South Dakota Pharmacist

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In This Issue:

SOUTH DAKOTA PHARMACIST
Volume 30 Number 3

SDPhA CALENDAR

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"The mission of the South Dakota Pharmacists Association is to promote, serve and protect the pharmacy profession."

South Dakota Board of Pharmacy
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Sioux Falls, SD 57106
(605)362-2737
www.pharmacy.sd.gov

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: *http://www.sdpha.org.*

AUGUST

1 License Renewal Window Opens
6 APhA Pharmacy-Based Immunization Delivery
Certificate Training Program (see information on page 15)
8 a.m. - 5 p.m. – Radisson Hotel, 605 E. Broadway Ave., Bismarck, ND
6-9 NACDS Total Store Expo
Boston, MA

SEPTEMBER

5 Labor Day
16-17 SDPhA Annual Convention
Swiftel Center, Brookings, SD

OCTOBER
American Pharmacists Month

1 SDAPT Fall Conference and CE Day
Sioux Falls, SD
10 Native American Day
15-19 NCPA Annual Convention
New Orleans, LA
16-22 National Hospital and Health-System Pharmacy Week
18 National Pharmacy Technician Day
Fall District Meetings

Cover Photo by Sue Schaefer, Pierre, SD

SOUTH DAKOTA PHARMACIST
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THIRD QUARTER 2016
Volume 30
Number 3

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DIRECTOR'S COMMENTS

Sue Schaefer | Executive Director

Sizzling Summer, Sizzling Pharmacy Issues and Opportunities

It's the busiest time in the Association Office that I can remember. SO many challenges in pharmacy, and at the same time, opportunities!

The Association just signed a contract to work with the South Dakota Department of Health to provide a wonderful Diabetes Toolkit for all pharmacies in South Dakota! Not only is this a wonderful opportunity to work with the Department, it also indicates the value of the profession in treating disease states is being understood and acknowledged. We thank Erica Bukovich and our DOH partners for designing an impressive toolkit to help you educate your patients. I believe this is the tip of the iceberg, and we are looking forward to working more closely with our state partners to help share the value and importance pharmacy can play regarding patient care.

I'm sure many of you have been dealing with many frustrations regarding the new plan year and its "issues". Plans continue to be challenging. Also, several laws to provide clarity and transparency have been passed by states and immediately tested. We're patiently awaiting the outcome of those challenges in Iowa and Arkansas to determine if action is warranted in South Dakota. One of the most important things you can do as a pharmacist, is let the South Dakota Insurance Division know if you feel our audit and PBM management laws are being ignored or manipulated. Please contact them with any problems you've had. They can only investigate and act if you share your information.

As President Loe mentioned in his article, the volume of issues we're dealing with in pharmacy is unprecedented. We continue to try to move the football forward, but are always faced with difficult obstacles. The important thing to remember is we need to remain a strong team to face the difficulties head-on. Stay engaged!! We need you!

For those of you who want to immunize, South Dakota has again been approached to work with IHS and our surrounding states to promote another immunization training opportunity … this time in Bismarck at the Radisson Hotel. The date has been set for August 6th. A special rate has been secured for SDPhA members, so please send me an email at sue@sdpha.org for specifics if you're interested, or complete the forms located herein to register.

The Department of Social Services recently contacted the Association and we met to discuss the new CMS requirement regarding Actual Acquisition Cost (AAC) reimbursement methodology. This new regulation must be in place by April of 2017, so the Department has engaged a firm to develop a Cost of Dispensing survey. The Association has agreed to stand by and provide any information and assistance needed to help the Department. If you're contacted, please fill out your survey and return it.

We're also working to stay on top of two legislative interim summer studies – Medicaid Reimbursement Methodologies and Substance Abuse. Legislators are asking a lot of questions regarding drug pricing, and the problem with the opioid overdoses. We'll bring you some additional information as it becomes available.

Rob also mentioned the Tech-Check-Tech issue recently before the Board of Pharmacy at the request of Hy-Vee. They would like to request a variance for a test site in Sioux Falls. The SDPhA Board agreed that additional information is needed, and will be not only offering Hy-Vee an opportunity to meet with the Board, but we feel it's important to develop a survey to determine your level of interest, concern, support, etc., so please get engaged and help us get the best information possible. We are here to represent and support you, but you need to help us determine priorities and how we can help you address concerns, if possible.

Convention is quickly approaching! I hope you'll take the time to check out our lineup and make your reservation for our meeting this September! It's so exciting that we'll be in Brookings … where it began for so many of you! We'll be at the Swiftel Center, and sleeping rooms have been secured at the Hampton Inn across the road. The dates are September 16th and 17th. We'll be open for business/registration on Thursday evening at the Swiftel Center with a small "Mixer" opportunity, and begin in earnest with the first CE on Friday morning. We won't plan anything, Association-wise, for Friday evening

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PRESIDENT'S PERSPECTIVE

Rob Loe | SDPhA President

"Bring in the Pharmacists" So says an article in the May 17 edition of *The Wall Street Journal* on how to make hospitals less harmful. The author, Pittsburgh Attorney James B. Lieber, explained something many of us have known for a long time ... involving pharmacists in healthcare decreases medical errors that can lead to severe patient harm.

Furthermore, the National Center for Health Statistics recently reported that medical errors are now the third leading cause of death in the United States. These recent reports further bolster the case for Provider Status and the changing role of Pharmacists in direct patient care. From the Ashville Project to the National Governors Association Paper and numerous studies in between, we know that Pharmacists can improve healthcare outcomes and reduce costs.

Our work group that assembled to explore provider status continues to meet and evaluate options to advance this agenda on a state level. On the federal level, we haven't seen much progress with House Bill 592 and Senate Bill 314 recently, but we continue to monitor and remain optimistic they will move through congress at some point. It remains imperative that we continue to educate, showcase our expanded skills in the changing healthcare environment and keep the momentum on both the federal and state level.

Your Association continues to be involved in a growing numbers of issues. Many of these issues are complex and some are even difficult for our profession to discuss. DIR fees, preferred network access, PBM transparency and MAC Pricing, AAC Medicaid pricing, a weakening Pharmacist job market, drug disposal, opiate abuse and the list goes on and on. It's our goal to represent our members on these, and other issues, as best we can, with the limited resources we have.

South Dakota Pharmacists dispensed 276,000 prescriptions for hydrocodone in 2015. The deaths from opiate overdoses in our country have reached a crisis level. This is just one more area where pharmacists can make a positive impact and help save lives. At last look, the Comprehensive Addition and Recovery Act has passed both the House and Senate and is awaiting the President's signature. This legislation will make grants available to states and local governments to address various aspects of the opiate crisis. Contained in the legislation is the co-prescribing to Reduce Overdose Act. We will continue to hear more about naloxone prescribing and administration in the future. What will our role be?

The Board of Pharmacy had an agenda item of tech-check-tech at its last meeting. The Association will be sending out a survey to gather member opinions in the near future. We want and need your thoughts and opinions!

The dates for the SDPhA Annual Convention are September 16th and 17th in Brookings. We have put together a top notch line up of presenters with great continuing education. In addition, the Beef Bowl is at the new Dana J. Dykhouse Stadium where the Jacks will take on Cal Poly on Saturday at 6pm. I look forward to seeing you all there. In the meantime, enjoy your summer!

"Not everything that can be counted counts."
"Not everything that counts can be counted."

DIRECTOR'S COMMENTS

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to allow you to visit the campus and/or take in your favorite restaurant with friends and colleagues. We have also secured a block of Jacks tickets for their game against Cal Poly on Saturday night. Tickets and sleeping rooms are limited, so please make your reservations to attend ASAP! Once you register online for convention, you'll see a drop down box open up for JACKS tickets. If you need in excess of six, please contact me directly and we'll do our best to hook you up! We sure hope you can join us as we work to "Improve Patient Care" together.

Warm and Sunny Regards Always,

Sue

SOUTH DAKOTA BOARD OF PHARMACY

Kari Shanard-Koenders | Executive Director

NEW REGISTERED PHARMACISTS/PHARMACIES

The following 53 candidates recently met licensure requirements and were registered as pharmacists in South Dakota in the last quarter: Lesleigh Ailts, Tyler Aldren, Brittan Alexander, Sarah Anderson, William Anderson, Laura Bakker, Cynthia Bartha, Colton Bass, Travis Beck, Tyler Bertsch, Nicholas Bitz, Bailey Bolinske, Kaitlin Bottelberghe, Haylee Brodersen, Mackenzie Byron, Rachel Byrum, Latosha Cherry, Catherine Creech, Sarah Dady, Cassandra Dirks, Ashley Eckert, Eddy Ekobena, Rose Fitzgerald, Melinda Hanten, Amanda Janisch, Katti Kraemer, Hubert Lahr, Lynsee Lanners, Claire Larson, Laura Martin, Abigail Passe, Ashley Pederson, Michael Petrilli, Erin Rau, Catherine Richwine, Bradley Rotert, Jessica Rounds, Joshua Satlak, Matthew Schettle, Angela Schultz, Dawn Schuster, Mollie Sloot, Mikaela Smedsrud, Keith Starks-Gunn, Mindy Stewart, Dylan Stoebner, Jacquelyn Thomas, Briana Van Noort, Rachael Vetter, Kyle Weiss, and Brittany Williams. Twelve candidates met requirements through reciprocity.

New full-time pharmacy permits issued over the same time period were: Lewis Family Drug – Clear Lake (change of ownership); Shopko Pharmacy – Dell Rapids; Wyodak Pharmacies, dba Vilas Pharmacy – Lead. New part-time pharmacy permits issued over the same period were: Regional Hospital Dialysis AMDD, Rapid City and Dakota Plains Surgical Hospital - Aberdeen (change of ownership).

NALOXONE BILL (HB 1079) UPDATE

HB1079 was passed by the 2016 Legislature, signed by the governor, and became effective on July 1, 2016. Section 2 of the Bill states "A licensed health care professional may, directly or by standing order, prescribe an opioid antagonist to a person at risk of experiencing an opioid-related overdose, or prescribe to a family member, friend, or other close third party person the health care practitioner reasonably believes to be in a position to assist a person at risk of experiencing an opioid-related overdose". This allows pharmacies to develop collaborative practice agreements with physicians to be able to do this. We also suggest that you mention the availability of Naloxone to individuals who are chronically taking opioids. It is another important tool in the arsenal helping to fight opioid addiction and potentially save lives.

PREPARE YOURSELF FOR A PHARMACY BREAK-IN

As our country continues to be plagued by prescription drug abuse, misuse and addiction, all pharmacy businesses are well poised to be targets for drugs and money. It is safe to say that this is a devastating ordeal to endure; however, there are actions you can take to mitigate the overall effects of such an event before it happens. While we do not require it by law or rule, an alarm system is a must for any pharmacy and camera systems are more important than ever. It is essential to have them on different electrical zones in case power is cut. Outside and inside cameras may help catch a criminal whether he/she makes it in the door or not. In South Dakota, we have had four break-ins in 2016 to date. One recent break-in focused on controlled substance medications; fortunately, the pharmacy had a perpetual inventory on all controlled substances. This makes the process of determining losses for the DEA Form 106 more efficient and less painful. In other words, our advice to you is to arm yourself with the best systems possible to combat this unfortunate trend.

DRUG SUPPLY CHAIN SECURITY ACT (DSCSA)

As of July of 2015, Transaction History(TH), Transaction Information(TI), and Transaction Statements (TS) collectively given the acronym of "T3" should be sent to you on all transactions (any transfer of a product where a change of ownership occurs) as part of the DSCSA. Be aware that there are several exceptions to this rule. They are: Intracompany distributions, distribution among hospitals under common control, public health emergencies, dispensed pursuant to a prescription , product sample distribution, blood and blood components for transfusion, minimal quantities by a licensed pharmacy to a licensed practitioner, certain activities by charitable organizations, distributions pursuant to a merger or sale, certain combination products, certain medical kits, certain IV products, medical gas distribution, approved animal drugs. See CFR Section 581(13) and 581(24) and FDA DSCSA web page: http://www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/DrugSupplyChainSecurityAct/default.htm

PHARMACIST RENEWALS START AUGUST 1, 2016

With pharmacist licensure renewals fast approaching, the Board office wants to remind you the 2017 renewal application will contain more questions. In 2012, the Primary Care Task Force (PCTF) was appointed by Governor Daugaard to bring forth recommendations pertaining to ensuring access to primary care across South Dakota. One of the recommendations was to create a data system collecting specific data elements on health care

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professionals in South Dakota. In 2013, Senate Bills 3 and 4 passed which mandated Department of Labor Relations (DLR) to collect information on any person that is licensed or certified by any department, board, or commission in South Dakota. The DLR data elements are required by SDCL 13-1-60 through SDCL 13-1-62. Further reminder – **get your renewal in early.**

SD HEALTH PROFESSIONALS ASSISTANCE PROGRAM UPDATE

Since 1996, the SD HPAP has assisted with the recovery and return to work of hundreds of healthcare providers in South Dakota. HPAP recognizes mental illness and substance use disorders are diseases that may negatively impact an individual's physical, mental, social, vocational, intellectual, emotional, and spiritual well-being. HPAP also believes these illnesses can be successfully managed and treated. The mission of the program is to ensure public safety by providing confidential alternatives to support health professionals' recovery efforts. The Board has a primary goal that all pharmacists practice with reasonable skill and safety and thus, the Board contracts with HPAP for these services. National statistics indicate 2% of working licensed pharmacists are clinically impaired (suffer from an illness or addiction) and should be participating in an HPAP program. Current pharmacist HPAP utilization in SD is less than one percent. We have a link to the SD HPAP on our website and it is http://www.mwhms.com/home.html. Please share if needed.

BOARD SAYS THANK YOU AND BEST WISHES TO INSPECTOR

Inspector Bill Vander Aarde, of Milbank, has tendered his resignation. We have enjoyed the time he has been with the Board and he has enjoyed inspecting. This vacates a 0.25 FTE Inspector position in the north east and north central part of the state. If you live in the area, please to go to http://sd.gov/employment.aspx to review and please consider applying for this rewarding position.

PRESCRIPTION DRUG MONITORING PROGRAM UPDATE

PDMPs are making news and being named one of the keys to prevent diversion of controlled substances. Utilization of PDMPs directly correlates to the program's number of approved users. At the end of April 2016, the total number of approved direct care users for the South Dakota PDMP is 2,573. This includes 996 pharmacists, 727 physicians, 270 physician assistants, 230 nurse practitioners, 94 dentists, and 256 prescriber delegates. The program's ultimate goal is to have all SD practitioners approved for access and utilizing the SD PDMP as a tool to improve patient care and reduce diversion. If you are not an approved user, become one! Access https://southdakota.pmpaware.net/login and click on "Create an Account".

The SD PDMP hit a milestone of 3,508 online queries by prescribers in May. Pharmacist queries still outpace prescriber queries with pharmacists performing 3,950 online PDMP queries in May. The top prescribed controlled substance in SD remains Hydrocodone/Acetaminophen combination products. See chart below.

A topic that continues to generate inquiries from users is the zip code requirement for a patient search. In light of new information, we are updating our recommendations. With the importance of being able to share with other states through NABP PMP InterConnect® and receive the most complete Rx

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May Most Prescribed Drugs	RXs	Quantity	Days Supply	Quantity/Rx
Hydrocodone Bitartrate/Acetaminophen	20,023	1,316,257	247,637	66
Tramadol HCl	13,372	1,000,990	243,533	75
Lorazepam	8,066	404,839	194,832	50
Zolpidem Tartrate	7,768	269,613	268,382	35
Clonazepam	7,386	471,716	239,369	64
Dextroamphetamine Sulf-Sacce/Amphetamine	6,739	384,239	253,545	57
Alprazolam	5,810	367,699	170,351	63
Methylphenidate HCL	5,779	313,198	212,829	54
Oxycodone HCL	4,632	395,672	92,759	85
Oxycodone HCL/Acetaminophen	4,020	254,623	50,920	63

SOUTH DAKOTA STATE UNIVERSITY

College of Pharmacy and Allied Health Professions

Jane Mort | Acting Dean

Greetings from the College of Pharmacy and Allied Health Professions.

You may have noticed that the name of the College has changed to the College of Pharmacy and Allied Health Professions. This new name better represents the programs that the college offers which include not only pharmacy but also medical lab science and a masters in public health.

Another change at the college is that Dennis Hedge has taken over the role of Interim Provost at South Dakota State University and I am now Acting Dean for the College. These changes were made on May 16th and will continue until a new provost is named. In addition, Dr. Barry Dunn was appointed President of SDSU effective May 23. These changes followed the retirement of David Chicoine from the role of President and the appointment of Provost Nichols as the President of the University of Wyoming.

While there have been a number of changes at SDSU, one thing remains constant and that is our outstanding students. This spring we saw the graduation of 76 PharmD students and during our hooding ceremony on May 6th we learned of their future employment plans. In addition, our students remain competitive in the residency market with 76% (19 of 25) of our graduates applying for a residency, obtaining a position. This is compared to 68% placement for national graduates applying for a residency.

Another great success I want to share is the outstanding accomplishments of our Pharmaceutical Sciences faculty in their efforts to obtain research funding. Specifically, Dr. Josh Reineke received two awards. The first being the South Dakota Research Team Development award for the project "SD Center for Translational Nanomedicine." This award allows him to organize and do preliminary research and development work in order to pursue state funding in 2018 for a research center. The second was a South Dakota Board of Regents Competitive Research Grant Program award for his project "Desmoplastic Pancreatic Cancer Model Development and Application to Novel Therapeutic Screening." In addition, Dr. Tummala was awarded a Sanford-Profile grant for his project entitled "Developing new nutritional supplement based product line for improved colon health" for a period of two years. The future also looks bright as we move forward to hire two additional endowed positions to add to the Markl Faculty Scholar.

While the fourth year students are energetically involved in their Advance Pharmacy Practice Experiences, and research is going strong at the College, summer is a great time to stop by campus. We'd be happy to see you.

SD SOCIETY OF HEALTH-SYSTEM PHARMACISTS

Rhonda Hammerquist, Pharm.D., BCPS | SDSHP President

The South Dakota Society of Health-System Pharmacists held the 40th Annual Conference at the Rushmore Plaza Holiday Inn in Rapid City on April 8 and 9.

A total of 10 hours of CE was provided to the 82 attendees with a separate technician track on Saturday with targeted CE for technician members. Attendees gave overwhelmingly positive evaluations for the speakers and high regards were given to the South Dakota Practice Advancement Pearl, Clinical Pearl, and Clinical Debate sessions. The annual meeting also ushered in new board members including:

- Past President: Tadd Hellwig
- President: Rhonda Hammerquist
- President-Elect: Jessica Harris
- Secretary: Gary Van Riper
- Treasurer: Nicole Hepper
- Board Members: Brittney Meyer and Deidra VanGilder
- Technician Board Member: Lynna Brenner
- Resident Board Member: Aaron Larson
- Student Board Members: Kendra Ernste and Khia Warzecha

SDSHP would also like to thank out-going board members Andrea Aylward, Joel Van Heukelom, and Brittany Bailey for their service and contributions to SDSHP.

In addition to the excellent educational programming, several awards were presented at the annual conference. Dana Darger was awarded the Gary W. Karel lifetime achievement award, which recognizes an individual of high moral character, good citizenship and high professional ideals who has made significant contributions to health-system pharmacy practice in South Dakota. Joe Strain was awarded the SDSHP Pharmacist of the Year and Katie Diehl was recognized as the SDSHP Pharmacy Technician of the Year. On behalf of the SDSHP board, members, and all pharmacists in the state of South Dakota, congratulations to our award recipients!

Upcoming Events

The 4th Annual Statewide Resident Conference is scheduled for Thursday, July 21st at Cedar Shore Resort in Oacoma, SD.

Mark your calendars for the 15th annual Gary Van Riper Society Open Golf Classic at Central Valley Golf Course in Hartford on Friday July 22, 2016. This 4-person scramble is a fundraising event to support our student pharmacists with scholarships and funding for SDSU Student travel to the ASHP Clinical Skills Competition.

Please visit SDSHP's new website at www.sdshp.com to learn more about SDSHP, register for the Golf Classic, and see the latest dates for CE programming and other events!!

SOUTH DAKOTA BOARD OF PHARMACY

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Search Request Reports, we now recommend: (1) If MN is a desired state for the search, include the patient's first name, last name, date of birth, and **NO** zip code and **only** select MN. This will return data from SD and MN. (2) For SD and other out-of-state searches (IA, ND) include the patient's first name, last name, date of birth, and **include** a zip code. This may mean performing two searches on a patient for the most complete return of data. Please contact our office with any questions or concerns about the SD PDMP.

BOARD MEETING DATES

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

BOARD OF PHARMACY STAFF DIRECTORY

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Jessica Neal, Senior Secretary ....jessica.neal@state.sd.us
Board of Pharmacy Website...................www.pharmacy.sd.gov
PDMP Data Access Website
.... https://southdakota.pmpaware.net/login
PDMP Data Submitters Website ...https://pmpclearinghouse.net

ACADEMY OF STUDENT PHARMACISTS

Nicole Stenzel | APhA-ASP SDSU Chapter President

My name is Nicole Stenzel and I have the high privilege of serving the South Dakota State University chapter of the American Pharmacist's Association Academy of Student Pharmacists for the 2016-2017 school year. I am very happy to share with you my first update on the chapter.

In April, we were happy to host the White Coat Ceremony for 80 P1 students from the class of 2019. At the College's Spring Convocation, the chapter awarded five chapter members with Member of the Year awards. From the Pre-Pharmacy member base: Melanie Heeren for her dedication to involvement and willingness to take leadership positions as a freshman member. From the P1 class: Kassie Friese for her hard work and flexibility as serving our chapter as Chapter Delegate during the Midyear Regional Meeting last October. From the P2 class: Elizabeth Murray for her dedication to the chapter in serving as our Midyear Regional Meeting Coordinator for the upcoming Midyear Regional Meeting in Sioux Falls this fall. From the P3 class: Nicole Heeren for her success in serving as a liaison to the P3 members in Sioux Falls. And from the P4 class: Mollie Sloot for her successful career in APhA-ASP and incredible dedication to the chapter. We also extended a warm welcome to our incoming P1 class, the Doctor of Pharmacy class of 2020, by inviting them to join us for an ice cream social at the end of April. Students were given ice cream, a chance to mingle and network, and a few tips and tricks from current P1 students.

In May, we successfully graduated our P4 students receiving their Doctor of Pharmacy degrees, as well as our P2 students receiving their Bachelor's of Science in Pharmaceutical Sciences. Pictured below are some of our active P2 members on graduation day. The chapter was happy to present the APhA-ASP Senior Recognition Award to P4 student Leah Eckstein during the 2016 hooding ceremony. Leah served as chapter president during the 2014-2015 academic year and dedicated so much to our chapter.

Pictured left to right: April Lick, Kristen Binger, Nathan Sutera, Nicole Stenzel, Nathan Smith, Lauren Wilde, Alex Besey, and Taylor Davis.

In June, the new Executive Board for the chapter held online meetings in order to discuss plans for the upcoming year and the rest of the summer. Stay tuned for our next update to hear about our Midyear Regional Meeting plans as well as plans to beat our 2015-2016 patient care screening number of 1,170 screenings. We look forward to another successful and exciting year!

Did You Know?

As pharmacists, you can submit immunization information to the South Dakota Department of Health's Immunization Registry?

Contact Tammy LeBeau to get registered! Tammy is the Coordinator for South Dakota's Immunization Information System (SDIIS) and can be reached at her direct extension, 605-773-4783.

New Federal Overtime Rules Likely to Have Implications for Pharmacy Residents

Rachel Balick, Assistant Editor | www.pharmacist.com

May 24, 2016

Physicians and medical residents continue to be exempt from wage and overtime regulations, but pharmacists in residency programs are not

New federal rules could raise pharmacy residents' salaries as pharmacy resident programs must comply with a final rule issued by the Department of Labor (DoL) that takes effect December 1, 2016.

Employers must increase minimum salary for certain employees to keep them exempt from wage regulations, such as those related to overtime pay. According to APhA, the final rule does not exempt pharmacy residents, leaving them among the millions of health care workers who will soon see a bigger paycheck.

Under the final rule, the initial increase to the Fair Labor Standards Act minimum salary level to qualify for an exemption is from \$455 to \$913 per week (i.e., from \$23,660 to \$47,476 annually). Future automatic updates to the thresholds will occur every 3 years, starting on January 1, 2020.

Practicing physicians—including medical residents—are not entitled to a minimum salary or overtime because they qualify for an exemption for the practice of medicine. According to APhA comments to DoL, pharmacy residents should qualify for the same exemption as medical residents because pharmacists cannot accept a residency until they have completed their PharmD—just as medical residents must complete specialized education before being permitted to practice as a resident.

APhA wrote in comments to DoL on its proposed rule that the new rules could place a prohibitive strain on already cash-strapped residency training programs, particularly those that are community-based, and could have a damaging effect on patients.

APhA also requested more flexibility in the implementation of the new rule.

"Without proper time to plan for salary increases," the Association wrote, "entities, many of which are community pharmacies as well as small businesses, may face budget constraints and some may be forced to discontinue these important programs that assist in training pharmacists as clinical care providers."

Pharmacy technicians may be affected by the DoL final rule, depending on their job duties.

SD ASSOCIATION OF PHARMACY TECHNICIANS

Sue DeJong | President

Summer's finally here! My absolute favorite time of the year. Bring on the boating, camping, hiking and biking!

Thank you to SDPhA for your wonderful and continued support of SDAPT. With your help we are able to increase the technician membership in SDAPT, keep our membership fee at a low price and offer informative and helpful continuing education to SDAPT members.

SDAPT's Fall Conference and CE day will be October 1, 2016 the Avera Prairie Center, Sr. Colman Room in Sioux Falls. Conference registration will begin at 8:00am and the day's events will end at about 3:00pm. Our first CE will start at 8:30am with a law CE presented by the Board of Pharmacy. Cheri Kraemer will follow with Compounding/Essential oils. DCI will present at 10:40am on Drug Diversion/Abuse. They are always interesting! Cassie Heisinger's CE will be on Diabetes - New drugs/treatments. Jennifer Ball will present our last CE of the day on Transplants - RX meds and Otc's. A noon lunch will be provided as we conduct our business meeting.

Please see our SDAPT website and Facebook page for SDAPT membership and conference registration and details. Mark your calendars and plan now to attend! I encourage all technicians to also attend the SDPhA convention September 16th and 17th in Brookings. Convention registration is being offered now. These are great opportunities to learn and network with other technicians. I hope that you'll be able to take advantage of these events.

Wishing you all summertime fun!

130th Annual South Dakota Pharmacists Association Convention
Swiftel Center • Brookings, SD
September 16-17, 2016

Line-up (Tentative)

Friday, September 16

8:00 a.m. – 9:30 a.m.	**Curt Muller, Inspector | Criminal Investigator (Invited)** Special Investigations Branch Office of Inspector General - Office of Investigations U.S. Department of Health & Human Services Office of the Inspector General **CAPT Jon Schuchardt, RPh (Invited)** Indian Health Service Great Plains Area Pharmacy Consultant
9:30 a.m. – 10:30 a.m.	**Pharmacy Law** Dr. Dave Helgeland
10:30 a.m. – 11:30 a.m.	**Business Meeting**
11:30 a.m. – 1:30 p.m.	**Vendor Time/Luncheon/Awards Presentations**
1:30 p.m. - 3:00 p.m.	**New Drug Update** Dr. Joe Strain
3:00 p.m. – 3:30 p.m.	**SDSU Ice Cream Social**
3:30 p.m. – 5:00 p.m.	**Board of Pharmacy/PDMP Update** Executive Director Kari Shanard-Koenders PDMP Director Melissa DeNoon
5:00 p.m. – 6:00 p.m.	**Antibiotic Stewardship** Dr. Aly Howard

Saturday, September 17

8:00 a.m. – 9:00 a.m.	**Light Breakfast/Second Business Meeting**
9:00 a.m. – 10:30 a.m.	**Medication Review for Community Pharmacy** Dr. Tadd Hellwig
10:30 a.m. – 12:30 p.m.	**Immunization Update** Dr. Alex Middendorf Dr. Amy Heiberger

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FIRST & GOAL
IMPROVING PATIENT CARE
SEPTEMBER 16-17, 2016 ★ BROOKINGS, SD

130th Annual South Dakota Pharmacists Association Convention

Registration Form

Swiftel Center | Brookings, SD | September 16-17, 2016

Name: ____________________
Address: ____________________
City: ____________ State: ______ Zip: ________
Business Name: ____________________
Business Address: ____________________
City: ____________ State: ______ Zip: ________
Business Phone: ____________________
Home Phone: ____________________
Email: ____________________
Spouse/Guest Name: ____________________

eProfile ID:

All SDSU Student Registrations are FREE!
(Hotel Not Included)
Registration must be submitted prior to August 19, 2016.

	SDPhA Member	Spouse or Guest	Children	SDAPT Member	Pharmacy Technician	Pharmacy Student	Non-SDPhA Member	
Full Registration*								
Before August 19, 2016	$150	$75	$20	$75	$125	Free	$225	________
After August 19, 2016	$175	$100	$20	$100	$140	Free	$250	________
One-Day Registration**								
Fri., Sept. 16, 2016	$100	$50	$10	$50	$90	Free	$150	________
Sat., Sept. 17, 2016	$50	$50	$10	$50	$50	Free	$75	________
Extra Tickets								
Friday Lunch	$15	$15	$10	$15	$15	Free	$15	________
Friday Supper	$15	$15	$10	$15	$15	Free	$15	________
Saturday Breakfast	$15	$15	$10	$15	$15	Free	$15	________

I would like to sponsor a student. I have included an additional gift of .... ________

I would like to contribute to the SDPhA Commercial & Legislative Fund.
I have included an additional amount of .... ________

Total Due $ ____________

Please send payment and registration to:
South Dakota Pharmacists Association
PO Box 518 Pierre, SD 57501
Tax ID#: 46-019-1834

Register Online at www.sdpha.org

For Hotel Reservations Call:
Hampton Inn & Suites
3017 Lefevre Dr. • Brookings, SD 57006
(605) 697-5232

Convention Registration Cancellation Policy:
Cancellations will be accepted without penalty prior to September 7, 2016.
A $25 cancellation fee will be applied to all cancellations after September 7, 2016.
Refunds will be issued after October 1, 2016.

*Full Registration includes all educational sessions, exhibits, meals and evening events.

**One-Day Registration includes educational sessions, exhibits, meals, and evening event, if applicable.

COMMERCIAL AND LEGISLATIVE (C&L) & DISTRICT DUES CONTRIBUTIONS 2016/2017

First Name ____________________ Last Name ____________________

Address ____

City ______________________________ State __________ Zip Code __________

Home Phone ____________________ Mobile Phone ____________________

Employer/Company ____

Work Address ____

Work City ______________________________ State __________ Zip Code __________

Work Phone ____________________ Work Fax ____________________

Email Address ____

Do you wish to receive SDPhA email alerts regarding important pharmacy issues? ☐YES ☐NO

2016 - 2017 Commercial & Legislative (C&L) Fund

(Memberships set by SDPhA C & L Executive Committee, 2007)

Pharmacy or Business Membership ($100.00)
(Includes One Individual Membership)

Name of Pharmacy/Business ____

Name of Individual Included ____

Corporate Membership ($200.00)
(Two or more stores of the same corporation)

Name of Corporation ____

Name of Individual Included ____

Individual Membership

☐ $50 Level ☐ $75 Level ☐ Other $__________

District Dues
(Circle your District)

Aberdeen-$10.00 **Black Hills**-$20.00 **Huron**-$10.00 **Mitchell**-$10.00 **Mobridge**-$10.00

Rosebud-$10.00 **Sioux Falls**-$20.00 **Watertown**-$20.00 **Yankton**-$15.00

TOTAL ENCLOSED $ __________

Mail to SD Pharmacists Association • Box 518 • Pierre, SD 57501-0518 • FAX: 605-224-1280

American Pharmacists Association's Pharmacy-Based Immunization Delivery

A Certificate Program For Pharmacists

Hosted By: **North Dakota Pharmacists Association and Great Plains Area Indian Health Service**
When: **August 6, 2016 8 am – 5 pm**
Where: **Radisson Hotel, 605 E. Broadway Ave., Bismarck, ND 58501**

For questions about this program, please contact:
Mike Schwab, North Dakota Pharmacists Association
Phone: (701) 258-4968 | Fax: (701) 258-9312 | Email: mschwab@nodakpharmacy.net

APhA's *Pharmacy-Based Immunization Delivery* certificate training program (13th Edition) is an innovative, intensive, and practice-based continuing pharmacy education, based on national educational standards for immunization training from the Centers for Disease Control and Prevention. This program is designed to educate pharmacists about the professional opportunities for vaccine advocacy and administration. This practice-based curriculum represents a fusion of science and clinical pharmacy. The program, which emphasizes a health care team approach, seeks to foster the implementation of interventions that will promote disease prevention and public health.

The purpose of this certificate training program is to prepare pharmacists with comprehensive knowledge, skills, and resources necessary to provide immunization services to patients across the life span.

The goals of this program are to:

Educate pharmacists about:

- The impact of vaccines on public health.
- Pharmacists' roles in immunization.
- Immunologic principles of vaccine development and immunizations.
- Vaccine-preventable diseases and the vaccines used to prevent them.
- Strategies for improving immunization rates.
- Requirements for pharmacists who provide immunization services.

Prepare pharmacists to:

- Read an immunization schedule and identify appropriate vaccines for individuals across the life span and with special needs.
- Educate patients about the benefits of vaccines and dispel myths about vaccines.
- Safely administer vaccines to patients via subcutaneous, intramuscular, intranasal, and intradermal routes.
- Operate an immunization service in compliance with legal and regulatory standards.
- Partner with immunization stakeholders to promote immunizations and the immunization neighborhood.

Direct pharmacists to resources necessary to:

- Promote public health through immunizations.
- Access regularly updated information about vaccines and their use.
- Effectively communicate with patients and other stakeholders about resources.
- Operate an immunization service in compliance with legal and regulatory standards.

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APhA's *Pharmacy-Based Immunization Delivery* certificate training program has three components: online interactive self-study with assessment; the live seminar with online final assessment; and hands-on assessment of intramuscular and subcutaneous injection technique. A Certificate of Achievement will be awarded to participants who successfully complete all program components, including an evaluation.

Key Learning Objectives of the Live Training Seminar

At the completion of this activity, the participant will be able to:

1. Describe strategies for increasing immunization rates, including physician collaborations, community level activities, and immunization coalition activities
2. Describe pharmacy operations and a process for administering vaccines in various pharmacy practice settings
3. Evaluate patient histories and make patient-specific recommendations based on the appropriate immunization schedule
4. Demonstrate effective strategies for communicating with patients who have concerns about vaccines
5. Describe current evidence regarding vaccine safety
6. Recognize the signs and symptoms of adverse reactions that can occur after vaccination
7. Describe procedures for management of patients with adverse reactions to vaccination that constitute an emergency
8. List the steps for administering currently available intranasal and intradermal vaccines
9. Demonstrate appropriate intramuscular and subcutaneous injection techniques for adult immunization

For a complete list of learning objectives and for all APhA accreditation information and policies, please visit APhA's website, http://www.pharmacist.com/pharmacy-based-immunization-delivery.

Seminar Agenda

- Check-in and Continental Breakfast
- Welcome, Introductions and Acknowledgements
- Clinical Review

Morning Break

- Managing a Pharmacy-Based Immunization Program
- Strategies for Increasing Immunization Rates

Lunch

- Applying ACIP Immunization Schedules
- Communicating with Patients

Afternoon Break

- Vaccine Administration Technique
- Transitional/Summary Remarks
- Skills Assessment

Faculty

Holly Van Lew, PharmD, BCPS, NCPS
LCDR U.S. Public Health Service, Indian Health Service
Phoenix Indian Medical Center

Ann Gorman, PharmD, BCPS, NCPS, NCPS-I
CDR, U.S. Public Health Service, Indian Health Service
Red Lake Indian Health Service, Red Lake, MN

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Continuing Pharmacy Education (CPE) Information and Activity Completion Requirements

Initial release date: 04/15/2014; expiration date: 04/15/2017
Activity Type: Practice-based
Target Audience: Pharmacists in all practice settings

- Successful completion of the self-study component involves passing the self-study assessment with a grade of 70% or higher and will result in 12 contact hours of CPE credits (1.2 CEUs). **ACPE Universal Activity Number: 0202-9999-14-002-H01-P**
- Successful completion of the live seminar component involves attending the full live seminar, passing the final assessment with a grade of 70% or higher and demonstrating competency in 2 intramuscular and 1 subcutaneous injection. Successful completion of this component will result in 8 contact hours of CPE credit (0.80 CEU). **ACPE Universal Activity Number: 0202-9999-14-003-L01-P**

Once credit is claimed, Statements of Credit will be available online within 24 hours on participant's CPE Monitor profile at www.nabp.net. The Certificate of Achievement will be available online upon successful completion of the necessary activity requirements on the participant's "My Training" page on www.pharmacist.com

The American Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

Activity Requirements - Course material and exams will be accessed online - In order to participate in this activity, registrants must have access to a computer with minimum system requirements: Internet connectivity with current version of internet browsers, such as Chrome, Firefox, Safari, or Internet Explorer (V8 and above); Adobe Acrobat Reader, Flash Player 8 or higher, Windows 95, Pentium 3 or equivalent processor, 64 MB of free memory (not 64 MB total), and Audio: Sound card and speakers or earphones. For full technology requirements, please visit http://www.pharmacist.com/pharmacy-based-immunization-delivery

Pharmacy-Based Immunization Delivery: A Certificate Training Program for Pharmacists was developed by the American Pharmacists Association.

Refund Policy: Once you register and utilize your enrollment code to access APhA course materials, there will be no refund granted under any circumstances.

American Pharmacists Association™ Improving medication use. Advancing patient care. APhA

NDPhA NORTH DAKOTA PHARMACISTS ASSOCIATION

See Registration Form on Next Page

The American Pharmacists Association's Immunization Certificate Training Program

Date: August 6, 2016

Time: 8:00-5:00

Where: Radisson Hotel, Bismarck, ND

Immunization Registration Form

Host Organizations: North Dakota Pharmacists Association & Great Plains Area Indian Health Services

Contact Person: Mike Schwab
Email: mschwab@nodakpharmacy.net
Phone: 701-258-4968
Fax: 701-258-9312

(Please check one)

- ○ $150 NDPhA or SDPhA Member
- ○ $200 Non-NDPhA Member in ND
- ○ Indian Health Service Employee Rate

____
Registrant Name:

____
Billing Address:

____
City, State and Zip Code

____
Phone:

____
Email Address:

Please circle one: Pharmacist Student Other

- ○ Yes, I have a current CPR certificate. Exp. Date: ______
- ○ No, I do not have a current CPR certificate. I plan to be certified by: ______

Credit Card: VISA MASTERCARD AmEx

Name on Card: ____

Card Number: ____Exp. Date: ____________

Security Code: ___________

Make Checks Payable to: NDPhA
Mail to: NDPhA, 1641 Capitol Way, Bismarck, ND 58501 or email mschwab@nodakpharmacy.net

Pharmacy Marketing Group, Inc.

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.

Will You Avoid These Estate Planning Mistakes?

Too many wealthy households commit these common blunders.

Many people plan their estates diligently, with input from legal, tax, and financial professionals. Others plan earnestly, but make mistakes that can potentially affect both the transfer and destiny of family wealth. Here are some common and not-so-common errors to avoid.

Doing it all yourself. While you could write your own will or create a will or trust from a template, it can be risky to do so. Sometimes simplicity has a price. Look at the example of Warren Burger. The former Chief Justice of the United States wrote his own will, and it was just 176 words long. It proved flawed – after he died in 1995, his heirs wound up paying over $450,000 in estate taxes and other fees, costs that likely could have been avoided with a lengthier and less informal will containing appropriate language.[1]

Failing to update your will or trust after a life event. Relatively few estate plans are reviewed over time. Any life event should prompt you to review your will, trust, or other estate planning documents. So should a life event affecting one of your beneficiaries.

Appointing a co-trustee. Trust administration is not for everyone. Some people lack the interest, the time, or the understanding it requires, and others balk at the responsibility and potential liability involved. A co-trustee also introduces the potential for conflict.

Being too vague with your heirs about your estate plan. While you may not want to explicitly reveal who will get what prior to your passing, your heirs should have an understanding of the purpose and intentions at the heart of your estate planning. If you want to distribute more of your wealth to one child than another, write a letter to be presented after your death that explains your reasoning. Make a list of which heirs will receive particular collectibles or heirlooms. If your family has some issues, this may go a long way toward reducing squabbles and the possibility of legal costs eating up some of this or that heir's inheritance.

Failing to consider what will happen if you and your partner are unmarried. The "marriage penalty" affecting joint filers aside, married couples receive distinct federal tax breaks in this country – estate tax breaks among them. This year, the lifetime gift and estate tax exclusion amount is $5.45 million for an individual, but $10.9 million for a married couple.[1,2] If you live together and you are not married, it is worth considering how your unmarried status might affect your estate planning with regard to federal and state taxes. As Forbes mentioned last year, federal and state taxes claimed more than more than $15 million of the $35 million estate of Oscar-winning actor Phillip Seymour Hoffman. He left 100% of his estate to his longtime partner, and since they had never married, she could not qualify for the marriage exemption on inherited assets. While the individual lifetime gift and estate tax exclusion protected a relatively small portion of Hoffman's estate from death taxes, the much larger remainder was taxed at rates of up to 40% rather than being passed tax-free. Hoffman also lived in New York, a state which levies a 16% estate tax for non-spouses once estates exceed $1 million.[1]

Leaving a trust unfunded (or underfunded). Through a simple, one-sentence title change, a married couple can fund a revocable trust with their primary residence. As an example, if a couple retitles their home from "Heather and Michael Smith, Joint Tenants with Rights of Survivorship" to "Heather and Michael Smith, Trustees of the Smith Revocable Trust dated (month)(day), (year)". They are free to retitle myriad other assets in the trust's name.[1]

Ignoring a caregiver with ulterior motives. Very few people consider this possibility when creating a will or trust, but it does happen. A caregiver harboring a hidden agenda may exploit a loved one to the point where he or she revises estate planning documents for the caregiver's financial benefit. The best estate

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Financial Forum

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plans are clear in their language, clear in their intentions, and updated as life events demand. They are overseen through the years with care and scrutiny, reflecting the magnitude of the transfer of significant wealth.

Citations.
1 - raymondjames.com/pointofview/seven_estate_planning_mistakes_to_avoid [10/16/15]
2 - fool.com/retirement/general/2015/12/11/estate-planning-in-2016-heres-what-you-need-to-kno.aspx [12/11/15]

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

Certificates of Insurance

Joan is leasing a new building for her expanding pharmacy practice. As part of her lease, she must provide a certificate of insurance to her landlord. The landlord is insisting on a number of provisions that must be included on the certificate. However, her insurance company is unwilling to provide the certificate as required by the landlord. Joan is unhappy and stressed at being caught in the middle of this tug of war.

A certificate of insurance is a document issued by an insurance company that provides evidence of property and/or casualty insurance coverage. This certificate is evidence for Joan's landlord that she has coverage on her property and on other items required under the lease. The trend has been that landlords, vendors, customers, and others who have a contractual relationship with the insured business want additional provisions included on the certificate. Examples of these provisions include longer notice periods for policy cancellation, statement that coverage can't be voided by the insured's actions, or statements that the policy coverage meets the requirements of the contract.

This is where the tug of war begins. The certificate is only evidence that insurance coverage exists. It is not an insurance policy. The certificate cannot change the policy or guarantee compliance with a contract. At least 16 states have specific laws that do not allow the insurance companies to add these sorts of provisions to the certificate. Numerous other states have implemented this prohibition through issuance of bulletins by the insurance commissioner. Here are two examples.

Indiana's law[1] became effective in 2013. The law specifically states that a certificate does not amend, extend or alter the coverage provided by the policy referenced. It also states that the certificate cannot grants rights to a person that are not contained in the policy, such as an extended notice period. Massachusetts has a very similar law[2] that was passed in 2015. In addition to what Indiana's law says, Massachusetts also says that the certificate shall not be construed as an insurance policy. Both states' laws provide that it is a violation of the law to knowingly prepare, issue, <u>request</u> or <u>require</u> the issuance of a certificate contrary to the law. In both states, the insurance commissioner can enforce the law with a cease and desist order and the imposition of a fine (up to $500 in Massachusetts and up to $1,000 in Indiana).

In many states, the certificate of insurance is a filed form. This means that the insurance company must have the certificate form filed with and approved by the Department of Insurance prior to using it. In these states, the insurance company is not allowed to deviate from the state-approved certificate.

These laws and regulations are what put Joan in the middle of the tug of war. The landlord or other party is trying to modify the insurance policy issued to Joan through changes on the certificate. The policies themselves are also state-approved forms and cannot be changed arbitrarily. That may be why they are attempting to make the changes via the certificate. That is why Joan's insurance company is reluctant to change the policy or the certificate of insurance. In many jurisdictions, it is a violation of the law for the insurance company to do so. In the states with laws specifically addressing certificates, Joan or the landlord could also be in violation of the law and fined accordingly for asking or requiring that the changes be made. In these situations, the insurance company is not just trying to be difficult. They are trying to comply with the law. You should ask your insurance company for an explanation as to why the requested changes can't be made. This can then be passed on to the landlord or other requesting party.

Citations.
1. *Ind. Code Section 27-1-42.*
2. *Mass. Gen. L. Ch. 175L.*

© Don R. McGuire Jr., R.Ph., J.D., is General Counsel, Senior Vice President, Risk Management & Compliance at Pharmacists Mutual Insurance Company.

Continuing Education for Pharmacists

Pharmacist Patient Assessment Skills for Optimizing Self-Care, Part 3 of 4: Evaluation of the Respiratory and Cardiovascular Systems

Oehlke

Messerschmidt

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Clinical Pharmacist,
Sanford USD Medical Center

Goal: To enhance pharmacists' knowledge and skills iregarding patient assessment.

Learning Objectives - Upon successful completion of this course, the pharmacist should be able to:

1. Perform a basic assessment of the respiratory system.
2. Evaluate a patient for signs and symptoms of respiratory distress.
3. Identify symptoms associated with a cough that indicate the need for physician referral.
4. Perform a basic assessment of the cardiovascular system including pulse, respiratory rate, and blood pressure.
5. Describe the proper technique for blood pressure measurement.
6. Identify the characteristics of the most common causes of chest pain.

Introduction

SL is a 54-year-old male who approaches the pharmacy counter with an over the counter (OTC) cough and cold product. The patient explains that he has been taking this multi-symptom cold formula for the past two days, but when he actually read the product directions, he saw a warning which recommended that patients with heart disease or high blood pressure should consult a physician before using the product. He asks for your advice regarding an alternative treatment as his blood pressure has been elevated. Recalling the QuEST/Scholar process which was introduced in the first installment of this series, you begin your consultation by assessing the patient.

In this section, we will continue to explore opportunities for utilizing basic patient assessment skills in the ambulatory care setting, with a focus on assessment of the respiratory and cardiovascular systems.

As you read this module, think about the case above and how you would apply the QuEST process in order to formulate the best plan for this patient's care.

RESPIRATORY SYSTEM

Typical respiratory symptoms such as shortness of breath or cough may arise from a variety of pulmonary, as well as non-pulmonary conditions (e.g., heart failure, gastroesophageal reflux). The initial assessment should start with evaluating the patient for any obvious signs of respiratory distress that indicate a need for physician referral (Table 1). Observe the patient's pattern and ease of breathing. It should be smooth and even, and appear effortless, with a rate of 12 to 20 breaths per minute. Note the depth of the respirations and whether the patient is using accessory muscles (i.e., neck, abdominal, or intercostal muscles). These muscles are used to augment breathing when the diaphragm cannot move sufficient air.

Next, listen to the patient's breath sounds for any abnormalities. Wheezing is a high pitched, continuous, squeaky sound that can sometimes be heard without the aid of a stethoscope. It is caused by air flowing through narrowed or partially obstructed airways. This narrowing may be due to excessive secretions, inflammation, or bronchospasm, and it is com-

QuEST Process[1]

- **Qu**ickly and accurately assess the patient (e.g., symptoms, current medications and medical conditions, allergies)
- **E**stablish that the patient is an appropriate candidate for self-care
- **S**uggest appropriate strategies for self-care
- **T**alk with the patient about:
  - √ The medication's actions, proper administration, and potential adverse effects
  - √ What to expect from treatment
  - √ Appropriate follow-up

monly seen in lung diseases such as asthma or chronic obstructive pulmonary disease (COPD), or in acute bronchitis. Wheezing may also be induced by exposure to certain medications (e.g., aspirin, NSAIDs, beta-blockers) in susceptible individuals. Stridor is a serious, high-pitched, wheezing type of sound that occurs when there is a significant partial obstruction of the upper airway, such as when a foreign object like food, or swelling due to an infection threatens to occlude the airway.

Next, evaluate the patient's ease of breathing. A patient with dyspnea may say they are short of breath, winded, or breathless. To help determine the severity of their symptoms, note whether they can speak in complete sentences without being forced to stop for a breath. Also, ask how their breathing is affecting their daily life. Can they carry groceries into the house? Do they have any problems dressing or bathing themself? If the patient has dyspnea that has not been formally evaluated, or if they have any other signs or symptoms of respiratory distress, they should immediately be referred to their physician.

If the dyspneic patient has a previous diagnosis of obstructive lung disease and is using an inhaler, the pharmacist should always assess medication adherence; this includes having the patient demonstrate their inhaler technique. Studies have shown that a large percentage of patients do not use their inhalers correctly. Providing oral or written instruction on administration technique is not good enough, as this approach results in only about one-half of patients being able to use their inhaler correctly[2]. An actual demonstration of appropriate technique by the pharmacist, while the patient observes and then repeats the demonstration, is the most effective method of teaching this somewhat complicated task. This approach results in 75% of patients using acceptable technique. Since the efficacy of an inhaled medication is highly dependent upon proper administration, it is well worth the extra time it takes to teach the correct administration method to make sure the patient is getting the most benefit.

Another common respiratory complaint is cough. This symptom can be classified in a number of ways: acute (less than three week duration) or chronic, and productive (associated with the expectoration of secre-

Table 1. Signs and symptoms of respiratory distress

Increased respiratory rate
Use of accessory muscles
Retractions of the intercostal spaces
Wheezing or stridor
Dyspnea
Pursed lip breathing
Cyanosis of the skin or lips
Changes in mental status (e.g., confusion, somnolence, restlessness or anxiety)
Nasal flaring, especially in newborns

True or False?

Pursed lip breathing and use of accessory muscles are signs that a patient should be evaluated by a physician.

tions from the lower respiratory tract) or nonproductive (dry, hacking). It is important to remember that the cough reflex is a vital respiratory defense mechanism designed to expel secretions and debris from the respiratory tract; therefore, it can be counterproductive to suppress.

The most common etiologies of a cough are postnasal drip due to allergies or upper respiratory tract infection, cigarette smoking, poorly controlled or undiagnosed asthma, and gastroesophageal reflux[3]. Other less common causes include heart failure, malignancy, other pulmonary diseases, and drugs such as angiotensin converting enzyme (ACE) inhibitors.

A typical ACE inhibitor induced cough can begin anytime from hours to months after initiation of the offending drug. It usually starts out as a tickling sensation in the back of the throat, and the resulting cough is generally described as being non-productive and poorly responsive to antitussives. The typical ACE inhibitor induced cough generally resolves within one to four weeks after drug discontinuation[3].

A cough associated with a common cold is usually caused by post-nasal drainage and may respond to the use of a decongestant/antihistamine combination. Any cough that lasts for more than one week, or is accompanied by symptoms suggestive of an underlying infection or more serious condition should always be evaluated by a physician (Table 2).

Table 2. Symptoms associated with a cough that indicate a need for physician referral

Fever
Night sweats
Hemoptysis
Unintended weight loss
Productive cough with purulent sputum (e.g., thick, colored)
Increasing symptoms in a patient with underlying pulmonary disease
Poor response to self-treatment

VITAL SIGNS and CARDIOVASCULAR SYSTEM

The vital signs (pulse, respiration, blood pressure, and temperature) are considered to be the baseline indicators of a patient's health status. Pain assessment is often times considered the fifth vital sign. Evaluation of the vital signs may be incorporated into any practice setting, measured together or separately, and obtained in a brief period of time.

Pulse

A person's pulse represents the number of cardiac cycles per minute. Because it is easily accessible, the radial pulse (wrist) is most commonly taken. When determining the radial pulse, the pharmacist should:

- Place the pads of the index and middle fingers on the palmar surface of the wrist near the base of the thumb.
- Press down until pulsation is felt, being careful not to occlude the artery.
- If the rhythm is regular, count the number of beats in 30 seconds and multiply the number by two.
- If the rhythm is irregular, count the number of beats in one minute.
- Record the finding as beats per minute (bpm).

The normal resting adult pulse should be between 60 and 100 bpm. In an adult, a heart rate less than 60 bpm is called bradycardia, and a heart rate greater than 100 bpm is called tachycardia. However, a well-conditioned athlete or patient on medications that may slow the heart rate (e.g., beta-blockers) may have a normal, resting heart rate of less than 60 bpm.

Respiratory Rate

Respirations are often counted and evaluated without the patient's knowledge because sudden awareness of this measurement may alter the patient's normal respiratory rate and pattern. The pharmacist should observe the rise and fall of the patient's chest, and the ease with which breathing is accomplished. For a normal adult, the rate is expected to be 12 to 20 respiratory cycles per minute. Count the number of respiratory cycles (i.e., inspiration and expiration) that occur in 30 seconds and multiply by two. Record the value as respirations per minute (rpm). For adults, a respiratory rate of less than 12 rpm is called bradypnea, and a respiratory rate of greater than 20 rpm is called tachypnea. Also observe the regularity and rhythm of the breathing pattern.

Blood Pressure

Blood pressure is a peripheral measurement of cardiovascular function. It is the pressure placed on arterial walls by the blood, and it is controlled by heartbeat force, blood volume, and vessel tone. Blood pressure has two components. Systolic blood pressure represents the maximum pressure that is felt on the arteries during left ventricular contraction. Diastolic blood pressure is the resting pressure that the blood exerts between each ventricular con-

> ***True or False?***
> The five vital signs include pulse, respiration, blood pressure, temperature, and pain.

BP Measurement

Because signs and symptoms of hypertension are commonly absent or ambiguous (e.g., headache, dizziness), accurate measurement is essential. Indirect measures of blood pressure are made with a stethoscope and a sphygmomanometer. Each sphygmomanometer is composed of a cuff with an inflatable bladder, a pressure manometer, and a rubber hand bulb with a pressure control valve to inflate and deflate the bladder. Cuffs are available in a number of sizes to accommodate the wide range of arm circumferences. To determine the appropriate cuff size, compare the length of the bladder with the circumference of the patient's upper arm. For the most accurate measurement, the bladder length should be at least 80% of the arm circumference.

Electronic sphygmomanometers, which do not require the use of a stethoscope, are also available. The electronic sphygmomanometer senses vibrations

Table 3. Guidelines for proper blood pressure measurement[5]

- Ask the patient if he or she has smoked or ingested caffeine within the previous 30 minutes. If the patient answers "yes", record the information and recognize that it may impact the blood pressure.
- The patient should be seated in a chair with their back supported, feet flat on the floor, and bare arm supported at heart level.
- Make sure the patient has been allowed to rest for at least five minutes before measuring their blood pressure.
- Determine the appropriate cuff size.
- Palpate the brachial artery along the inner arm near the crease of the elbow.
- Center the bladder of the cuff over the brachial artery and wrap the cuff snuggly around the arm, placing the lower edge of the cuff approximately one inch above the antecubital space (fold of the arm).
- Position the manometer dial so it can be easily read.
- Instruct the patient not to talk during the measurement.
- Determine the maximum inflation level (how much to inflate the cuff). While palpating the radial pulse, inflate the cuff to the point at which the radial pulse can no longer be felt, then add 30 mmHg to this reading.
- Rapidly deflate the cuff and wait 30 seconds before reinflating.
- Insert the stethoscope earpieces, making sure they point forward when in place.
- Place the bell of the stethoscope lightly, but with an airtight seal, over the palpable brachial artery. Note that the diaphragm of the stethoscope also may be used; however, the bell is designed to detect low-pitched sounds and should be used if possible.
- Rapidly inflate the cuff to the maximum inflation level.
- Slowly release the air, allowing the pressure to fall steadily at 2 to 3 mmHg/second.
- Note the pressure at the first appearance of repetitive sounds and record this as the systolic pressure.
- Continue listening, noting the pressure at which the last sound is heard. This is the diastolic pressure.
- Continue listening until 20 mmHg below the diastolic pressure, then rapidly and completely deflate the cuff.
- Record the patient's blood pressure in even numbers, along with the patient's position (i.e., sitting, standing, lying), cuff size (if a non-standard size is used), and the arm (right or left) used for measurement.
- Wait 1 to 2 minutes before repeating the pressure measurement in the same arm.

and converts them into electrical impulses. The impulses are transmitted to a device that translates them into a digital readout. The instrument is relatively sensitive and is also capable of simultaneously measuring the pulse rate. It does not, however, indicate the quality, rhythm, and other characteristics of a pulse and should not be used in place of your touch in assessing the pulse.

Identifying, treating and monitoring a patient's blood pressure are extremely important steps in reducing the risk of cardiovascular disease, as 72 million Americans have high blood pressure.[4] In addition, blood pressure is an established parameter for initiating and adjusting medication therapy. Guidelines for performing blood pressure measurement are summarized in Table 3.

Measurement Errors

Many factors can affect a blood pressure reading including age, race, time of day, weight, emotions and medications. Table 4 contains a list of medications that have the potential to increase blood pressure. Patient position is another important factor to consider to ensure accuracy. For example, if the patient has their legs crossed during measurement, the result may be falsely elevated. Using a cuff that is too small may also produce falsely elevated readings. Conversely, a cuff that is too large can produce a falsely low reading.

For the most accurate blood pressure assessment, two or more readings, each separated by two minutes, should be averaged. If the first two readings differ by more than 5 mmHg, additional readings should be obtained and averaged. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VII) provides guidelines for the classification of blood pressure readings which are summarized in Table 5.

Table 4. Medications that have the potential to increase blood pressure[4]

Adrenal steroids (prednisone, fludrocortisone, triamcinolone)
Amphetamines/anorexiants (phendimetrazine, phentermine, sibutramine)
Antivascular endothelin growth factor agents (bevacizumab, sorafenib, sunitinib)
Calcineurin inhibitors (cyclosporin and tacrolimus)
Decongestants
Erythropoiesis stimulating agents (erythropoietin and darbepoietin)
Estrogens (usually oral contraceptives)
Nonsteroidal antiinflammatory drugs, cyclooxygenase-2 inhibitors
Others: venlafaxine, bromocriptine, bupropion, buspirone, carbamazepine, clozapine, desulfrane, ketamine, metoclopramide

Table 5. Classification of blood pressure for adults ages 18 and older (JNC VII)[6]

Blood Pressure Classification	Systolic Blood Pressure (mmHg)*	Diastolic Blood Pressure (mmHg)*
NORMAL	<120	<80
PREHYPERTENSION	120-139	80-89
Stage 1 HYPERTENSION	140-159	90-99
Stage 2 HYPERTENSION	>160	≥100

*Treatment determined by highest BP category

True or False?

Many factors affect a blood pressure recording including age, race, diurnal variation, weight, emotions, and medications.

Pharmacists who participate in blood pressure screenings should be aware that hypertension is diagnosed by a physician only after a patient has had elevated readings on two separate occasions. Additionally, pharmacists should be familiar with the national guidelines that delineate individual blood pressure goals and preferred pharmacological treatment based upon each patient's concurrent disease states.[6,7] Irregular blood pressure measurements (high or low), in which the patient is experiencing symptoms, should be referred for medical attention. Both hypertensive urgencies (with no signs of organ impairment) and emergencies (with evidence of target organ dysfunction) are characterized by the presence of a very elevated blood pressure (i.e., greater than 180/120 mm Hg) and should be referred.

Cardiovascular System

Although few pharmacists routinely perform a complete cardiovascular assessment, a basic understanding of how to evaluate common cardiac symptoms will help the pharmacist determine the most appropriate course of action, including referral to a physician.

Chest pain is probably one of the more worrisome symptoms a pharmacist can encounter. Chest pain occurring secondary to myocardial ischemia is termed angina pectoris, but it is also important to remember that similar pain may result from gastrointestinal, pulmonary, abdominal, or musculoskeletal disorders. Although each may possess subtle differences in symptomatology (Table 5), it can still be quite difficult to determine the cause. Therefore, most cases of new onset chest pain should be referred to a physician for further evaluation, especially in patients with underlying risk factors for cardiovascular disease (CVD).

Table 5: Characteristics of common causes of chest pain

	Cardiac	Gastrointestinal	Musculoskeletal
Patient history	Cardiac risk factors	Gastritis or indigestion	Trauma
Type of pain	Heavy pressure, crushing, squeezing across anterior chest; often radiating to arms, neck, jaw, shoulder, back	Substernal burning; may radiate to the back; may be squeezing; may be hard to distinguish from cardiac pain	Sore, dull achy feeling or sharp, knifelike pain
Associated symptoms	Sometimes dyspnea, nausea, vomiting, sweating; dizziness, lightheadedness or fainting	Regurgitation, dysphagia, nausea	May have local tenderness
Aggravating factors	Physical exertion, stress, cold	Large or fatty meals, bending over, lying down	Physical movement, coughing, breathing
Relieving factors	Rest, nitroglycerin	Antacids	Rest, heat, pain medications

Palpitations are an uncomfortable awareness of the heartbeat that may be an indicator of a relatively benign or serious underlying condition. Patients may describe them as a fluttering or pounding sensation in their chest. They may say their heart is racing, skipping beats, or having extra beats. Patients with palpitations should have a complete medication history taken, with special attention given to the use of sympathomimetics, vasodilators, anticholinergics and the withdrawal of beta-blockers. Non-prescription drug usage, including caffeine and illicit drugs (e.g., cocaine, amphetamines) should also be evaluated when appropriate. These patients should be referred to a physician if palpitations are persistent, or are accompanied by shortness of breath, lightheadedness, dizziness, or fainting, or if there is a history of coronary heart disease (CHD). Patients with known cardiovascular disease should always consult their physician or pharmacist before initiating a new OTC medication or dietary supplement since many of these products can cause cardiovascular side effects or interact with their prescription medications[8].

CONCLUSION

Patients commonly present to their community pharmacy seeking advice regarding the treatment of their respiratory and cardiovascular conditions. In the introductory case, SL is concerned about the impact of his multi-symptom cough and cold product on his underlying hypertension. A thorough patient assessment would reveal that his only symptom is a dry cough, and changing his multi-symptom cold medication to a single ingredient cough suppressant would eliminate any unneces sary medications, such as decongestants, that may adversely affect his health.

Additionally, by measuring his current blood pressure, the pharmacist would be able to reassure the patient and determine whether or not any intervention was necessary.

By utilizing these basic patient assessment skills, the pharmacist is able to recommend appropriate self-care treatment and build a trusting relationship in the process.

REFERENCES

1. Leibowitz K, Ginsburg D. Counseling self-treating patients quickly and effectively. Proceedings of the APhA Inaugural Self-Care Institute; May 17-19, 2002.
2. Kuehn BM. Education key to treating airway disease. JAMA 2007;298(22):2601-7.
3. Irwin RS, Baumann MH, Boulet LP, et at. Diagnosis and management of cough: Executive Summary. Chest 2006; 129:1S-23S.
4. Dipiro JT, et al (eds): Pharmacotherapy: A Pathophysiologic Approach. 7th ed. McGraw Hill;2008.
5. William JS, Brown SM, Conlin PR. Blood-pressure measurement. N Engl J Med 2009;360(5):e6.
6. Chobanian AV, Bakris GL, Black HR, et al. Seventh report of the Joint National Committee on prevention, detection, evaluation, and treatment of high blood pressure. Hypertension 2003;42(6):1206-52.
7. Rosendorff C, Black JR, Cannon CP, et al. Treatment of hypertension in the prevention and management of ischemic heart disease: A scientific statement from the American Heart Association Council for high blood pressure research and the Councils on Clinical Cardiology and Epidemiology and Prevention. Circulation 2007;115(21):2761-2788.
8. Tachjian A, Maria V, Jahangir A. Use of herbal products and potential interactions in patients with cardiovascular diseases. J Am Coll Cardiol 2010;55:515–25.

SUGGESTED READINGS

Berardi RR, Ferreri SP, Hume AL, Kroon LA, Newton GD, Popovich NG et al, editors. Handbook of Nonprescription drugs: An Interactive Approach to Self-Care. 16th ed. Washington DC: The American Pharmaceutical Association; 2009.

Dipiro JT, et al (eds): Pharmacotherapy: A Pathophysiologic Approach. 7th ed. McGraw Hill; 2008.

Jones RM and Rospond RM. Patient Assessment in Pharmacy Practice. 2nd ed. Baltimore (MD): Lippincott Williams & Wilkins; 2006.

Longe RL and Calvert JC. Physical Assessment: A Guide for Evaluating Drug Therapy.1st ed. Vancouver: Applied Therapeutics, Inc; 1994.

ASSESSMENT QUESTIONS

1. **The most effective method of assuring that a patient is using their inhaler correctly is to:**
   A. Answer any questions they ask about their inhaler
   B. Provide them with verbal instructions, then ask if they have any questions
   C. Provide them with written instructions and tell them to call if they have any questions
   D. Demonstrated the appropriate technique, then have the patient show you how they are going to use their inhaler; supplement with written instructions

2. **Wheezing is caused by air movement through narrowed airways. This narrowing can occur from:**
   A. Inflammation and/or infection
   B. Excessive secretions
   C. An adverse drug reaction
   D. All of the above

3. **Which of the following descriptions indicate the need for immediate physician referral?**
   A. A respiratory rate of 18 breaths per minute in a 60 year-old patient
   B. An asthma patient who is not wheezing, but looks "blue" around his lips
   C. A COPD patient who complains of chronic shortness of breath when he climbs the stairs
   D. None of the above

4. **Which of the following scenarios describes a patient who would be an appropriate candidate for self-treatment of his cough?**
   A. A 63 year-old COPD patient with a productive cough and a new complaint of coughing up green sputum
   B. A 25 year-old with a cold, and a cough that kept him from sleeping well last night
   C. An otherwise healthy 30 year-old who complains of a cough associated night sweats fever, and unin tended weight loss
   D. An 18 year-old with a three week history of poor response to OTC cough suppressants

5. **Age, race, time of day, weight, emotions, patient position, and medications may affect which of the following?**
   A. Proper beta-blocker dosing
   B. Blood pressure measurement
   C. Nasal congestion
   D. Treatment of cough

6. **Proper blood pressure monitoring should include which of the following?**
   A. Patient resting for at least 30 minutes
   B. Large cuff size
   C. Feet placed flat on the floor
   D. Slow inflation of the cuff

7. The normal resting adult pulse should be between ____ and ____ beats per minute.

A. 12 and 20

B. 40 and 90

C. 60 and 100

D. 90 and 120

8. For a normal adult, the respiratory rate is between ____and ____ respiratory cycles per minute.

A. 12-20

B. 16-20

C. 40-90

D. 60-100

9. For adults, a respiratory rate of less than 12 rpm is called

A. Bradycardia

B. Bradypnea

C. Tachycardia

D. Tachypnea

10. Chest pain associated with a musculoskeletal origin is most typically described as a:

A. Heavy pressure radiating to the neck or jaw

B. Burning sensation that is worse when lying down

C. Sharp, knifelike pain that is exacerbated by physical movement

D. A crushing pain associated with nausea and sweating

11. Palpitations:

A. Are always indicative of a serious underlying cardiac condition

B. May be felt as a fluttering or pounding sensation in the chest

C. Are usually benign and only need to be evaluated by a physician if the patient experiences fainting

D. Are always considered a medical emergency

12. Heavy pressure, crushing, and squeezing across the anterior chest, often radiating to the arms, neck, jaw, shoulder and back, may be indicative of which of the following?

A. Cardiac chest pain

B. Musculoskeletal chest pain

C. Gastrointestinal chest pain

D. GERD chest pain

"Pharmacist Patient Assessment Skills for Optimizing Self-Care, Part 3 of 4: Evaluation of Respiratory and Cardiovascular Systems"

Knowledge-based CPE

To receive **2.0 Contact Hours** (0.2 CEUs) of continuing education credit study the attached article and answer the 12-question test by circling the appropriate letter on the answer form below. A test score of 75% or better is required to earn credit of **2.0 Contact Hours** (0.2 CEUs) of continuing pharmacy education credit. If a score of 75% (9/12) 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: #0063-0000-14-043-H01-P.

Learning Objectives - Pharmacists*: 1.Perform a basic assessment of the respiratory system; 2. Evaluate a patient for signs and symptoms of respiratory distress; 3. Identify symptoms associated with a cough that indicate the need for physician referral; 4. Perform a basic assessment of the cardiovascular system including pulse, respiratory rate, and blood pressure; 5. Describe the proper technique for blood pressure measurement; 6. Identify the characteristics of the most common causes of chest pain.*

Circle the correct answer below:

1. A B C D	**5. A B C D**	**9. A B C D**
2. A B C D	**6. A B C D**	**10. A B C D**
3. A B C D	**7. A B C D**	**11. A B C D**
4. A B C D	**8 A B C D**	**12. A B C D**

Course Evaluation *– must be completed for credit.*	**Disagree**						**Agree**
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Content was applicable / useful in practice:	1	2	3	4	5	6	7
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*List any learning objectives above not met in this course:*____

*List any 'learning gaps' that you believe were not addressed:*____

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Length of time to complete course was reasonable for credit assigned:	1	2	3	4	5	6	7

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IN MEMORIAM

Timothy Page

Timothy Regan Page, 62, of Watertown, SD, passed away Sunday, June 5, 2016 surrounded by family.

Timothy Regan Page was born on April 20, 1954, in Spencer, IA to Rex and Marilynn (Sprague) Page. Tim grew up in Madison, SD graduating in 1972. He attended South Dakota State University earning a Bachelor Degree in Pharmacy in 1977. Tim attended the University of Iowa and graduated with his Masters Degree in Pharmacy in 1979. He earned his PharmD from the University of Minnesota in 2006.

He married Lynette "Lyn" Miller on June 3, 1978 in Brookings, South Dakota. He worked as a pharmacist in Ottumwa and Spencer, IA, Mexico, MO, and Watertown, SD.

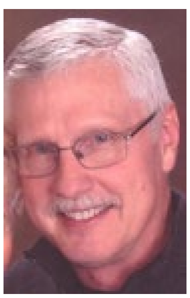
Tim loved spending time with Jesus and his family. He enjoyed biking, photography, outdoor adventuring, and officiating at track meets.

He was a member of Watoma Club, the American Society of Hospital Pharmacists, South Dakota Health-System Pharmacists and South Dakota Pharmacy Association.

Tim is survived by his wife, Lyn Page; his children, Bryan (Nikki) Page of Sioux Falls, SD, Lindsie (Mike) Billeter of Sioux Falls, SD and Brittany (Grant) Kuper of Moorhead, MN; his two grandchildren, Jack David and Fox Timothy Billeter; his father Rex Page of Madison, SD; his siblings, Scott (Chriss) Page of Mankato, MN, Steve (Janice) Miller of Olympia, WA, Jill (David) Harbison of Winter Haven, FL, John Page of Pineville, LA and Jeff Page of Columbus, NE.

He was preceded in death by his mother, Marilynn Page; and his brother, Charles Page.

Paul Parker



Paul Parker, 64 of Indian Land, South Carolina and a former Arlington resident died Saturday, June 18, 2016 at his home of Congestive Heart Failure.

Paul Parker was born March 3, 1952 in Omaha, NE to Rex and Marion (Breaw) Parker. After graduating from Arlington High School in 1970, Paul went on to receive his Pharmacy Degree from South Dakota State University in 1976. He married Peggy Jo Stensgaard on September 6, 1975. He co-owned Precision Painting with Dave Kaufman for 2 years. In 1979, Paul was called into the Ministry and pastored his first church with Peggy in Howard, SD. In 1981, Paul and Peggy moved to Casper, WY where they planted a church and remained for 14 years. In 1995, Paul became the Regional Superintendent of the Mountain Plains Region for Open Bible Churches and at that time moved to Colorado Springs, CO. He retired from that position in 2007. In 2008, Paul became a corporate salesman for Affiliated Business Consultants of Colorado Springs. Paul traveled throughout the United States connecting the buyers and sellers of small businesses. It was a job that suited him well as he loved to meet new people. He was always ministering wherever he went. Paul and Peggy moved to Indian Land, SC in 2015 where he remained until his death.

Paul celebrated life and enjoyed many things, sports of every kind, golfing with his wife Peggy, fishing with his kids and grandkids and Nick's Hamburgers. (When he came home)

Paul's life deeply touched many but none greater than his wife Peggy, his daughter Amanda McKinney, son Bryce (Ashlie), four precious grandchildren, Marcus, Lydia and Jayden McKinney and Brylie Parker. a brother, Boyd (Ann) Parker and several nieces and nephews.

He was preceded in death by his parents.

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