PHARMACY PHILE

University of Waterloo Society of Pharmacy Students
ISSUE 46 | July 2013

TEVA Strategic Planning Event2013

PRESIDENT & VP'S MESSAGE

Dear Students, Faculty and Staff,

We have now completed the summer term and the class of 2013 has written their final exam. We are looking forward to starting a new term in the fall with events, such as the Golf tournament, and welcoming in the new class with our annual welcome night.

At this years formal, students were treated to a night filled with a delicious dinner put on by the Kitchener/Waterloo convention center. The students had the option of a stuffed chicken, halibut or vegetarian dish. Afterwards, awards were presented to some deserving students and a dance ensued. This year, although not as rowdy as the previous formal, showcased that the students know how to keep up spirits during a tough school schedule.

Students were also invited to a leadership dinner put on by Teva Canada where we were encouraged to pass on ideas and talk to some brilliant minds in our field. This formal event, held each year, was a great way to spend a summer night.

As the fall term is coming near there are a couple of things to look out for from SOPhS. First of all, we will be installing a pool table in the main lounge at the end of August in time for the next term. For those of you concerned, we will still keep the ping-pong and a foosball table in the lounge leaving plenty of study space and resting space for those of you who need it.

As well, we just finished a town hall meeting where we will meet with faculty and discuss issues brought up. The answers to these issues will be posted in the next PharmPhile coming up in September. As for the golf invitational; which is taking place Monday September 16th, the faculty are still looking for golfers and volunteers for this event. If interested, feel free to message SOPhS at pres@sophs.ca.

I just wanted to finish off by sending out my congratulations to the graduating class of 2013. I know it wasn't easy and through the close relationships we have built with this class I know that you will all progress the field in a way that can only be in the right direction. Best of luck in your future endeavors.

Until next time,

Marcus Walz and Jonathan Potvin

IN THIS ISSUE

SOPhS
SOCIETY OF PHARMACY STUDENTS

CAPSI CORNER: RUN FOR THE CURE

The **Canadian Breast Cancer Foundation CIBC Run for the Cure** is Canada's largest single day, volunteer-led fundraising event dedicated to raising funds for breast cancer. Last year, Canadians united to raise over $30 million in the 2012 Canadian Breast Cancer Foundation CIBC Run for the Cure. The fundraising efforts and volunteer support of over 170,000 annual participants allows the Foundation to continue funding ground-breaking research, education, awareness and advocacy initiatives.

For the past few years, UW School of Pharmacy has been a part of this initiative. CAPSI National Council has been holding a fundraising competition between pharmacy schools across Canada. Last year, all pharmacy schools participated with the University of Manitoba coming out on top. Collaboratively, pharmacy schools raised $45,000 for the Canadian Breast Cancer Foundation.

This year, UW pharmacy is participating in the run on **Sunday October 6th at Conestoga College in Kitchener**. Our school's fundraising goal this year is $1500, which we plan on surpassing, as we have already raised **$1080** from our annual **SOPhS and CAPSI's Run for the Cure Sports Day**, with several teams participating in soccer, volleyball and slo-pitch. The Rx2014s won first place for slo-pitch, and the almighty Rx2013s won both beach volleyball and soccer. Best team name was awarded to "Breast Friends Forever" and best costume went to "Kiss my Ace". There were also several great prizes won, including the grand prize of a 25 person tour of Brick Brewery.

If you know you will be in the area this fall for co-op, or you are in school term (Rx 2015), and you would like to participate in the run, register now!

1. Go to www.runforthecure.com

2. Click on locations, and select Kitchener-Waterloo -

3. Click on "I want to join or re-start a team".

4. Our team name is "UW School of Pharmacy"

5. This year there is only one registration option, a $40 registration fee. However, there is no minimal donation that needs to be met per individual. Remember: accompanying dogs are welcome!

OR go to http://www.runforthecure.com/site/TR/RunfortheCureFY14/Ontario?pg=team&fr_id=1710&team_id=54927

Everyone knows someone who has been affected by breast cancer. Join UW pharmacy's initiative to fight back. If you would like to help out with any of these events, contact any UW CAPSI council member or Run for the Cure committee member.

Sarah Johnson and Holly Meginnis
UW CAPSI Senior and Junior Reps

CO-OP CHRONICLE

Brittany Franchuk, Rx 2015

Setting: St. Joseph's Health Centre – Medication Reconciliation

Trina McFarlane (TM): Tell us about the roles and responsibilities you took on at St. Joseph's Health Centre.

Brittany Franchuk (BF): This term I was involved in medication reconciliation with my primary focus being to collect best possible medication histories (BPMH's). In order to expose students to different types of patients and different health care professionals St. Joe's rotates their students and assigns them to different floors each month. Thus I had the opportunity to be on a medicine unit, surgical unit, in the ER and even be in ICU for a bit. Although I was technically doing the same job on each floor, I faced different challenges in each department due to differences in my patient population. For example, patients being intubated and unconscious in ICU, stroke patients not being able to communicate on the medicine floors, patients being transferred or discharged home from ER while in the middle of typing up the BPMH etc. Despite mostly collecting BPMH's once a patient was admitted, I also helped create medication charts and be involved in discharge medication reconciliation for some of our COPD and CHF patients. At St. Joe's discharge medication reconciliation is a requirement for these two types of patients as they often are re-admitted to hospital and are known as "frequent flyers". Thus in an effort to prevent future unnecessary hospital admissions/stays pharmacy provides medication charts and discharge counselling to encourage compliance and the patient is also followed by a nurse navigator in the community.

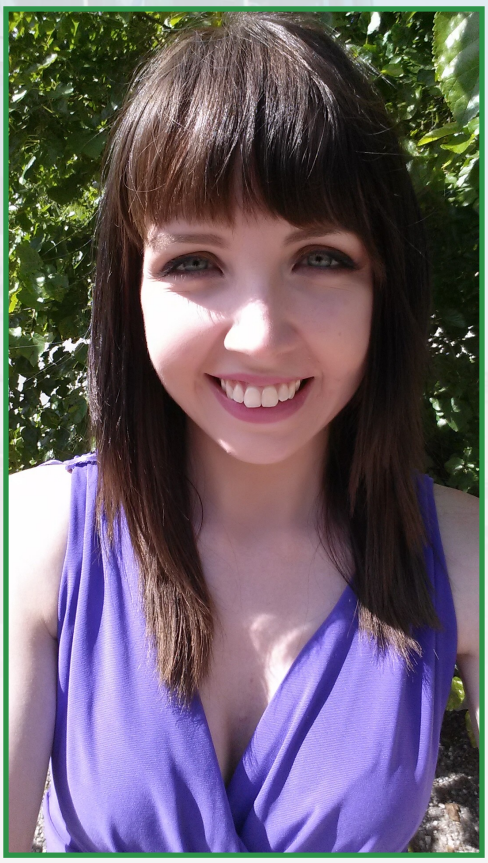
In addition to the above, other roles and responsibilities I had this term included counselling patients about their inhalers (while under the supervision of a pharmacist), counselling patients who were starting on warfarin (while under the supervision of a pharmacist), resolving DTP's that were identified via the BPMH with physicians and residents and providing a presentation about this years OPA conference to the pharmacists in our hospital.

TM: What lessons were you able to take from the 2A term and utilize while on co-op?

The most important lessons from the 2A term that I utilized while on co-op were from IPFC 2. Several times this term while reconciling meds I had to distinguish the difference between therapeutic and prophylaxis doses of anticoagulants, review how patients bridge between warfarin and low molecular weight heparin (LMWH) and even counsel a few patients who were starting on warfarin. My COPD/Asthma knowledge also came in handy since pharmacy was often asked to review inhaler technique and provide discharge counselling to patients who had exacerbations due to non-compliance or whose inhaler regimen had been changed while in hospital. I was also able to assess if their inhaler regimen was appropriate when reconciling their medications. In addition to this, I felt thankful that we had learned antibiotics this past term as you obviously see those on a daily basis in hospital. Although it was often the pharmacist who would review antibiotic indications and durations I was still able to help flag patients who needed their antibiotics reassessed when being admitted. Last but not least, interpreting lab values was yet another valuable skill to have while working in a hospital setting since kidney function was often the reason why medications had been discontinued or put on hold. Thus the lab value that I most frequently checked/followed was SCr. Other lab values I used this term were K, Na, ALT, AST, INR, BS and BP which were useful to determine when medications needed to be restarted or held.

TM: What are some barriers or challenges that you face while on co-op?

BF: The biggest barrier that I faced while on co-op was the fact that the hospital I worked at still uses a paper based system since they're in the middle of converting to being fully electronic. This means that each patient's record/chart was literally a binder that only one person could use at a time. Thus I felt like I spent a lot of time walking around looking for and waiting for charts which as you can imagine was inefficient and took time away from providing actual patient care. Other downsides of using a paper based system was that there were times we were missing important information about our patients (such as previous admissions at other hospitals, previous medication changes and why etc.) that they were unable to tell us and by only having certain things be electronic meant I often had to document the same thing in more than one place.



With that said, another big challenge I faced was having to overcome lots of language barriers while on co-op due to the hospital's catchment area with the most common one being polish. This definitely tested my use of "patient friendly language" and non-verbal communication skills and in some cases I had to get a translator. However, even with English speaking patients I ran into challenges when it came to insulin in particular since many patients were unable to remember how many units they use and unfortunately their prescription at their community pharmacy simply said use as directed. This type of situation taught me how to be resourceful as I often had to track down family, ask for the actual medication vials and boxes to be brought in from home for review and in some cases contact the prescribing doctor.

Finally, last but not least, another barrier I faced (which was the most surprising) was when some community pharmacies were not willing to collaborate easily. On more than one occasion when calling the community pharmacy to obtain a medication history they would either question why we even needed it in the first place,

Continued on page 4

"Co-op Chronicle" continued from page 3

say they were too busy and ask us to call back later or fax it much later than they said they would going too which slowed down the medication reconciliation process. Having worked community pharmacy last co-op term I understand that they too are busy and it's easy to forget to fax something, but these types of things were happening so often that it definitely made me realize that we as future pharmacists need to bridge the gap that exists between hospital and community especially when our patient is in a time of need.

TM: You have mentioned that a paper-based system can be a barrier. This might also be what the staff are used to and comfortable with. How do you cope with this challenge and how do you think the staff will react when the hospital goes fully electronic?

BF: Despite initially being a bit frustrated with the paper based system I realized I had no choice but to adapt and make do with what we had until they fully implement the electronic system. Thus my strategy was to focus my efforts on communication and follow-up (ie. making sure that doctors/residents received my notes regarding medication clarifications, documenting in more than one place so that all health care professionals would be able to see our pharmacy interventions etc). Unfortunately, a lot of the current staff are very resistant and hesitant about the upcoming change since I believe they are afraid of and dreading the extra work and learning curve that will come with a new program/system. However, I hope that someday they can look back and see how much more efficient the hospital has become and realize that it was needed and worth it!

TM: So far, what was your favourite "floor" to do BPMH's at St. Joes?

BF: As mentioned, this term I had the opportunity to work on a few medicine floors, surgery, ER and even ICU for a bit. With that said, I would have to say that surgery was my favourite floor since they have a quick patient turnover rate (which keeps you busy) but at the same time some patients would stay long enough that there was opportunity to follow-up with them. The quick patient turnover rate was due to the fact that patients were often transferred to other floors once their main surgical issue has been resolved. In contrast, I found the medicine floors to have slower turnover, but more opportunity for follow-up and developing therapeutic relationships while the ER was the opposite. As for ICU, although I had the chance to see some more complicated/complex cases I didn't have as much direct patient interaction since most of the time I was unable to interview the actual patient due to their circumstances (ie. Intubated, too sedated, unconscious etc). Thus surgery was my favourite since it offered the best of both worlds in regards to turnover and following-up and their residents collaborated with pharmacy the most.

TM: Since you were on a surgical unit, were you able to watch any surgeries?

BF: Unfortunately, I never had the opportunity to watch any surgeries during my time on the surgery unit (I just did med rec for the floor) and as far as I know of none of the previous pharmacy students have either. However, St. Joe's is considered a community teaching hospital thus I'm sure if I had asked they may have been able to arrange something. Thus let this be a lesson for other students – you'll never know if you don't ask!

TM: Does one day in particular stand out to you?

BF; The days that stand out the most to me are days where the patient thanked me for helping them and wanted to express that by shaking my hand or giving me a hug when being discharged. Those moments really touched me as it was then that I knew I had made a difference and had helped make that patients hospital stay more enjoyable. The thing to keep in mind though was that moments like these often weren't actually related to their actual medical issue but rather because I did something simple like smile, spend a little extra time talking to them or listened to their non-medical concerns such as wanting something to drink, wanting to have a shower etc and followed up to make sure those basic needs were met. Other moments that stand out to me were when a doctor personally thanked me for teaching his patient how to use his inhalers and when I caught a major drug interaction that was interfering with a patient's pain management regimen.

TM: What was the biggest lesson you learned from co-op?

BF: One of the biggest lessons I learned this co-op was that the transition from hospital to community is a big area for improvement. This term I saw far too many readmissions that I feel could have been prevented with better coordination and continuity of care. Since our hospital still uses a paper based system they would rely on the patient to bring their discharge papers and prescription to their family doctor and pharmacy, but in reality we should be communicating with our fellow health care professionals directly. By relying on one person (in this case the patient) to get a message through there is a high chance for error or a chance the message will never get through in the case of a non-compliant patient who avoids their family doctor and doesn't fill prescriptions regularly. Thus as future pharmacists I think it's important that we remember the importance of collaboration and keeping everyone within the circle of care in the loop. By doing this it will ensure that our patients are actually being followed-up with in an appropriate amount of time.

TM: Since you are not from Toronto, how do you like living there on this co-op?

BF: Living in Toronto was fun at first as there were lots of things to explore, good shopping and some friends from undergrad that I got to catch up with. I also found travelling via a subway to be very convenient! However, as the summer went on and got hotter the northern girl in me missed being out of the city and being somewhere closer to lakes and cottage country. Thus although it was a good experience living here for a bit I'm looking forward to moving back and re-uniting with our class again!

TM: Any words of wisdom to fellow students?

BF: Always remember to smile, empathize and listen. You have no idea what an impact the little things can have on a patient's day.

FACULTY SPOTLIGHT: DR. JEFF NAGGE

Interviewee: Dr. Jeff Nagge

Interviewer: Holly Meginnis, Rx2015

If I mention the name "Jeff Nagge" to anybody at the School of Pharmacy, everybody knows who I am talking about - the cardiology professor, the professor who loves warfarin or the professor who dislikes guidelines. Everyone knows the name Jeff Nagge, but how much do you really know about him? I thought it would be great for us students to get to know a little more about who Jeff Nagge really is!

HM: Tell us a little bit about your pharmacy background - where did you earn your pharmacy degree? Aside from imparting knowledge to students at the school, where else do you currently practice pharmacy?

JN: I completed my undergraduate pharmacy degree at the University of Toronto, a hospital pharmacy residency at McMaster, and then back to the University of Toronto for my Doctor of Pharmacy degree.

About half of my time is spent at the School of Pharmacy, and the other half of my time is spend practicing at the Centre for Family Medicine Family Health team right next door to the School. The last half of my time (note - the numbers may not add to one) is spent teaching in the undergraduate and graduate programs at the McMaster School of Medicine.

HM: What does a typical (and I use this word lightly) day at the Centre for Family Medicine look like for you?

JN: As you allude to Holly, there isn't exactly a "typical" day. One day might start with some appointments in the thrombosis clinic, during which I see patients to reassess the appropriateness of continued anticoagulation therapy. In between patients I field questions from the physicians I work with about their patients (and sometimes about whatever sporting event was played the previous evening). The afternoon may include patient assessment in the cardiovascular risk reduction clinic, or the multi-disciplinary heart failure clinic. About the only constant in my day is the supervision of learners. I always have a pharmacy student or a medical resident with me when I see patients, and quite often, I have both.

HM: Dear Pharmacist - so my doctor told me I need to start taking warfarin but I have heard that stuff is rat poison, and I refuse to take rat poison. Why does my doctor want me to take rat poison? Is he trying to kill me!? No, I'm kidding, though I bet you get tons of questions about warfarin being rat poison- how do you best field those inquiries?

JN: I am always honest with patients. I tell them that yes, it can be used as rat poison. I even tell them about how I got rid of the rats infesting the basement of the apartment that I lived in at the University of Toronto by mixing peanut butter with some warfarin that I borrowed from Sunnybrook hospital (this actually led to getting rid of my roommate's girlfriend too, because the rats died in the wall of his room and the smell was overpowering; alas, I digress). I then point out that warfarin is a natural drug; it was originally isolated from sweet clover. Also, I mention that warfarin has been used safely in humans since the mid-1950's, and there aren't too many drugs that we have more experience with than that.

HM: Briefly describe your teaching philosophy.

JN: I believe strongly that students are best served by helping them to develop critical thinking and self-directed learning skills. These skills are essential to enjoy success in any pharmacy setting.

When teaching in the classroom, I use the Friday mini-cases to challenge students to independently find, appraise, and apply information to address clinical scenarios. The mini-cases are also a preview for IPFC-9, which is delivered using the Problem-Based Learning (PBL) method. The PBL method is a student-centred teaching approach that uses clinical cases to direct student learning. There are no lectures in IPFC-9; rather, students use the hours normally reserved for lectures to research their learning objectives, and then meet in small groups to discuss their findings with each other.

When students are on clinical rotation with me, I use the Socratic teaching method, which involves asking questions of learners to stimulate critical thought. By the end of the rotation, students learn that for every question they have for me, I give them two more in response, right Holly?

Continued on next page

'Faculty Spotlight: Dr. Jeff Nagge' continued from page 4

HM: IPFC 4 is a fairly daunting course for students (cough, understatement). In your opinion, what's the best way to tackle it all as we move through our degree and get out into the "real world"?

JN: On one hand, IPFC-4 is challenging because of the volume of information, and at times it may seem overwhelming. It will likely require a change in how you organize your time to ensure that you study in the most effective manner. However, I think it's important for students to move beyond worrying what their actual grade in a course is, and focus more on making sure that they understand important concepts. Some of those concepts include: 1) being systematic in their assessment of patients for drug therapy problems (i.e. are all important DTPs identified and properly prioritized?); 2) being systematic in the assessment of drug therapy alternatives (i.e. were all reasonable alternatives considered, and was one logically selected one based upon comparative efficacy, safety, cost, convenience and consideration of patient-specific factors?); 3) appraising the quality of information available (i.e. is it high-quality clinical trial information or simply expert opinion?); and 4) focusing on how you can use your knowledge about drug therapy to help patients make informed decisions about their medications.

HM: What was your favourite class as a student? What (if any) class was the most challenging and why?

JN: My favourite classes were therapeutics, pharmacology and pathophysiology. That is probably not too surprising to most people who know me.

The most challenging course that I ever took was Introduction to the Profession of Pharmacy in my first year at the University of Toronto. It was a course that required us to write several essays, and the class average was about 64%. Ironically, this course also turned out to be one of the most valuable that I took, because I realized how important it was to improve my writing skills.

HM: I know that many people in this area either love or hate the Toronto Maple Leafs, and you make your hatred towards the Leafs known. Where did this hatred come from, and how did you become fan of the Montreal Canadiens, a team that is on a clear decline and will likely never win the cup in our lifetime?

JN: I would never say I have hatred for Toronto Maple Leaf fans. Clearly, those who cheer for the Leafs have an underlying illness, and as a health-care professional I need to show compassion toward them.

My allegiance to the Montreal Canadiens started when I was a young lad playing hockey on a frozen tennis-court in my home town of Maryhill. I always pretended to be Guy Lafleur, because his name sounded cool.

By the way, you're fired for your last comment.

HM: Just to restore peace to our relationship after that whole Leafs vs. Canadiens dispute, how about those Jays?

JN: I'm afraid that by the time this interview is published, we'll already be saying "just wait till next year!"

HM: If you weren't a pharmacist and professor, you would be....

JN: I would like to think I'd be a professional golfer. Dream big, right?

HM: Any words of wisdom or advice for UW students?

JN: I think that University life is meant to be enjoyed. While I was doing my Pharm.D. degree, one of my mentors told me that I will have more free time as a student than I will at any other point in my life. I found it very hard to believe that at the time, but it turns out he was absolutely correct.

HM: Finally, I know you used to be a bartender, how do you make a perfect margarita?

JN: There are two non-negotiable, absolutely essential ingredients: 1) key limes (not the big dark green ones, but the small, light green round ones); and, 2) good quality tequila.

Start by squeezing about 8 limes into a cocktail shaker. Add 1.5 oz of Patron silver tequila, 0.5 oz of Cointreau liqueur (on a student-budget, Triple sec is an acceptable substitute), and a couple of drops of blue agave syrup.

Add three ice cubes and shake for a minute. Use one of the squeezed limes to rim a margarita glass, and dip the glass in some crushed sea salt. Strain the drink into the glass, and enjoy.

*Disclaimer - never drink and drive, and never drink before an IPFC-4 or 9 exam.

Fresh from the Pharm: Summer Quinoa Salad

Angela Quach, Rx2015

I'd like to continue on with 'Fresh from the Pharm' blog written by Chelsea Barr, Rx2013. I often enjoy cooking and coming up with recipes. Here is one of my favourite recipes, which is something light and fresh for n the summer.

List of ingredients:

1 cup of quinoa

2 cups of water

Sea salt to taste

Fresh ground pepper to taste

¼ cup fresh lemon juice

1/8 cup olive oil

¼ red onion (diced)

2 cups of pre-shaven carrot and coleslaw mix

1/8 cup chopped parsley

½ can black beans (or your beans of choice)

½ tomato (diced)

1 whole orange/red pepper

Directions

In a pot, combine the quinoa and water. Bring to a boil, then reduce heat to low-medium and let the quinoa cook with the lid covered on the pot until the water has been absorbed and the quinoa is fully cooked (about 10 minutes). Cool slightly and then fluff with a fork.

Transfer the quinoa to a serving bowl and stir in the parsley, red pepper, onion, beans, carrots, coleslaw, beans, lemon juice, and olive oil. Keep the mixed quinoa salad in the fridge for an hour. Season with salt and pepper before serving.

Bruyère Geriatric Day Hospital: An Interprofessional Team Approach

Danielle Paes, Rx2014
Written May 2013

I recently had the pleasure of working alongside Dr. Barb Farrell, a clinical pharmacist and scientist who conducts pharmacy practice research focussed on 'care of the elderly' at Bruyère Continuing Care Hospital in Ottawa. During my placement at the hospital, I gained some unique insight into the functioning of their busy Geriatric Day Hospital (GDH); this valuable program helps seniors living in the community strengthen their independence by optimizing their medical, cognitive, physical and social function over a 12 week period. Patients are referred to the GDH team for a variety of reasons including increased fall risk, declined cognition, and/or rehabilitation after hospital discharge (all common occurrences in the frail elderly population, as we've learned in class). What makes the Bruyère GDH so special however is their holistic approach to patient care; the multidisciplinary team puts interprofessional collaboration at the core of their practice, and the positive effects of this are evident from the feedback they receive from patients and their families.

At the GDH, the individual expertise of each team member is highly valued and appreciated; the advice of specific healthcare providers is often solicited when assessing patient cases and problem solving; conflict is regularly mitigated by open and honest communication. As part of my learning, I witnessed many successes that were a direct result of a team-based approach. At the daily GDH rounds, every professional adds their independent patient assessment to the story - this helps to paint a very complete picture of each patient case. The social workers discuss the patient's living situation and matters like caregiver burden; the occupational therapists discuss mobility at home; and the pharmacist provides insight into what medications might be contributing to patient side effects. By the end of the team discussion, the group is able to come to a consensus about the most appropriate care plan for each elderly patient in their care.

Within the interprofessional team, the pharmacist plays an integral role in the patient's medication management; they are often involved in helping develop appropriate care plans to tackle the issue of polypharmacy. Many GDH patients are taking over 15 medications each day, a number of which they aren't even sure what for; helping reduce unnecessary medication use and pill burden is just part of the programs overall goal to improve quality of life.

During my time at the hospital I was able to see firsthand the positive influence this type of synergistic approach to healthcare can have on the quality of patient care provided. When healthcare professionals work together, the patient ultimately benefits as a result of the numerous advantages to this collaborative approach; these include:

- Continuity of care – promotes patient safety
- Comprehensive patient assessments and continuous patient monitoring
- Reduced risk of missing a critical finding - many independent eyes on one patient
- Education and learning opportunities about other health professions – ability to refer patient to the right person for the type of care based on knowledge of what other care providers do.

As a result of working at Bruyère, I have come to appreciate that interprofessional collaboration is truly valuable when managing complex conditions, especially in the elderly! I believe that as the profession of pharmacy continues to evolve, there will be a greater need for healthcare providers to band together to provide patients with the best care possible!

Generic Drop-Out: Pressures on the Pharmacists of Alberta

Melissa Raymer
Rx 2015

On Tuesday, March 19, 2013, the Alberta Government chose to side-step the efforts of the Council of the Federation.[1] Rather than following the model to reduce the price paid for generic versions of Atorvastatin, Ramipril, Venlafaxine, Amlodipine, Omerprazole and Raberprazol to 18% of the brand name cost across the country, Alberta declared a plan to reduce the price their provincial government will pay for ALL generic drugs to 18%.[1,2] Adding insult to injury, this decision was made without consulting Alberta's pharmacists, leaving many professionals feeling betrayed by their own government.[3]

With the dramatic drop in generic drug prices from 35% to 18% of the brand name cost, independent pharmacies are concerned about how they will make ends meet. In Alberta, the dispensing fees for both public sector drug plans (including the government funded program Alberta Blue Cross, comparable to the Ontario Drug Benefit Program) and for private sector drug plans are capped. The professional fee in Alberta is not allowed to exceed $10.22 if the acquisition cost of the drug is less than $74.99, and the additional inventory allowance cannot exceed $0.71.[4] The inventory allowance is a replacement of the 'percentage mark-up' common to pharmacies in Ontario. While the additional inventory allowance has been extended to $1.71 on April 15, 2013 to help pharmacies deal with the transition to lower generic prices, the allowance will return to $0.71/prescription on April 1, 2014.[4] With relatively few cash-paying patients in Alberta (i.e. patients without a drug plan), this funding model is unsustainable.

For my second co-op work term, I had the opportunity to work with Value Drug Mart Associates Ltd. in Alberta. Speaking to multiple professionals from this organization in the wake of the announcement, and watching pharmacies prepare for the dramatic drop in prices, has been an eye-opening experience. There is not only a large amount of frustration on behalf of the pharmacy community, but there is also a growing sense of uncertainty about the professions future. This uncertainty has motivated various pharmacy groups to speak out. Advocacy groups such as the Alberta Pharmacists Association, as well as corporations like Value Drug Mart, are using public campaigning and politically lobbying to spread a common message: these cut-backs will negatively impact the quality of Alberta's healthcare.

I had the opportunity to discuss the recent change in generic pricing and the resulting politically lobbying with one of my project supervisors: Jody Shkrobot. Past President of the Canadian Pharmacist's Association (June 2011- May 2012), current Pharmacy Services and Professional Affairs Manager at Value Drug Mart Associates Ltd, on top of being a pharmacy owner, Mr. Shkrobot is spear-heading the **"I Care About my Pharmacist" Campaign**. I Care About My Pharmacist a public awareness campaign—backed by Value Drug Mart—aimed at increasing professional and public knowledge about the budget cuts to pharmacy in Alberta.[3] He explained that while the dramatic reduction in generic drug pricing is the focus of the campaign, reversing the reduction is not the goal. Ideally, the campaign is about getting the Alberta government to open a negotiation table with our profession. By creating a line of communication, Alberta's pharmacists can be consulted and provide input before future changes in funding occur. The ultimate, the goal of the campaign, as Mr. Shkrobot explained, is to "…get Alberta Health to work with pharmacists to create a sustainable funding model that appropriately compensates us [*pharmacists*] for the healthcare services we provide." This model would include appropriate reallocation of the funds saved by reducing generic drug pricing to ensure Albertans have continued access to quality healthcare services at their community pharmacy. More information about the I Care About My Pharmacist campaign can be accessed at: http://icareaboutmypharmacist.org/

Ironically, before these dramatic cuts were announced and implemented, the Alberta government had already recognized pharmacies were struggling to make ends meet. To address the issue, and at the same time take advantage of what pharmacists could offer to the healthcare system, the Alberta Government introduced the "Pharmacy Services Framework" and accompanying "Compensation Plan for Pharmacy Services" in 2012.[5] Featuring the reimbursable medication review services termed the "Comprehensive Annual Care Plan" and the "Standard Medication Management Assessment (both of which reflect Ontario's MedsChecks program), these services were designed to allow pharmacists to be reimbursed for their detailed patient interactions. The scheme also included reimbursement for administering injections, as well as compensation for refilling and adapting prescriptions. However, even with these services established, many pharmacies will now be lucky if they can manage to use the reimbursement earned to 'break even' with their projected losses from the generic price reduction.

After reading this article, if you feel that this issue does not apply to you (as you are planning to practice outside of Alberta), I want to leave you with a critical point to consider: with more than one provincial government taking aim and cutting funds for our profession, what will the state of our profession be upon graduation? Will we have a stable work environment to enter in Ontario, or will we be making dramatic sacrifices to find pharmacy employment elsewhere? With the pharmacies experiencing cut-backs across the country, will there even be employment to seek out in other locations? And lastly, if every province and territory follows Alberta's lead and drops the price paid for all generics to 18% (or possibly lower), will the pharmacy profession be sustainable anywhere in Canada?

References

Council of the Federation. *Provinces and Territories Seek Significant Cost Savings for Canadians on Generic Drugs*. http://www.councilofthefederation.ca/pdfs/NR-CoFGeneric%20drugs %20(Fi nal)-Jan%2018.pdf. Updated January, 18, 2013. Accessed May 26, 2013.

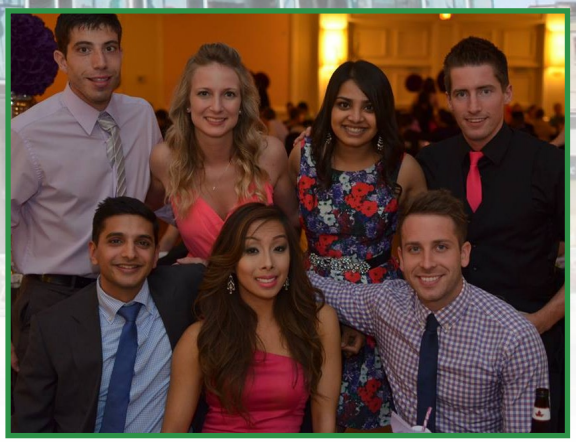
Province of Alberta. The 28th Legislature, Issue 38. *Alberta Hansard*. http://www.assembly.ab. ca/ISYS/LADDAR_files/docs/hansards/han/legislature_28/session_1/20130319_1330_01_han.pdf. Updated March 19, 2013. Accessed May 26, 2013.

Value Drug Mart Associates Ltd. I Care About My Pharmacist. http://www.icareaboutmypharma cist.org/index.html. Updated May 13, 2012. Accessed May 27,2013.

lberta Health. *Pharmacy fee reimbursement*. http://www.health.alberta.ca/services/pharmacy-fee-reimbursement.html. Updated 2013. Accessed May 26, 2013.

Alberta Health. *Compensation for Pharmacy Services*. Alberta: Government of Alberta; 2012. www.health.alberta.ca/documents/Pharmacy-Services-Compensation-2012.pdf. Accessed May 26, 2013.

PHARMACY FORMAL PHOTOS



SOPhS Council 2013-2014

SOPhS Communications

Have an opinion about our expanded scope of practice? Experience something on co-op that you'd like to share?

SOPhS encourages you to submit an article for the Pharm Phile newsletter! Submissions can be sent to pharmsoc@uwaterloo.ca by the end of every month for inclusion in the next edition!

If you have any interest in becoming involved with the SOPhS Communications Committee please send an email our way! We are especially looking for individuals interested in helping out with the SOPhS website.

Pharmacy Phile
ISSUE 46 | July 2013

Please check out the calendar on the next page, or the weekly SOPhS Updates, for information about all of our events. If you have an event coming up that you would like to inform students about, please submit an article for a SOPhS Update to pharmsoc@uwaterloo.ca using the guidelines available on the SOPhS website (Communications, under Student Resources).

SOPhS
SOCIETY OF PHARMACY STUDENTS

Society of Pharmacy Students (SOPhS)
10A Victoria Street
Kitchener, Ontario N2G 1C5
www.sophs.ca

@UWSOPhS
follow us on twitter

SOPhS 6 WEEK CALENDAR

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	18	19	20	21	22	23 Last day of co-op term PLOT due	24
	25	26 Tuition Fees Due	27	28	29	30	31
	Sep 1	2 Labour Day	3	4	5	6	7
Week 1	8	9 Lectures begin	10	11	12	13	14
Week 2	15	16 Waterloo Pharmacy Golf Invitational at Grey Silo Golf Club	17	18	19	20	21
Week 3	22	23	24	25	26	27	28

SOPhS Calendar Notes

Please note that event dates may be subject to change. Contact SOPhS if you are unsure of an event date.

You may also find this information on the class calendars on the SOPhS website (www.sophs.ca) class. It is our hope that these calendars will provide you with all of the event and deadline information you need during each term.If you would like to add an event to the SOPhS calendar please email the SOPhS Secretary at secretary@sophs.ca.