or through the skin (patch).

The nicotine patch is available in strengths of 21 mg, 14 mg, and 7 mg. It provides a slow, constant release of nicotine throughout the day. Patients who smoke 10 or more cigarettes a day should begin therapy with the 21 mg patch. Those smoking 10 or fewer cigarettes per day should begin with the 14 mg patch. Package labeling indicates that the first patch used (either 21 mg or 14 mg) should be used daily for six weeks, following which the patient would begin to taper down his/her dose by using each remaining strength(s) for two weeks. Recent research, however, suggests that smokers should consider using nicotine replacement therapy even more aggressively than package instructions recommend. In light of this and other mounting evidence, in 2013 the FDA modified product labeling with regard to duration of use and concomitant use with other nicotine products. The new labeling removes the statement of "stop using the [NRT product] at the end of [X] weeks" and replaces it with "It is important to complete treatment. If you feel you need to use [the NRT product] for a longer period to keep you from smoking, talk to your health care provider." In addition, previous labeling read, "Do not use if you continue to smoke, chew tobacco, use snuff, or use [a different NRT product] or other nicotine containing products." However, the "do not use" statement has been removed. Since NRT is delivering the same medication (nicotine) as cigarettes, without the added harmful chemicals, it is a better alternative to keep patients on these products longer if it will help them become successful in quitting smoking.

Two additional nicotine replacement therapy products available over-the-counter include the nicotine gum and lozenge. Both products are available in the U.S. in strengths of 4 mg and 2 mg, and are marketed in a variety of flavors. In addition, a nicotine mini lozenge is available in strengths of 2 mg and 4 mg. The primary difference between the lozenge and mini lozenge is the time they take to dissolve—approximately 20-30 minutes for the lozenge as compared to 10-13 minutes for the mini lozenge. In addition, the mini lozenge is marketed as being a more discreet method to smoking cessation contained in a smaller, more portable, and convenient package.

It is important that patients wishing to utilize these options understand their proper usage. The nicotine gum should be

used following the "chew and park" method. In this manner, the patient begins to slowly chew the gum which releases a peppery taste. When this occurs, the gum should be parked between the gums and cheek until the peppery sensation subsides. The patient would then repeat the process until most of the nicotine is gone (when the taste or tingle does not return). Each piece of gum lasts approximately 15-30 minutes. The nicotine lozenge is used by being placed in the mouth and allowed to dissolve slowly. It should not be chewed, crushed, or swallowed. Patients should be instructed to occasionally rotate the lozenge to different areas of the mouth. When using either the nicotine gum or lozenge, patients should be instructed not to eat or drink anything for 15 minutes prior to use, or while using the product. This is because acidic foods, such as coffee, juice, or soda, can alter the pH of the mouth and decrease absorption of the nicotine. Dosing for both the gum and lozenge is based on the "time to first cigarette" upon waking. If the patient smokes within 30 minutes of waking, they should begin therapy with the 4 mg dose. As with the nicotine patch, a tapering dose schedule is recommended with the gum and lozenge. For the gum, patients should chew one piece of gum every 1-2 hours for the first six weeks. After that, the time between doses is increased. At a minimum, patients should use nine pieces per day, but should not exceed 24 pieces per day. The nicotine lozenge follows a similar dosing schedule, one piece every 1-2 hours for the first six weeks, and a minimum of nine pieces per day. The difference is that the maximum number of lozenges per day is 20.

The last two forms of nicotine replacement therapy are available only by prescription and include the nicotine inhaler and nicotine nasal spray. The nicotine inhaler is not a true pulmonary inhaler, but instead deposits nicotine in the oropharynx, from which it is absorbed across the mucosa. While the inhaler was intended to assist with smoking cessation by leveraging the sensory/ritual components of smoking (handling and "puffing" on the inhaler), the proper dosing technique does not mimic the deep inhalation that many smokers associate with conventional cigarette smoking. One inhaler cartridge contains 10 mg of nicotine (and 1 mg of menthol), of which 4 mg of nicotine can be extracted and 2 mg are systemically absorbed. A single inhaler can be used for one 20-minute period of continuous puffing, or periodic use of up to 400 puffs per inhaler. Patients should use 6-16 cartridges per day. As the majority of the nicotine is delivered to the oral cavity, patients should refrain from eating or drinking 15 minutes prior to, or during, use with this product. The nicotine nasal spray contains an aqueous solution of nicotine (10 mg/mL). Each spray contains 0.5 mg of nicotine, and two sprays equal one dose (1 mg nicotine). Patients should begin therapy with 1-2 doses per hour, with a maximum of 40 doses per day. Each 10 mL bottle delivers 200 sprays per bottle (or 100 doses). Of all of the available cessation products, the nicotine nasal spray provides the fastest delivery and highest nicotine levels. For this reason, it is often the best choice for highly dependent smokers or those needing to control urgent withdrawal symptoms. Recommended duration of treatment with the nasal spray is three months. This is due to the potential dependence to this medication as a result of its speed of onset of action, greater capacity for self-titration of dose, and frequent and rapid fluctuations in plasma nicotine concentration.

Nicotine replacement therapy does not completely eliminate all symptoms of withdrawal because the available delivery systems do not reproduce the rapid and high levels of nicotine achieved through inhalation of cigarette smoke. For example, nicotine from cigarette smoking reaches the brain within 10 seconds of inhalation. Nicotine absorbed through the mucosa, such as by cigar or pipe smokers, is much slower. For these reasons, the type of tobacco product the patient is using should be taken into consideration when selecting a form of nicotine replacement therapy for cessation. Despite the differences in onset of action of the NRT products, studies have found all produced similar quit rates and were equally effective at reducing the frequency, duration, and severity of urges to smoke.

In addition to nicotine replacement therapy, two non-nicotine products are also considered first-line agents for smoking cessation. These medications, varenicline and sustained-release (SR) bupropion, work by differing mechanisms of action. Bupropion SR was the first non-nicotine medication shown to be effective for smoking cessation and was approved by the FDA for this use in 1997. Bupropion is an atypical antidepressant that inhibits the reuptake of dopamine, noradrenaline, and serotonin in the central nervous system. Although it is not entirely clear by which mechanism bupropion works as a smoking cessation aid, increases in these neurotransmitters is believed to play an important role due to the reductions that occur as a result of nicotine withdrawal. Bupropion SR therapy should be started prior to the patient's quit date. Dosing begins at 150 mg daily for six days, titrated to 150 mg twice daily for 7-9 weeks. Bupropion SR used for smoking cessation has a boxed warning for neuropsychiatric symptoms and suicide risk. The label states that serious "changes in mood (including depression and mania), psychosis, hallucinations, paranoia, delusions, homicidal ideation, hostility, agitation, aggression, anxiety, and panic, as well as suicidal ideation, suicide attempt, and completed suicide" have been reported.

Varenicline, which was approved in 2006, is the newest FDA-approved agent for smoking cessation. Varenicline is

a partial agonist of $\alpha_4\beta_2$ nicotonic acetylcholine receptors. This receptor type is believed to have the highest sensitivity to nicotine and is thought to play a mediating role in dopamine release. Like other partial agonists, varenicline has both agonist and antagonist effects. Binding at the receptor increases dopamine release, decreases nicotine cravings, and alleviates withdrawal symptoms (agonist effects). In addition, blocking of nicotine's binding at these receptors reduces nicotine-induced dopamine release and, consequently, its rewarding/reinforcing effects (antagonistic effects). Varenicline studies have shown improved cessation rates at study weeks 9-12, and follow-up weeks thereafter when compared to placebo and, in certain instances, bupropion SR. Psychiatric adverse events such as depression, anxiety, and suicidal ideation have been noted in clinical trials with varenicline and have been reported in postmarketing surveillance. Varenicline also carries a boxed warning for neuropsychiatric symptoms and suicidality. The label states "postmarketing reports have included changes in mood (including depression and mania), psychosis, hallucinations, paranoia, delusions, homicidal ideation, hostility, agitation, anxiety, and panic, as well as suicidal ideation, suicide attempt, and completed suicide" and that symptoms may appear as worsening of a pre-existing psychiatric disease or in patients with no history of psychiatric disease. However, other studies have found no increased risk of self-harm in patients treated with varenicline, and still others have postulated that patients attempting to abstain from smoking may already be experiencing anxiety and depression, and therefore be at a higher risk for suicidal ideation. Varenicline therapy should be started one week prior to the patient's quit date. Recommended dosing follows a one-week titration schedule of 0.5mg once daily for days 1 – 3, then 0.5 mg twice daily on days 4 – 7, culminating in 1 mg twice daily from day eight through the end of treatment.

Several combinations of over-the-counter and prescription pharmacotherapy smoking cessation aids can be safely used. According to the USPHS guidelines, effective combinations are as follows: long-term (more than 14 weeks) nicotine patch with another form of NRT (gum or spray); the nicotine patch with the nicotine inhaler; and the nicotine patch with bupropion SR. These three medication combinations have been shown to produce a significantly greater likelihood of maintaining long-term abstinence than the nicotine patch used alone. Only the nicotine patch plus bupropion SR has been FDA approved for combined use. However, as mentioned earlier, the FDA has removed labeling on OTC products that previously stated that combinations of the gum, patch, and lozenge could not be used together.

Guidelines currently do not recommend the combination of varenicline with NRT due to the antagonistic properties of varenicline which could increase the risk of adverse events. In a large, multicenter, randomized clinical trial that compared the combination of varenicline plus the patch versus varenicline alone, researchers found that varenicline plus the patch was associated with a higher abstinence rate at 12 weeks and at six months than the patch used alone. However, there was a higher incidence of adverse effects such as nausea, sleep disturbances, skin reactions, constipation, and depression in the combination therapy group. Another study tested the combination of varenicline plus bupropion versus varenicline alone. A randomized, double-blinded clinical trial showed that varenicline plus bupropion produced significantly higher prolonged abstinence rates at 12 weeks and 26 weeks versus varenicline alone. However, at 52 weeks the difference in abstinence rates was no longer significant. Furthermore, adverse events such as anxiety and depression were significantly more common in the combination therapy group than in the varenicline alone group. Therefore, this combination does not appear to be as effective as other approved combinations.

A summary of the first-line smoking cessation medications is provided in Table 3.

NONPHARMACOLOGIC

Example scenario from practice

(Part 2 of 2) During your group smoking cessation class, you ask each participant to share their experiences with quit attempts in the past. The majority of the patients reveal that they have quit at some point in their lifetime, for varying amounts of time. Each patient stated that they used various forms of NRT to control their cravings, yet every patient in the class relapsed for a variety of reasons—family members smoking, stressful life events, or health setbacks.

Recommendation

During this quit attempt, the patients need to focus on not only the physical symptoms of nicotine withdrawal, but on the social aspects as well. Lifestyle changes and nonpharmacologic smoking cessation strategies should be discussed during the class to equip patients with the tools they need to face various situations and to remain smoke-free.

Explanation

To assist patients in becoming smoke-free, the pharmacist should provide two specific types of counseling: supportive and practical counseling advice. Supportive counseling is a therapeutic approach aimed at facilitating optimal adjustment. This type of counseling can be provided by pharmacists, but may be best provided by those specifically trained in this

Table 3: Pharmacologic Treatment Options for Tobacco Cessation

Drug	Dosing	Administration	Contraindications	Counseling Points
Nicotine patch	• 21 mg for >10 cigarettes/day • 14 mg for ≤10 cigarettes/day • 7 mg used when tapering	• Apply 1 new patch daily • Remove patch at night and adhere a new one in the morning	• Caution with hypertensive patients	• Rotate application site • Do not apply on irritated skin • May cause vivid dreams • D/C use and contact health care provider if redness does not resolve within 4 days or if rash occurs
Nicotine gum	• 2 mg for <25 cigarettes/day • 4 mg for ≥25 cigarettes/day	• 1 piece every hr • Maximum: ≤24 pieces/day	• Caution with patients with peptic ulcer disease; may delay healing	• Use proper chewing technique (i.e., chew and park) • D/C if any jaw, teeth, or mouth problems occur • Do not eat or drink for 30 min before and during use
Nicotine lozenge	• 2 mg if first cigarette ≥30 min after waking • 4 mg if first cigarette <30 min after waking	• 1 piece every 1 to 2 hrs • Maximum: 5 lozenges/6 hrs 20 lozenges/day	• D/C if mouth problems, persistent indigestion, or severe sore throat occurs. • Consult medical provider for sodium restricted patients	• May cause unpleasant taste • Do not eat or drink for 30 min before and during use
Nicotine inhaler	• 10 mg per cartridge	• Inhale as needed (eg, every 1 to 2 hours) • Maximum: 16 cartridges/day	• May cause bronchospasms in COPD and asthma patients	
Nicotine nasal spray	• 0.5 mg per spray (10 mg/mL)	• Apply one spray into each nostril every 1 to 2 hrs • Maximum: 10 sprays/hr 80 sprays/day	• Avoid use in patients with chronic nasal problems (i.e. ,allergic rhinitis) • May cause bronchospasms in COPD and asthma patients	• Do not use for more than 6 months
Varenicline	• 0.5 mg tablet • CrCl <30 mL/minute: 0.5 mg /day; maximum dose: 0.5 mg twice daily • End stage renal disease: 0.5mg once daily.	• 0.5 mg/day for 3 days, then 0.5 mg twice a day for 4 days, then 1 mg twice a day	• Black Box Warning: Serious neuropsychiatric events have been reported with use • Caution with CVD; may increase major CV events	• Start 1 to 2 weeks before quit date • May be started up to 4 weeks prior to quit date
Bupropion SR	• 150 mg tablet	• 150 mg/day for 3 days, then 150 mg twice a day • Start 1 to 2 weeks before quit date	• C/I in seizure disorders, history of anorexia/bulimia • Abrupt discontinuation of ethanol or sedatives • Use of MAO inhibitors (concurrently or within 14 days of discontinuing either bupropion or the MAO inhibitor) • Patient receiving linezolid, intravenous methylene blue, or other dosage forms of bupropion	• May cause insomnia

field, such as those services provided through the quit line. Practical counseling is a form of problem-solving that involves generating solutions, evaluating, and selecting a solution.

One common strategy used to find ways to cope with triggers is "ACE: Avoid, Change, or Escape." In this strategy, the smoker identifies times when they would be most likely to smoke (such as in the car, during breaks at work, when drinking coffee, when socializing with certain friends, or in particular situations). One way to identify these situations is to have the smoker use a cravings or trigger journal. For at least one to two weeks before their quit date, the smoker could write down every time he/she craved or smoked a cigarette. He/she should note the time of day, intensity of the craving (on a scale of 1-10), if and how much he/she smoked, and any contributing factors. This journal can then help the patient identify his/her smoking and/or craving patterns. Once these high-risk behaviors are identified, the pharmacist would work with the patient on a plan to avoid the situation (such as certain social situations), change the circumstances (alter their routines), or escape (if put into the situation, a plan to remove themselves from temptation). A sample cravings journal can be found in Figure 2.

Having taught group smoking cessation classes for several years, the authors of this article wish to share some practical counseling tips that have been successful in helping patients avoid tobacco use in various situations.

Avoiding tobacco while driving in the car

- Ask the patient to take an alternate route to work.
- Remove ashtrays, cigarettes, and any smoking paraphernalia from the vehicle.
- On the patient's quit date, have the vehicle cleaned and/or detailed to remove smells of smoke; from this point forward, the patient and/or any passenger should not smoke in the car.
- Put the cigarettes in the trunk of the car so that they are not easily accessible.

Avoiding tobacco while drinking coffee

- Have the patient switch to decaffeinated coffee or tea.
    - Cigarette smoke is an inducer of CYP1A2, the pathway by which caffeine is metabolized. Smoke therefore increases the clearance of caffeine by 56 percent. Therefore, if a patient successfully quits smoking, continuing the same amount of caffeine intake can result in jitteriness, anxiety, palpitations, and other symptoms of increased caffeine. These symptoms may mimic or worsen the symptoms of nicotine withdrawal.
- The patient can have his/her morning coffee while in the car on the way to work.

Avoiding tobacco while talking on the phone

- Doodle while on the phone (to keep the hands busy).
- Use the hand you typically smoke with to hold the phone.
- Pace or walk while on the phone.

Avoiding tobacco while drinking

This is one of the most difficult situations for patients, as many associate smoking and drinking as two social activities that are done together. In addition, alcohol lowers the patient's inhibition, thus increasing the risk for a slip.

- Avoid drinking while quitting smoking.
- Switch to non-alcoholic drinks.
- Go only to smoke-free bars or restaurants, and avoid going outside for a smoke break. Ask a friend to help assist you in moments of weakness.
- If possible, include a non-smoker or friend also attempting to quit in your group when going out.

When employing practical counseling strategies, it is important to note that there is not a one-size-fits-all approach. Each solution must be individualized for the patient. One patient may be able to alter his/her routine in ways that another cannot. For example, a patient who typically smokes with his/her morning coffee may decide to switch to tea in order to break themselves of the routine. For another patient, giving up his/her morning coffee could be non-negotiable. Group settings, such as the one described in the scenario above, are a great opportunity to have patients help each other come up with ideas of ways to avoid triggers, manage cravings, and avoid slips and relapses. Often, patients have

Figure 2: Cravings Journal

	Craving Time	Intensity of Craving (1-10)	Cigarette?/Amount	Situation
1				
2				
3				
4				

been successful at quitting smoking before they experienced a relapse. Having them share what worked for them during their successful quit attempt may help another patient who is just beginning the quitting journey.

CONCLUSION

In summary, tobacco cessation is a difficult process that requires multiple, patient-specific interventions by various health care providers to motivate patients and ensure their success. This article touches on just some of the interviewing and counseling techniques that can be utilized in practice. While tobacco cessation is a difficult, and sometimes uncomfortable, topic to address, repeated interventions by health care professionals can result in higher patient quit rates. The authors, therefore, encourage all pharmacists to ask every patient about their tobacco use status at every visit utilizing the "Ask, Advise, Refer" method. This counseling technique takes minimal time but can significantly influence a patient's desire to think about quitting.

The authors encourage review of the current USPHS Clinical Practice Guidelines for a comprehensive representation of all recommendations for current and recent tobacco users. Copies of this guideline can be obtained through the Agency for Healthcare Research and Quality (www.ahrq.gov). In addition, health care providers wishing to gain additional training and experience in assisting patients with tobacco cessation should consider the Tobacco Treatment Specialist (TTS) training and certification course. This is an intensive training program available at various institutions throughout the country. A listing of accredited TTS training programs can be found on the Association for the Treatment of Tobacco Use and Dependence (ATTUD) website (www.attud.org). ■

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Continuing Education Quiz

Select the correct answer.

1. According to the most recent Surgeon General's Report regarding tobacco use patterns, which of the following best describes the status of tobacco use in the U.S.?
a. Higher number of current smokers than former smokers
b. First use of cigarettes is typically seen in patients over the age of 30
c. Most people use only one form of tobacco product.
d. While cigarette use is declining, e-cigarette use is increasing.

2. While over half of current smokers have a personal desire to quit, less than half report receipt of counseling from health care providers.
a. True
b. False

Questions 3-5 pertain to the following case:

3. A patient presents to your clinic to pick up her son's albuterol inhaler. She mentions that he seems to be using it more often and is concerned that it is due to her recent relapse and return to smoking. Her relapse resulted following a new, stressful job where most of her co-workers smoke. You respond, "It sounds like you enjoy smoking because it's a way for you to de-stress at work, yet you're concerned about the effects it's having on your son." You gave this response because it involves:
a. Rolling with resistance
b. Developing discrepancies
c. Partnership
d. Acceptance

4. As this patient has agreed to talk with you about her tobacco use status, you ask her about her previous quit attempt. She states she was successful for six months following instruction from her physician to begin nicotine patch therapy once daily. When questioned further about the encounter, she mentions that her conversation with her physician was brief, and involved lecturing on the negative health risks of tobacco use. She stated she felt as if she didn't have a say in the plan, but was nervous about the health risks described. Which of the following key characteristics of the spirit of motivational interviewing was not utilized in this encounter?
a. Rolling with resistance
b. Developing discrepancies
c. Partnership
d. Acceptance

5. The patient goes on further to state that the lecturing from her physician made her feel judged and ashamed of her habit. These feelings could have potentially been avoided by use of the following motivational interviewing spirit characteristics:
a. Rolling with resistance
b. Partnership
c. Expressing empathy
d. Acceptance

For questions 6 through 10, match the given definition to the most appropriate term. Answers may be used once, more than once, or not at all.

6. Advocating for the well-being and prioritization of patient needs

7. Acknowledging the skills, experiences, and knowledge patients already have

8. A brief process used to appropriately address and triage patients in need of cessation assistance

9. A stage of readiness to make a behavioral change within the next six months

10. A stage of change that calls for setting a quit date and development of a treatment plan
a. Ask, Advise, Refer (AAR)
b. Ask, Advise, Assess, Assist, Arrange (AAAAA)
c. Compassion
d. Contemplation
e. Evocation
f. Expressing empathy
g. Preparation

11. A 32-year-old man presents to your pharmacy with a question about over-the-counter nicotine replacement therapies (NRT). He is concerned about the cost of these agents, but his wife has been bothered by his smoking for years. He has given a great deal of thought to quitting the past few months and wants to quit in a month so he can start the new year smoke-free. This is his first quit attempt and wants more information about his options. Which of the following best represents the patient's current stage of change?
a. Pre-contemplation
b. Contemplation
c. Preparation
d. Action

12. To assist the patient in progression to the next stage of change, the following technique is most appropriate:
a. Provide an informational brochure on the benefits of smoking cessation
b. Use motivational interviewing techniques to explore his motivators for cessation
c. Refer him to the national quit-line and provide the phone number
d. Set a quit date and review treatment options

Questions 13-16 pertain to the following case:

Patient H.L. is a 42 year-old female who comes to the pharmacy to purchase nicotine replacement therapy. She has smoked 1-1/2 packs per day (PPD) for the past 21 years, but over the last two months has successfully cut down to nine cigarettes/day. She believes that she has reached a plateau with her quit attempt and needs additional help in the form of nicotine replacement therapy. Her goal is to be completely smoke-free by the end of the month (in two weeks). After talking more with H.L., you both agree that the nicotine patch would be the preferred product for her to use.

13. Which of the following is the proper dose and duration for the initial step therapy for H.L. with the nicotine transdermal patch?
a. Apply the 21 mg/day patch once daily for four weeks.
b. Apply the 14 mg/day patch once daily for six weeks.
c. Apply the 7 mg/day patch once daily for six weeks.
d. Apply one-half of the 21 mg/day patch once daily for four weeks.

14. Which of the following counseling points below would also be appropriate for L.H. regarding the nicotine transdermal patch?
a. The patch should be worn for 24 hours, but may be removed before bedtime if it causes insomnia.
b. The patch may be cut in half if she experiences side effects from excessive nicotine influx.
c. The patch should be applied every morning, and removed within 12 hours.
d. The patch should be placed in the same area each day to help increase absorption of the nicotine.

Patient H.L. returns to your pharmacy a week later. She states that the transdermal patch irritated her skin. You offer to show her other brands of the patch. However, she is not interested in trying the patch again. After talking with her friends, she tells you that she is now considering the nicotine gum.

15. What is the minimal number of pieces of the nicotine gum H.L. should use per day to prevent nicotine withdrawal symptoms?
a. 6
b. 9
c. 16
d. 20

16. When counseling H.L. on the proper use of the nicotine gum, which of the following is the most appropriate counseling tip?
a. Chew the gum until it tastes peppery, and then park it between the gum and cheek.
b. Do not eat or drink for at least 30 minutes prior to using the gum.
c. Chew the gum continuously while it tastes peppery, and then park it between the gum and cheek.
d. Do not eat or drink for at least 30 minutes after using the gum.

Please use the following case to answer questions 17-18.

Patient S.W. is a 51-year-old female who is admitted to the hospital due to complaints of exacerbated asthma and difficulty breathing. She currently smokes 1-1/2 packs per day, and drinks four cups of caffeine daily in the form of coffee. Current medications include salmeterol/fluticasone 250/50; lisinopril/hydrochlorothiazide 20/12.5 mg; metformin 1,000 mg; atorvastatin 80 mg; and zolpidem 10 mg.

17. S.W. is admitted to a non-smoking hospital. What type of nicotine replacement therapy would be appropriate for this patient to receive while in the hospital to help avoid nicotine withdrawal?
a. Nicotine transdermal patch 21 mg/day
b. Nicotine transdermal patch 14 mg/day
c. Varenicline 1 mg daily
d. Bupropion SR 150 mg daily

18. Which of the following statements regarding S.W.'s smoking cessation while in the hospital is true?
a. Cigarette smoke induces the metabolism of atorvastatin; therefore, her dose should be decreased when she is not smoking.
b. Nicotine withdrawal elevates blood pressure; therefore, her lisinopril/hydrochlorothiazide medication can be discontinued.
c. Cigarette smoke impairs the metabolism of zolpidem; therefore, the dose of zolpidem should be increased when she is not smoking.
d. Cigarette smoke induces the metabolism of caffeine; therefore, she should decrease her caffeine consumption when she is not smoking.

19. Which of the following medication combinations is FDA-approved for smoking cessation?
a. varenicline + nicotine gum
b. varenicline + nicotine inhaler
c. bupropion SR + nicotine patch
d. bupropion SR + nicotine nasal spray

20. Which of the following statements regarding varenicline is true?
a. Sleep disturbances such as abnormal dreams are a common adverse event.
b. Patients should be tapered off of varenicline when it is time to discontinue the drug.
c. The starting dose for varenicline is 0.5 mg twice daily.
d. Varenicline contains a black box warning due to its risk of serious nephrotoxicity.

21. Which of the following statements best represents a practical counseling approach?
a. "I hear you saying that you are used to handling a cigarette. Do you think that using a stress ball would help to keep your hands busy and avoid you from reaching for a cigarette?"
b. "On a scale of 1-10, how ready would you say you are today to quit smoking?"
c. "My best advice for you and your health is to quit smoking."
d. "Do you currently use tobacco products?"

Cigarette Diary	Time	Environment	Activity	Craving (1-10)	Notes
Monday					
1	7:35 a.m.	Home	Morning Coffee	9	
2	8:20 a.m.	Car	Driving to Work	6	
3	10:10 a.m.	Work	Smoke Break	5	
4	12:45 p.m.	Work	Lunch Break	6	
5	3:15 p.m.	Work	Smoke Break	4	
6	5:20 p.m.	Car	Drive Home	4	
7	7:00 p.m.	Home	After Dinner	7	
8	8:25 p.m.	Home	Watching TV	6	
9	9:00 p.m.	Home	Before Bed	8	Fight with husband
Tuesday					
1	7:20 a.m.	Home	Morning Coffee	9	
2	8:00 a.m.	Car	Driving to Work	7	
3 & 4	9:45 a.m.	Work	Smoke Break	10	Stressful meeting
5	11:15 a.m.	Work	Smoke Break	8	
6	1:00 p.m.	Work	Lunch Break	7	
7	2:10 p.m.	Work	Smoke Break	5	Went on break with friends
8	4:45 p.m.	Car	Driving Home	3	
9	5:35 p.m.	Home	Cooking Dinner	3	
10	6:15 p.m.	Home	After Dinner	6	
11	8:20 p.m.	Home	Watching TV	6	
12	9:10 p.m.	Home	Before Bed	4	

22. True or False: Practical counseling is a form of problem-solving that involves generating and selecting solutions.
a. True
b. False

Patient Case: Patient L.Y. is a 43-year old female who wishes to stop smoking. She has significantly cut down her smoking habits to approximately half a pack per day, but is still struggling to fully eliminate smoking. At your suggestion, she has kept a cravings journal for the past week. A two-day sample of her journal is shown above.

23. Based on L.Y.'s journal entries, what would be the best practical counseling recommendation at this time?
a. "It appears that your work friends peer-pressured you to smoke. You should avoid seeing these friends while you attempt to quit smoking."
b. "Your biggest nicotine cravings occur in the morning when you have your cigarette with your morning coffee. If you can give up this cigarette, the rest should be a breeze!"
c. "Looking at your journal, what do you feel is one cigarette a day that you can eliminate from your routine?"
d. "It appears that some of your lowest cravings times occur during your work smoke breaks. Can you go for a walk instead of smoking a cigarette during those times?"

▶ *Continued from page 16*

This month's issue of *America's Pharmacist* discusses helping our patients with smoking cessation. This is just one of many ways that you can become a health care destination for current as well as new patients. Many of you offer classes for patients with hypertension or diabetes. Consider partnering with a physician to offer classes in smoking cessation. You could bring in someone to teach a yoga class to show people a way to calm themselves when breaking their habit. By broadening the offerings in your pharmacy, you begin to position your store as a place that people can come to for more than just filling prescriptions and become a resource for health advice and support. ■

Liz Tiefenthaler is the president of Pharm Fresh Media, a full-service marketing company focused on helping independent pharmacies gain new customers and build loyalty with their current customers. She can be reached at liz@pharmfreshmedia.com.

Reader Resources

NCPA activities and our advertisers

▶ *Continued from page 12*

cate the public about a particular health topic such as allergies, skin cancer, or smoking cessation. To discuss sponsorship ideas, email ncpaF@ncpanet.org.

Scholarship Program: The NCPA Foundation takes great pride in supporting high-achieving pharmacy school students who dream of pharmacy ownership. The number of scholarships awarded annually is based on corporate sponsorship. Last year, more than $90,000 in scholarship aid was awarded to students with a demonstrated interest in independent ownership. Please contact ncpaF@ncpanet.org for sponsorship details.

Since 1953, the NCPA Foundation has preserved the legacy of independent pharmacy through programs to improve the success of independent pharmacy, community health awareness campaigns, scholarships to NCPA student members, and disaster aid and resources to help independents recovery as quickly as possible after an unexpected event. This is all made possible through donations from individuals and companies. I am grateful for the support of current donors and hope to bring new funding partners onboard over the next few months. ■

Donnie Calhoun, PD, is NCPA Foundation president and was NCPA president in 2013-14.

▶ *Continued from page 14*

The drug is available in 20, 40, 80, and 120 mg extended-release capsules.

Upon review of the medication error reports received by FDA, it is believed that the errors can largely be attributed to the drugs being approved and marketed within six months of one another. Both drug names begin with the letter F and end with the letter A, and are of the same length and number of syllables. Prescribers and pharmacists may choose the wrong item from computer screens. Furthermore, the container labels might appear similar since both display the proprietary name of the product in red font.

The Institute for Safe Medication Practices has added this name pair to the *ISMP List of Confused Drug Names* (www.ismp.org/Tools/Confused-Drug-Names.aspx). Consider adding computer alerts to verify the indication for these drugs. Prescribers should include the indication with prescriptions. Pharmacists should educate all patients before dispensing these drugs to confirm the indication. ■

This article is from the Institute for Safe Medication Practices (ISMP). The reports described were received through the USP–ISMP Medication Errors Reporting Program. Errors, near misses, or hazardous conditions may be reported on the ISMP website at www.ismp.org. ISMP can be reached at 215-947-7797 or ismpinfo@ismp.org.

Two Swans Taught Me to Love Cash

by Gabe Trahan

My first paying job was to feed two swans—not just any swans, these were royal swans, Sam and Betty. Local legend has it that the birds were given to the town of Swanton, Vt., by the Queen of England. During the summer, the town fathers paid me $25 a month in cash to feed the swans a blend of donated stale bread and slightly rotted lettuce. In the winter I was a pin boy for a local bowling alley, manually resetting bowling pins to their correct position, clearing fallen pins, and returning bowling balls to bowlers. I received 80 cents per string and dime tips from some of the players. Over the years, I advanced to mowing lawns, delivering newspapers, and waiting tables, all paying—you guessed it—cash. In the 1980s while managing drugstores, I co-owned a video store that rented movies and offered one-hour film developing, all cash sales. I miss easy cash sales. I'm sure you do, too.

So let's bring cash back! First, find 8-12 feet of merchandising space. In that space, assemble and display the following bath safety products: a shower bench without a back, a shower bench with a back, a transfer bench, a handheld showerhead, a dual tub grip, a bed pan, and an E-Z lock raised toilet seat with arms. Fill open space in your display with inventory ready to take home in its original retail box/packaging.

Next, set up a "Mobility Headquarters." The crown jewel of the headquarters will be a massive display of canes. Display signs throughout the store that read, "Let us size your cane so it fits perfectly for you!" An end-cap of reachers is also a nice way to add to your cash stash.

Even more cash ideas: If you are not already doing durable medical equipment billing, consider stocking front-wheel walkers with gliders and four-wheel rollators with padded seats and handbrakes (note: the best colors for rollator sales are dark blue, red, purple, and pink). Add accessories such as trays, colorful baskets, and bags for walkers. Additionally, bring in at least three lift chairs and display one size each of small, large, and extra-large chairs. Consider offering free curbside delivery for chair purchasers or charging for in-home chair set-up and delivery. If you sold one lift chair a month, you would be making more cash than you would by filling 50 statin drug prescriptions ….and you wouldn't have to wait to get your cash. Good luck, and don't forget the signs!

P.S.—I cared for Sam and Betty when I was 12. I bought my first pair of red Converse sneakers with my first paycheck. I'm 60 now, still have a pair of Chuck Taylors, and Sam and Betty are still returning to Swanton every summer. ■

Gabe Trahan is NCPA's senior director of store operations and marketing. Gabe uses 30-plus years of front-end merchandising experience to help NCPA members increase store traffic and improve profits. Visit www.ncpanet.org/feo to watch videos, read tips, and view galleries of photo examples by Gabe. Follow him on Twitter @NCPAGabe for additional tips.

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