SOUTH DAKOTA PHARMACIST

IN THIS ISSUE

SDPhA

GAME ON

134th Annual CONVENTION

REGISTER ONLINE AT WWW.SDPhA.ORG

SUMMER EDITION 2020

SOUTH DAKOTA PHARMACISTS ASSOCIATION

Our mission is to promote, serve and protect the pharmacy profession.

SOUTH DAKOTA PHARMACISTS ASSOCIATION
320 East Capitol, Pierre SD 57501
605-224-2338 // 605-224-1280 *fax*
www.sdpha.org

SOUTH DAKOTA BOARD OF PHARMACY
4001 W. Valhalla Blvd. Ste. 106
Sioux Falls, SD 57106
605-362-2737 // www.pharmacy.sd.gov

Calendar

JULY

3	South Dakota Pharmacists Association office Closed
4	Independence Day
13–31	American Association of Colleges of Pharmacy (AACP) Virtual Annual Meeting
24	19th Annual GVR Society Open Golf Classic Hartford, SD

AUGUST

8–10	NACDS Total Store Expo – Cancelled

SEPTEMBER

24	South Dakota Board of Pharmacy Meeting Location TBA 1–5 pm
24–25	South Dakota Pharmacists Association 134th Annual Convention Virtual Annual Meeting

Please note: If you are not on our mass e-mail system check our website periodically for district meetings and other upcoming events. They will always be posted at: **www.sdpha.org**.

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The South Dakota Pharmacist is published quarterly: January, April, July, and October.

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Director's COMMENTS

Amanda Bacon // Executive Director

Happy Summer! I hope this finds you all well and having enjoyed a wonderful 4th of July holiday!

It seems like it took 20 years to get to July, yet also happened in the blink of an eye. It's been a whirlwind, hasn't it? We've completed our first-ever round of virtual Spring District Meetings, and now we're planning the first virtual convention in the Association's 134-year history. (Can you imagine what the founders of this organization would say?!) This was a particularly difficult decision for us – we wanted nothing more than to be able to gather together in person in Brookings this year. So, while it's not what we wanted to do, we knew it was the right thing to do. Don't worry, though– we're already set to return to the home of SDSU in Sept. 2022. I got your back, Jacks!

With the move to virtual, we made some adjustments to the schedule we hope will make it easier for you to participate. We've moved to Thurs., Sept 24 and Friday Sept. 25. We do have a tentative schedule posted on the website, but please know, like basically all of life right now, that schedule is a bit of a fluid situation, and things could well change. We appreciate so much our speakers who have embraced this change with open arms and are committed to working through technology so we can bring you the same level of excellence in continuing education offerings you have come to expect from the annual meeting. Please keep a close eye on our social media, website, and your email in the coming weeks for more information on how to register. We are learning as we go in this process, so we appreciate your grace and your understanding. Together – we got this!

In addition to virtual Spring Meetings and now convention, this has been a season of constant and rapid change for SDPhA. At the onset of the pandemic – the frenzied pace of our advocacy work at the state and federal was truly all-consuming. We may not have been able to participate in our typical opportunities to meet with our Congressional delegation this Spring, but we are in constant contact on matters of concern and importance to our pharmacists. We have also worked tirelessly with our national partners on everything from COVID-19 viral and antibody testing to funding programs and other key issues directly impacting your day-to-day like DIR fee relief, PBM reform, pricing transparency, dispensing requirements, compounding requirements, provider status and scope of practice (both as part of the pandemic and beyond). In spite of the pandemic, we do continue to see some forward momentum in some key areas. We remain highly encouraged by The Supreme Court rescheduling Rutledge V. PMCA for the October term, and what a favorable ruling may mean for the ability for states to better regulate PBMs.

Finally, we expect COVID-19 (and convention) to continue to dominate most of the work in the next few months, and we are already looking ahead at what this could potentially mean for our lobbying efforts in 2021 and beyond. We are in a very unique position, at a very unique time in the history of our nation. In so many aspects, now is the time we get to rise together and say what works, what doesn't, and what we want the profession of pharmacy to look like moving forward. We are learning vital lessons in real time. Opportunity lies in how we choose to apply those learnings.

Please take care, stay safe and be well,

AMANDA BACON

SDPhA Executive Director

PS – We've had such a fantastic response to our Pharmacy Technician University course offering the past few years that we are very pleased to announce some course additions to the lineup. You'll find the basic info on pages 12-16. You can find more **on our website** or just shoot me an email with your questions.

President's PERSPECTIVE

Lori Ollerich // SDPhA Board President

Greetings everyone! As I write this, summer-like temperatures have officially arrived in South Dakota, but due to COVID-19, a lot of summer plans and activities have been put on hold. I hope you are all able to find some free time to get out into the open air and enjoy some of what our beautiful state has to offer (even if it's in your own backyard) - while social distancing, of course!

Amanda has been hard at work scheduling and organizing virtual meetings for the board to discuss virtual fall convention plans since our Custer State Park annual board retreat did not happen this year. Be on the lookout for more information coming to your inbox within the next few weeks! We hosted district meetings via Zoom this spring – thanks to all who were able to log on to join us! We were pleased as always to receive nominations for awards and appreciate those who presented names. This is a great way to recognize those around you, and I encourage everyone to take the time to evaluate potential nominees each year. We are consistently impressed at the great contributions in the workplace and community. Please know that while only one winner will be announced for each category, we are incredibly proud of each one of you!

As we look forward to holding our first virtual Convention, this will also mark the end of my year as SDPhA president. If you would have told me 4 years ago that during my presidency we'd face a global pandemic and rioting across the US, I would have respectfully declined the nomination, but because I can't see into the future, here we are. I would like to thank you all for your support throughout my time on the Board. I would also like to thank the Board Members I have served with over the years for your tireless efforts, lively conversation, and most of all for your friendship. In my opinion, this is the best team in the state to be a part of! If you are reading this and have ever thought of serving on the Board, as a district officer, or any other capacity, don't hesitate to reach out to those serving to learn more about how to get involved. It takes ALL of us working together, and I know our great leaders will do just that going forward!

In closing I would like to take this opportunity to recognize Erica Bukovich for her contributions to the organization during her time of service on the board. It was a pleasure getting to work beside another Iowa girl! Last but not least, I would also like to recognize Amanda for all of the work she does to keep things moving forward and keeping our membership informed. She organized all of the district Zoom meetings and has made the unknown a little more bearable for all of us. Thank you for all the things you do on a daily basis! With that I will sign off and remind each of you that haven't taken the time or forgotten OR may not have spent your stimulus money yet to go to **www.sdpha.org** and pay your district dues and make a contribution to the C&L fund!

Respectfully,

LORI OLLERICH

SDPhA Board President

South Dakota BOARD of PHARMACY

Kari Shanard-Koenders // Executive Director

BOARD WELCOMES NEW REGISTERED PHARMACISTS/ PHARMACIES

Congratulations to the following thirty candidates who recently met licensure requirements and were licensed as new pharmacists in South Dakota: Nicholas Bettinger, Natalie Bollin, Brittany Boterman, Hannah Brokmeier, Alisa Chamblee, Makayla Ernst, Ryan Flynn, Shanee Hanning, Amanda Hurst, Philip Jacobson, Sarah Jesse, Jane Killian, Christopher Kotschevar, Tameka Magett, Rachel Mitchell, Zachary Muller, Alexis Nyberg, Emilee Pierson, Monica Pillatzki, Graham Protexter, Taylor Rothenberger, Janae Sampson, Taylor Sebert, Holden Sjogren, Savannah Suchor, Chandni Thakkar, Trevor Treglia, Shelby Van Driel, Dennis Weber III, and Stacy Weyrich.

Two full-time pharmacy licenses were approved and issued during the period. They are Encompass Health Rehabilitation Hospital of Sioux Falls, LLC, dba Encompass Health Rehabilitation of Sioux Falls; and Spring Meds, Inc. There were two part-time pharmacy licenses issued: Pharmacy Corporation of America, dba Advantara Pierre and Pharmacy Corporation of America dba Advantara Clark City.

BOARD UPDATE FOR QUARTER TWO 2020

What a difference three months makes! The April newsletter went to print prior to knowing how the COVID-19 pandemic was going to affect everyone's life. Now, the world is remarkably and forever changed. In mid-March, the board staff transitioned to work at home juggling less than optimal equipment; but continued to work tirelessly to ensure that licensure duties remained seamless and that patients in South Dakota continued to be served by prepared and healthy pharmacists, technicians, and interns. We are thankful for being able to work closely with the SD Pharmacists Association, the SD Department of Health, NABP, and many others to ensure our pharmacies were able to continue to take care of patients. We posted pharmacy relevant COVID-19 guidance and passed and then rescinded a Board Policy Statement to assist pharmacists with inappropriate hydroxychloroquine (HCQ) prescribing. We also worked to pass emergency rules which transitioned to be part of Governor Noem's Executive Order 2020-16, allowing suspension of numerous rules permitting pharmacists to take care of patients and not paperwork in a worst-case pandemic scenario. See: https://doh.sd.gov/boards/pharmacy/assets/Executive%20Order%202020-16.pdf. One inspector sewed hundreds of masks, and inspectors called pharmacies for status checks. We stood up a listserv to keep you all informed. We answered myriad "what if" questions and many real time questions. Further we worked to help the state, Sanford USD Medical Center, Avera, Monument Health, and Lewis Drug with distribution of HCQ to pharmacies. Inspections were completed telephonically or virtually. On June 1, we returned to the office and our new normal. The state stockpile allocated Personal Protective Equipment (PPE) to the Board to provide to licensees and we began PPE distributors in June. We are very pleased to assist many pharmacies in the state with needed surgical masks, KN95's, and face shields. At its June meeting, the Board passed a Policy Statement on Pharmacists conducting COVID-19 testing, see: https://doh.sd.gov/boards/pharmacy/assets/PolicyStatement_COVID-19_PharmacistTesting.pdf. The Board and I are incredibly proud of the staff for handling this juggling act with precision and grace. The Board is also proud to license and register you, who we consider heroes in this pandemic.

CANNABIDIOL (CBD) IN SOUTH DAKOTA, WHAT IS LEGAL?

by Paula Stotz, Inspector

The Board office receives many questions regarding the legality of CBD in SD. With the passage of the 2018 Federal Farm Bill, hemp may be grown and produced in a manner consistent with the farm bill. As of April 1, 2019, the DEA changed the definition of marijuana and removed hemp from Schedule I. See: https://www.deadiversion.usdoj.gov/21cfr/21usc/802.htm

In the 2020 legislative session, House Bill 1008 passed and was signed by Governor Noem with an emergency clause placing it in effect immediately after signing. Products derived from hemp with less than 0.3% delta-9 tetrahydrocannabinol (THC) may now be sold in South Dakota. See: https://sdlegislature.gov/Legislative_Session/Bills/Bill.aspx?File=HB1008ENR.html&Session=2020&Version=Enrolled&Bill=1008

Although CBD products derived from hemp are now legal in South Dakota, the production is highly unregulated. There is no law or rule on allowed levels of contaminants in CBD products, like chemical solvents used to extract CBD from the plant, heavy metals from the soil; ex. Cadmium, Lead, and Mercury, and hemp can also be contaminated with microbes; ex. Aspergillus. Recently, Summitt Labs, voluntarily recalled KORE ORGANIC Watermelon CBD oil tincture, due to random sampling of the product was found to contain lead levels at 4.7 ppm. See https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/summitt-labs-issues-voluntary-nationwide-recall-kore-organic-watermelon-cbd-oil-due-high-lead#recall-announcement. A person who chooses to use CBD products may test positive for THC, because CBD products do contain THC; although in small amounts. Most drug tests to detect the presence of THC are not quantitative nor do they reveal whether the THC is from cannabis or hemp. THC from marijuana is still a Schedule I drug. A person could lose a job or be excluded from employment if an employer has a no tolerance drug policy.

The Board encourages that you purchase CBD products from reputable, reliable sources. Pharmacies who desire to sell CBD products may want to consider the following:

1) Is the Manufacturer cGMP certified?
2) Are the CBD products derived from marijuana or hemp?
3) Ensure that each shipment of CBD products include a Certificate of Analysis (CoA).
4) Are the products tested by a 3rd party to identify possible contaminants?
5) Although hemp-based CBD is now legal to sell in South Dakota, side effects and drug interactions with prescription and over the counter drugs are a reality. Pharmacist counseling on the sale of CBD products is prudent.
6) CBD products cannot be marketed as a drug to treat, prevent or cure any disease.

PDMP UPDATE

by Melissa DeNoon, PDMP Director

The PDMP realizes the importance of our users' ability to obtain data from other PDMPs and we continue to work with states to set up interstate data sharing. Recently added states include: WA, OK, ME, AL, ID, MS, PA, NH, and the Military Health System's PDMP which brings our total to 31 other PDMPs available for querying. We are anxiously awaiting the ability for SD users to obtain data from NE and WY's PDMPs; both states hope to be able to set up sharing with SD in 2020.

The PDMP's 2018 COAP Grant Statewide Gateway Integration Project is underway and we currently have 31 healthcare entities (HCEs) with live integrations or working to go live. Integration of PDMP data into health systems' electronic health records (EHRs) and pharmacies' software systems is the future of PDMPs as integration provides the key in-workflow, one-click access to this valuable clinical decision-making tool. Grant funding will pay PMP Gateway fees for the two-year grant period; HCE participation is dependent on their current EHR or pharmacy software system vendor's Gateway integration status. For more information and to access the SD PDMP Integration Guide and Integration Request Form, follow the link on the SD PDMP's web page, https://doh.sd.gov/boards/pharmacy/PDMP/.

PDMP staff wants to remind users of the option to add a mobile phone number to your PMP AWARxE account. If your account contains a mobile phone number and you need to utilize the Reset Password functionality on the website's login screen, you will be given the option to reset your password via a code texted to your mobile phone or via an email containing a link to reset your password. The text message option may be the better option, especially if the user email on your account is your work email as employer firewalls may identify password reset emails as spam because they come from no-reply-pmpaware@globalnotifications.com. For more information on this option and complete instructions, log into your account and navigate to Menu/Training/AWARxE NarxCare User Guide then to Section 6.4.2 Resetting a Forgotten Password on page 50. Please note that if you use the mobile reset option, the validation code is only active for 20 minutes and if you use the email option, the password reset link is also only active for 20 minutes.

(continued)

MEDDROP DRUG TAKE-BACK BUNDLE REPORT

Bundle Report Month	Total # Bundles Returned	Total Weight Returned	Total Aggregate Weight Returned
Oct-17	1	35	35
Feb-18	3	95	130
Mar-18	2	64	194
Apr-18	2	54	248
May-18	5	179	427
Jun-18	5	128	555
Jul-18	2	79	634
Aug-18	7	197	831
Sep-18	6	204	1035
Oct-18	4	135	1170
Nov-18	6	192	1362
Dec-18	5	169	1531
Jan-19	9	303	1834
Feb-19	5	159	1993
Mar-19	6	209	2202
Apr-19	10	377	2579
May-19	10	374	2953
Jun-19	8	274	3227
Jul-19	10	314	3541
Aug-19	12	381	3922
Sep-19	13	373	4295
Oct-19	16	500	4795
Nov-19	16	575	5370
Dec-19	15	448	5818
Jan-20	18	601	6419
Feb-20	22	736	7155
Mar-20	15	473	7628
Apr-20	14	392	8020

BOARD-SPONSORED MEDDROP DRUG TAKE-BACK PROGRAM UPDATES

The SD Board of Pharmacy is excited to announce 45 more SD pharmacies received a MedDrop drug take-back receptacle this spring! This brings the total number of participating pharmacies to 83 in 43 SD counties. The availability of drug take-back receptacles is key in reducing the avenue of diversion created by unused, unwanted, and expired drugs in an individual's medicine cabinet. The SD Board of Pharmacy established the MedDrop Program to address the concerns voiced by our state's pharmacists regarding the lack of easily accessible drug take-back receptacles for their patients and the public. Trilogy MedWaste's MedDrop receptacles are in place in South Dakota hospitals and retail pharmacies and provide an option for the safe disposal of an individual's non-prescription and prescription drugs, including controlled substances, and are a key component in South Dakota's strategy to address our state's misuse, abuse, and diversion of controlled prescription drugs. SD's locator tool for all available take-back sites can be found by visiting www.avoidopioidsd.com, 'Take Action', 'Take Back Sites'. Trilogy MedWaste sends monthly bundle reports which provide information on the bundles returned for destruction; see chart detailing bundle report data since program inception.

Respectfully submitted, for the Board,
Stay Safe and Healthy,

KARI SHANARD-KOENDERS

R.Ph., M.S.J., SDBOF Executive Director

BOARD MEETING DATES

Check our website for the time, location and agenda for future Board meetings.

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NATIONAL ASSOCIATION OF BOARDS OF PHARMACY
www.NABP.pharmacy

SDSU COLLEGE of PHARMACY and ALLIED HEALTH PROFESSIONS

Jane Mort // Dean, College of Pharmacy & Allied Health Professions

Let me begin by saying how proud I am to work with such dedicated and caring colleagues both across South Dakota and in our College. Over the last three months I have witnessed exemplary acts of caring and an outstanding commitment to the profession as practitioners have stepped up to provide frontline care during the COVID-19 pandemic. In addition, as we reexamine our country's disparities and injustices, I am honored to work in a profession and within an institution that values individuals and diversity.

At the College, we have engaged in extensive revisions to our schedule, course delivery method, and experiential activities. The success of these efforts rested heavily on faculty members who worked hard to develop new materials for online instruction over a very short transition period. In addition, our experiential office made sure our fourth-year students completed the requirements so that every one of them graduated on time. This would not have gone smoothly without the exceptional character of our students. They were equal partners in this transition, and I commend them for their adaptability, tenacity, and professionalism.

In May we celebrated the graduation of 75 PharmD students through a virtual hooding event and commencement ceremony. While having an event on campus would have been preferred, the virtual venue offered a unique opportunity to connect with students and their families and celebrate the accomplishments of our graduates. One of the great things about the virtual event is the ability to watch it later. I invite you to meet all of our 2020 graduates at this link - 2020 Pharm.D. Hooding Ceremony – https://youtu.be/ewb7xHqiYYg

We continue to plan for in-person classes this fall by adapting schedules and making adjustments to our facilities. Again, our faculty and staff members are energetically working to make sure that these learning activities yield the same high-quality experiences with excellent corresponding outcomes.

Finally, as I enter into retirement, I want to thank all of my colleagues for their dedicated commitment to academic excellence. It has been my honor to serve the College and South Dakota State University for 34 years in a variety of roles. However, serving as Dean for the last four years has been a high point of my career. That would not be true without your service and support of the College.

Thank you!

JANE MORT, PHARMD
Dean
College of Pharmacy & Allied Health Professions

SDSU's Student Collaboration for the Advancement and Promotion of Pharmacy

Anna M. Mohr // SCAPP/APhA-ASP SDSU Chapter President

The Student Collaboration for the Advancement and Promotion of Pharmacy (SCAPP) at South Dakota State University had a successful year despite facing challenges with the COVID-19 Pandemic. With the initiation of online classes, SCAPP continued to host chapter meetings online and reach patients through educating on virtual platforms. It has been two years since SCAPP expanded from only including the American Pharmacists Association Academy of Student Pharmacists (APhA-ASP), the South Dakota Pharmacists Association (SDPhA) and the South Dakota Society of Health Systems Pharmacists (SDSHP) to also including the American College of Clinical Pharmacy (ACCP), the Pediatric Pharmacy Association (PPA), the National Community Pharmacists Association (NCPA), and the American Society of Health-System Pharmacists (ASHP). This expansion allowed SCAPP to provide a wide variety of opportunities across various areas of pharmacy to members. A few events that were made possible include touring Brookings Health System, making blankets for children at Sanford's Children's Hospital, working with a local independent pharmacist with medication synchronization program, and hosting journal clubs.

The 2020-2021 theme is embracing change which reflects the obstacles and modifications we have faced throughout this past year. Everyone has been making adjustments in both daily living and in health care as a reaction to the pandemic, and our world will be different once the pandemic is resolved. Embracing the changes and making the best of the situation will help us all through this tough time as a community and shape us as future pharmacists.

The goals of our chapter are to provide members with opportunities in patient care, community, professionalism, and education. We are excited to have been able to complete 1,302 screenings this past year despite the cancellation of spring screening events. Before the transition to online learning, members provided patient care screenings at the South Dakota State Fair in Huron, the Banquet in Sioux Falls, Legislative Days in Pierre, and the Harvest Table in Brookings. We are planning on expanding patient care opportunities to serve more diverse populations at the multicultural center in Brookings. Additionally, through the More Than A Count campaign sponsored by SDPhA, members were able to advocate for the pharmacy profession. The campaign focuses on providing education to the public of the diverse role a pharmacist plays in the health care system. This past year through Generation Rx we were able to use our social media platform to educate the public on opioid use and abuse. Pharmacy students posted videos of themselves talking about various topics relating to addiction and opioid use. We would like to give SDPhA a big thank you for your continued support and contributions to SCAPP! We appreciate all you do for our organization and are excited for another great year as student pharmacists!

Respectfully,

ANNA M. MOHR
SCAPP/APhA-ASP SDSU Chapter President

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INTRODUCTION
- Introduction & Orientation
- CSPT Training Questionnaire

BASIC PHARMACEUTICS
- Parenteral Dosage Forms
- Ratios
- Proportions

DOSAGE CALCULATIONS
- Weight-Based Dosages
- Dosage Calculations: Parenterals
- Dosage Calculations: Milliequivalents and Units

COMPOUNDING CALCULATIONS I
- Compounding Calculations
- Percentage Calculations
- Drug Concentration Calculations
- Dilution Calculations

COMPOUNDING CALCULATIONS II
- Infusion Calculations
- Alligation Calculations

PHARMACOLOGY REFERENCES
- CSPT® Medications List
- Pharmacology Key Points Reference
- Injectable Anticoagulants
- Dispensing Insulin and Other Injectable Medications

MEDICATION SAFETY
- Safety Data Sheets

INSTITUTIONAL PHARMACY PRACTICE
- Hospital: Medication Preparation
- Hospital: Medication Delivery
- Medication Disposal in the Hospital
- Dispensing Medications for Surgeries
- Medication Delivery in the Hospital
- Using Barcodes
- Hospital: Patient Safety Practices

REVIEW
- CSPT Practice Exam

STERILE COMPOUNDING I
- Sterile Compounding
- Sterile Compounding: Personal Protective Equipment
- Sterile Compounding: Aseptic Handwashing
- Simulation: Aseptic Hand Washing
- Sterile Compounding: The Laminar Flow Hood
- Laminar Flow Hood Simulation

STERILE COMPOUNDING II
- Sterile Compounding: Syringes and Needles
- Sterile Compounding: Supplies and Equipment
- Preparation of Sterile Compounds
- Using Aseptic Technique for Sterile Compounding
- Quality Standards and Requirements
- Maintaining Environmental Processes for Sterile Compounding
- Simulation: IV Fluid Preparation
- Simulation: IV Piggyback
- Simulation: IV Push
- Simulation: Manipulate Ampules
- Simulation: Reconstitute Lyophilized Powder
- Simulation: Parenteral Nutrition

STERILE COMPOUNDING SUPPLEMENTAL RESOURCES
- ASHP's Guidelines on Compounding Sterile Preparations
- ISMP's Guidelines for Safe Preparation of Compounded Sterile Preparations

CHEMOTHERAPY COMPOUNDING
- Chemotherapy Overview
- Chemotherapy Prep
- Simulation: Chemotherapy Agent Preparation

HAZARDOUS MEDICATION HANDLING
- ASHP's Guidelines on Handling Hazardous Drugs
- NIOSH List of Antineoplastic and Other Hazardous Drugs

DRUG INFORMATION RESOURCES
- Package Inserts Part I
- Package Inserts Part II
- Drug Information Resources

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SD Association of Pharmacy Technicians

John Thorns // SDAPT President

Greetings from SDAPT,

Hope this finds everyone doing well. In regards to the technician conference scheduled for October 3rd of this year this has changed and is going virtual. More to come, as information becomes available. The speakers are coming together, and we will have some topics that were suggested in last year's surveys. Specifically, what role a pharmacy technician plays in the care of the elderly who suffer from dementia or Alzheimer's. Also, we will have a speaker talk about mindfulness and how it relates to your interactions with your patients. If you haven't heard of mindfulness, google it. I use this and it is amazing. If you do have any questions, please email SDAPT or like us on Facebook. And remember, you are the first people a patient sees when they walk in your pharmacy and a simple smile will go miles in helping someone out.

Take care and be safe.

Appreciatively,
JOHN THORNS
SDAPT President

WELL-BEING index

Have you ever wondered how your Well-Being compares to others? Consider investing six minutes in your well-being. The Well-Being Index is a brief online self-assessment, invented by the Mayo Clinic and brought to you through a partnership with the American Pharmacists Association (APhA), which provides you immediate individualized feedback including tools and local and national resources to address your well-being. You can set-up the frequency you wish to assess your well-being and track your progress.

Your information and score are private and your individual score will not be shared with APhA or anyone else. You do not have to be an APhA member to participate.

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South Dakota SOCIETY of HEALTH-SYSTEM PHARMACISTS

Haylee Allen, PharmD, BCPS, BCPP // SDSHP President

Greetings from the South Dakota Society of Health-System Pharmacists!

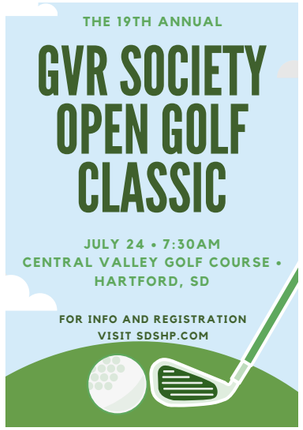
Summer looks a little different this year than years past due to the ongoing impacts of COVID-19 in our communities. SDPHP activities have not been spared, as we made the difficult decision to cancel our 2020 Annual Meeting and hold off on our spring social events for the safety of our members. We do hope that we can safely gather for some social activities in October to celebrate Pharmacist's Month! We will provide more details as we get closer to October!

Our Board of Directors approved SDSHP's 2020-2021 strategic plan earlier this spring. This strategic plan will guide and focus SDSHP's efforts until the Annual Meeting in April 2021, which will be hosted in Sioux Falls, SD. A specific focus of our strategic plan is to implement online and virtual platforms that allow us to deliver continuing education to our pharmacist and technician members across the state on demand throughout the year. We hope to have some more information soon, so stay tuned!

Last year, SDSHP launched the SDSHP Grant Program, which aims to partially fund residency projects that align with our mission and vision. PGY1 and PGY2 pharmacy residents in South Dakota are eligible to apply, and additional application instructions will be distributed mid to late July. We were pleased to award the first SDSHP Grant for the 2019-2020 residency year to Spencer Lehmann, a PGY1 pharmacy resident at Monument Health, who created a Clinical Pearls Website for our members.

The 8th Annual SDSHP Statewide Residency Conference is being held, but will be a virtual conference this year in light of COVID-19. Content will be split up and presented on July 8th and July 9th. Pharmacy residents throughout the state are invited to this conference, which provides the residents an opportunity to network with others and gain knowledge on topics that will benefit them throughout their residency year. A big thank you to our resident liaison – Khia Warzecha – for her efforts in not only coordinating this event, but also in being flexible and resilient with the changes for this year's conference!

The 19th Annual Gary Van Riper Society Open Golf Classic will be held at the Central Valley Golf Course in Hartford, SD on Friday, July 24th. This event supports SDSU student pharmacists by providing academic scholarships and funding for travel to the ASHP Clinical Skills Competition in December. Please note that this event is open to all golfers; golfers do not need to be members of SDSHP or even work in a pharmacy to play! If you are interested in registering online, please visit the "Events" tab on SDSHP.com.



Finally, we are pleased to congratulate the accomplishment of one of our members: Tom Johnson. Tom Johnson was officially sworn in as ASHP President this June. We wish Tom a successful year ahead! We invite you to stay engaged by visiting SDSHP's website at www.sdshp.com. There you can learn more about SDSHP and find a current list of upcoming events!

Respectfully submitted,
HAYLEE ALLEN
PharmD, BCPS, BCPP
SDSHP President

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Pharmacist Consult: CDC – Hepatitis A, Part 1: Questions and Answers for Health Professionals

Knowledge-based CPE

Course Sponsorship: This course is sponsored by the South Dakota State University College of Pharmacy and Allied Health Professions, Brookings, SD.

Course Development: The following material was published by the Centers for Disease Control and Prevention (CDC): *Hepatitis A Questions and Answers for Health Professionals*.

Permission has been granted by the CDC for the use of this material in Continuing Pharmacy Education for pharmacists.

GOAL: To enhance pharmacists' knowledge of hepatitis A and related patient safety issues.

LEARNING OBJECTIVES:

1. Define acute hepatitis A, and describe its symptoms, diagnostic criteria, and modes of transmission;
2. Identify 'at risk' population groups;
3. Evaluate the hepatitis A virus (HAV) incubation period and survival characteristics;
4. Counsel patients on appropriate prevention measures;
5. Explain the purpose hepatitis A genotyping;
6. Describe geographic-genotype connections.

OVERVIEW & STATISTICS: Hepatitis A Questions and Answers for Health Professionals

What is the case definition for acute hepatitis A?

The clinical case definition for acute viral hepatitis is discrete onset of symptoms consistent with hepatitis (e.g., nausea, anorexia, fever, malaise, or abdominal pain) AND either jaundice or elevated serum aminotransferase levels.

Because the clinical characteristics are the same for all types of acute viral hepatitis, hepatitis A diagnosis must be confirmed by a positive serologic test for immunoglobulin M (IgM) antibody to hepatitis A virus, or the case must meet the clinical case definition and occur in a person who has an epidemiologic link with a person who has laboratory-confirmed hepatitis A (i.e., household or sexual contact with an infected person during the 15–50 days before the onset of symptoms).

Surveillance, Case Management, Serology

1. Additional guidance on viral hepatitis surveillance and case management is available: www.cdc.gov/hepatitis/statistics/surveillance-guidelines.htm
2. Additional information on hepatitis A serology is available: www.cdc.gov/hepatitis/resources/professionals/training

How common is hepatitis A virus infection in the United States?

Hepatitis A rates in the United States have declined by more than 95% since hepatitis A vaccine first became available in 1995. (National Notifiable Diseases Surveillance System (NNDSS), https://www.cdc.gov/mmwr/mmwr_nd/index.html)

In 2015, a total of 1,390 cases of hepatitis A were reported to CDC from 50 states, a 12.2% increase from the number of reported cases in 2014. However, the overall incidence rate in 2015 was 0.4 cases per 100,000 population, the same as 2014. After adjusting for under-ascertainment and under-reporting, an estimated 2,800 hepatitis A cases occurred in 2015.

How is the hepatitis A virus (HAV) transmitted?

Person-to-person transmission through the fecal-oral route (i.e., ingestion of something that has been contaminated with the feces of an infected person) is the primary means of HAV transmission in the United States. Infections in the United States result primarily from travel to another country where hepatitis A virus trans-mission is common, close personal contact with infected persons, sex among men who have sex with men, and behaviors associated with injection drug use (1,2) (see https://www.cdc.gov/hepatitis/statistics/2015surveillance/index.htm).

Exposure to contaminated food or water can cause common-source outbreaks and sporadic cases of HAV infection. Uncooked foods contaminat-ed with HAV can be a source of outbreaks, as well as cooked foods that are not heated to temperatures capable of killing the virus during preparation (i.e., 185 degrees F [>85 degrees C] for one minute) and foods that are contaminated after cooking, as oc-curs in outbreaks associated with infected food handlers (3–5).

Waterborne outbreaks are infrequent in developed countries with properly maintained sanitation and water supplies (6). In the United States, floods are unlikely to cause outbreaks of communicable dis-eases, and outbreaks of HAV caused by flooding have not been documented (see https://www.cdc.gov/disasters/floods/after.html).

Who is at increased risk for acquiring hepatitis A virus (HAV) infection?

- Persons with direct contact with persons who have hepatitis A
- Travelers to countries with high or intermediate endemicity of HAV infection
- Men who have sex with men
- Users of injection and non-injection drugs
- Persons with clotting factor disorders
- Persons working with nonhuman primates
- Household members and other close personal contacts of adopted children newly arriving from countries with high or intermediate hepatitis A endemicity

Active Learning Questions:

1. Heating food to a temperature of _____ for _____ minute(s) will effectively kill the hepatitis A virus (HAV).

2. **True** / **False:** Waterborne outbreaks are common, even in developed countries with properly maintained sanitation and water supplies.

What are the signs and symptoms of hepatitis A virus (HAV) infection?

Among older children and adults, infection is typically symptomatic. Symptoms usually occur abruptly and can include the following:

- Fever
- Fatigue
- Loss of appetite
- Nausea
- Vomiting
- Abdominal pain
- Dark urine
- Clay-colored bowel movements
- Joint pain
- Jaundice

Most (70%) of infections in children younger than age 6 are not accompanied by symptoms. When symptoms are present, young children typically do not have jaundice; most (>70%) older children and adults with HAV infection have this symptom (7,8).

When symptoms occur, how long do they last?

Symptoms of hepatitis A usually last less than 2 months, although 10%–15% of symptomatic persons have prolonged or relapsing disease for up to 6 months (9–13).

What is the incubation period for hepatitis A virus (HAV)?

The average incubation period for HAV is 28 days (range: 15–50 days) (6,14–15).

How long does hepatitis A virus (HAV) survive outside the body?

HAV can live outside the body for months, depending on the environmental conditions.

How is the hepatitis A virus (HAV) killed?

In contaminated food, HAV is killed when exposed to temperatures of >185 degrees F (>85 degrees C) for 1 minute. However, the virus can still be spread from cooked food that is contaminated after cooking. Freezing does not inactivate HAV.

Adequate chlorination of water, as recommended in the United States, kills HAV that enters the municipal water supply (5,16–17). Transmission of HAV from exposure to contaminated water is considered rare given that no substantial or con-sistent increase in prevalence of anti-HAV has been documented among sewage workers. In the environment, HAV can be killed by cleaning household or other facility surfaces with a freshly prepared solution of 1:100 dilution of household bleach to water (18).

Can hepatitis A become chronic?

No. Hepatitis A does not become chronic.

Can persons become re-infected with hepatitis A?

No. IgG antibodies to HAV, which appear early in the course of infection, provide lifelong protection against the disease (10).

How is HAV infection prevented?

Vaccination with the full, two-dose series of hep-atitis A vaccine is the best way to prevent HAV infection. Hepatitis A vaccine has been licensed in the United States for use in persons 1 year of age and older. Additional Guidance is available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5507a1.htm.

Active Learning Questions:

1. **True** / **False:** Most older children and adults infected with HAV will present with jaundice.
2. **True** / **False:** It is unlikely for a person previously infected with HAV to become re-infected.

Immune globulin can provide short-term protection against hepatitis A, both pre- and post-exposure. Immune globulin must be administered within 2 weeks after exposure for maximum protection. Additional Guidance is available at: https://www.cdc.gov/mmwr/volumes/66/wr/mm6636a5.htm?s_cid=mm6636a5_e.

Given that the virus is transmitted through the fecal-oral route, good hand hygiene—including handwashing after using the bathroom, changing diapers, and before preparing or eating food—is integral to hepatitis A prevention (https://www.cdc.gov/handwashing/show-me-the-science.html).

HEPATITIS A VIRUS GENOTYPES
What are the different types of hepatitis A virus genotypes?

There are 6 HAV genotypes, with only geno-types I, II and III infecting humans. HAV geno-types I, II and III are further divided into sub-types A and B. HAV genotypes and subtypes have a distinctive geographic distribution (36).

- HAV genotype I is the most common genotype occurring around the world
- HAV genotype IA is prevalent in South and North America, Europe, Asia and Africa
- HAV genotype IB is predominant in the Middle East and South Africa
- HAV genotype II is not as common
- HAV genotype III is common around the world
- HAV genotype IIIA circulates in Asia, Europe, Madagascar and the USA.

What are the clinical implications of different HAV genotypes?

No differences in clinical presentation of infections with different genotypes are clearly established. However, HAV genotype IB is found more frequently among acute liver failure cases compared to the non-liver failure cases, suggesting its potential greater virulence. Host factors such as age of patients and underlying liver diseases as well as viral factors such as HAV RNA levels and genomic mutations were reported in some studies to be associated with disease severity (37).

How does hepatitis A genotyping help to establish transmission in an outbreak setting?

Hepatitis A genotyping is done to determine genetic identity of the HAV sequences in an outbreak. Sequence differences in the VP1-P2A junction of the HAV genome has been widely used to identify HAV sub-genotypes, and evaluate genetic relatedness among sequences derived from hepatitis A infected individuals (38). Genotyping assists significantly in the identification of a common source of infection during hepatitis A outbreaks, especially when paired with epidemiologic evidence (39).

Disclosure: *The developers and reviewers of this course have had no financial relationships with any commercial entities having a vested interest in this topic.*

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Pharmacist Consult: CDC- Hepatitis A, Part 1: Questions & Answers for Health Professionals

Learning Assessment – Post-test / Select correct answer(s) for each question.

1. For a clinical case definition of acute viral hepatitis, symptoms should include:

- **A.** One of more of the following: nausea, anorexia, fever, malaise, or abdominal pain
- **B.** Either jaundice OR elevated serum aminotransferase levels.
- **C.** Both jaundice AND serum aminotransferase levels
- **D.** A and B

2. The clinical characteristics are the same for all types of acute viral hepatitis.

- **A.** True **B.** False

3. A positive diagnosis for hepatitis A virus (HAV) must be confirmed by _____ .

- **A.** Positive serologic test for immunoglobulin M (IgM) antibody to hepatitis A virus,
- **B.** Meet the clinical case definition AND occur in a person who has laboratory-confirmed hepatitis A
- **C.** A and B
- **D.** A or B

4. Select the statement about HAV that is **incorrect**:

- **A.** HAV transmission in the U.S. primarily involves the fecal-oral route
- **B.** Travel to another country where HAV is common is a known risk factor for infection
- **C.** Hepatitis A rates in the United States have declined by 9% since hepatitis A vaccine first became available in 1995.
- **D.** Sex among men who have sex with men (MSM) is a known HAV risk factor

5. Select the **correct** statement(s) regarding HAV infections.

- **A.** Older children and adults who contract an HAV infection are typically symptomatic, while most young children (younger than 6 years) present as asymptomatic.
- **B.** Only 30% of adults with HAV end up developing jaundice.
- **C.** Symptoms typically last less than two months, although prolonged or relapsing disease may persist for up to six months for 10-15% of symptomatic persons.
- **D.** Young children infected with HAV typically develop jaundice.

6. The average incubation period for HAV is _____ days (range: _____ days)

- **A.** 7 / 3-10 **C.** 28 / 15-50
- **B.** 7 / 15-50 **D.** 28 / 5-10

7. Select the **correct statement(s)** below regarding the heartiness of the hepatitis A virus.

- **A.** HAV is killed when contaminated food is heated for one minute to temperatures greater than 185 degrees F (>85 degrees C).
- **B.** HAV can still be spread from properly cooked food that is contaminated after cooking.
- **C.** Adequate chlorination of water, kills HAV that enters the water supply.
- **D.** Freezing effectively inactivates HAV.

8. Select the **correct statement(s)** below hepatitis A infections.

- **A.** IgG antibodies to HAV, which appear early in the course of infection, provide lifelong protection against the disease
- **B.** Handwashing is an integral part of preventing the spread of HAV
- **C.** A single dose of the hepatitis A vaccine is the surest way to prevent infection.
- **D.** Immune globin may provide short-term protection against hepatitis A both pre– and post-exposure, but must be administered within 14 days of exposure for maximum results.

9. There are 6 HAV genotypes, with only genotypes I, II and III infecting humans. Genotype _____ is prevalent in North and South America, Europe, Asia, and Africa, while _____ is the predominant genotype in the Middle East and South Africa.

- **A.** IA / IB **C.** IA / IIIB
- **B.** IB / IA **D.** IIIA / IIIB

10. Select the correct statement(s) below regarding HAV genotyping.

- **A.** There are major differences in the clinical presentation of infections with different genotypes.
- **B.** Genotyping assists significantly in the identification of a common source of infection during hepatitis A outbreaks, especially when paired with epidemiologic evidence
- **C.** Disease severity may be affected by certain host factors, such as the age of a given patient and underlying liver conditions.
- **D.** All of the above

Pharmacist Consult: CDC- Hepatitis A, Part 1: Questions & Answers for Health Professionals

Knowledge-based CPE

To receive 1.0 Contact Hours (0.1 CEUs) of continuing education credit, preview and study the attached article and answer the 10-question post-test by circling the appropriate letter on the answer form below and completing the evalua-tion. A test score of at least 70% is required to earn credit for this course. If a score of 70% (7/10) is not achieved on the first attempt, another answer sheet will be sent for one retest at no additional charge.

The South Dakota State University College of Pharmacy is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. The Universal Program Identification number for this program is: #0063-0000-18-028-H01-P.

Learning Objectives for Pharmacists: ***1.*** *Define acute hepatitis A and describe its symptoms, diagnostic criteria, and modes of transmission;* ***2.*** *Identify 'at risk' population groups;* ***3.*** *Evaluate the hepatitis A virus (HAV) incubation period and survival characteristics;* ***4.*** *Counsel patients on appropriate prevention measures;* ***5.*** *Explain the purpose hepatitis A genotyping;* ***6.*** *Describe geographic-genotype connections.*

Circle Correct Answer:

1. A B C D	**3.** A B C D	**5.** A B C D	**7.** A B C D	**9.** A B C D
2. A B	**4.** A B C D	**6.** A B C D	**8.** A B C D	**10.** A B C D

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PHARMACY & THE LAW

By Don. R. McGuire Jr., R.Ph., J.D.

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

Since this article was submitted, the Supreme Court has rescheduled this case to the October 2020 term.

The Supreme Court & PBM Regulation

The case of Rutledge vs. Pharmaceutical Care Management Association (PMCA) is to be heard by the U.S. Supreme Court in late April 2020. It is a very important case for the pharmacy profession in their ongoing battle with Pharmacy Benefits Managers (PBM). The individual legal issues in the case are complicated, but the general point of the case is fairly simple; can an individual state regulate PBMs within its borders?

The law at issue was passed by the Arkansas General Assembly in 2015. The law contained many provisions, but the major ones address Maximum Allowable Cost (MAC) and pharmacy reimbursements. It provided that pharmacies must be reimbursed at a cost higher than or equal to the pharmacy's cost, even if this amount would be greater than the MAC. It also required the PBM to update MAC lists within 7 days of an increase in costs. The law also allowed a pharmacy to reverse a charge and re-bill it if the pharmacy was unable to order the drug at less than or equal to the MAC. It also introduced a "decline to dispense" option if the pharmacy would lose money on the transaction.

PCMA brought suit in Federal Court for the Eastern District of Arkansas asserting that Arkansas' law was preempted by the Employee Retirement Income Security Act of 1974 (ERISA) and by Medicare Part D regulations. The District Court ruled that Arkansas' law was preempted by ERISA based on a previous 8th Circuit Court of Appeals case, but was not preempted by Medicare Part D regulations. PCMA appealed to the 8th Circuit and the appeals court ruled that the Arkansas law was preempted by both sets of laws. ERISA preempts any state law relating to employee benefit plans. Medicare Part D regulations prohibit interference with CMS standards that exist between Plan D sponsors and pharmacies.

The Solicitor General of the United States asked the U.S. Supreme Court to take the case because he believes the ruling is contrary to prior Supreme Court precedent. The Attorneys General from 31 states and the District of Columbia also asked the Supreme Court to take the case. The Supreme Court is not required to take all appeals, and it often doesn't, so it is significant that the Court decided to take this case.

The major importance of the case is that states have had difficulty in passing laws to regulate PBMs that aren't later found to be preempted by Federal law. The ERISA precedent that the District Court relied on came from a previous attempt by Iowa to regulate PBMs. Iowa's law specifically mentioned ERISA and Arkansas had tried to avoid a similar fate by not mentioning ERISA in their law.

PMCA argues the Arkansas law interferes with 2 different CMS standards. The first is the Negotiated Price standard. This standard addresses the price for a particular drug that has been negotiated between the part D sponsor and the network dispensing pharmacy. Under this standard, the District Court found this law didn't directly affect the CMS standard because the negotiated prices provisions are not a substantive standard. The appeals court disagreed because of the number of provisions that dealt directly with reimbursements to the pharmacy. The second standard is the Pharmacy Access standard. This standard requires plans to have sufficient numbers of pharmacies in their network to assure convenient access for the plan participants. The appeals court found here that the "decline to dispense" option would decrease pharmacy availability for the plan participants. The most novel argument in the case concerns the question of the ERISA preemption. This has been interpreted very broadly in the past. If the state law relates to and has a connection with an employee health plan, then ERISA controls and the state law is preempted. The argument in this case is that Arkansas' law doesn't affect ERISA plans because it acts on the third party administrators and claims processors, some of whose customers include ERISA plans. Arkansas argues their law affects the relationship between PBMs and pharmacies, not ERISA plans.

Once the case is heard, it will likely take months for a ruling to be handed down. If the Supreme Court can be persuaded that the Arkansas law is not directed at ERISA plans, the ruling would allow that law to stand and create a roadmap for other states to follow Arkansas' lead. If unpersuaded, the Arkansas law will be struck down. While other attempts could be made by individual states, the ultimate solution will most likely have to come from the Federal level.

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

FINANCIAL FORUM

*This series, **Financial Forum**, is presented by PRISM Wealth Advisors, LLC and your State Pharmacy Association through Pharmacy Marketing Group, Inc., a company dedicated to providing quality products and services to the pharmacy community.*

HOW MUCH MONEY WILL YOU NEED IN RETIREMENT?

Have You Underestimated?

What is enough? If you're considering retiring in the near future, you've probably heard or read that you need about 70% of your end salary to live comfortably in retirement. This estimate is frequently repeated… but that doesn't mean it is true for everyone. It may not be true for you. Consider the following factors:

Health. Most of us will face a major health problem at some point in our lives. Think, for a moment, about the costs of prescription medicines, and recurring treatment for chronic ailments. These costs can really take a bite out of retirement income, even with a great health care plan.

Heredity. If you come from a family where people frequently live into their 80s and 90s, you may live as long or longer. Imagine retiring at 55 and living to 95 or 100. You would need 40-45 years of steady retirement income.

Portfolio. Many people retire with investment portfolios they haven't reviewed in years, with asset allocations that may no longer be appropriate. New retirees sometimes carry too much risk in their portfolios, with the result being that the retirement income from their investments fluctuates wildly with the vagaries of the market. Other retirees are super-conservative investors: their portfolios are so risk-averse that they can't earn enough to keep up with even moderate inflation, and over time, they find they have less and less purchasing power.

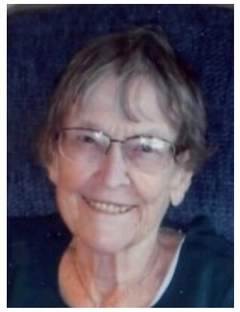
Spending habits. Do you only spend 70% of your salary? Probably not. If you're like many Americans, you probably spend 90% or 95% of it. Will your spending habits change drastically once you retire? Again, probably not.

Will you have enough? When it comes to retirement income, a casual assumption may prove to be woefully inaccurate. You won't learn how much retirement income you'll need by reading this article. Consider meeting with a qualified financial professional who can help estimate your lifestyle needs and short-term and long-term expenses.

Pat Reding and Bo Schnurr may be reached at 800-288-6669 or pbh@berthelrep.com.

OBITUARIES

Elizabeth Nelson



Elizabeth Nelson, 92 of Arlington died Sunday, June 7, 2020 at Avantara Arlington in Arlington.

Elizabeth was born December 19, 1927, in Huron, SD, the daughter of Lester and Frances (Hyde) Wallenfelt. In 1936 her family moved to Watertown, where she attended school and graduated from Watertown High School in 1945. She attended Carleton College in Northfield, MN for 2-1/2 years. In 1949 she married John Nelson in Watertown. In 1954 they moved to Arlington, where they purchased Nelson Drug and have resided ever since, having the home where they raised their family for 65 years.

She enjoyed sewing, knitting, counted cross-stitch, reading, playing bridge and dominoes, bowling, golfing, and spending time with her family and friends. The fifty years they spent at Lake Poinsett were especially enjoyable. She loved traveling adventures and sailing with her friends and children in the Caribbean.

Elizabeth is survived by her children: Kathy (Mahlon) Gray, Tulsa,OK; Julie (Craig) Seas, Arlington; Nancy (Curt) Cutler, Sioux Falls; Dave (Jolene) Nelson, Rochester, MN; grandchildren: Matthew (Casey) Gray, Megan (fiancé Tom Younger) Gray, Jesse Seas, Rachel Seas, Adam Cutler, Anna (Aaron) Himrich, Andrew (Mariah) Nelson, Eric Nelson, and beloved Alex Cutler, who greeted her at the gates of Heaven; step-grandson: Mahlon Summers (Toni). She was blessed with five great-grandchildren: Landon Steffensen, Paisley and Sloane Gray, Mackenzie Himrich, Aubrey Nelson; and five step-great-grandchildren: Colby, Caleb, Conner, and Colton Summers and Brant Norrid.

She was preceded in death by John, her husband and best friend of 68 years, her parents, two sisters Mary Welch and Helen Winjum, and brother Paul Wallenfelt.

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