

america's

OCTOBER 2006



Published by the
National Community
Pharmacists Association

PHARMACIST

THE VOICE OF THE COMMUNITY PHARMACIST

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america's PHARMACIST

Published monthly by the National Community Pharmacists Association

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America's Pharmacist Volume 128, No. 10 (ISSN 1093-5401, USPS 535-410) is published monthly by the National Community Pharmacists Association. Editorial and executive offices: 100 Daingerfield Road, Alexandria, VA 22314-2885, 703-683-8200.

Periodicals postage paid at Alexandria, VA, and other mailing offices.

Postmaster: Send address changes to *America's Pharmacist*, 100 Daingerfield Road, Alexandria, VA 22314-2885.

Annual subscription rates: \$50 domestic; \$70 foreign; and \$15 NCPA members deducted from annual dues.

For membership information, send an e-mail to: membership@ncpanet.org.

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NCPA® represents the nation's community pharmacists, including the owners of more than 24,000 pharmacies. The nation's independent pharmacies, independent pharmacy franchises, and independent chains represent a \$92 billion marketplace, dispensing nearly half of the nation's retail prescription medicines.

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Looking Back, Looking Ahead

Pharmacy has traveled far since our convention in Fort Lauderdale, Florida, last year. Community Care RxSM (CCRx) closed the books on a successful Medicare discount card program, and we all jumped into the great unknown with the Part D drug benefit.

For far too many pharmacies and patients, January was a nightmare. It was no comfort knowing that NCPA had fought Part D. Independent community pharmacists once again put their Medicare patients ahead of their own interests and got them their medicines.

January also saw Congress give final approval to Medicaid cuts that could cost community pharmacies \$6.3 billion over four years. Our extensive efforts on Capitol Hill against those short-sighted cuts provoked President Bush to attack "prescription drug pharmacists," accusing them of overcharging Medicaid through "inflated markups...inflated prices."

NCPA President Jim Rankin wrote President Bush that to attack community pharmacists "as profiteering from the Medicaid program is as ludicrous as it is insulting." Jim, thank you for your defense of our profession and all that you've done for it and NCPA this year.

In the spring, NCPA launched the Asthma Intervention Program, a pilot project designed to see if independent pharmacists could identify patients with uncontrolled asthma and help them control it through medication therapy management (MTM). The answer is, "Yes, they can."

Programs like that now can be run through our subsidiary Community MTMSM (CMTM), a Web-based communications platform. CMTM's first client is our own CCRx. So now, after years of talking about it, MTM run by and for pharmacists is a reality. We must seize this opportunity and make MTM work for patients, payers, and our profession.

We've also made unprecedented strides in coalition-building. We collaborated with America's Health Insurance Plans and the National Association of Chain Drug Stores (NACDS) to simplify and standardize the electronic claims processing messages from prescription drug plans to community pharmacies.

NCPA worked closely with both those organizations and the Centers for Medicare & Medicaid Services on formation of the Pharmacy Quality Alliance, which will try to develop quality criteria that will help move pharmacy closer to a model where it is rewarded for not only dispensing medications to patients but for ensuring that they are the most appropriate for the patient's condition. This could be the paradigm shift that moves community pharmacy into a new business model.

Finally, there is our joint effort with NACDS to forge the Coalition for Community Pharmacy Action. You can read more on page 76 about this historic development to have 55,000 community pharmacies speak with one, strong voice.

Bruce Roberts, PD
NCPA Executive Vice President & CEO

Praise Is Welcomed, Support Is Valued More

Once again, Health and Human Services Secretary Mike Leavitt had some kind words for community pharmacists. Writing in the Secretary's Progress Report IV on the Medicare Prescription Drug Benefit, recently Leavitt says:

"In many respects, pharmacists are the untold heroes of the successful implementation of Part D. Beginning at midnight on January 1, they were available for Medicare beneficiaries filling prescriptions; answering questions; enrolling beneficiaries in plans that were right for them; and working through billing problems. We have worked with the plans, and will continue to do so, to ensure that legitimate concerns that pharmacists have expressed related to timely payment and other billing issues are resolved promptly."

In the first such "progress" report in February, Leavitt also praised community pharmacists for their support during the drug benefit's first hectic month. "The efforts of pharmacists over the last month have been nothing less than heroic," he said. "I've visited with and heard from pharmacists all over the country. They have been selfless, compassionate, and committed to service."

In addition, Mark McClellan, administrator of the Centers for Medicare & Medicaid, said many nice things about pharmacists this year. Speaking at NCPA's annual legislative conference

in May, he said: "One thing that's been clear over the months that have passed since I last spoke with you—and especially since January 1—is that pharmacists have been tremendous partners. Among the tens of thousands we forged to launch this benefit effectively, no partnership was more important than this one."

Well, if the secretary and the administrator would express support for prompt payment legislation currently pending in Congress, such as H.R.2582 and S.2563, it would be greatly appreciated.

Prescriptions Not Filled, Not Taken

More than one-third of all patients do not fill every prescription they receive, and the non-fill level for some conditions was nearly half, according to a study by Wilson Health Information and the J. Scott Group.

"While 65 percent of study respondents reported that they did fill all prescriptions received, the percentage is misleading as an indicator of compliance in that 65 percent [of those] did not comply with prescriber directions, either not taking all of

Reasons For Not Filling	
Patient-perceived lack of need	42%
Too costly	27%
Changed by physician	20%
Concerned with side effects	17%
Insurance did not cover	16%
Used OTC instead	8%
Forgot to fill	4%
Other	13%

Filled, Directions Not Followed	
Forgot to take	79%
Ran out of Rx	19%
Too costly	9%
Patient-perceived lack of need	9%
Side effects	7%
No improvement seen	3%

Totals more than 100% due to multiple mentions

the medication, or not taking as directed, the study said.

The study of 32,000 patients identified the non-fill level for 55 diseases or conditions. For about 14 of them, including depression, anxiety, migraine, and ulcers, the non-fill level was roughly 50 percent. (See box above.)

Taxonomy Code Changes Will Aid in Pharmacist Care Billing

The Pharmacist Services Technical Advisory Coalition

(PSTAC) has gained important revisions in the Health Care Provider Taxonomy Code List for Pharmacy Service Providers and Pharmacy Suppliers that will help pharmacists bill for patient care services.

The Code List is a set of unique alphanumeric codes, 10 characters in length, that describes the types of patient care services provided by health care providers and is structured into three distinct "Levels," including Provider Type, Classification, and Area

Independent Pharmacy Today

Service-Oriented, Job Creators

A wide range of patient services distinguish independent community pharmacies from their competitors. The top services offered last year were delivery (88 percent), nutrition (88 percent), charge accounts (84 percent), durable medical equipment (74 percent), compounding (68 percent), and herbal medicine (63 percent). Independent pharmacies create jobs, too.

The average independent employed 12.8 full-time equivalent (FTE) employees in 2005 with 2.8 FTE pharmacists, including the owner. The average independent also employed 4.3 FTE pharmacy technicians. In 2004, the FTEs were 9.8 (2.3 pharmacists and 3.6 technicians).

Source: 2006 NCPA-Pfizer Digest

of Specialization.

PSTAC was founded in 2002 by NCPA and six other national pharmacy associations to improve the coding infrastructure necessary to support billing for pharmacists' professional services.

IACP Establishes Grassroots Group

The International Association of Compounding Pharmacists has launched Patients and Professionals for Customized Care (P2C2), a grassroots organization designed to mobilize patients, physicians, pet owners, veterinarians, and others who rely on compounded medicines. P2C2 is being driven by a host of online activities conducted via its Web site, www.SaveMyMedicine.org.



Members receive a monthly newsletter and also get periodic action alerts when issues arise. P2C2 is using online advocacy tools to enable members to write letters to their members of Congress, the Food and Drug Administration, and media outlets. The site is also collecting patient and prescriber testimonials. □

THE AUDIT ADVISER

Audit Flag: Insulin

Q: Doctors write insulin prescriptions "as directed" and third-party auditors are interested in how many vials of insulin my patients receive. How do I protect myself in an audit situation?

A: Patients receiving two or more vials of insulin per month may create an audit flag that will result in an audit. While it is possible for a patient to use large amounts of insulin, third parties view two or more vials as unusual.

Instead of using "As Directed" for directions, obtain detailed

Inside Third Party

Eye on PBMs

Every month, *America's Pharmacist* highlights an example of PBM abuse of the nation's independent community pharmacies. These transgressions not only hurt our business and our profession, they negatively affect our patients, their employers, and our local economies. E-mail a recent example of a problem you've had with a PBM to mike.conlan@ncpanet.org, or fax it to 703-683-3619. We may edit it for length and clarity.

(Editor's note: The following is a response from NCPA Executive Vice President and CEO Bruce Roberts, RPh, to a charge by giant PBMs that prompt payment legislation would cost taxpayers \$55 billion over 10 years.)

PBM Delays, PBM Gains

It is not surprising to see the Pharmaceutical Care Management Association (PCMA), the lobby group for seven multi-billion dollar corporations, attack H.R.5182, the Fair and Speedy Treatment (FAST) of Medicare Claims Act of 2006. H.R.5182, introduced by Reps. Walter B. Jones (R-N.C.) and Marion Berry (D-Ark.), is the most comprehensive approach now under consideration in the U.S. House and Senate, to address some of the problems caused by the Medicare Part D prescription drug benefit that went into effect on January 1.

These problems include slow reimbursement to pharmacists by the pharmacy benefit managers (PBMs) and low reimbursement rates to pharmacists for cost-saving generic medications. The shortcomings of the Part D program seriously threaten patient access to community pharmacies in the United States and have resulted in these small businesses waiting for an average of \$60,000 in Part D claims from the PBMs.

For the record, PBMs are the largely unregulated drug middlemen that administer the prescription drug benefit of health insurance plans for private companies and governments. Although PBMs originated as companies providing a useful claims processing function, each of the three largest PBMs now owns its own mail order drug company and attempts to drive as many beneficiaries as possible away from local pharmacies and into its self-owned mail order warehouses.

Mail order is more profitable for PBMs,

because they cut side deals with drug manufacturers for additional discounts for brand name drugs and use different reimbursement schedules to pay themselves compared with what they pay retail pharmacies. The savings from these discounts are kept by the PBMs and not passed on to the insurance plans or their beneficiaries. In fact, numerous lawsuits have been filed, and millions of dollars in settlements have been ordered because of these fraudulent business practices. Dozens of investigations into PBM practices are ongoing.

Simply put, PCMA opposes provisions of H.R.5182 that would require PBMs to reimburse pharmacists in a more timely manner on their Medicare claims because they make millions of dollars by delaying payments to pharmacies. H.R.5182 would require PBMs to extend the same electronic fund transfers most PBMs provide large chains and others to small business pharmacies.

PCMA also opposes a key element of the bill that would increase the percentage of generic medicines dispensed, saving Medicare billions of dollars. Data from a 2003 NDCHealth study show that community pharmacies dispense cost-saving generics at least 46 percent of the time, compared to a 30 percent generic dispensing rate for mail order. CMS data also shows that the average brand name prescription costs \$110 and the average generic prescription costs \$20. The efforts of the giant PBMs to keep generic dispensing rates low for community pharmacists generate millions of dollars for their corporations but costs taxpayers hundreds of millions of dollars because it decreases the percentage of generics dispensed.

Numerous studies have shown that, given the choice, patients prefer their local pharmacy over mail order. NCPA strongly opposes efforts by the PBMs to commoditize the prescription benefit and eliminate the important face-to-face relationship between patients and their local community pharmacist by coercing patients into mail order delivery of their prescription medications.

PCMA has every right to try to protect the seven corporations it serves who must answer to Wall Street and their shareholders. However, NCPA will stand with patients, community pharmacists, and the American taxpayer. H.R.5182 currently has more than 140 bipartisan cosponsors.

information on dosing parameters. Remember to accurately calculate and transmit the correct days supply. You can bet that an auditor will select "As Directed" prescriptions for multiple vials of insulin to view during an onsite audit. If the amount of insulin your pharmacy dispensed for a patient is justified by the documentation on the hard copy prescription, you should not have a problem. If all of your insulin prescriptions state "As Directed" expect aggressive challenges from the third party.

By H. Edward Heckman, R.Ph., PAAS National, the Pharmacy Audit Assistance Service. For more information call toll free to 888-870-7227.

NEW INDEPENDENT PHARMACIST

NCPA Summer Internship Provides Wide Range of Opportunities

By Charles Hartig

Internships play a vital role in pharmacy and provide the opportunity for students to grow professionally. They provide hands-on training and learning, and are of exceptional value to any future pharmacist.

In many cases, as another pharmacy school year closes, students across the nation go to work at a local hospital or retail pharmacy as interns. However, there are some positions outside the norm of traditional pharmacy settings, including the professional opportunity of a lifetime I had this past summer, working at the National Community Pharmacists Association headquarters in Alexandria, Virginia.

At NCPA I managed a laundry list of projects, and was able to examine and assist many specialty pharmacy interests I didn't know existed. Some of these projects are listed as follows:

- Reviewing cost of dispensing studies to assist with analysis of different methodologies and measurements of cost in the retail pharmacy setting
- Surveying individual states on the number of closures of independent pharmacies to assess the impact of Medicare Part D
- Planning the Young Pharmacists Focus Group at the 108th Annual NCPA Convention and Trade Exposition
- Writing medical education grants to several large pharmaceutical companies
- Researching and writing a

Medicaid frequently asked question (FAQ) document to be distributed to pharmacists nationwide

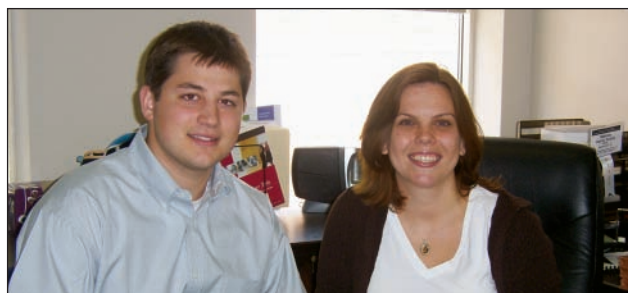
- Attending the Drug Enforcement Agency hearing on e-prescribing of controlled substances
- Attending the U.S. Pharmacopeia meeting on sterile and non-sterile compounding standards
- Attending the NCPA legislative conference and meeting with congressmen over a three-day period
- Implementing and updating an ownership resources map as an independent owner Web tool

Unlike a menial office job or an internship abundant with counting tablets and capsules, I was able not only to utilize clinical knowledge of pharmacy, but also to apply a practical creative aspect of pharmacy knowledge. Working to establish the Young Pharmacist Focus Group, I was able to use non-clinical skills in developing a letter, survey, meeting agenda, and many essential convention tasks. Grant writing is a unique opportunity for many pharmacy students. Assisting in the writing and reviewing of hundreds or thousands of dollars in grant money is a job not usually left to an intern.

NCPA is a stone's throw from Washington, D.C., and with the office nearby, the opportunity to attend meetings with lawmakers, government agencies, and other health care organizations provided hands-on experience about the inner work-

ings of the nation's capital.

Another appealing aspect about the NCPA summer internship was the flexibility available to tackle any projects of interest. These were all approved through preceptors and other pharmacists to fit the scope of a variety of pharmacy-related issues. My preceptor, Stacey Swartz, PharmD, allowed me to see long-term projects come to fruition. My presen-



Charles Hartig and his preceptor Stacey Swartz, NCPA director of management and educational affairs.

tations and projects were utilized throughout NCPA, and my opinion as a future pharmacist was valued.

Along with the professional benefits of working for NCPA, I was able to gain many personal experiences from the internship. Living in downtown Washington D.C. and taking advantage of the numerous national historic sites/monuments is a simple task. The city also has an active nightlife. Summer in Washington is filled with interesting events and people.

All of the pharmacy organizations in the D.C. area assist in the spirit of professional interest and personal experience when they group pharmacy interns and rotation students together while giving them

a tour of each respective pharmacy organization. Visiting the national pharmacy associations (including NCPA, the American Pharmacists Association, the American Society of Health-System Pharmacists, the American Society of Consultant Pharmacists, the Academy of Managed Care Pharmacy, and the National Association of Chain Drug Stores) was fun and interesting, fostering intern communication and camaraderie. The intern tours

allowed each person to get a sneak peak into each other's work environment.

Last summer I learned so much and had more fun than I ever thought a pharmacy internship could allow. I was able to work on a multitude of issues. Working for NCPA allowed me to look at pharmacy in a new holistic sense, which I am sure will assist me in my future endeavors.

If you are interested in an out-of-the-box experience, I encourage every student to look into non-traditional internship roles in pharmacy. □

Charles Hartig is a 2009 PharmD candidate at the Drake University College of Health and Sciences.



The New Independent for pharmacy students is supported with a grant from the NCPA Foundation.

Confused in Translation

We know verbal and telephone orders can be problematic for practitioners (prescribers, nurses, pharmacists), but have you ever thought how dangerous this practice can be when patients are on the receiving end? It is not uncommon for patients to receive verbal or telephoned instructions from practitioners about how their medications should be taken. Unfortunately, as practitioners, we often do not consider how difficult it may be for patients to listen to, comprehend, transcribe, and retain important and vital medication information.

In a recent report to the Institute for Safe Medication Practices, a patient described how her symptoms and misunderstanding of her physician's instructions resulted in taking twice the intended dose of Levoxyl (levothyroxine) for several weeks. After feeling lethargic and irritable for a few weeks, the woman notified her physician. The physician ordered lab work to confirm that her symptoms were related to low thyroid levels. During an office visit to review the lab work, the physician explained that her thyroid levels were low and that he needed to increase her dose of Levoxyl to 175 mcg daily. He also mentioned that if she was still symptomatic after a period of time, they could double the dose occasionally to get her levels back to normal. (What he meant was that she might need to take an additional 175 mcg once or twice a week.)

After taking the Levoxyl as prescribed (175 mcg daily) for one week, she was still symptomatic and feeling terrible. She then "remembered" what her physician had said in the office

about doubling the dose if she still had symptoms. She then began taking two tablets (350 mcg) daily. Several days later, she tried to contact her physician to verify that this was correct, but found out that he was away for two weeks, so she continued to take 350 mcg daily. Her doctor discovered the error three weeks later after she became increasingly sick with nausea,



vomiting, lightheadedness, and fever.

In her report, the patient noted that "some patients experience confusion when hearing so much information at once" and that "it's too hard to write everything down and listen at the same time." To reduce confusion, she recommended that "doctors should write things down on a notepad for the patient to take home with them."

Since patients may misunderstand medication information for any number of reasons, we should do our best to minimize the potential for confusion. Consider the following when communicating medication information to patients:

- Speak slowly and clearly. Be cognizant of language barriers.
- Provide printed information for the patient to take home and emphasize important dosing information.
- Always describe the patient's dose in metric weight first (i.e., mg), and

then provide instructions regarding the number of tablets needed for each dose as well as when to administer each dose.

- Avoid using the instructions "as directed" on prescriptions, as patients may not recall how to take the medication when they get home.
- When telephoning patients with instructions, ask them to: (1) retrieve a pen and paper before giving any dosing changes; (2) write down the date and the information as received; and (3) read back the dose and instructions to verify understanding. Advise the patient to keep the dated instructions with the prescription bottle for reference since the directions on the prescription bottle may differ from the new administration directions.
- To prevent future confusion, prescribers should send a prescription to the patient with the new instructions or contact the patient's pharmacy with the new instructions and refill information. □

This article has been provided by the Institute for Safe Medication Practices (ISMP) and has previously appeared in the ISMP Medication Safety Alert! Community/ambulatory Care Edition. This e-newsletter is a monthly compilation of medication-related incidents and error-prevention recommendations designed to inform and alert community pharmacy practitioners to potentially hazardous situations that may affect patient safety. Individual subscription prices are \$45 per year for 12 monthly issues. Discounts are available for organizations with multiple pharmacy sites. For more information contact ISMP at 215-947-7797 or e-mail to community@ismp.org.

Building an **INDI**

A unique cooperative program continues to strengthen and grow independent community pharmacy ownership in South Carolina

By Jennifer L. Baker, PharmD



▲ Dawn Perry, PharmD (center), cuts the ribbon at the grand opening of her business, Lake Carolina Pharmacy, in Columbia, South Carolina.

DEPENDENT

Foundation

Marla Bilton-Westbury's calling into independent pharmacy ownership came through a tragedy in the little town of St. George, South Carolina, about 40 miles northwest of Charleston. Until the first half of last year, three busy pharmacies served the 2,100 residents and surrounding communities. Two of these pharmacies, run by independent owners and located next to each other in the small downtown, were lost to ruinous fires. Those losses left a hole in patient care services, and the community turned to a new practitioner raised in St. George who had returned home after pharmacy school to raise her own family and serve the community.

"After the devastating fire in town, I knew that it was my duty to build a new pharmacy for the citizens in my town," says Westbury, a 2002 PharmD graduate of the University of South Carolina College of Pharmacy. "Unfortunately, I did not know where to begin. The South Carolina Pharmacy Association introduced me to the Community Pharmacy Institute program."

In 2004, the South Carolina Pharmacy Association (SCPhA), along with the Carolina Pharmacy Network (CPN), the association's organization for independent pharmacies, and with support of wholesaler partners, created the Community Pharmacy Institute, where tomorrow's pharmacy entrepreneurs can obtain hands-on management skills to successfully run their own independent community pharmacy. Program funding has come from current CPN wholesaler partners Smith Drug Co. (Spartanburg, South Carolina), and King Drug Co. (Florence, South Carolina).

The full-time program takes pharmacists licensed to practice pharmacy in the state who wish to become owners, and teaches them the foundation of skills necessary for survival as a small business. This goal is achieved through three key

components: practical experience, completion of a self-paced pharmacy management course, and business/professional networking. At the program's conclusion, the pharmacist commits to becoming a pharmacy owner or junior partner in a new or established independent pharmacy in South Carolina, and an active member of the CPN.

Richard A. Jackson, PhD, professor and director of the Center for Community Pharmacy Practice and Research at the Mercer University Southern School of Pharmacy in Atlanta, regularly meets with the resident pharmacist to review projects and discuss coursework. Jackson believes that good financial management enables a pharmacy to expand pharmacy care services.

"What is lacking in some people's thoughts is that the business and clinical components of pharmacy are conflicting, when in fact they are synergistic," Jackson says. "A pharmacy owner who is a business success can well afford to provide an abundance of needed clinical services. Likewise, providing needed clinical services can contribute significantly to the pharmacy's business success."

Dawn M. Perry, PharmD, was the first pharmacist to participate in the CPN Community Pharmacy Institute. At the end of 2005, Perry opened Lake Carolina Pharmacy in a planned community in northeast Columbia, South Carolina. Perry says she faced challenges in the actual building of the pharmacy and learning to manage her new business' cash flow, but feels she is prepared to run a successful business with the tools she gained from the Institute.

Perry is quickly approaching the first anniversary of her pharmacy and is satisfied with the progress she is making. In Westbury's case, one of the two pharmacies decided not to rebuild, and the other pharmacy has been working out of a trailer for more than a year on the ground where its store once

stood. After being approached by many people within the community, Westbury decided she would open a family pharmacy to meet the now underserved population of St. George. Overflowing with compassion for her hometown and her profession, she is prepared to meet the challenges of community pharmacy service and ownership. However, recognizing the need to survive as a business owner, she turned to the SCPhA to develop the necessary financial skills.

The Prescription Center in Charleston, South Carolina, served as the practice site for the program. Owner Mel Rauton, RPh, also the 2006-07 SCPhA president, served as her preceptor. The pharmacy has a prominent place in historic downtown Charleston; Rauton became owner of the store through a junior partnership and was able to provide much insight into his own challenges.

Westbury worked at the pharmacy three days a week sharing the progress and findings of her projects, and discussing what she learned in her management course. Several of her projects benefited the Prescription Center, as it received a “free” analysis of its business operations and plans as part of the resident’s work. Rauton is actually using the information gathered in these projects as he plans for the future of his pharmacy. These projects included:

- Developing a marketing plan for a pharmacy site
- Determining an equitable selling price and plan to buy into a business as a junior partner
- Performing a financial analysis of a pharmacy practice site
- Performing a cost-to-dispense analysis
- Analyzing a third party plan

Westbury’s primary project focused on her ownership aspirations by developing a business plan and completing a loan package for the new pharmacy she plans to open. Westbury says that in addition to basic financial skills, the most important thing she gained through this experience was the networking contacts.

“I will be forever grateful to Mel Rauton for all of his



“I can honestly say that the program has changed my life. Not only has it provided me with basic management skills, but it has also given me the confidence to know that I will be able to own and operate an independent pharmacy and fulfill my dreams.”

— Marla Bilton-Westbury

‘been there-done that’ advice, and Richard Jackson’s wisdom and patience as we worked through my business plan,” says Westbury, who has previously worked for both chain and independent pharmacies. “I can honestly say that the program has changed my life. Not only has it provided me with basic management skills, but it has also given me the confidence to know that I will be able to own and operate an independent pharmacy and fulfill my dreams.”

In the fall of 2006, Westbury will break ground to build Westbury Pharmacy, just a few blocks from the site of the previous independent pharmacies. Located on Main Street, her pharmacy will serve as a place to receive excellent health care and interact with the community. Rocking chairs will be placed out front as an invitation to all to feel at home.

“It was very rewarding to hear her say at the end of the program, that unlike at the beginning, she now feels confident to be a pharmacy owner. She now has the tools, but she already had the will to succeed. There is something to that old axiom that knowledge is power,” Jackson says proudly. “What pleases me more is that she demonstrates that young, female pharmacists can assume effective and successful roles as pharmacy owners. This dedicated individual will serve as a role model to others through her work ethic and ability to work through any adversity.”

With two new pharmacies opening in South Carolina within a year as a direct product of the CPN Community Pharmacy Institute, the future of independent pharmacy is being preserved and strengthened with each applicant and participant. ■

Jennifer L. Baker, PharmD, RPh, is director of professional affairs for the South Carolina Pharmacists Association (SCPhA), Columbia, South Carolina, and program director of the Carolina Pharmacy Network’s Community Pharmacy Institute. For more information and for an online application, visit the SCPhA Web site (www.scrx.org), or contact Baker at 803-354-9977.



Read More at America’s Pharmacist Online

America’s Pharmacist originally featured the Community Pharmacy Institute in its October 2005 issue (“South Carolina’s Growing Independents”). This article is available online at the *America’s Pharmacist* section of the NCPA Web site (www.americaspharmacist.net). You can read a PDF version of any article in the magazine dating from January 2005 to the present by providing your name and member number.

Intervening Against ASTHMA

Pharmacists improve patient outcomes and add value during national asthma study

By Jennifer Bruckart

In its first seven months, the Asthma Intervention Program already has had a positive impact on patients and opened new lines of communications between patients and pharmacists.

“This program is a great way to build rapport with patients, reinforce what their physicians are saying, and serve as a kind of problem-solver for the physicians,” says program participant John Forlenza, PD, owner of Forlenza’s Pharmacy in Edwardsville, Pennsylvania.

The Asthma Intervention Program, a research study jointly developed by NCPA, Medical Care and Outcomes, and sponsor GlaxoSmithKline, uses a series of patient-pharmacist interventions, as well as communications with the patient’s physician, to examine the impact pharmacists can have in improving health outcomes in 5,000 adult asthma patients.

The program uses the Asthma Control Test™ (ACT), a five-question assessment tool recommended by the American Lung Association, to assess how well a patient’s asthma is being controlled. Patients receiving low scores on the test receive a follow-up call from the pharmacist two months later and take the Asthma Control Test again to see if any improvements have occurred. The study also collects and monitors changes in patients’ asthma medication history over a 12-month period.

Uncovering Problems

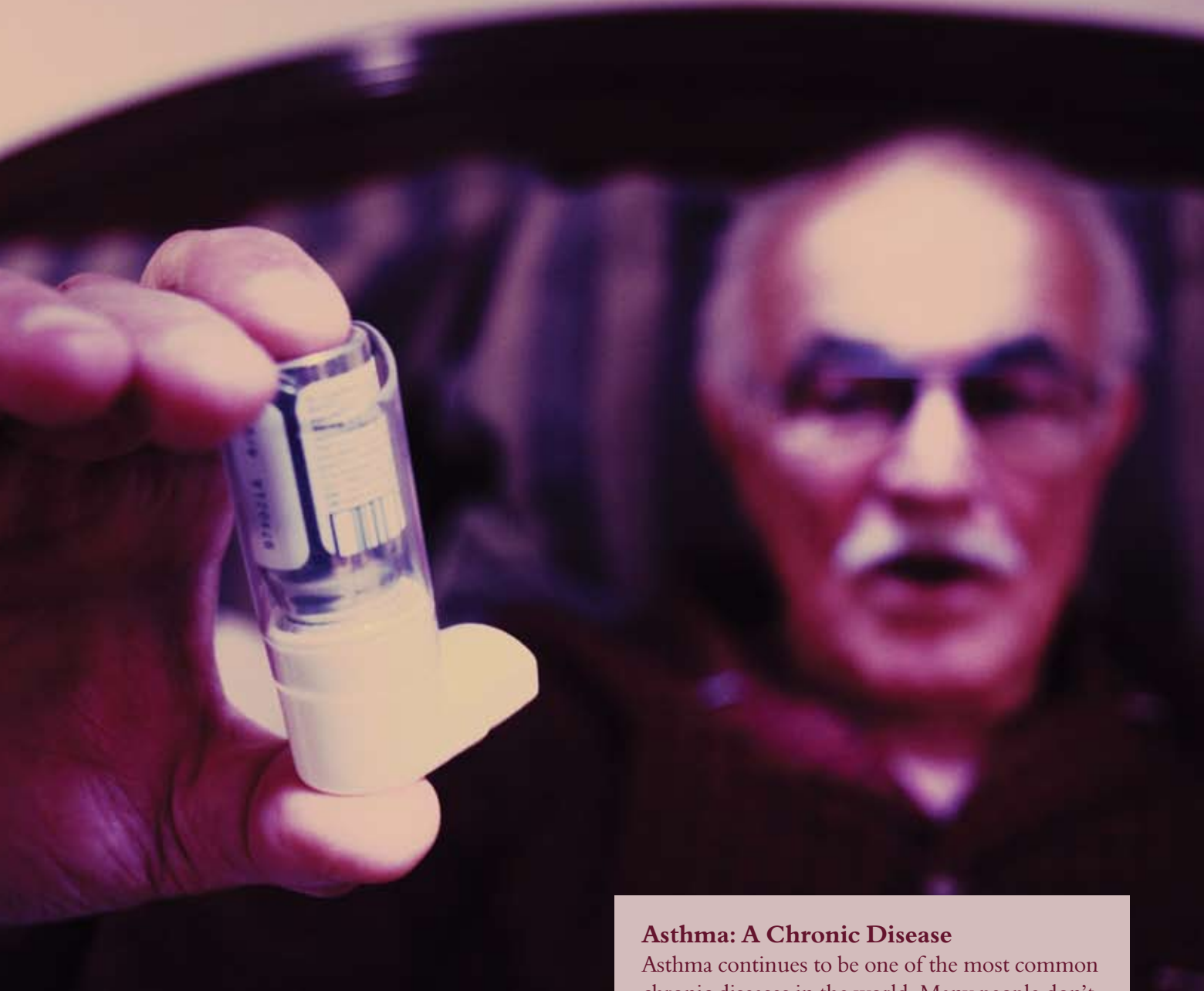
To date, more than 73 percent of patients tested have received failing ACT scores on their initial test, indicating they do not have their asthma under control. Richard Peters, RPh, pharmacy manager for Glen Raven Pharmacy in Burlington, North Carolina, discovered several of his patients were in that category.

“When I sat down and went through the program questions, I found out they were not doing as well as I thought,” Peters says. “I was really surprised to hear the answers to the questions and to realize the low quality of life they were experiencing.”

William Schaefer, RPh, owner of Rose City Drugs in Rose City, Michigan, identified several patients with uncontrolled asthma, including one woman who thought she had her asthma fairly well controlled until her ACT score indicated otherwise.

“A lot of patients experience the symptoms but learn to





cope and accept them instead of working to improve them,” Schaefer says.

Adding Value

Although counseling has long been a part of pharmacists’ regular practice, the Asthma Intervention Program has allowed more in-depth dialogue and created a more meaningful relationship for patients and pharmacists. Some pharmacists have used the program as a tool to talk to patients about ways to control their asthma, including identifying and avoiding triggers, as well as providing more detailed information about the correct use of rescue inhalers.

Gerard Herpel, PD, owner of Deep Creek Pharmacy in McHenry, and Tri-Towns Pharmacy in Westernport, both in Maryland, had two patients who were waking up in the middle of the night several times a week due to wheezing, coughing, and other symptoms. Neither one realized it was due to asthma.

Asthma: A Chronic Disease

Asthma continues to be one of the most common chronic diseases in the world. Many people don’t think of asthma as being a serious chronic disease. Many people with asthma and parents of children with asthma mistakenly think their disease is under control, yet asthma accounts for almost two million emergency room visits each year.

Herpel discovered one of the patients wasn’t using his albuterol inhaler as regularly as he should to lessen the symptoms.

“Since he started using the inhaler more regularly, he’s come back and said he can finally sleep through the night,” Herpel says.

Along with helping pharmacists identify patients with uncontrolled asthma, the study also has helped uncover compliance issues.

“I was able to identify a lot of problems, including one patient who couldn’t afford her medication,” Rose City’s Schaefer says.

Joe Cross of Danny's Drug's in Oneida, Tennessee, discovered a patient who was unable to get the asthma medications she needed because state Medicaid limits only paid for two brand name drugs per month.

Cross contacted the patient's physician and recommended changing one of the patient's brand name drugs to a generically available equivalent, freeing up one brand drug for her asthma.

Expanding Patient Care Services

Many pharmacists involved in the program see patient care services as a growing part of the future of pharmacy, especially in light of continued reimbursement cuts from public and private prescription drug plans.

"We have to prove we are providing health benefits to our patients," Peters of Glen Raven Pharmacy says. "This program is a way to prove our worth and allow others to see the consequences of what we do."

Schaefer's pharmacy already offers a number of patient care services, including A1C tests for diabetes patients, cholesterol screenings, and bone mineral density tests.

"People are really looking for that type of relationship with their pharmacist. Once they experience these types of services, they keep coming back for it," Schaefer says.

Joel Zive, owner of Zive's Pharmacy in the Bronx, New York, said he's always been a proponent of expanded patient care service offerings in pharmacies, and he has been providing asthma education for six years. For him, the Asthma Intervention Program was a natural fit for his pharmacy.

Interacting With Physicians

One important component of the program includes sharing information with a patient's physician. After a patient takes the initial Asthma Control Test, his/her ACT score is sent to the patient's physician, and patients are encouraged to schedule an appointment to talk about their asthma control.

Some pharmacists also have used this communication as an opportunity to talk with the patient's physician. In some instances, those conversations have prompted the physician to modify a patient's dosage or add an inhaled corticosteroid medication to help improve asthma control.

Sheldon Birch, PharmD, of Dave's Drugs in Tooele, Utah, has enrolled 27 patients and has indicated several patients already have shown improvement as a result of changes in their medication.

One patient initially scored an eight out of a possible 25 points on the Asthma Control Test, indicating very poor control of the disease. "She felt like her asthma was totally out of control. She was waking up nearly every night and using her inhaler a lot," Birch says.

He sent the test results to her physician, and the patient also scheduled an appointment with her physician, who increased her dosage of an inhaled corticosteroid and added another asthma medication and an allergy medication. She

The asthma facts and figures listed below are from the Global Initiative for Asthma, a collaborative effort by National Heart, Lung, and Blood Institute, National Institutes of Health, and the World Health Organization.

Facts and Figures

- It is currently estimated that as many as 300 million people worldwide suffer from asthma, and that number continues to rise.
- As more countries become urbanized the prevalence of asthma is increasing. Estimates say that by 2025 there could be an additional 100 million diagnosed asthmatics.
- It is estimated that asthma accounts for one in every 250 deaths worldwide.
- The United States has an estimated 10.9 percent of the entire population suffering from clinical asthma.
- The death rate among 5 to 35 year olds from asthma in the United States is 0.5 per 100,000 people.
- Approximately five out of every 100,000 people with asthma die from it each year in the United States.
- The number of people with asthma in the United States is estimated at 35.5 million, out of a total population of 316.9 million.
- Asthma accounts for about 14.7 million missed school days and 11.8 million missed work days annually in the United States.

took the Asthma Control Test again and scored a 13.

"She was so pleased that her doctor took an interest in her and changed her medications," Birch says.

Another of his other patients initially scored a six out of 25 points on the test. "She was using her albuterol inhaler like cough drops," Birch says.

Birch discovered it was a payment issue. Although the patient's physician had prescribed her additional medications, she couldn't afford them, so she didn't fill them. As a result, she had been to the emergency room 12 times in the past 12 months and had had three extended hospital visits.

"She ended up telling her family members about the program she was enrolled in to try to get her asthma under control, and a relative took an interest and helped her pay for the medications she needed," Birch says. "She was able to pay for two new medications and now says her asthma is well controlled."

Researchers continue to monitor the study data as the second and third interventions are completed. Be sure to look for more Asthma Intervention Program updates in future issues of *America's Pharmacist*. ■

Jennifer Bruckart is NCPA associate director of external communications.

‘Small Town Guy’ Makes It

BIG

Nelson Pharmacy’s investment and belief in Kris Zepeda pays dividends

By Chris Linville

Photography by Garry Peebles

Kris Zepeda, PharmD, is a self-described “small town guy.” And Seagraves, Texas (population 2,300), where he grew up, certainly qualifies in that category. To a slightly lesser extent the same could be said for Brownfield, a town of some 9,500 residents 22 miles away, where Zepeda worked at Nelson Pharmacy while completing his undergraduate studies at Texas Tech University.

While at Nelson Pharmacy, Zepeda was accepted to Texas Tech University Health Sciences Center School of Pharmacy. After his first year, he came back to Brownfield, located in west Texas, and realized how much he liked it.

“I thought this would be a great place to work,” he says.

He liked it so much there that he made what might be considered a bold proposition to the pharmacy’s owners, Bob Simpson and Tom Hesse. Zepeda told them that when he finished pharmacy school, he hoped to come back to Brownfield and work at Nelson Pharmacy.

“They said, ‘We just figured you were anyway.’ And I said, ‘If that’s the case, I think you should go ahead and pay for my school.’ They said ‘Sure,’ and that’s how it happened. We made an oral contract; we never put anything on paper.”

For his part, Simpson says he didn’t think twice about having the pharmacy pay for Zepeda’s college education. It was essentially an investment to secure a young and energetic future owner. Simpson also says that Homer Nelson, who founded Nelson Pharmacy in the late 1930s, had given him a loan to pay for pharmacy school at the University of Texas at Austin, where he graduated in 1965 before starting his 40-year career at the pharmacy.

“I really didn’t hesitate, because in a way I had been in the same situation myself,” he says.

So for the next three years, Zepeda’s books, tuition, and other expenses were paid for by Nelson Pharmacy, to the price tag of about \$10,000 annually. When he graduated in





2004, instead of being given a signing bonus, Zepeda received 10 percent of the company, gaining an ownership stake. He jumped right in and hasn't stopped. "I graduated on a Saturday, and went to work on a Monday," he says.

Simpson, who retired in January after selling his ownership shares to Zepeda and Hesse, says, "We didn't pay him as much as he probably could have made elsewhere, but we promised him a junior partnership, and he wanted to be able to try some different things that he knew he wouldn't be able to do working for someone else. We gave him pretty much of a free hand.

"He's a hard worker, and he is a very good asset to the community, and to the pharmacy profession."

Independent Thoughts

Zepeda's desire to become an independent pharmacist began at an early age. His mother was a pharmacy technician when

he was a child, and he would visit her at the pharmacy and see how it operated.

"I became enamored with it; I thought it was a neat profession," he says. "From then on, I knew that that was what I was going to do."

His interest was fueled even more when he joined Nelson on a part-time basis. "The way that they worked, and the things that they did were all of the things that I was about," he says.

Nelson Pharmacy became a fixture in the Brownfield community through the efforts of Homer Nelson and his son Punch Nelson. "Everybody knows about Nelson Pharmacy," Zepeda says. In describing the demographics of the pharmacy's patient base, Zepeda says that it has a mix of old and young, with a fair amount of indigent families, young mothers, and a significant Hispanic population.

Nelson Pharmacy has 11 employees (six full-time and three



Nelson Pharmacy has served the Brownfield, Texas area for more than 60 years.

part-time), with Zepeda and Hesse as the two full-time pharmacists. The pharmacy is 5,500 square feet with 1,500 feet of that as storage. Of the remaining 4,000 square feet, 3,000 feet is front end space and the remaining 1,000 the prescription area.

Zepeda says Nelson is a full-line boutique pharmacy, and its automated dispensing capabilities help it provide between 250-300 prescriptions daily. It is also a member of the Professional Compounding Centers of America (PCCA), offering specialty and veterinary compounding. Nelson has an extensive line of OTC products and durable medical equipment. Along with those services, Zepeda says Nelson also hosts bridal and baby showers.

Sales have been fairly steady in recent years, Zepeda says, and are projected to be in the range of about \$3.5 million this year. Perhaps surprisingly, he says that Medicare Part D was not a significant obstacle.

Zepeda explains that many of Nelson's patients pay by cash. They also have a number of Medicaid patients. As Part D went into full swing, an effort was made to electronically sign up as many patients as possible, and making sure they received any and all medications they might need. "That automatically brought us a lot more patients," Zepeda says.

He also said that the pharmacy also had regular Contract Health Services patients who were taking only two of their medications, because that's all they could afford.

"Well now they are getting all 15 of them," Zepeda says. "To make a long story short, our volume has helped compensate for our decrease in margins."

He says Nelson looked to mitigate any Part D issues before they could get out of control. "We took a very hands-on approach in signing people up," Zepeda says. "You just have to be patient. Do the grunt work; sign people up; keep working through things. Any rejection issues or other problems were over after the first month."

New Initiatives

Zepeda is not shy about looking for innovative methods for

providing pharmacy services. As Simpson points out, "He's pretty assertive about trying different things."

One way that Zepeda is trying to stay ahead of the curve is through a telepharmacy he opened outside Brownfield. He explains that in Texas, a prescription inventory is allowed in a rural location in a medically underserved area, provided that it's at least 10 miles from any pharmacy.

"You set up shop there and you have your entire inventory, and all that it requires is an electronic check," he says. "We do everything through a Webcam. We have a pharmacy tech out there, and we put on headsets here, and through a software program, the customer can put on a headset at his end and look at the Web cam and into the computer screen—they can see us and we can see them—so we can counsel via the Web cam, and check the prescriptions through it."

Zepeda says he spent part of a rotation at Texas Tech learning about telepharmacy. At the time, he says that most telepharmacies he had seen had start-up costs in the neighborhood of \$50,000-\$60,000, primarily due to the software being used.

"I was able to do everything (not including the drug inventory) for about \$3,000," he says. Zepeda says some good professional relationships he forged with public officials in Yoakum County (site of the telepharmacy) helped keep expenses low. Zepeda says he plans to open more telepharmacies at some point.

Zepeda is also eager about the potential for medication therapy management (MTM) as a valuable service that Nelson Pharmacy can provide.

"We're excited about that," he says. "I can't wait to implement it. We own a two-story building next door to us where we could easily set up a room to facilitate MTM."

Challenges and Opportunities

Zepeda recognizes that independent pharmacists are certainly facing challenges in the current environment. He doesn't hide his feelings when describing how he thinks the government is undermining the work that he and his colleagues across the country are doing.

"The biggest problem we face, the biggest problem that all pharmacists face, is that legislation is abusing our profession," Zepeda says. "They're cutting in on the margins that we get paid, and they have no idea how we make money. So our biggest challenge right now is to alter legislation that's making it very threatening to our profession. Things like Medicare Part D...the reason they are doing that is because legislators don't understand our profession. If they did, they wouldn't do it."

However, Zepeda generally looks at things from a positive aspect. Small-town life keeps him motivated. He thrives on the personal touch and the one-to-one interaction.

"When someone comes through the door, before they even come to the window, we have their medicine records, we know their whole life story, what's going on, why they need what they need, all their little idiosyncrasies," he says. "It's just

a small town, down-home approach. We really know all of our customers, and we're very involved. We take care of our people because we know we're going to see them at the shop or at the restaurant. So we go out of our way for them."

Zepeda also understands how important it was for others to give him opportunities to help launch his independent pharmacy career, and he wants to help others as well. In the next several years, he's hoping to set up a rural community pharmacy residency. He would also like to buy another pharmacy and perhaps bring in younger pharmacists with potential ownership opportunities.

Zepeda is also active in many different organizations that can help shape policies in a proactive manner at both the local, state, and national level, including the West Texas Pharmacy Association, the Texas Pharmacy Association, and the NCPA Committee on Management.

He also has advice for up and coming pharmacists who are weighing their options: "Work for yourself, because in the long run you'll be a lot happier. That's for sure. You'll have control over your professional future."

As for himself, Zepeda says he's doing exactly what he wanted. In fact, he adds, "I've never had a bad day at work. And the reason is that every day, I get a chance to help somebody.

"Once I worked at Nelson Pharmacy, I always knew that I wanted to be an independent pharmacist. If it wasn't here, I

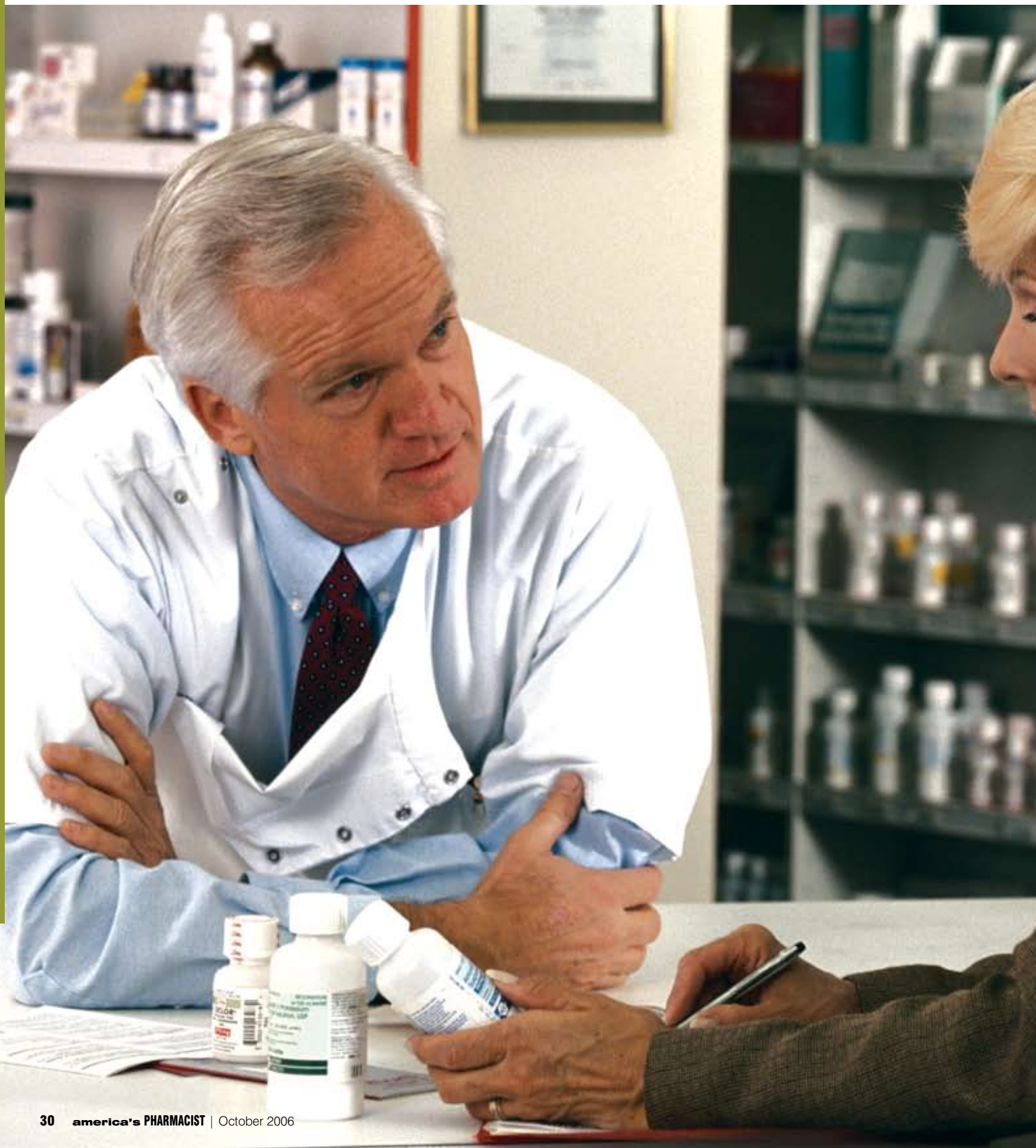


One-to-one patient care is important for Zepeda.

would be one somewhere else. I'd go open up a pharmacy or I would go buy one. I would never work anywhere other than an independent pharmacy." ■

Chris Linville is managing editor of America's Pharmacist.

Preparing Your



Pharmacy for

MTM



PHOTOGRAPHY: BREAD & BUTTER

Community Care Rx has begun the national rollout of its medication therapy management (MTM) program, and pharmacies already are seeing the benefits to both their patients and their business with the addition of this important patient care service under Medicare Part D.

With its MTM program, CCRx expands the role of community pharmacy by demonstrating that pharmacists, in addition to their important dispensing role, also are clinical service providers, risk managers, and financial advisors to the patients they loyally serve. Importantly, pharmacists are now compensated for this valuable service. CCRx is paying pharmacists \$60 (geographically adjusted) for a 30-minute MTM session.

Have you thought about how you will prepare your pharmacy for the CCRx MTM program? It's time to educate yourself and your staff about this new, vital opportunity.

Staffing and Time Management

MTM is an investment in your future and will require the pharmacist to move some time from the dispensing function to patient consultation. Evaluate your current staffing levels and determine if pharmacist dispensing can be made more efficient through increased use of technicians or automated dispensing systems, freeing up time for the pharmacist to conduct MTM sessions.

CCRx is using Community MTM Services, Inc. (CMTM), a Web-based communications service that will facilitate the delivery of MTM and other patient



care services by community pharmacists. CMTM will make it possible for pharmacists to deliver MTM efficiently and easily. Your CCRx MTM sessions are budgeted to reimburse pharmacists for a consultation that should last approximately 30 minutes. Evaluate traffic flow in your pharmacy as you decide when it is best to schedule MTM visits in your store.

Documentation and Billing

CCRx understands how busy pharmacists are. That's why CCRx chose CMTM to deliver medication therapy management services. With CMTM, pharmacists will access an online system that makes it simple to document findings of the consultation by utilizing check boxes, pull down menus, and brief fill-in boxes. Even the coding and claims submission will be handled for you. Pharmacists will simply verify that the patient's and pharmacist's data are correct and click the submit button.

Payment for CCRx MTM visits will arrive separately from dispensing payments every 60 days. You will receive the check from CMTM.

Patient Education Materials

CCRx wants pharmacists to have successful outcomes and patient compliance as a result of their time and effort spent on MTM. With the CMTM service pharmacists will have access to patient education materials at the touch of a button. You'll be able to print materials for your patient at the time of the MTM session.

Private Consultation Area

To ensure patient privacy, designate a specific area of your store for MTM sessions. Partitions can be used in a common area to make it private but make sure the area is quiet. Ideally, the area should have a computer with Internet access and a printer. With CMTM there is no need to create a medical records storage area within your pharmacy. Your patients' records are stored in a secure online environment. You can 'pull' a chart and print it at any time.

CMTM will deliver the names of those CCRx patients who qualify for MTM to you. It is up to you to demonstrate

the importance of your role as not only one who dispenses medications but also that of a trusted clinician improving the overall health of your patients. MTM is only the beginning of the value-added services pharmacists will provide to the health care system, and CCRx is the first Medicare Part D program with the vision to recognize the valuable role community pharmacists will play in keeping patients healthy and compliant.

Preparing for the Session

Adequate preparation for a CCRx MTM session includes more than simply scheduling the patient. To help your patient maximize the benefit of receiving an MTM session with you and to ensure effective interaction, please ask your patient to bring the following to the scheduled appointment:

- All prescription medications they take
- All over-the-counter herbal products, medications, vitamins, and supplements
- List of all prescribers the patient uses
- Blood glucometer log (for patients with diabetes)
- Most recent blood pressure log if available (hypertension)
- Copies of most recent laboratory results (such as Alc and cholesterol) if available

Preparing for the Patient

You should familiarize yourself with your patient's medications and chronic conditions before the MTM session in order to have a maximally efficient visit. Take a look at the patient's 'chart' within CMTM and see if any red and green flags have been identified on the medication list. If so, you should do the following:

- Red flags are potential drug-drug interactions, duplicate therapy, or other possible circumstances in which you may need to contact the prescriber and request a change in therapy for the patient's safety.
- Green flags reflect potential cost-saving opportunities for the patient in which the pharmacist may contact the prescriber to request a cost-saving therapeutic interchange.

By clicking on the 'Medications' tab in the patient's CMTM chart, you can view the patient's claims history for each medication. This useful tool enables the pharmacist to check for any possible issues with compliance. For example, the patient fills a 30-day supply of a medication that is taken once daily and is refilling the prescription every 60 days. It's possible the patient is not taking the medication properly and needs to be counseled about compliance during the MTM session.

Detailed information is found in the CCRx "MTM Encounter Preparation Guide" located in the Protocol Library in Community MTM. The Protocol Library contains a collection of resources provided by CCRx (www.communitycarerx.com) to assist your pharmacy in providing MTM and other patient care services. To access this document you must be contracted with Community MTM and have a user name and password. ■

The National Provider Identifier

What You Need to Know

With the implementation of the National Provider Identifier program (NPI) slated for next spring, independent pharmacists will likely have their fair share of questions about the rollout of this mandated program. This article attempts to identify and explain the primary components of the NPI and how it will affect pharmacists.

What is an NPI? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the secretary of the Health and Human Services Department adopt a standard unique health identifier for health care providers. On January 23, 2004, the secretary published a final rule that adopted the National Provider Identifier (NPI) as this identifier.

All HIPAA-covered health care providers, whether they are individuals or organizations, must obtain an NPI for use to identify themselves in all HIPAA covered, HIPAA standard transactions (such as the National Council for Prescription Drug Programs [NCPDP] format for retail prescription drugs and the X12N 837 for pharmacy professional services, Part B drugs and supplies, and durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS]). Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

HIPAA-covered entities, such as providers completing electronic transactions, health care clearinghouses, and large health plans, must use only the NPI to identify covered health

care providers in standard transactions by May 23, 2007. Small health plans have a one year extension (until May 23, 2008) before complying with the NPI rule. Small health plans are defined as plans with \$4 million or less in revenue.

What does an NPI look like? The NPI consists of nine numeric digits followed by one numeric check digit. The NPI does not have embedded intelligence. There is no method of determining whether an NPI belongs to an individual or an organization by looking at the number.

Are all pharmacists and pharmacies required to obtain an NPI? All health care providers that are covered entities under HIPAA are required to obtain an NPI. If a pharmacy sends or receives HIPAA-covered transactions, the pharmacy must obtain an NPI. The same is true for a pharmacist. If the health care provider does not conduct HIPAA-covered transactions, but is a health care provider under HIPAA's definition (as are pharmacies and pharmacists), then the provider may, but is not required, to obtain an NPI.

Will a pharmacy's and a pharmacist's NPI be required on all claims? NPIs are required of HIPAA-covered entities on HIPAA-covered or standard transactions. In most cases, the pharmacy as the billing entity will be required to submit an NPI as the identifier. Whether a pharmacist

NPI is required on a HIPAA transaction depends upon the trading partner (such as the payer). If the pharmacist NPI is requested, then the pharmacist NPI would be on the HIPAA transaction.

When a pharmacist NPI is requested, it is usually to identify the rendering provider, and the pharmacy NPI would also be supplied on the same claim transaction to identify to whom the claim should be paid (such as the billing provider). Both NPIs would be on the claim transaction. This situation may occur when using the X12N 837 claims format or the paper version of the X12N 837—the Centers for Medicare & Medicaid Services (CMS) Form 1500. Only one NPI will be required on the NCPDP format—the NPI for the billing provider.

Will a pharmacy continue to use its NCPDP provider identification? A pharmacy may use its NCPDP provider identification for non-HIPAA covered transactions such as workers' compensation claims. The choice of which identifier to use in this case will be specified by the trading partner (payer). A pharmacy must use its NPI for all HIPAA-covered transactions.

NCPDP will continue to issue NCPDP identification numbers, even if they are not used on a HIPAA standard transaction. It is expected that many processors will cross-walk the NPI to the NCPDP provider identification and will continue to use the NCPDP identification for processing in the near to intermediate term. The relationship and demographic information found on the NCPDP database files will always be needed by the industry. NCPDP will continue issuing NCPDP provider identification numbers—even if the only future use is internal to NCPDP and users of the NCPDP Pharmacy Database. There are no plans to phase out the numbers.

Will pharmacists use their state license number? If pharmacists are submitting or receiving a HIPAA standard transaction, they must obtain and use an NPI. If not, the choice of what number to use to identify the pharmacist shall be specified by the trading partner (such as the payer).

What is a legacy identifier? A legacy identifier is any identifier that has been used by providers that is being replaced by the NPI on HIPAA transactions. For a pharmacy, this includes the NCPDP provider identification, Medicaid identification, Medicare supplier identification, state license numbers, and other identifiers used to identify the pharmacy on a HIPAA standard transaction.

When would a pharmacist or pharmacy apply for multiple NPIs? Only organizations can have multiple NPIs. Individuals can obtain only one NPI through their lifetime, except in unusual circumstances such as replacing an NPI due to fraudulent activity associated with the NPI.

For an organization, NPIs can be obtained for its business subparts at the discretion of the organization. Organizations with multiple locations such as pharmacy chains would likely obtain NPIs for each location; a pharmacy location involved in both traditional dispensing services and long-term care services might also obtain an NPI for both business components. In general, a pharmacy may want to consider replacing one NPI for each NCPDP identification it has today. In the future, if a pharmacy has a business need that can't be satisfied by one NPI, then an additional NPI should be considered.

CMS requires durable medical equipment (DME) organizations to obtain NPIs for each location. However, pharmacies that are also DME suppliers may choose to use only one NPI.

How do you apply for a NPI? You can apply for an NPI in one of three ways:

1. With a pharmacy's permission, NCPDP submits pharmacy applications to the CMS NPI enumerator in electronic files and provides the pharmacy's NPI to them. NCPDP recommends this option as a service to the industry. This authorization process is under way and the NCPDP bulk enumeration process has begun. Go to www.ncdp.org/frame_news_npi-info.htm, download the application and fax it to NCPDP. If you have many pharmacies, an Excel spreadsheet template is available for ease of use. Please note that the NCPDP process is for pharmacies only; pharmacists who want to obtain an NPI must apply directly to the CMS enumerator. (See number 2 and number 3 as follows.)
2. You may prepare a paper application and send it to the National Plan and Provider Enumeration System (NPPES), or the enumerator that will be assigning the NPIs on behalf of CMS. CMS has contracted with Fox Systems of Fargo, North Dakota, to serve as the NPI enumerator. A copy of the application can be obtained through one of three ways. By mail at: NPI Enumerator, PO Box 6059, Fargo, ND 58108-6059; by e-mail at: customerservice@npienumerator.com, or by phone at: 800-465-3203 or TTY 800-692-2326. All of this information can be obtained on the CMS Web site (www.cms.hhs.gov).
3. You may apply through a Web-based application process. The Web address is the same as number 2 above.

The estimated time for completing an application is 20 minutes.

What information should pharmacies have available?

A pharmacy must have their employer identification number (EIN), along with basic demographic information, taxonomy codes for services provided, and legacy numbers such as NCPDP provider identification number, Medicaid number, Medicare supplier identification number and other identification numbers (optional). If the pharmacy is a sole proprietorship and not incorporated, then the pharmacy is not con-

sidered an organization and will be obtaining an individual (Type 1) NPI.

What are taxonomy codes? Taxonomy codes describe the type and specialty of providers. A minimum of one taxonomy code is required for obtaining an NPI. Taxonomy codes are those maintained by the National Uniform Claim Committee (NUCC) to describe provider types and specialties. There are currently taxonomy codes for pharmacists, pharmacy technicians, and pharmacies, along with other specialties such as DME. They are listed at www.wpc-edi.com/taxonomy.

When should NPI information be updated? Federal law requires that health care providers certify that the information submitted to NPPES is correct and that changes are sent to NPPES within 30 days of a change of information on the application, using one of the three application methods described previously for obtaining an NPI.

NCPDP is requesting authorizing pharmacies to fill out the form at www.ncdp.org, and update NCPDP within 20 days of a change of information. The form provides a method for individual pharmacies to certify the information is correct.

How was NCPDP selected as a bulk enumerator? NCPDP was certified by CMS as an electronic file interchange organization (EFIO) to submit records for enumeration on behalf of pharmacies with their authorization in May 2006. NCPDP is currently accepting updated information and authorizations from pharmacies, sending files to the NPPES, and obtaining pharmacy NPIs.

If pharmacies authorize NCPDP to enumerate them on the NCPDP application (www.ncdp.org/frame_news_npi-info.htm), NCPDP will submit the electronic application information for NPI enumeration. If a pharmacy is affiliated with many pharmacies or a pharmacy chain with many stores, an Excel template is available on the Web site.

Six days after NCPDP sends a file of pharmacies to NPPES to be enumerated, NPPES sends a response. Records on the response file are either enumerated, rejected, or pending to the enumerator. NCPDP researches and resubmits rejected records. This sometimes requires calling the pharmacy and working with the pharmacy to resolve the problem. The enumerator must resolve pending records. The enumerator will contact NCPDP and/or the pharmacy contact person to aid in resolution. Pending records that have been finalized are sent on another file six days later.

NCPDP notifies pharmacies of their NPI on enumerated records. In the case of independent pharmacies, an email will be sent from NPI_EFIO@ncdp.org. For chains, an e-mail and file of NPIs will be sent once all pharmacies are enumerated. This e-mail from NCPDP should be maintained on file, as some payers or processors may require a copy as validation of the pharmacy NPI.

Why should a pharmacy use NCPDP's application process?

NCPDP has been successfully enumerating pharmacies since 1981, during which time it has provided pharmacies with NCPDP provider identification numbers (formerly known as National Association of Boards of Pharmacy [NABP] numbers). Along with enumeration, NCPDP maintains the NCPDP Pharmacy Database. Pharmacies benefit from the various industry uses of this information. Specifically, entities within the pharmacy industry will most likely use the NCPDP Pharmacy Database information for affiliating pharmacies with their respective chain headquarters or networks, claims processing, direct mailings of product recalls and publications, network development, health plan directories, and rebate information.

Health plans, claims processors, and other entities within the health care industry also will most likely be interested in using the NCPDP Pharmacy Database information to obtain NPIs to identify participating pharmacy network providers and to verify claims submissions, to name a few reasons.

Entities within the health care industry may obtain pharmacy NPIs from authorizing pharmacies by subscribing to the NCPDP Pharmacy Database. However, please note that only CMS will have the complete list of provider NPIs. Also note that the NCPDP Pharmacy Database is for the authorized registration of pharmacy NPIs only. Pharmacists who desire to obtain a NPI must apply directly to the CMS NPPES.

Using NCPDP to obtain a pharmacy NPI will insure that information is current in the NCPDP Pharmacy Database, as well as the NPPES, which does not contain all the information needed by industry and is subject to the rules of the yet-to-be-published dissemination notice.

NCPDP's Pharmacy Database will contain pharmacy NPIs as well as legacy NCPDP provider identification numbers (formerly the NABP numbers). Pharmacies benefit in that the health care industry will have access to a much-needed crosswalk between the two identification numbers. The crosswalk between the pharmacy's NCPDP provider identification and pharmacy NPI is currently a major tool used by health plans and claims processors to properly process pharmacy claims and to minimize disruption or errors in claims payment.

Authorizing pharmacies that enroll in the NCPDP Pharmacy Database should also minimize the number of claims processors and health plans contacting pharmacies for their NPIs.

Even if a pharmacy chooses to apply for a NPI directly with the CMS NPPES, or if a pharmacy has already obtained a NPI from the NPPES, it should still register its NPI with NCPDP for the reasons stated previously.

The single Web-based or paper application process takes pharmacy chains significantly longer than the time it takes to update NCPDP using an Excel spreadsheet. At 20 minutes per pharmacy, a 20-pharmacy chain could take more than

one day; applying over the CMS Web site while updating existing records with NCPDP will take considerably less time per pharmacy. Enumerating a large group of pharmacies can result in significant administrative burden associated with gathering, formatting, editing, validating, applying via the Web (which takes 20 minutes per pharmacy), and maintaining data in NPPES.

How can NCPDP do the needed work at no additional cost to pharmacies? NCPDP can do all the work required at no additional cost to a pharmacy just as they do today in maintaining the NCPDP Pharmacy Database. NCPDP sells this database to the industry to recoup its pharmacy NPI enumeration costs. NCPDP, with pharmacy authorization and the required information on an NCPDP-developed application form or Excel format, obtains and maintains pharmacy NPI(s) as required by federal law. NCPDP agrees that all this work will be at no additional cost to pharmacies.

Can pharmacies use either the prescriber's individual NPI or the prescriber's organization/clinic NPI on a prescription drug claim? The NCPDP Telecommunication Standard defines the prescriber identification in an electronic transaction for a prescription drug as the NPI assigned to the individual prescriber, and NOT the prescriber's organization/clinic NPI. Therefore, only the NPI for the individual prescriber will be required on retail prescription drug claims on the NCPDP format. For retail prescription drug claims, pharmacies must be sure that they are using the individual prescriber NPI to avoid disruption or errors in prescription drug claims processing and payment.

The Workgroup on Electronic Data Interchange (WEDI) and NCPDP have published a joint white paper that makes recommendations on using NPIs as prescriber identifiers on a claim and what to do if no NPI is available. It recommends that the pharmacy submit claims using the identifier required by the trading partner (such as payer)—usually the legacy identifier previously used by the pharmacy such as the state license. If the state prohibits the use of the DEA as a prescriber

identifier on claims when the NPI is implemented, using the DEA may no longer be possible.

The white paper can be downloaded at www.ncdpd.org. CMS has not yet published an NPI Dissemination Notice in the *Federal Register*. To date, the only known method for pharmacies to obtain prescriber NPIs is by contacting the prescriber or their office. It is important that the office provides pharmacies with the prescribers' individual NPI, and not that of the organization.

What percentages of pharmacists and pharmacies have been enumerated to date? CMS does not publish statistics by provider type or taxonomy at this time. Information on the number of providers enumerated can be found at www.cms.hhs.gov.

I read recently that Medicare is already requiring NPIs. Is that true? Medicare is not requiring NPIs on HIPAA standard transactions. However, effective May 1, 2006, an NPI was needed on the CMS-855S application to process Medicare supplier identification enrollment documents or make any updates to a supplier file.

NCPDP has developed processes so that new pharmacies and pharmacies who change ownership receive priority when NCPDP submits records to NPPES for NPI enumeration. NCPDP provides independent pharmacies with an e-mail containing the pharmacy NPI to attach to the CMS-855S application. For chain pharmacies, written notification is being provided to satisfy this Medicare requirement.

I have heard that CMS will be disseminating NPIs for industry use? Can you elaborate? Health plans, claims processors, and other entities within the health care industry will be interested in obtaining NPIs to identify participating network providers, and to verify claims submissions, to name a few. However, only CMS will have the complete list of provider NPIs. CMS has not yet published an NPI Dissemination Notice in the *Federal Register* to describe how NPIs will be distributed to the health care industry. To date, the only known method of obtaining prescriber NPIs is by contacting the prescriber. It is important that physician offices provide pharmacies with the prescribers' individual NPI and not that of the organization.

Entities within the health care industry may obtain pharmacy NPIs from authorizing pharmacies by subscribing to the NCPDP Pharmacy Database. Pharmacies that enroll in the NCPDP Pharmacy Database should minimize the number of claims processors and health plans contacting pharmacies for their NPIs. The NCPDP Database contains a crosswalk between the pharmacy's NCPDP provider identification and NPI (for pharmacies that authorize NCPDP) and is currently a major tool used by health plans and claims processors to properly process pharmacy claims and to minimize disruption or errors in claims payment. ■

For more information and updates relating to the National Provider Identifier program, please consult the following Web sites:

- Centers for Medicare & Medicaid Services (CMS): www.cms.hhs.gov (also contains an FAQ section)
- National Council for Prescription Drug Programs (NCPDP): www.ncdpd.org
- Workgroup on Electronic Data Interchange (WEDI) and the National Provider Identifier Outreach Initiative (NPIOI): www.wedi.org/npioi/index.shtml



NCPA's 108th Annual Convention *and* Trade Exposition



October 7–11, 2006

The Venetian Hotel and Casino
Las Vegas, Nevada

LOOK INSIDE

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- Past Presidents
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This section includes just a few of the convention's varied events, scholarship winners, and historical notes. It recognizes the exhibitors, sponsors, and corporate members whose support for the convention and throughout the year contributes to NCPA's success. For a detailed look at NCPA's activities, visit booth #327 for a copy of the 2006 Annual Report.



Opening General Session



One of the most sought-after presenters in North America, **Eileen McDargh** is well-known for her insight on issues involving work/life balance and responding to change with resiliency. Noted for her ability to speak the truth with clarity, wisdom, humor, and compassion, McDargh draws upon practical business know-how, life experiences, and more than two decades of consulting to national and international organizations. *Executive Excellence* magazine selected her as one of the top 100 thought leaders in leadership and among the top ten consultant providers of leadership development.

McDargh has written several books, including *Work for a Living & Still Be Free to Live* and *The Resilient Spirit*. She's been a guest on CNN as well as other television and radio programs and is a frequent contributing author. She is a certified speaking professional (CSP) and earned the National Speakers Association's CPAE "Hall of Fame" designation, an honor held by fewer than 3 percent of speakers nationwide.

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Second General Session

Sponsored by Cardinal Health

Husband-and-wife duo **James Carville and Mary Matalin** represent two of the sharpest political minds in Washington. Both are key players on the national political stage, between them having worked for every president during the last 25 years.



Renowned for his razor-sharp wit and penetrating analysis of the political world, Carville has managed

more campaigns than any political consultant in America and around the world. He offers bombastic, enthusiastic, shoot-from-the-hip, no-holds-barred political commentary combined with a quick wit and a Southern drawl, which earned him the nickname the "Ragin' Cajun."

Matalin is one of the nation's hardest-hitting conservative political commentators and has slugged it out in the political trenches as an election-time political strategist and as a trusted advisor in the corridors of power. She served as campaign manager on President George H.W. Bush's 1992 re-election bid. She also served concurrently as counselor to Vice President Cheney and assistant to President George W. Bush.

Both are regular guests on political news programs, including CNN's *Crossfire*. They both have written several books and together co-authored *All's Fair: Love, War, and Running for President*.

Third General Session

This year's political forum will feature an in-depth discussion of the 2006 midterm elections. For community pharmacy, this year's congressional elections loom large. What happens next for both Medicaid

and Medicare will be determined at the ballot box. As NCPA works toward building a Community Pharmacy Majority in Congress, we will review key races, the issues that are driving this election, and what changes are likely to occur. The national landscape suggests that this could prove to be a watershed election, but a race-by-race analysis indicates that a Democratic takeover of either the House or Senate is still uncertain.

Get the real "odds" on the election and what these results will mean for community pharmacy. The forum will cover all of the hot topics, from the role of health care in this election to the voters' predispositions over the direction of the country. The panel will be comprised of a number of leading political analysts, strategists, and media pundits who can provide us with an inside view of what to expect during the last month of the campaign. Political analyst **Craig Crawford**, featured on CBS, NBC, and the nationally syndicated radio show *Imus in the Morning*, will be one of the featured panelists.



Closing Night Celebration

The Phantom of the Opera

For decades, Andrew Lloyd Webber's *The Phantom of the Opera* has thrilled audiences worldwide. Now, *Phantom* makes its Las Vegas premier in an all-new spectacular production. The Venetian Hotel and Casino is proud to present *Phantom—The Las Vegas Spectacular*. This 90-minute adaptation, 7–8:30 p.m. on Tuesday, October 10, 2006, will include every song from the original score in the hotel's brand-new \$40 million state-of-the-art theater modeled after the Paris Opera House. The production will feature never-before-seen special effects and a sensational Broadway-caliber cast under the direction of 20-time Tony Award winner Harold (Hal) Prince, the show's original director.



Each full NCPA convention registrant is entitled to a single complimentary ticket to the special performance of *The Phantom of the Opera*. Registrants interested in attending the performance must request a ticket on the official convention registration form.

Following the theater presentation, NCPA will host a gala closing night dessert reception. This reception of tantalizing treats and beverages will be the last event of the convention and a final opportunity to mingle with friends and peers before heading home. You won't want to miss this first-class send-off affair, which promises to satisfy even the strongest sweet tooth's confectionary cravings.



NOTE: Programming subject to change without notice.

Each year, NCPA strives to provide convention attendees with timely, topical educational programs that help them improve patient care as well as business performance.



Once again, NCPA will provide a variety of educational programs in conjunction with its 108th annual convention. Program topics range from implementing Medicare Part D, entering the long-term care pharmacy niche, and improving

your business acumen to expanding your patient care services. There is definitely something to benefit every independent community pharmacist.

Workshops

Creating a Community Pharmacy Majority—Keys to a Successful Grassroots Movement

While we are independents, there is no denying that there is political power in numbers. Negotiation rights, prompt pay legislation, PBM reform, and fair dispensing fees all begin and end at the local and state level. In addition to pharmacists, one of the strongest voting bases is the customers in your stores. This program will guide you through the most successful grassroots campaigns and provide the necessary tips to leverage your political power.

Federal Regulatory Update in Long-Term Care

This year has brought some challenging developments to the long-term care market in Medicare Part D and other new federal regulations. This informative program is a must for pharmacists providing services to long-term care facilities, for updates to the survey process and tips for valuable communication on regulations, interpretive guidelines, and survey protocols to assist your facilities in their required surveys.

Forecasting the Financial Impact of Medicaid on Your Independent Community Pharmacy

In 2007, Medicaid will be moving to a new reimbursement model for community pharmacy—what does this mean for your practice? Lower reimbursement seems likely, but how much should you plan to have in reserve, how will cash flow be affected, are there strategies to cut down costs, and are there areas of opportunity? These questions and more will be addressed in this session to bring you the latest word on Medicaid.

Medicare Part D Audits—What You Need to Know to Avoid

- Inappropriate billing practices
- Steering customers to drugs/plans
- Failure to offer negotiated prices

The next potential stage of development for the community pharmacist with Medicare Part D is the approach of federal fraud-, waste-, and abuse-based audits of Medicare providers, including pharmacy.

PDPs will be audited by CMS, and in turn, they will audit community pharmacy providers. This not-to-miss session will bring you the perspective of CMS, the plans, and an audit expert to guide you through this landscape.

Medication Therapy Management (MTM)—Myth vs. Reality

We have all heard a lot about MTM, but what will it really mean to your community pharmacy practice? How will differing PDPs interpret MTM requirements, and will they embrace face-to-face patient counseling in the community setting? Will it pay? How often? How much? A key question is will there be widespread adoption of MTM beyond Medicare Part D? This insightful perspective from an industry insider will tackle these questions and look forward to the real impact of MTM and beyond to its potential.

Prescription for Profits: Practical Tools to Assess the Financial Health of Your Pharmacy (Two-part program)

As a pharmacy owner or manager, when you receive your financial statements, your job is not quite finished. In fact, it has just begun. Your challenge is to create a plan to improve the profits and cash flow picture in your business. In this session, you will walk through a



process—a Profit Assessment—to help you evaluate and measure the financial performance of your pharmacy. Using three years of sample financial statements and ratios and a “cause and effect” roadmap, you’ll learn how to get a real handle on financial performance.

You’ll discover a key management tool designed to help you develop an effective and measurable action plan to move forward (calculator recommended).

Successful Exit Strategies for Ownership Transfer—A Practitioner Panel

This peer panel will bring you the insight you need to look toward the future when you will be selling your community pharmacy and give you examples of success stories from owners who kept their pharmacy legacies alive and serving their communities. Learn new ways you may not have considered and established methods that really work.

When Disaster Strikes: Emergency Preparedness for the Community Pharmacy

Hurricanes Katrina and Rita provided many painful lessons from which we all can learn. No one expects to be affected by disaster. One tornado, hurricane, fire, or other unexpected event can destroy your business structure but not your pharmacy practice. Every pharmacy should have a plan for these life-changing events. This session will help you plan your own disaster checklist and the necessary tools you will need to keep business operating in your community in the event of a disaster.

EXPERIENCE *the* POSSIBILITIES





OSCAR B. GOODMAN
MAYOR

NATIONAL COMMUNITY PHARMACISTS ASSOCIATION
LAS VEGAS, NEVADA
OCTOBER 1, 2006

Dear Las Vegas Visitors:

Welcome to America's most dynamic city – Las Vegas, a place where things have been shaken and stirred! You could not have chosen a better city to hold your convention and I am convinced that once you get a taste of what Las Vegas has to offer, you will definitely be back. As the happiest Mayor in the universe, I am delighted to tell you about the excitement that is Las Vegas.

Las Vegas continues to capture the world's imagination as the city where anything is possible. With world class hotels, award-winning restaurants, luxurious spas, fantastic shopping, the finest golf courses, and spectacular entertainment - Las Vegas remains one of the most electrifying destinations in the world.

Downtown Las Vegas is undergoing a dramatic change, a renaissance. It is evolving into a vibrant place for living, working, entertainment and the arts. The enticing mix that makes the new Downtown Las Vegas includes:

- The neon-drenched excitement of the Fremont Street Experience, visited by over 21 million people each year.
- Multi-million dollar casino and hotel renovations and expansions.
- Fremont East Entertainment District featuring trendy new gathering places for dining, dancing, cocktails and enjoyment.
- An emerging eclectic mix of live-in artists and galleries known as the 18b Arts District.
- Almost 18,000 living spaces being built and planned in the heart of the city.
- World Market Center, a state-of-the-art home furnishings trade show complex in Downtown Las Vegas. When fully completed, the complex will exceed 12 million square feet with 8 buildings.
- Union Park, a phenomenal 61-acre planned development neighboring the World Market Center. This project will include the Lou Ruvo Alzheimer's Institute, designed by renowned architect Frank Gehry, a 350,000 square-foot Performing Arts Center, and multiple business and retail opportunities.

Again, welcome to fabulous Las Vegas. Best wishes for a memorable stay in our city.

Sincerely,

A handwritten signature in black ink, appearing to read 'Oscar B. Goodman'.

Oscar B. Goodman
Mayor
City of Las Vegas

CITY OF LAS VEGAS
400 STEWART AVENUE
LAS VEGAS, NEVADA 89101

VOICE 702.229.6241
FAX 702.385.7980
TDD 702.386.9108
EMAIL ogoodman@ci.las-vegas.nv.us
WEBSITE www.ci.las-vegas.nv.us





OFFICE OF THE GOVERNOR

KENNY C. GUINN
Governor

October 1, 2006

GREETINGS FROM THE GOVERNOR

As Governor of the State of Nevada, it is my pleasure to welcome you to Nevada for the National Community Pharmacists Association's 2006 Las Vegas Convention. May this year's gathering be informative and enjoyable for each of you.

We are all certainly indebted to the men and women of your organization for the outstanding service that you provide to our communities. Our lives are dependent on the broad knowledge and expertise of our community pharmacists, and we exercise great faith in their competence and efficiency. We truly appreciate the invaluable work that you all do.

Thank you for bringing this valuable conference to our great state. Our community is famous for fine dining, superior hospitality, first class shopping, great entertainment, and a wide range of recreational opportunities. Whether you've traveled a significant distance to be here, or have made Las Vegas your permanent home, I hope that you will enjoy and take advantage of the many unique and inviting entertainment opportunities available in southern Nevada.

Again, welcome to the National Community Pharmacists Association's 2006 Las Vegas Convention, and best wishes for a successful event.

Sincerely,

KENNY C. GUINN
Governor

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555 E. WASHINGTON AVENUE, SUITE 5100 • LAS VEGAS, NEVADA 89101 • TELEPHONE: (702) 486-2500 • FAX: (702) 486-2505

(01/5/06)

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(as of 8/14/06)

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Abbott Diabetes Care

Adams Respiratory Therapeutics

Adora Calcium by Thompson

Aetrex Worldwide, Inc.

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Dakota Drug Inc.

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EXP Pharmaceutical Services Corp.

Expert-Med, Inc.

Fashion Alert Medical Jewelry

Federation of Pharmacy Networks

First DataBank

Flavorx, Inc.

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Freedom Data Services

G&M Inc.

Gallipot Inc.

GeriMed/Rx Med/IV Med

Gladson Design Group

GlaxoSmithKline, Consumer Healthcare

Global Pharmaceuticals Div. of IMPAX

Gold Promotions Inc.

Greenstone Limited

Guaranteed Returns

H. D. Smith Wholesale Drug Co.

Hallmark Cards

Hamacher Resource Group

Hawkins Pharmaceuticals Group

HCC

Health Business Systems Inc.

(an SXC Company)

Health Care Logistics

Home Diagnostics Inc.

Humco

Independent Pharmacy Cooperative

Innovation Associated

Innovatix

InSource

International Journal of Pharmaceutical

Compounding

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Medicine Shoppe International/

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Medicine-On-Time

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Merck US Human Health

Mission Pharmacal Company

Moore Wallace, an RR

Donnelley Company

Morris & Dickson

MTS Medication Technologies

Mylan Pharmaceuticals Inc.

Natural Creations

Nature Well

National Community Pharmacists

Association (NCPA)

NCPA Foundation

Net-Rx

Nnodum Pharmaceuticals

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Omron Healthcare

Opus Medication Systems

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Paddock Laboratories, Inc.

Parata Systems

Partners in Pharmacy

Patriot Pharmaceuticals

PBA/TrueCare Pharmacies

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PDX-RX.com-PCI-FDS

PEP Systems, Inc.

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Pfizer

Pharmacist Mutual Companies

Pharmacy Automation Supplies

Pharmacy Development Services

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Pharmacy Times

PhytoPharmaica

PPOK/Rx Linc

Prasco Laboratories

PriCara, Unit of Ortho-McNeil, Inc.

Procter & Gamble

Professional Compounding

Centers of America, P.C.C.A

Prolab Imaging Products

Protech Ortho Mat Co.

PRS Pharmacy Services

Purdue Pharma L.P.	Sandoz US	Trinity Computer Systems
QS/1 Data Systems	Santarus, Inc.	U.S. Food and Drug Administration/ Center for Drug Evaluation and Research
Qualitest Pharmaceuticals, Inc.	Scriptech, LLC	Ultimed Inc.
Ranbaxy Pharmaceuticals RDC	ScriptPro Pharmacy Automation	United Drugs
Reese Pharmaceuticals Company	Seablue	United States Pharmacopeia
Reliant Pharmaceuticals	Sintek International AB	Upsher-Smith Laboratories Inc.
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Health Business Systems	Passport Drawing	Roche Laboratories	Willard B. Simmons Pharmacist of the Year Award
HCC	Passport Drawing	ScriptPro, LLC	Technology Seminar
Innovations	Technology Seminar	Sure Scripts	Technology Seminar
Mallinckrodt Pharmaceuticals	Education Grant, Prescription Drug Safety Award, Pruitt-Schutte Student Business Plan Competition	TeleManager Technologies	Technology Seminar
McKesson/Health Mart	CE Cyber Café, Registration Area	TEVA Pharmaceuticals	General Support
		Wyeth Pharmaceuticals	Bowl of Hygeia Reception

NCPA 2006 CORPORATE MEMBERS

NCPA Honors Corporate Members

On behalf of the nation's independent community pharmacies, NCPA recognizes those companies that have shown their support for independent pharmacy by joining our Corporate Member Program.

NCPA encourages independent pharmacy owners and managers to show their support for NCPA Corporate Member companies by carefully considering them when they purchase goods and services. NCPA members can contact any of these companies directly by visiting www.ncpanet.org.



Corporate Members

3M Pharmaceuticals
Abbott Diabetes Care
Abbott Laboratories, Inc.
Aetrex Worldwide, Inc.
Align Pharmaceuticals
Allergan, Inc.
AmerisourceBergen Corp.
Amgen, Inc.
Anda, Inc.
Apex-Carex Healthcare
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Bayer Diabetes Care Division
BD Diabetes Care
Bellco Health
Berlex Laboratories
Biovail Pharmaceuticals, Inc.
Boehringer Ingelheim Pharmaceuticals
Bristol-Myers Squibb
Buy-Sell A Pharmacy.Com
Cardinal Health
CARE Pharmacies, Inc.
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NCPA Honors IPO Members

On behalf of the nation's independent community pharmacies, NCPA recognizes the support of our 2006 Independent Pharmacy Organization members.

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Oklahoma, Inc.
Pharmacy Services Inc.
Quality Care Pharmacies
Rx Plus Pharmacies, Inc.
Southern Pharmacy Cooperative
United Drugs
United Pharmacists Network, Inc.

NCPA Bookstore Exhibit Hall

NCPA is offering its comprehensive library of business tools and educational materials—distinctive to the needs of future and current independent pharmacy owners.

Convention bookstore hours:

- Sunday, October 8 — 1:30 p.m. – 5:30 p.m.
- Monday, October 9 — 11:30 a.m. – 3:30 p.m.
- Tuesday, October 10 — 12:00 – 3 p.m.

UPDATED!

*NCPA Employee
Policy and Procedures
Wizard V2.0*



If you are a member, you can pick up a free copy of the 2006 NCPA-Pfizer Digest at the bookstore or go online to www.ncpanet.org/store.

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GUARDING THE FUTURE OF INDEPENDENT PHARMACY

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- I've contributed in the past, but want to increase my commitment.
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Just as NCPA is the only organization dedicated to meeting the needs of all independent pharmacy owners, the NCPA Foundation is the only research and education foundation devoted exclusively to supporting improved patient care in independent pharmacy and to developing programs for pharmacy students that recognize them for appropriate academic achievements, while introducing them to independent pharmacy practice. The NCPA Foundation is committed to supporting the growth and advancement of independently owned, community pharmacy practices by providing assistance to students, faculty, and innovative practitioners dedicated to improving patient care.

Research Grants

The NCPA Foundation supported research projects that provide useful information to community pharmacy. In the last year, the foundation supported the following grants:

- Northeastern University—*Economic Impact and Differential Costs of Community Pharmacy*
- Shenandoah University—*Patient Care Services in Community Pharmacy: What Is the Bottom Line*

Effective Pharmacy Management CD

The ninth edition of Effective Pharmacy Management is available in CD format. The CD provides instruction on developing and owning a community pharmacy practice. It is provided at no charge to all schools of pharmacy to assist educators by providing management materials for their students. The CD is also available to purchase for pharmacists and students. The project is supported by a grant from the NCPA Foundation.

Scholarships and Educational Loans

The NCPA Foundation has granted more than \$10 million in student scholarships and educational loans since its inception in 1953. This year, the foundation is providing Presidential Scholarships of \$2,500 each to 15 pharmacy students for demonstrating excellence in leadership, academic performance, and interest in independent community pharmacy.

In addition, the J.C. and Rheba Cobb Memorial Scholarship and the Willard B. Simmons Memorial Scholarship award \$2,000 to pharmacy students who also demonstrate an interest in civic affairs.

Every scholarship recipient is recognized at an awards ceremony during the annual convention.

NCPA Summer Intern

The NCPA Foundation supports the summer internship program annually. This year, Charles Hartig of Drake University worked with NCPA at its national headquarters in Alexandria, Virginia. Charlie undertook a variety of initiatives including reviewing cost of dispensing studies to assist with analysis of different methodologies and measurements of cost in the retail pharmacy setting, and he assisted in planning the Young Pharmacists Focus Group at the 108th Annual NCPA Convention and Trade Exposition.

John W. Dargavel Medal

Honoring John W. Dargavel, NCPA's executive secretary from 1933 to 1961, the medal is presented annually by the NCPA Foundation to honor those whose contributions on behalf of independent pharmacy embody the spirit of leadership and accomplishment personified by John Dargavel. The 2006 award winner is David Sparks, president of the Professional Compounding Centers of America.

Student Advisory Councils

The NCPA Foundation provides support for student activities and the student leadership and student regional councils. These students are vital to the success of the NCPA student chapters. These students assist the NCPA Department of Student Affairs in making school visits and provide assistance to the pharmacy schools in their regions.

2006 Student Leadership Council

- Mindy Sexton**, *president*
Texas Tech University Health Sciences Center
- Michael Franklin**, *secretary*
Samford University
- Charisse Birdwell**
University of Houston
- Kathryn Clasen**
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- Jinali Desai**
University of Georgia

Presidential Scholarship Recipients

- | | |
|--|---|
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2006 NCPA Foundation Scholarship Recipients

The J.C. and Rheba Cobb Memorial Scholarship
Sarah Frank – University of Arkansas for Medical Sciences

The Willard B. Simmons Memorial Scholarship
Lindsey White – University of Kentucky

George Guenther

University of Washington

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University of Southern California

Nathan Wiehl

University of Kansas

2006 Student Regional Council

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University of Houston

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Samford University's McWhorter School of Pharmacy

Casey Woltz

Southwestern Oklahoma State University

NCPA Pruitt-Schutte Student Business Plan Competition

NCPA continues to make progress in promoting the entrepreneurial drive to pharmacy students. NCPA and the NCPA Foundation established the competition to promote interest in independent community pharmacy ownership. The competition is supported by the families of pharmacy entrepreneurs Neil Pruitt Sr., and H. Joseph Schutte, and Mallinckrodt Pharmaceuticals. The competition's goal is to motivate pharmacy students to create the blueprint neces-

sary for buying an existing independent community pharmacy or to develop a new business. The finalists compete live at the annual convention.

Thirty pharmacy schools submitted business plans this year. The finalists are from the University of Houston, University of Kentucky, and Washington State University. All three teams receive cash awards for their school and their student chapter, and the first place team receives a trip to NCPA's 2007 Multiple Location Conference in Aruba. More information about the competition is on the student section of the NCPA Web site.

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** Contribution made in the memory of Kenneth Riddle.*

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1899–00	Simon Jones	Louisville, KY	Cincinnati, OH
1900–01	William Anderson	Brooklyn, NY	Detroit, MI
1901–02	James Seeley	Detroit, MI	Buffalo, NY
1903–04	B.E. Pritchard	Pittsburgh, PA	Washington, DC
1904–05	Thomas Voegeli	Minneapolis, MN	St.Louis, MO
1905–06	M.T. Breslin	New Orleans, LA	Boston, MA
1906–07	Charles Mann	Detroit, MI	Atlanta, GA
1907–08	Thomas Potts	Philadelphia, PA	Chicago, IL
1908–09	William Elkins Jr	Atlanta, GA	Atlantic City, NJ
1909–10	Charles Huhn	Minneapolis, MN	Louisville, KY
1910–11	H.B. Guilford	Rochester, NY	Pittsburgh, PA
1911–12	H.C. Shuptine	Savannah, GA	Niagara Falls, NY
1912–13	Henry Merritt	Plains, PA	Milwaukee, WI
1913–14	James Finneran	Boston, MA	Cincinnati, OH
1914–15	Samuel Henry	Philadelphia, PA	Philadelphia, PA
1915–16	M.A. Stout	Bluffton, IN	Minneapolis, MN
1916–17	Robert Frick	Louisville, KY	Indianapolis, IN
1917–18	Walter Cousins	Dallas, TX	Cleveland, OH
1918–19	Charles Harding	Cincinnati, OH	New Orleans, LA
1919–20	Theodore Hagenow	St.Louis, MO	Rochester, NY
1920–21	J.J. Possehl	Milwaukee, WI	St.Louis, MO
1921–22	Ambrose Hunsberger	Philadelphia, PA	Denver, CO
1922–23	Curtis Gladding	Hartford, CT	Detroit, MI
1923–24	J.H. Webster	Detroit, MI	Boston, MA
1924–25	F.R. Peterson	Portland, OR	Washington, DC
1925–26	Frank Stone	Washington, DC	Memphis, TN
1926–27	Samuel Davis	Nashville, TN	Philadelphia, PA
1927–28	William Oren	Indianapolis, IN	Kansas City, MO
1928–29	Denny Brann	Des Moines, IA	San Francisco, CA
1929–30	Thomas Roach	Oklahoma City, OK	Minneapolis, MN
1930–31	J.H. Riemenschneider	Chicago, IL	Atlantic City, NJ
1931–32	John Dargavel	Minneapolis, MN	Detroit, MI
1932–33	John Goode	Asheville, NC	Boston, MA
1933–34	Monte Powell	Denver, CO	Chicago, IL
1934–35	Harvey Henry	Los Angeles, CA	New Orleans, LA
1935–36	Charles Ehlers	Cincinnati, OH	Cincinnati, OH
1936–37	George Secord	Chicago, IL	Pittsburgh, PA
1937–38	Thomas Smith	Wilmington, DE	St.Louis, MO
1938–39	John Witty	Portland, OR	Chicago, IL
1939–40	Albert Fritz	Indianapolis, IN	St.Paul, MN
1940–41	Samuel Watkins	Dora, AL	New York, NY
1941–42	Hugh Beirne	New Haven, CT	Cleveland, OH
1942–47	J. Otto Kohl	Cincinnati, OH	Chicago, IL
1947–48	John Tripeny	Casper, WY	Chicago, IL
1948–49	Edgar Bellis	New York, NY	Atlantic City, NJ
1949–50	Frank Moudry	St.Paul, MN	New York, NY
1950–51	Charles Gilson	Centredale, RI	Long Beach, CA
1951–52	Elbert Gibbs	Birmingham, AL	Minneapolis, MN
1952–53	A.C. Mayerson	Chicago, IL	St.Louis, MO
1953–54	M.V. Hardesty	Louisville, KY	Chicago, IL

Term	President	From	Where Elected
1954-55	G.M. Eisele	Hot Springs, AR	Houston, TX
1955-56	John McKeighan	Flint, MI	Atlantic City, NJ
1956-57	Charles Seward	Pasadena, CA	Cincinnati, OH
1957-58	H.E. Henderson	Seattle, WA	Minneapolis, MN
1958-59	Angus Taylor	Minneapolis, MN	Philadelphia, PA
1959-60	Ralph Rooke	Richmond, VA	St.Louis, MO
1960-61	Tom Sharp	Nashville, TN	Denver, CO
1961-62	Bert Corgan	Denver, CO	Miami Beach, FL
1962-63	Frank Lobraico	Indianapolis, IN	New York, NY
1963-64	T. Donald Perkins	San Diego, CA	Chicago, IL
1964-65	Leonard Dueker	St.Louis, MO	San Francisco, CA
1965-66	J.C. Cobb	Tishomingo, OK	Washington, DC
1966-67	Charles Dunnington	Brockton, MA	St.Louis, MO
1967-68	George Wilharm	Minneapolis, MN	Houston, TX
1968-69	Michael Perhach	Binghamton, NY	Boston, MA
1969-70	Chris Haleston	Portland, OR	Las Vegas, NV
1970-71	Nick Avellone	Bay Village, OH	Atlantic City, NJ
1971-72	E. Crawford Meyer	Louisville, KY	New Orleans, LA
1972-73	George Benson	Seattle, WA	Chicago, IL
1973-74	Harold Shinnick	Chicago, IL	Portland, OR
1974-75	E. Boyd Garrett	Nashville, TN	Las Vegas, NV
1975-76	William Wickwire	Los Altos, CA	Miami Beach, FL
1976-77	Salvatore D 'Angelo	New Orleans, LA	San Francisco, CA
1977-78	Sam McConnell Jr.	Scottsdale, AZ	Washington, DC
1978-79	Kenneth Mehrle Cape	Girardeau, MO	New Orleans, LA
1979-80	Paul Dumouchel	Waltham, MA	Las Vegas, NV
1980-81	Jesse Pike Sr.	Concord, NC	Atlanta, GA
1981-82	Neil Pruitt	Toccoa, GA	San Antonio, TX
1982-83	John Johnson	Bellevue, NE	Boston, MA
1983-84	James Vincent	Yuma, CO	Las Vegas, NV
1984-85	John White	Tallahassee, FL	Miami Beach, FL
1985-86	H. Joseph Schutte	Louisville, KY	New York, NY
1986-87	Lonnie Hollingsworth	Lubbock, TX	Louisville, KY
1987-88	Darwyn Williams	Webster City, IA	Las Vegas, NV
1988-89	Donald Arthur	Tonawanda, NY	Atlanta, GA
1989-90	Joseph Mosso	Latrobe, PA	San Antonio, TX
1990-91	William Katz	Newington, CT	Nashville, TN
1991-92	William Scharringhausen	Park Ridge, IL	Baltimore, MD
1992-93	Donald Moore	Kokomo, IN	Seattle, WA
1993-94	Calvin Anthony	Stillwater, OK	Indianapolis, IN
1994-95	Gene Graves	Little Rock, AR	Boston, MA
1995-96	Louis Mitchell	Swedesboro, NJ	Las Vegas, NV
1996-97	Dennis Ludwig	Boulder, CO	New Orleans, LA
1997-98	Kenneth Epley	Salem, OR	Denver, CO
1998-99	W. Whitaker Moose	Mount Pleasant, NC	St.Louis, MO
1999-00	C. Robert Blake	West Union, OH	Las Vegas, NV
2000-01	John R.Carson	San Antonio, TX	San Antonio, TX
2001-02	James L.Martin	Austin, TX	Philadelphia, PA
2002-03	Joe Smith	Falls Church, VA	Nashville, TN
2003-04	Sharlea Leatherwood	Kansas City, MO	Seattle, WA
2004-05	Tony Welder	Bismarck, ND	Boston, MA

PARTNERS IN PHARMACY

In Boston 101 years ago, the Women's Organization of National Association of Retail Druggists (WONARD) was founded through the efforts of Mrs. J. O. Gooding, Mrs. Leslie Wallace, both of Boston, and Mrs. William Estelle Lee of Philadelphia. Wallace was the first president. WONARD held an annual convention each year with the exception of the World War II period.

The organization's objectives were to become involved in the interests of all aspects of the pharmaceutical profession—educationally, philanthropically, and socially, and to support legislation for the improvement of the retail drug and pharmacy business. In 1913 the first *WONARD Bulletin* was published. This quarterly publication recorded the organization's activities and served to bind the various members and chapters together. Later pages were provided in the *NARD Journal* and then bi-annual newsletters. There have been seven editors over the years with Mrs. William Estelle Lee as the first.

Mrs. Fred Cotte of Cincinnati proposed the idea of formulating a scholarship fund in 1912 at the Milwaukee convention. The first scholarship was granted in 1915 and as funds were made available, one or more scholarships were awarded on a continuing basis. The scholarships go to students pursuing a career in pharmacy at an accredited college in the United States. Scholarship winners must have completed two years of pre-pharmacy, and the scholarships are awarded to students based on scholastic achievement, financial need, and career goals.

WONARD's Golden Anniversary was celebrated in 1955 in Atlantic City, New Jersey. Mrs. Harry Prafke of Chicago was the presiding officer at this historic event. Thirty-three chapters have existed through the years, representing several states throughout the country. Seventy-six women have served as national president. The membership was also made up of members-at-large who were not affiliated with any chapter. When the organization was dissolved in 2003, there was only one remaining chapter (Muncie, Indiana, No. 33).

The title of honorary president was bestowed upon two worthy women, Miss Blanche Whitecar of Philadelphia in 1963, and Mrs. Gertrude Ernst of Boston in 1969. It was through the generosity of Whitecar, who left the organization stock in Smith, Kline and French when she died, that the scholarships have continued and increased in numbers over the last years.

When the National Association of Retail Druggists (NARD) changed its name to the National Community Pharmacists Association (NCPA) in 1996, WONARD, in an effort to become more inclusive, soon followed suit, changing its name to Partners in Pharmacy in 1998. Last year, WONARD/Partners in Pharmacy celebrated its centennial. For more than 100 years, the organization has sought to be a close partner to NARD/NCPA in the quest for improving and recognizing one of the most trusted professions in America—pharmacy and the pharmacists who serve the public.

— By Doris Rhea

Scholarship Recipients

- Bryan Rodgers — Mercer—Southern School of Pharmacy
- A'ishah Khan — University of Florida College of Pharmacy
- Laura Marran — University of Arizona College of Pharmacy
- Melinda Christina Albritton — Shenandoah University/Bernard J. Dunn School of Pharmacy
- Bonnie East — Shenandoah University/Bernard J. Dunn School of Pharmacy
- Anthony Thomas Pudlo — Drake University
- Jennifer Quistgaard — University of Minnesota College of Pharmacy, Twin Cities
- Whitney Fisk — Texas Tech Health Sciences Center School of Pharmacy
- Sally Hanna — Shenandoah University/Bernard J. Dunn School of Pharmacy
- Arpie Mikaelian — Western University of Health Sciences

(The NCPA Foundation provided funds to support the travel expenses to the convention of the 10 Partners in Pharmacy scholarship recipients.)

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Medication Errors Harm 1.5 Million Americans Annually

Medication errors made in hospitals and clinics around the country harm at least 1.5 million Americans every year, according to a study by the National Academy of Sciences.

"There are at least 1.5 million preventable ADEs (adverse drug events) that occur in the United States each year," 7,000 of which result in deaths, the academy's Institute of Medicine said. "The true number may be much higher," it added.

In terms of money, the mistakes cost the U.S. health care system about \$3.5 billion a year, without factoring in the loss of work-hours by its victims, said the institute, which offers the government independent counseling on health issues.

"What is most striking about these statistics is that much of this harm is pre-

ventable, since a variety of strategies and techniques exist for reducing medication errors," the researchers said.

Health providers should be more forthcoming about medication errors and their consequences, and "make greater use of information technologies in prescribing and dispensing medications."

It highly recommended the use of e-prescriptions, to "avoid many of the mistakes that accompany handwritten prescriptions." All prescribers and pharmacies, it added, should use e-prescriptions by 2010.

"Furthermore, by tying e-prescriptions in with the patient's medical history, it is possible to check automatically for such things as drug allergies, drug-drug interactions and overly high doses," it added.

November Health Events

National Family Caregivers Month

National Family Caregivers Association
www.thefamilycaregiver.org

National Alzheimer's Disease Month

Alzheimer's Association
www.alz.org

American Diabetes Month

American Diabetes Association
www.diabetes.org

Great American Smokeout—Nov. 16

American Cancer Society
www.cancer.org

The Institute of Medicine estimated that, on average, at least one patient per hospital per day risks being prescribed or administered the wrong medication.

Pharmacists, Nurses Make Difference in Diabetes Care

Giving pharmacist or nurse case managers authority to adjust a patient's medications without waiting for a physician's approval could improve care for people with diabetes, according to a study reported in the July 26 issue of the *Journal of the American Medical Association*. The meta-regression analysis was sponsored by the Agency for Healthcare Research and Quality.

Researchers from the Ottawa Health Research Institute in Ottawa, Canada, University of California at San Francisco, Stanford University, and the Veteran Affairs Palo Alto Health Care System identified 66 controlled trials of quality improvement interventions for detailed analysis. They also identified 11 distinct types of quality improvement strategies, including provider education, patient education, and performance audits with feedback to providers. Most interventions achieved minimal impact on long-term control of blood glucose.

The authors found that case management programs that allowed nurse or pharmacist case managers to make inde-

pendent medication changes improved patients' blood glucose levels more than twice as much as programs that required waiting for physician approval. Patients' mean blood glucose control, reflected in A1c levels, improved by 0.80 percentage points with nurse or pharmacist case management, compared with 0.32 percentage points with all other interventions. The researchers caution that these findings need to be confirmed by large prospective clinical trials.

Diabetes Study Says Obese Youngsters at Risk

Type 2 diabetes before age 20 leads to a high risk of kidney disease and death by middle age, a significant finding because worldwide obesity is exposing more children to the disease, researchers said.

In the United States so-called adult onset or type 2 diabetes will be more prevalent than juvenile or type 1 diabetes in children within 10 years, the study from the National Institutes of Health said.

The findings reported in a recent issue of the *Journal of the American Medical Association* were based on a study of

more than 1,800 U.S. Pima Indians between 1965 and 2002. Some of those in the study developed diabetes before age 20, while others came down with it between the ages of 20 and 55.

The study found that those who developed the disease earlier had end-stage kidney disease in their middle years at a rate that was up to eight times higher than the older group. In addition their death rate was two times higher than the older group.

The younger group is harder hit, the report said, because the disease has more time to be destructive. And while youth appears to provide some protection against the vision loss that is a complication of diabetes, it does not stop kidney damage, which can also lead to heart disease.

The current increase in obesity in children and adolescents in many parts of the world had led to a higher prevalence of type 2 diabetes in those groups, the study said. □



"Inside Pharmacist Care®" is the monthly news report of NCPA's National Institute for Pharmacist Care Outcomes division.

Emerging Trends in HIV Combination Therapy: The Pharmacology and the Pharmacist

By James D. Scott, PharmD

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

1. Discuss the current combination HIV therapies.
2. Discuss the evolution of combination therapies.
3. Describe the synergistic mechanism of protease inhibitors and potent cytochrome P450 inhibitors.
4. Discuss clinically relevant side effects and food restrictions of antiretrovirals
5. Identify key opportunities for pharmacist intervention with HIV treatment regimens.

HIV Infection Combination Therapy Development

In March 1987, treatment for Human Immunodeficiency Virus (HIV) and the resulting Acquired Immune Deficiency Syndrome (AIDS) began. With the approval of zidovudine (AZT, Retrovir) came the hope that hundreds of thousands of Americans had been waiting for: a treatment for AIDS. Although it was often poorly tolerated, some patients did benefit from it, and many more people benefited from the hope that it brought. AZT was to remain the only antiretroviral agent available for another four years. Then, in 1991 and 1992, two more antiretrovirals were approved: didanosine (ddI, Videx), and zalcitabine (ddC, Hivid), respectively. At the time, with so few agents available and with similar toxicities between the agents, monotherapy was the only option. As time went on more information about the virus, and more agents to treat it, became available. However, it was not until 1996 and 1997 that the use of combination therapy in general clinical practice became widespread.

The essence of the need for combination therapy to treat HIV infection stems from the natural development of resistance mutations. HIV is not 100 percent accurate when it reproduces itself. There is approximately one "mistake" in every

copy of HIV RNA that it creates. Sometimes this "mistake," or mutation is at an irrelevant portion of the genome and the virus continues its existence in a similar fashion. Sometimes, however, it is at an essential portion of the genome, and the virus can not survive and/or reproduce. These mutations are not the problem.

The clinical problem comes when the mutation occurs at a location in the viral genome that allows this mutated virus to grow better in the presence of antiretroviral medications than the original version of the virus (called the wild-type virus). When someone has been chronically infected and has never received treatment, it is believed that there is a sufficient number and variety of mutations that every clinically relevant resistance mutation can be found somewhere in the "viral population." However, it is unlikely that any given virus has more than one of these clinical relevant resistance mutations, and nearly impossible that it would have more than two of these mutations. Therefore, treatment with at least three antiretroviral medications allows for suppression of each virus in the population by at least one, but usually two or three medications.

If fewer than three antiretrovirals are used, there is a higher likelihood that the viruses in the patient's viral population that are resistant to one of the medications in the regimen will be able to grow and reproduce. Once the resistant mutant has become dominant, it will be a factor to consider when deciding on any future regimens for this patient. As such, while dual-therapy for HIV infection may allow the virus to be suppressed initially (due to suppression of the wild-type virus, which accounts for the vast majority of virus in the untreated patient), this regimen will not be as durable as a triple drug regimen due to the growth in numbers of resistant viruses in the population.

The first real foray into combination therapy started with the first class of antiretroviral agents, the nucleoside reverse transcriptase inhibitors (NRTIs). With the approval of the fifth NRTI, lamivudine

(3TC, Epivir), there were enough agents available to try combining these medications together. As studies were done, it was noted that zidovudine and lamivudine appeared synergistic when used together to fight the virus. This was found to be partially due to the effects of a particular resistance mutation, as well as the innate pharmacodynamic properties of the medications.

In late 1995, the treatment options for people living with HIV/AIDS began to change. Saquinavir mesylate (SQV, Invirase) was the first antiretroviral in a new class, called the protease inhibitors (PIs), to be approved. In short succession, two more protease inhibitors, ritonavir (RTV, Norvir) and indinavir (IDV, Crixivan), were approved. In June 1996, nevirapine (NVP, Viramune), the first agent of a third class of antiretrovirals, the non-nucleoside reverse transcriptase inhibitors (NNRTIs), was approved. With these broadened treatment options came the opportunity to begin exploring the combination of two or more classes of antiretroviral agents.

However, while these agents were very effective against HIV, they were not without their problems. Saquinavir mesylate was fairly well tolerated, but poorly absorbed (~4 percent). Ritonavir was better absorbed, but poorly tolerated. Many patients started on full dose ritonavir could not tolerate the gastrointestinal (GI) side effects (including diarrhea, gas, bloating, and nausea). Even the institution of a two-week step-up dosing initiation (300 mg BID _ 400 mg BID _ 500 mg BID _ and finally 600 mg BID) was marginally helpful. Indinavir was better tolerated and well absorbed, but was only available through a single mail order pharmacy. Access to indinavir was marginal for most of this time, especially when initiating therapy. Fortunately, by late 1997 two more protease inhibitors, nelfinavir (NFV, Viracept), and Fortovase became available. Fortovase was a new formulation of saquinavir that was available in a soft-gel capsule (saquinavir-SGC) and was much better absorbed (as compared to the

saquinavir mesylate's hard-gel capsule).

Despite these effective new agents, problems with treatment soon arose. Many patients with HIV had been treated with sequential monotherapy with the NRTIs. As such, the addition of one more agent (either a NNRTI or a PI) often resulted in a short-term suppression of HIV followed by a gradual resistance to the new agent. This resistance was due either to the evolution of a series of resistance mutations affecting the PIs, or one or two key resistance mutations affecting the NNRTIs.

One of the key points here is that the PIs typically require the development several class-wide mutations for drug failure to occur. Each PI has its own set of resistance mutations that weaken it more than others, but it typically takes from four to 10 PI mutations for the virus to be resistant to any given PI when it has been boosted with ritonavir. Each of these PI mutations weakens the effect of the drug. That is, they increase the amount of drug needed to inhibit the virus (IC_{50}). When the IC_{50} exceeds the amount of a given PI that can be absorbed and maintained in the blood, therapeutic failure can occur. Theoretically, if the serum level of a PI can be increased above the IC_{50} that has resulted from the build-up of resistance mutations, the PI may become effective again.

Conversely, NNRTIs are typically weakened significantly by a few key mutations. Once one or two of these mutations have developed, the increase in IC_{50} is so pronounced that it is not possible to increase the concentration of the drug to a sufficient level. Thus, the NNRTIs (usually as a class) become ineffective with the development of very few mutations (often just one). It is also important to note that some of the PIs have key mutations that will increase the IC_{50} to the extent that they can no longer be used, as well as still being susceptible to the standard PI mutations as discussed previously. Often, these key mutations affect only one specific PI, and do not weaken the other PIs.

Development of Boosted PIs

With the increased knowledge of resistance, the availability of viral load testing (which gives clinicians an idea of how much HIV is present, as well as changes related to treatment and resistance) and clinical experience with the new agents came the realization that treatment experienced patients (with multiple NRTI resist-

ance mutations) needed more from the PIs than standard dosing would allow. Additionally, those people who had been treated with standard dose PIs and now had some PI resistance mutations also needed to get more out of their medications in order to keep the virus suppressed and maintain their immune systems.

It was known early on that ritonavir was a potent inhibitor of many enzymes within the cytochrome P450 system, most notably 3A4 (CYP3A4). It was also known that most of the PIs were metabolized by CYP3A4. This connection would eventually allow for the pharmacokinetic enhancement of PIs in such a dramatic fashion as to significantly change the direction that treatment with PIs would take.

The initial use of two PIs together was intended to utilize this pharmacokinetic interaction to allow therapeutic levels of two PIs at the same time, while using lower doses of each in the process. The combination of 400 mg each of saquinavir-SGC and ritonavir twice a day provided the opportunity to more aggressively use PIs in patients who had already experienced the development of resistance. Saquinavir-SGC and ritonavir (the so-called RIT-SAQ combination) were a natural fit, as animal studies showed a 36 fold increase in saquinavir's area under the curve (AUC, a measure of bioavailability) when co-administered with similar doses of ritonavir. Additionally, ritonavir's inhibition of CYP3A4 in the gut and liver increases the absorption of saquinavir, while decreasing the impact of first-pass metabolism. While this combination was an effective regimen, tolerability was limited for many patients (due primarily to the historically poor tolerability of ritonavir).

As this regimen was being used clinically, more information was being gathered about ritonavir's ability to affect the CYP3A4 system. It was found to be not just a very effective inhibitor, but also a very potent inhibitor. That is, lower doses of ritonavir were as effective at inhibiting the CYP3A4 enzymes as higher doses. Since ritonavir GI toxicities are felt to be dose-related, the use of lower doses of ritonavir to enhance the pharmacokinetic profiles of other PIs (boosting) was proposed to be a significant clinical benefit. It was with this information that data emerged showing that saquinavir-SGC 1,000 mg with ritonavir 100 mg was as

effective and showed improved pharmacokinetics and tolerability compared to saquinavir-SGC 400 mg with ritonavir 400 mg, and similar pharmacokinetics between the saquinavir-SGC and saquinavir mesylate.

Saquinavir was not the only PI that showed a significant clinical benefit by boosting with ritonavir. Indinavir, amprenavir (APV, Agenerase), atazanavir (TAZ, Reyataz), and fosamprenavir (Lexiva) have also been shown to have improved pharmacokinetic profiles with the addition of low dose ritonavir. Kaletra is a co-administered product of the PI lopinavir with ritonavir (lopinavir/r). Lopinavir, while an effective PI at therapeutic concentrations, is very quickly removed from the blood stream. As such, its co-administration with ritonavir is essential for lopinavir to be a clinically useful anti-retroviral. The pharmacokinetic impact of ritonavir on nelfinavir, on the other hand, has had variable effects, resulting in a recommendation to not boost nelfinavir with ritonavir.

It should be noted that saquinavir-SGC (Fortovase) was withdrawn from the market earlier this year. This is based on data from the new 500 mg saquinavir mesylate tablet (which significantly reduces the pill burden) and equivalent pharmacokinetic data between saquinavir-SGC and saquinavir mesylate when co-administered with low dose ritonavir.

Clinical Use of Boosted PIs

The pharmacokinetic enhancement of PIs with low dose ritonavir has effects beyond the basic increase of AUC, C_{max} and C_{min} . Along with the increased likelihood of suppressing the virus, the increased C_{min} of boosted PIs decreases the development of PI associated resistance mutations. In fact, the use of several of these agents in PI-treatment naïve patients has been shown to not lead to the development of PI resistance mutations, even in the face of virologic failure. That is, if someone is being treated with a PI for the first time, and they fail to either completely suppress the virus or the suppression does not last (despite taking the medications appropriately), resistance tests show resistance mutations to the NRTIs in the regimen but not the PI. This has been shown with lopinavir/ritonavir, indinavir/ritonavir, fosamprenavir/ritonavir, and saquinavir/ritonavir.

Guidance in the Treatment Of HIV Infection

In 1993, with only three drugs available to treat HIV infection, the first set of treatment guidelines were published. These guidelines provided the best direction available at the time: start with one agent and when failure or intolerance occurs, change to another single agent, and then another. Sequential monotherapy was state of the art in 1993, and remained as such until 1996. Now we know that monotherapy with a nucleoside analogue (NRTI), such as zidovudine, didanosine, or zalcitabine, will have neither a significant nor prolonged effect on the treatment of HIV infection. Instead, combination therapy has been shown to result in significant reductions in the amount of HIV in the blood, significant increases in CD4 cells and immune function, and significant decreases in morbidity and mortality related to HIV infection and AIDS.

How the choice of medications that make up these combinations is made has evolved over time. The first set of recommendations for combination therapy (from the International AIDS Society-USA, IAS-USA) came in 1996. This was after the first PIs (saquinavir, zidovudine, and didanosine), and first NNRTI (nevirapine) were approved. These guidelines were followed by subsequent guidelines in 1997 and 1998 from the IAS-USA, and were joined by recommendations from the Department of Health and Human Services (HHS) in 1998. The HHS guidelines have been available online as a "living document" and are updated periodically based on new data. From their inception through 2003, both the IAS-USA and DHHS guidelines have offered potential regimens using a "menu" format. That is, one could choose one option from a NRTI combination that had sufficient data to support its use, along with a PI or NNRTI, to make a sufficient regimen. This format was used primarily because of the lack of moderate to long-term data on combination therapy. Data was available with individual agents in monotherapy, or pairs of agents in dual therapy.

By 2003, sufficient data was available from large studies to allow the HHS to offer recommendation of regimens containing specific combinations of three antiretrovirals. However, the IAS-USA continue to offer several options for combination therapy. The HHS guidelines (as

of April 2005) recommend the use of lopinavir/r with zidovudine, and either lamivudine or emtricitabine (Emtriva) for PI-based regimens. The use of efavirenz (EFV, Sustiva) with either lamivudine or emtricitabine, and either zidovudine or tenofovir DF, is recommended for patients being started on a NNRTI-based regimen (except in women who are pregnant or at high risk of becoming pregnant due to the risk of teratogenicity from efavirenz). The 2004 guidelines from IAS-USA also recommend efavirenz (with similar restrictions as mentioned above) in NNRTI-based regimens. NRTI combinations are slightly expanded with recommendations of either zidovudine or tenofovir DF (TDF, Viread), with either lamivudine or emtricitabine (regardless of whether it is part of a NNRTI or PI based regimen), or the combination of didanosine and emtricitabine. Additionally, the recommendations for PIs have been broadened and include lopinavir/ratazanavir with low dose ritonavir, saquinavir with low dose ritonavir, or indinavir with low dose ritonavir.

Combination Antiretrovirals Therapy: Patient Counseling Considerations

For many patients with HIV, simply having the infection is psychologically traumatic and emotionally draining. The addition of combination therapy (which can be complex at times) makes it even more difficult. Unlike most chronic illnesses, HIV doesn't affect just, or even primarily, the elderly. People of all ages can contract HIV, even with just one episode of a risky behavior. Many people are in their 20s, 30s, and 40s. Most people don't expect to need life-long medications during these ages, and have a difficult time adjusting. It is not uncommon for young patients with HIV who are initiating treatment to not even understand how to refill a prescription. With the increased complexity of a combination regimen, and the possibility of side effects from three or more medications, it is essential for pharmacists to have an understanding of several major counseling points, so that they may best help their patients get the most out of their treatment. These major counseling points include: the need for combination therapy to treat HIV, the need to take all of their medications (adherence), knowledge about correctly taking medications (includ-

ing food and water restrictions), and common or significant side effects.

NEED FOR COMBINATION THERAPY

The rationale for combination therapy was explained in detail earlier. But when counseling patients, it is essential to relate this information in a manner that they can understand and visualize. Many practitioners find the use of analogies helpful. For example:

If you were being attacked by someone and had to fight for your life, would you limit yourself to using just one hand or would you use both hand and your feet? And, if you knew that certain movements of your hand were more effective than others, you would use those movements as much as you could.

Once the patient has the basic understanding of why three or four medications are necessary, it usually does not need to be repeated. But occasional reinforcement may be helpful if patients seem to be losing motivation to take their medications.

Part of the discussion regarding combination therapy includes the need for low dose ritonavir to boost the primary PI. Often, patients are told that they will be on three antiretrovirals, only to find out there is a fourth. Additionally, ritonavir is often the largest agent in their regimen, and is taken as one capsule once or twice a day. Without proper counseling, it is easy for many patients to justify skipping the ritonavir to avoid things such as the size and texture. It is important for patients to understand why the ritonavir is an essential part of the regimen.

Another analogy is that of a sink with water. If you need to keep a certain amount of water in the sink, and the sink doesn't have a stopper, you have to add water regularly to replace the amount that goes down the drain. However, if you put a washcloth over the drain, that will slow down how fast the water leaves the sink. You can keep a higher level of water in there and use less water. The "water" is the primary PI, and the "washcloth" is the ritonavir.

Helping patients see it being as important as the rest of their regimen may help keep them motivated to take it regularly. Not taking the ritonavir when it is prescribed as part of their regimen is very likely to lead to virologic failure and or the development of resistance mutations.

NEED FOR ADHERENCE

From a pharmacist's perspective, it only

makes sense that patients should take all of their medications. We give them 30 tablets for a 30-day supply because they are supposed to take it every day. However, it is not as cut and dry from a patient's perspective. They are taking into consideration many different aspects of themselves and their lives. What side effects will I get, and where will I be when I get them? Who will see me take them, and do I want them to see me? It's probably okay if I just miss a dose here and there, because that won't affect anything.

The pharmacist has a potential key role in identifying a patient's specific barriers to adherence, and working with them to find ways of overcoming these barriers. Having a good rapport with their customers, being an active listener, and being non-judgmental are key starting points for pharmacists in helping their patients with their HIV medications.

How to Take Medications

Several of the HIV medications have specific restrictions with regards to food intake near the dosing time. While these restrictions can be cumbersome and add to the complexity, they are usually required to optimize the absorption and effects of the medication. Occasionally, a particular combination of medications may be needed to treat the HIV infection (given a patient's resistance mutations); but, different antiretroviral agents with conflicting food restrictions can significantly affect the complexity of the regimen and may result in a negative impact on adherence.

The NRTIs and NNRTIs are fairly simple when it comes to food restrictions. Didanosine products should be taken on an empty stomach to ensure optimal absorption. The exception to this is when it is co-administered with tenofovir DF. Tenofovir DF decreases elimination of didanosine, resulting in the need for a lower didanosine dose (decrease from 400 mg once daily to 250 mg once daily for patient >60 kg) and removing the didanosine food restriction. While tenofovir DF absorption is improved with food, levels are sufficient on an empty stomach to not require that it be taken with food. Efavirenz should not be taken with a high fat meal, as this will increase absorption and lead to a higher likelihood of central nervous system (CNS) side effects. As

efavirenz is usually taken at bedtime, this "high fat meal" often includes desserts (such as ice cream) and it may be helpful to mention this to patients (especially if they have a hard time sleeping due to the CNS effects while taking efavirenz).

In general the PIs are best taken with food. Food generally helps to maximize absorption, decrease inter- and inpatient variability of serum levels, and improve tolerability (primarily decreasing diarrhea). The following PIs are recommended (per their package inserts) to be taken with food or shortly after a meal: atazanavir, nelfinavir, lopinavir/r, ritonavir, saquinavir mesylate, and tipranavir (Aptivus). Fosamprenavir may be taken with or without food, and indinavir should be taken on an empty stomach or a light meal (although co-administration with low dose ritonavir negates the need for food restrictions with indinavir). Indinavir is the only antiretroviral with recommendations on water intake. Whether given with low dose ritonavir or not, patients taking indinavir should drink 1.5 liters of water per day. The reason for this is the potential for crystallization of indinavir in the kidney, leading to kidney stones, and it is more likely to happen when indinavir is taken with low dose ritonavir.

EXPECTED PI SIDE EFFECTS

The saying "forewarned is forearmed" couldn't be any more true for side effects from medications, including retrovirals. While there is always the occasional patient who feels as though they are reacting to every potential side effect listed for a given medication, educating patients helps them take control of the side effects. They understand what to expect, and know what to do about it (if anything can be done). In general, all classes of anti-retroviral agents have "class-wide" side effects, and the individual agents often have unique side effects of their own.

NRTI class-wide side effects include lipoatrophy (the loss of subcutaneous fat) and lactic acidosis (with or without hepatic steatosis). However, of the NRTIs on the market, zalcitabine, stavudine (d4T, Zerit), and didanosine are more likely to cause these adverse events. Zalcitabine, stavudine and didanosine are also more likely to cause peripheral neuropathy and pancreatitis. Zidovudine is known for causing nausea (which is typically most intense

during the first month on treatment) and occasionally anemia and/or neutropenia. Abacavir (ABC, Ziagen) has a 3-9 percent incidence of a hypersensitivity reaction, which is characterized by two or more symptoms that include the following: fever, headache, malaise, fatigue, rash, nausea/vomiting, and abdominal cramps. While there have been cases of fatal hypersensitivity reactions, serious reactions are easily avoided by discontinuing the abacavir and not rechallenging (rechallenge is most closely associated with a life-threatening reaction).

This reaction usually occurs early in therapy (90 percent of cases occur within the first six weeks). Patients should be counseled about this reaction and to call their medical provider immediately if they experience two or more of the symptoms just listed. Studies have alluded to cases of renal tubular acidosis with tenofovir DF, but they are not conclusive. While side effects have been seen with the remaining NRTIs, they are generally well tolerated.

Class-wide side effects of the NNRTIs include rash and drug-induced hepatitis. Of the two commonly used NNRTIs, nevirapine and efavirenz, nevirapine has a higher incidence and severity of both of these adverse events. Cases of severe rash leading to Stevens-Johnson syndrome have been seen with nevirapine. Using a starting dose of 200 mg daily for two weeks, before increasing to the standard dose of 200 mg twice daily, helps to decrease rash risk. Due to an increased risk of both of these side effects, it is not recommended to initiate antiretroviral treatment with nevirapine in female patients with a CD4 > 250 cells/mcl, or male patients with a CD4 > 400 cells/mcl. The most common side effect of efavirenz is CNS changes. The primary manifestation of this side effect is vivid dreams. These are typically more intense during the first two weeks to two months on therapy, but may linger with varying degrees of intensity. Other CNS side effects have included insomnia, fatigue, difficulty thinking, and depression. Drug interactions are an issue with NNRTIs, and a thorough listing of current prescription and OTC medications should be part of medication counseling.

Class-wide side effects of the PIs include GI (diarrhea, gas, bloating, nausea), lipoaccumulation (an increase in visceral fat in the abdomen, on the shoulders, and/or under the jaw), and dyslipidemia

(increases in cholesterol, triglycerides, and occasionally blood sugars). While these effects have been seen in all PIs, they are seen to a lesser extent in patients taking atazanavir. Additionally, saquinavir mesylate has a lower incidence of these effects compared to the other PIs (except atazanavir). Atazanavir frequently causes an indirect bilirubinemia. This is due to an inhibition of the enzyme that converts indirect bilirubin (which the body cannot clear) to direct bilirubin (which the body can clear). Jaundice is seen occasionally, but it is usually transient. Indinavir shares this side effect, along with the potential for kidney stones discussed earlier. The newest PI, tipranavir, is noted to have an increased risk of rash and elevated liver function tests. Drug interactions are a significant issue with PIs, and a thorough listing of current prescription and OTC medications should be part of medication counseling.

The fourth class of antiretrovirals is the fusion inhibitors (FI). Currently, only one medication from this class is available commercially. Enfuvirtide (Fuzeon) is available by subcutaneous injection only, and must be administered twice daily. Although there are relatively few systemic side effects, the injection site reactions can cause concern. Patients should rotate their injection sites each time, so that any given site can recover for 7–10 days before being used again. Reactions vary in size and intensity, but all resemble a local irritation. Some patients may develop lumps the size of marbles or golf balls, while many patients have no reaction at all. Massaging the site of injection can help, and altering to injection technique to find a well tolerated angle may also be of benefit. A gas-cartridge auto-injector is being studied for use with enfuvirtide to decrease the occurrence of injection site reactions.

Obviously, patients do not need to be counseled on the side effects of all antiretrovirals when picking up their medications. Counseling should be focused on the medications they are receiving or questions that they bring up.

Essential Treatment

Combination therapy is essential to successfully treating HIV. If fewer than three antiretroviral agents are used there is an increased risk of virologic failure and the development of resistance mutations.

However, with more medications, there are more problems in terms of effectively taking the medications and with possible side effects. Pharmacists are on the front line of patient care every day. Working with patients and providing appropriate education and information is critical in helping patients succeed with combination therapy for HIV. □

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[Editor's Note: This program is supported by an unrestricted educational grant from Roche Laboratories.]



CONTINUING EDUCATION QUIZ

Select the correct answer.

- The first antiretroviral agent for the treatment of HIV infection to become available in the United States was:
 - AZT
 - Zerit
 - Saquinavir
 - Nevirapine
- How many mistakes does the HIV virus typically make when it creates a new RNA strand?
 - One
 - Two
 - Three
 - Five
- The first non-nucleoside reverse transcriptase inhibitor to be available in the United States was:
 - AZT
 - Zerit
 - Saquinavir
 - Nevirapine
- Most protease inhibitors are rendered inactive by a single key resistance mutation.
 - True
 - False
- When the virus becomes resistant to an antiretroviral, the IC₅₀ of that drug:
 - Decreases
 - Increases
 - Stays the same
 - Decreases first, then increases

6. The purpose of boosting protease inhibitors in treatment experienced patients is to:

- Increase the risk of diarrhea
- Add a second therapeutic agent
- Make the regimen more complex
- Exceed the IC₅₀

7. Which of the following effects on the CYP450 3A4 allows for boosting of protease inhibitors?

- Induction
- Stabilization
- Inhibition
- Fluctuation

8. The combination of ritonavir and saquinavir was affective partially because of:

- Increased elimination of saquinavir
- Increased absorption of saquinavir
- Delayed therapeutic effects of ritonavir
- Exaggerated side effects of ritoanvir

9. The dosing regimen that replaced saquinavir 400 mg with ritonavir 400mg BID was:

- Saquinavir 1,000 mg, ritonavir 100 mg BID
- Saquinavir 800 mg, ritonavir 300 mg BID
- Saquinavir 600 mg, ritonavir 600 mg QD
- Saquinavir 100 mg, ritonavir 1,000 mg QD

10. Which of the following protease inhibitors can't be boosted with ritonavir?

- Indinavir
- Nelfinavir
- Saquinavir
- Nevirapine

11. Which organization publishes a set of guidelines to help physicians treat patients with HIV infection?

- American Academy of HIV Medicine
- Academy of Nurses in AIDS Care
- International AIDS Society-USA
- International Society for Anti-Infective Pharmacology

12. Which of the following regimens is NOT a recommended regimen in either of the two sets of accepted guidelines?

- Atazanavir, tenofovir DF, lamivudine
- Efavirenz, tenofovir DF, emtricitabine
- Saquinavir/ritonavir, zidovudine, lamivudine
- Lopinavir/ritonavir, zidovudine, emtricitabine

13. Given the known consequences of not treating HIV infection, most people with HIV in the United States are quite complacent about even the most complex treatment regimens.

- True
- False

14. Three key pharmacy counseling points (discussed in this program) for patients being treated for HIV infection do NOT include:

- a. The need for combination therapy
- b. Fostering the patient physician relationship
- c. The need for adherence
- d. Side effect management

15. Many patients take all of the following factors into consideration when they take their antiretrovirals EXCEPT:

- a. The bright tablet coloring
- b. Side effects
- c. Being seen taking the medications
- d. The feasibility of missing occasional doses

16. Didanosine should always be taken on an empty stomach, EXCEPT when it is taken:

- a. After refrigeration
- b. With zidovudine
- c. After ice cream
- d. With tenofovir DF

17. It is required that all protease inhibitors be taken with food.

- a. True
- b. False

18. The only antiretroviral with recommendations to maintain a certain amount of fluid intake is:

- a. Indinavir
- b. Atazanavir
- c. Saquinavir
- d. Nevirapine

19. Class-wide side effects of the nucleoside analogue reverse transcriptase inhibitors include all of the following EXCEPT:

- a. Lipoatrophy
- b. Peripheral neuropathy
- c. Lactic acidosis with hepatic steatosis
- d. Lactic acidosis without hepatic steatosis

20. Class-wide side effects of the protease inhibitors usually includes all of the following EXCEPT:

- a. Lipoaccumulation
- b. Hyperbilirubinemia
- c. Gastrointestinal discomfort
- d. Hyperlipidemia

Emerging Trends in HIV Combination Therapy: The Pharmacology and the Pharmacist

November 3, 2005 (expires November 3, 2008)

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- Last 4 digits of SSN _____ MM-DD of birth _____
 Name _____
 Pharmacy name _____
 Address _____
 City _____ State _____ ZIP _____
 Phone number (store or home) _____
 Store e-mail (if avail.) _____ Date quiz taken _____

Quiz: Shade in your choice

- | | a | b | c | d | e | | a | b | c | d | e |
|-----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 17. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 18. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Quiz: Circle your choice

21. Is this program used to meet your mandatory C.E. requirements? **a.** yes **b.** no
22. Type of pharmacist: **a.** owner **b.** manager **c.** employee
23. Age group: **a.** 21-30 **b.** 31-40 **c.** 41-50 **d.** 51-60 **e.** Over 60
24. Did this article achieve its stated objectives? **a.** yes **b.** no
25. How much of this program can you apply in practice?
a. all **b.** some **c.** very little **d.** none

How long did it take you to complete both the reading and the quiz? ____ minutes



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Community Pharmacy Marketing: What Works...and What Doesn't

By Bob Owens

About a hundred years ago (or so it seems), I was sitting in an advertising class listening to the professor tell us what made for a good ad. "White space...the block layout...clever headline." I was fascinated. Here, right before my eyes, were the answers to the mysteries of the marketing universe.

It wasn't until a little later in my career that I learned that *retail* was different—and *retail pharmacy* is different still. Because retail pharmacy is in the category of local store marketing, and there are special rules for local store marketing. Here's what my professor didn't just come right out and tell us:

1. You have to reach people who have both the **willingness** and the **ability** to come to your store. The closer they are to your store, the more likely they will be to come in.
2. You must give people a good reason to come to your store. "Personal service" won't get it.
3. Your store must be the kind of place where people will want to go. Comfort, access, décor, and merchandising are all important factors.
4. Your staff must enjoy working with

people and want new customers and patients. This can make or break anything else you are doing.

The Problem With Advertising

Seeing (and in this case, hearing, too) is believing, and for your advertising to work, your target customers will have to actually see your marketing message. The problem is, most advertising is never seen by the people that it is intended to reach.

The rule is this: advertise your message in something your customers have a good chance of seeing. To put numbers to it, your promotional message should reach 50 percent of your target market at least four to six times in a relatively short period of time. In the marketing trade this math is called "reach" and "frequency." Achieving reach and frequency that will make an impact is not as easy as it sounds, and there are no simple answers. Generally speaking, it will take a combination of media to achieve this.

Newspapers, for example, *can* work but size and frequency matters and your "offer" is critically important. So many pharmacists tell me that their newspaper advertising isn't working. Here's a few reasons why:

- Fewer people are reading the newspaper these days.
- Your ad is stuck in the paper with hundreds of others.
- Your ad may not have a compelling offer and a sense of urgency.
- If your target customers do manage to see your ad, chances are they will see it only once.

For pharmacies, direct mail and door hangers, although expensive, can work well if the offer is compelling and the graphics are compelling. The advantage to this type of media is that you can pinpoint where the promotional message is going, and print material like this has fewer ads competing for the attention of the target customer.

Radio can work, too, but should always be used to achieve frequency in combination with another medium. For example, newspaper plus radio spots with the same good offer for several days and four to six times a day can be effective.

The Right Message

If you don't give the customer a good reason to come in to the store, it's the same as giving them a good reason not to come. Every effective pharmacy pro-

The image shows a sample advertisement for a 'FREE Nutrition Seminar!' with eight numbered callouts pointing to specific elements:

- 1. Big Headline Here That Announces Your Great Offer Of A **FREE Nutrition Seminar!**
- 2. All about the FREE event: Why it is important, What people will learn, Who is conducting the seminar, Who should attend plus..., an extra incentive for attending.
- 3. Plus **FREE Nutrition Guide**
- 4. This Week Only While Supplies Last Hurry Limited Time Only
- 5. CALL FOR DETAILS AND TO RESERVE A PLACE
- 6. Line Map And Landmark Line Where and When You Do Business Address • Telephone • Hours
- 7. Your Logo and/or a Good picture of the Front of Your Store, You or Staff
- 8. Your Great Offer Repeated Here As A Coupon WITH EXPIRATION DATE AND RESTRICTIONS

I have created an imaginary event as an example to illustrate how some of the parts work together in the presentation of a "message." This could be a direct mail piece, door hanger, bag clipper, flyer, or even a newspaper insert. Note that the example here is not intended to win design awards, but instead to illustrate some of the key elements for promotional messaging:

1. Critically important: There is a definite offer, and the offer is boldly stated in a straightforward way.
2. A description of the event builds interest and gives people information targeted at people who have an interest in health topics.
3. An extra incentive, a "FREE Nutrition Guide," adds another reason to attend the seminar.

4. An image that supports the theme is useful, adds interest, and helps pull the ad together.
5. The block of text that creates the "sense of urgency" helps the "call to action."
6. A line map, landmark line and other access information is mandatory for all retail advertising.
7. An advantage of being a community pharmacy is that you can add a sense of familiarity and personality. People like to know who they are dealing with.
8. Put your offer in a coupon-type box (box with a dashed outline) and it will draw attention to it more than if it is just standing alone. People have been trained to look for coupons as a signal that they are getting some value, and it will work for non-price offers, too.

motional piece has to have a good offer and sense of urgency.

The design and presentation of promotional materials makes a difference. Words like NEW!, FREE!, and LIMITED TIME ONLY, WHILE SUPPLIES LAST! ... all suggest that there is something going on in your store that people should come to see. Design is important, too.

The temptation, however, is to promote a very low price for something, but often the result is a lot of traffic and very few real customers. One of the strengths of independent community pharmacy today is the ability to position yourself as an extension of the health care community, and a resource for good advice.

The example on page 71 illustrates several points. First, it is possible to have an offer that will create some excitement without giving away the store. Second, design and presentation are important.

Aim for the Right Target

If you want new pharmacy customers, the primary target is generally agreed to

be women 45 and older. They are the decision-makers, the caregivers and usually have mounting health concerns for themselves and their family. This makes them good pharmacy prospects. This also means that if you are advertising to them, make advertising choices and media content that will reach them. If you are advertising in the newspaper, on television or radio, select appropriate editorial content or programming.

Where to aim? The very first "rule" stated previously had one of the most powerful ideas in all of marketing: *reach people who have the willingness and the ability to come into your store.* Point your marketing message toward people who are within a convenient distance from your store; focus on your own neighborhood and saturate it first before spending money in other areas.

Bringing it All Together

While there is no "magic bullet" in marketing, adhering to certain principles can give you a better edge.

- Create a message with a strong health-related offer.
- Reach a large portion of your target

market by focusing on your neighborhood first.

- Deliver the message and offer frequently enough so that people have a better chance of seeing or hearing what you have to offer.

In the next issue, we'll talk about other marketing tools that work and how to use them. If you have some success stories to share or a question, I'd love to hear from you. □



Bob Owens is a regular contributor to America's Pharmacist and provides consulting services to independent pharmacies

across the country through his firm, Robert Owens International. He has recently launched a new package of services including coaching, online seminars and customized marketing programs for pharmacy owners who need more in-depth answers to questions to like the ones in this month's column. Owens can be contacted at 360-318-9485 or by email at robert@robertowens.net.

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Community Pharmacy Now Speaks With One, Strong Voice

In a historic move, NCPA and the National Association of Chain Drug Stores (NACDS) have established the Coalition for Community Pharmacy Action (CCPA), marking the first time that both independent and chain pharmacies are represented with a single, united voice on legislative and regulatory issues of common interest.

The coalition is mounting a comprehensive campaign to promote the various interests of all 55,000 community pharmacies—from direct lob-

bying, to research and strategic communications. “CCPA’s success is critical to the continued economic viability of not only community pharmacists, but also the health and safety of millions of patients who rely on their community pharmacists for medications and professional services,” says Bruce Roberts, RPh, NCPA executive vice president and CEO, who serves as cochairman of CCPA’s executive committee.

The nation’s community pharmacists—both independ-

ents and chains—have faced a series of threatening legislative and regulatory policies, including reimbursement cuts under Medicaid and Medicare, inadequate professional dispensing fees, and other legislative and regulatory actions that threaten community pharmacists and the patients they serve.

CCPA, a not-for-profit corporation with offices in Alexandria, Virginia, was formed earlier this year as a fully staffed and funded, permanent organization dedicat-

ed to representing community pharmacy on federal and state legislative and regulatory issues.

“While NACDS and NCPA will continue to represent the unique needs of their respective memberships on a wide variety of issues, we must present a unified front to protect the fundamental relationship between pharmacists and their patients,” says Robert Hannan, NACDS interim president and CEO, who also serves as executive committee cochairman for CCPA. “Working together, we can be more effective in influencing the formation of legislation and regulations affecting community pharmacy. The creation of the coalition presents a unique opportunity for community pharmacy to conceptualize and collaborate on a new scale.”

CCPA is currently addressing some of the most pressing government affairs issues facing community pharmacy practice, including reimbursement cuts in the Medicaid program, legislative corrections to the Medicare Part D drug benefit, and efforts to guarantee military health (TRICARE) beneficiaries the continued ability to obtain prescriptions from their local community pharmacies. Charles Sewell, NCPA’s senior vice president for government affairs, and Catherine Polley, RPh, vice president of state government affairs for NACDS, will serve as copresidents of the coalition. □

Make a Difference in an Election

CONTACT THE CAMPAIGN HEADQUARTERS

Before you work or vote for candidates, find out their stand on issues important to you. Ask for their brochures and position papers.

CONTRIBUTE TO THE CANDIDATE

With the ever-rising cost of running for office, money is an important component of campaigning. If you are supporting a candidate for federal office, you may only give a personal check. That may apply in state and local races, too.

VOLUNTEER TO HELP

Although money is important, volunteers are invaluable. Stuffing envelopes, answering the phone, and other duties of a campaign office usually are done by volunteers. Make sure you use the sign-in sheet each time you come to the campaign office. The candidate will appreciate your time and effort.

WALK A PRECINCT

Volunteer to go door-to-door in your precinct for the candidate. Better yet, bring the candidate. Most precincts are small enough to canvas in a few hours. The campaign should provide you with a voter registration list and materials to hand out.

PLACE TELEPHONE CALLS FOR THE CAMPAIGN

Campaigns need volunteers to make phone calls to identify voters who support the candidate. Many will allow you to make the calls from your home. They’ll provide you with a phone list and text on what to say.

PUT SIGNS UP FOR THE CAMPAIGN

As Election Day draws near, many campaigns begin to put up signs for the candidate to reinforce name identification. This activity usually only takes a few hours.

SEND POSTCARDS TO FRIENDS AND NEIGHBORS

This is an easy way to remind people that you support the candidate. Ask if they would like to volunteer.

OFFER TO HOST AN EVENT

Give people the opportunity to meet your candidate at your home or business. At home, make it an early evening event—coffee and cake. This gives the candidate the opportunity to meet people on an informal basis with time left to attend another event.

PUT A SIGN IN YOUR YARD

You are a respected member of the community. Your support for a specific candidate has an impact on other voters. The campaign will put up the sign for you, if you like.

WORK ON ELECTION DAY

Election Day is the most important day for any campaign. The campaign needs to get identified supporters to the polls. You can volunteer to drive people who can’t get there on their own. In addition, many poll watchers are needed to make sure that there are no irregularities at the voting booths.

These are just some ideas to encourage you to get involved in the election process. Remember, democracy is not a spectator sport. Together we can make a difference.