A Peer Reviewed Publication of the California Pharmacists Association Vol. LVII, No.4  Fall 2010

CALIFORNIA PHARMACIST

Special Pull-Outs:
Careers in Pharmacy
Policy Report
In this Issue:
A Special Tribute to
CPhA CEO Lynn Rolston

Creating Synergy, Forward
Moving the Profession
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As the year comes to a close, we all have an opportunity to look back at the year and reflect on the best of what it had to offer, and to honor those who had a hand in shaping its success. We also look forward to a new year with a fresh set of eyes for the opportunities that await. Appropriately so then, we say goodbye to outgoing CEO Lynn Rolston and recount her contributions to CPhA, while also looking forward to a bright future by focusing on a variety of career choices for pharmacists.

Thanks to the efforts of Guest Editor, Glenn Yokoyama, PharmD, FCPhA, FAPhA., this Careers in Pharmacy issue is not just for those at the beginning of their career, rather for all pharmacy professionals at any stage of their career. We have broken out the reading into three separate sections: Pharmacy Recruitment, Traditional Pharmacy Careers, and Pharmacy Specialty Careers. The intent from the start was to give pharmacists some insight into what each of these aspects of the profession looks like and to provide guidance on what steps need to be taken to make a career move.

There are several contributors who we are pleased to acknowledge. Molly Richardson, PharmD is a recruiter for a large firm specializing in advanced career positions such as pharmacy directors. She provides common sense advice for the recruitment process. Theresa Taylor, PharmD, who owns and operates her own staffing agency, provides guidance in creating strategies for your career. Our final recruitment article comes from Christine Fukunaga, PharmD, who oversees pharmacy recruitment in California for Kaiser Permanente. She provides readers with the “inside track” on what it takes to get hired with a large organization such as Kaiser Permanente.

In the traditional realm of pharmacy practice, we present two articles focused on hospital practice, and community care. Arash T. Dabestani, PharmD, MHA, FABC, from Stanford Hospital and Clinics has many years of management experience in the hospital setting. His article provides practical suggestions for pharmacists looking to secure a position in acute care pharmacy. For a deeper look into community pharmacy, we are fortunate to offer an article pharmacy ownership written by John Tilley, who currently is the President of both Tilley Apothecaries Inc, and of California Pharmacy Systems Inc. At one time in his career, Tilley owned 23 pharmacies covering five counties in California.

Rounding out the issue are several articles related to specialty fields of practice. Carly J. Paoli, PharmD, MPH writes about pharmacoconomics as a choice for post graduate training. We learn more about fast paced emergency room practice from Christine Joseph PharmD and delve into Infectious Disease Training with Annie Wong-Beringer, PharmD, and FCCP. Joyce Lin, PharmD, CACP details the practice of Anticoagulation therapy in an outpatient setting while Robert Kwan, PharmD explores the unique field of nuclear pharmacy. We look at the practice of an oncology pharmacist through the eyes of Florence H. Wong, PharmD and David K. Yu, PharmD, BCOP, and psychiatric pharmacy from the perspective of James Gasper, PharmD.

In addition, this issue highlights pharmacy residency programs in our business models section. Also of notable mention is an article by longtime CPhA member, Sydney Aronson, RPh, who provides readers with his perspective about the rise and development of pharmacy benefit management firms. With such a well-rounded series of articles, there is something here to educate, motivate and inspire everyone.

Enjoy the read,

Cathi Lord
Managing Editor
In today’s especially complex retail pharmacy environment, with increasingly slim reimbursement rates, keeping tight control of your numbers is a must. In addition to its flagship Pharmacy Management System solution, Cerner Etreby offers a variety of leading-edge technology options designed to optimize your financial outcomes and keep your pricing competitive. From zone pricing tables, a Pricing Wizard, to e-Remit™ electronic data reconciliation tools, every reimbursement opportunity is recognized allowing you to remain competitive and maximize profits. Plus, your operations will benefit from the reliability of a time-tested Windows® platform that has been continually perfected and enhanced since 1999.
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Visionary Leadership
Uniting the Profession
A Tribute to Retiring CEO, Lynn Rolston

by Cathi Lord

When you talk to anyone who has worked with Lynn Rolston, you will see a smile spread across their face as they recollect what it like was to work with her. She is a “get things done” kind of person who is highly focused and equally personable and compassionate. Her list of accolades is far too great to list, but suffice it to say, she leaves a lasting legacy of accomplishment at CPhA.

She led the effort to sue the State of California for the devastating Medi-Cal cuts they planned to implement that would seriously impact the underserved and the State’s Pharmacies. She lobbied tirelessly at the State Capitol to advance the scope of practice for pharmacists and to raise legislator’s awareness of critical pharmacy issues. She restructured the annual Outlook meeting in order to better meet members’ needs, and finally, she listened to the needs of all the disparate groups of pharmacists in California and responded with a message of unification which promised to strengthen them all. She is a consummate professional who has enjoyed a long career in pharmacy and the medical sciences. And now, retirement is calling her name. What will she do next and what will she cherish most about her time with CPhA?

In this interview with Lynn and our Past Presidents, we look at how the impact of her leadership was felt the most. We invite all readers of California Pharmacist to share their appreciation for Lynn’s efforts as well. Send your comments by mail to 4030 Lennane Drive, Sacramento, CA 95834, or post a farewell message on our website at www.cpha.com. We will take all of the responses and place them into a memory book for Lynn to keep.

What led you to a career in pharmacy?

My parents were very good role models who encouraged my curiosities about medicine, politics, science and history. They taught me to set my sights high and were both very accomplished in their own right. My mother held a PhD in Anthropology and my father was, literally, a rocket scientist. They were also history buffs who were politically active. In addition, I learned a lot about leadership from my father as he was an avid athlete who was either the captain of his own team or the manager of others.

I started my career in health care by working as an assistant to an oral surgeon. While there, I received hands on surgical training and learned a great deal about patient care. I worked my way through college as a pharmacy technician in a hospital setting where I met my husband, Larry Rolston. Through that experience, I learned the value of a pharmacist’s oversight on each and every medication.

I received my degree in Political
History and then went to work in the pharmaceutical industry.

My next move was to take a position with Merck which gave me the opportunity to learn more about the practice of medicine and the role of medications in patient care. I gained a great deal of knowledge about pharmaceuticals and the laws and regulations that governed them. I became more acutely aware of health care politics. For me, pharmacy linked all my areas of deep interest: politics, medicine, science and history. Having spent time in a number of industries related to pharmacy, I could see how important it was to connect the disparate parts of the profession.

What did you take away from your role at the Pharmacy Foundation of California?

My years with the Pharmacy Foundation of California further convinced me that what the pharmacy profession needed most was unity. The majority of our efforts at the Foundation were principally focused on educating the public about the value of pharmacy. But just how accessible the pharmacist was to the public was another matter. People have no idea how many ways pharmacists touch their lives. Pharmacy professionals can be invisible in many practice settings where patients do not have direct contact with them. Putting a public face on this profession would require all disparate groups to come together as one.

What comes next for Lynn Rolston?

I plan to spend the month of December vacationing and enjoying family. Then in January, I plan to jump back in through a number of projects including writing a second book, possibly running for political office, consulting, and maybe even working in the Brown Administration. This is all still fluid but one thing for sure is that I will always be a great friend of pharmacy and one of the biggest cheerleaders you have.

CPhA Presidents Speak of Lynn’s Accomplishments and Character

When the name Lynn Rolston is mentioned, what comes immediately to mind?

Sunshine and energy. Friendly, professional and intelligent.

The voice of pharmacy. – Brian Komoto

Strong interest in understanding and implementing changes which are good for pharmacy and focusing on bringing all the interests of pharmacy together...one voice.

– Paul Lofholm

Poise and confidence. – Jeff Goad

Facilitator who brought many different aspects of pharmacy together to achieve common goals. – Eric Gupta

What would you consider to be the highlights of Lynn’s service to the pharmacy profession?

One profession, one voice: to the best of her abilities and to her credit, she has worked to unify the profession to strengthen the profession's position within the medical community and for government affairs. Her optimism, networking and knowledge of the legislative process allowed pharmacy to expand its healthcare role…i.e. immunization and collaborative practice models. – Brian Komoto

Developing a cooperative environment with other health care providers, increased involvement with the CA State Board of Pharmacy, and enhanced recognition of pharmacy among health care groups and the California Legislature. In addition, she placed great emphasis on local association development and student pharmacy involvement in CPhA governance. – Jerry Mazzucca

Understanding and implementing legislative action; bringing pharmacy into coalitions with other health-related groups to strengthen our positions. – Paul Lofholm

Providing legislative and regulatory leadership that has kept our profession from losing ground while taking advantage of every opportunity to move us forward. – Jeff Goad

Creating an environment where various aspects of pharmacy could work together on common solutions. Throughout all of my activities on behalf of CPhA, this strength of Lynn’s has been stated numerous times by a variety of stakeholders. – Eric Gupta

What would you say are the signature achievements of Lynn’s career as the CEO of CPhA?

One profession, one voice: the profession is more unified that any other time in its history. Medi-Cal lawsuit: helped organize, strategize and coordinate fundraising to defend pharmacy reimbursement from unmanageable cuts. Synergy: combining and collaborating sessions to move the profession forward…a tribute to her leadership and networking skills. – Brian Komoto

Moving Outlook planning services to CPhA from the Foundation; development of Synergy Leadership Conference; reactivating Legislative Day; increasing membership by involving various ethnic groups which had not been active prior to Lynn's tenure. – Jerry Mazzucca

Straightening out our accounting system, offering new ideas to the Association and profession, visiting more local associations than had been done before to bring the messages down to the grass roots level, navigating the Medi-Cal Defense Fund’s efforts to maintain a fair compensation for pharmacists who care for the underserved – Paul Lofholm
Tribute to Lynn Rolston (cont.)

Bringing order and fiscal responsibility to our budgeting and forecasting process. Pulling together the right legal team and facilitating a fundraising campaign that led to the successful blockade of devastating Medi-Cal cuts. Maintaining the level of member services expected of CPhA with a dramatically reduced staff was a testament to her management skills. – Jeff Goad

Working with Lynn Carman to successfully defend pharmacy against the Medi-Cal budget cuts. – Eric Gupta

In what way did Lynn’s leadership most impact you as President of CPhA?

Her optimism, devotion to the profession and cooperative nature helped us move the board agenda forward and make my year rewarding. – Brian Komoto

Enhanced communication and understanding of Board of Trustee governance through development of BoT Resource Guide
Development of CPhA “Press Corps” to respond to news events
Establishment of PACE Alliance buying group with other state associations
Development of two new academies (Compounding and Managed Care).
Working on CA Healthcare Reform with other health groups.
These are several of the achievements which I was fortunate to attain during my presidential year because of the confidence Lynn and I placed in each other. Lynn allowed me to pursue my agenda for the year while retaining the right as CEO to make sure the goals we sought were realistic for the Association. – Jerry Mazzucca

While we started out to insert pharmacists services in any and all legislation pertaining to health care [Sen Kuehl and Sara Rogers] one month later we were engaged in a long fight to aggressively object to the Governor’s willingness to take Federal funds for Medi-Cal services and use them for other purposes, thus denying the object to the Governor’s willingness to take Federal funds for Medi-Cal services and use them for other purposes, thus denying the

Lynn was always generous in her leadership style, preferring to let me, as President, be in front, while behind the scenes, she provided the insight and institutional memory I needed. It’s a daunting task to keep a large organization such as CPhA on track for the long term while accommodating each new President’s “year of big ideas,” but Lynn has been able to pull it off year after year. I am forever grateful for the encouragement, leadership and wisdom she gave me during my three years as a presidential officer. I wish her all the best! – Jeff Goad

Lynn’s leadership was very helpful during the CEO transition as she organized the potential search firms to present to the Executive Committee and organized a strategic plan review with Bob Harris, CAE. These two pieces of the process were instrumental in carrying out a quick and effective CEO search and creating a venue so the Board of Trustees could set the framework for the Association’s future. – Eric Gupta

Parting thoughts and well-wishes

I have known Lynn for over 25 years and have always been impressed with her ability to work in a cooperative fashion with others. Lynn is always available to be of assistance and I have the greatest amount of respect and admiration for her administrative talents.

I hope she will continue to assist the pharmacy profession in some capacity and I wish her continued success in her career. – Jerry Mazzucca

I worked with Lynn at the Foundation and the Association. She brought new ideas and new ways to do things and we met the needs of the new century. The Association is better off for having Lynn Rolston as our CEO. I wish her well as she writes the next chapter in her life. Congratulations and best wishes. – Paul Lofholm

Lynn made a huge impression on me and the rest of the interviewing committee when she applied for the position of CEO of CPhA. We knew we needed someone who understood our profession deeply and who had the enthusiasm and energy to carry our message everywhere.

We thought Lynn had those attributes. Boy, were we right. I was president during her first year as CEO. It was a challenging year. Some touchy issues that had to be handled very carefully were done with style and attention to details.

Someone in a position such as CEO of CPhA needs to clearly understand and adroitly handle information management. – Lynn can be trusted to handle information. She tells people who “need to know” what they “need to know.” That, combined with total trustworthiness, is the mark of an exemplary individual. Lynn is that individual.

Lynn has my best wishes as she moves on in her career. – George Pennebaker

I wish Lynn all the best in her future endeavors. Her impact on the Association will not be forgotten. – Eric Gupta

– Paul Lofholm
CEO Transition is Smooth Sailing

This message marks the beginning of a very important transition in CPhA’s history as a new era with a new CEO is upon us. I would like to heartily thank our outgoing CEO, Lynn Rolston, for all of her hard work and dedication to CPhA over the years. Everywhere I have gone on behalf of CPhA, there was always someone who would speak very highly of Lynn and her work for the Association. We wish her the best in all of her future endeavors.

Of course, we also have a new CEO taking over the helm, and I am proud to introduce our new CEO: Jon Roth, CAE. Jon comes to us with approximately 20 years of experience in health care associations, and most recently, he served as CEO of the California Dental Association Foundation (CDAF). While with the CDAF, he took this start-up entity and grew it into an operation with a $3.5-million annual operating budget. He has proven himself to be a strategic operations manager throughout his career, and he has a working knowledge of health care reform and the opportunities that are present to pharmacists. I am looking forward to his leadership in the upcoming years!

Speaking of health care reform, I had the opportunity to attend the Distinguished Pumerantz Lecture by Kim Belshé, Secretary of California Health and Human Services, at Western University of Health Sciences in Pomona, California. During this lecture she mentioned that in order to provide quality care for these new enrollees, physicians need to ease up on their scope of practice concerns and allow all licensed health care practitioners to practice at the highest level of their scope. These are very encouraging words!

However, when I had the opportunity to speak with Secretary Belshé after her lecture, she was not aware of pharmacists’ desire or ability to practice as chronic care disease state managers, so we definitely have some educational work to do with our legislators, especially during this critical time of health care reform!

There has been positive movement in this area. In the middle of October, I was privileged to be part of a meeting that was coordinated by the California Medical Association Foundation (CMAF) that brought together leaders from CPhA, the Pharmacy Foundation of California (PFC), the California Medical Association (CMA), and CMAF. We spent a whole day at CMAF headquarters in Sacramento discussing the pharmacist-physician partnership and how we can work together to better care for patients, with a focus on diabetes management. We are excited about this opportunity to collaborate with our physician peers. Each medical local association has a Public Health Committee that has been tasked to look at the issue. From our side, we need to form Public Health Committees in each of our Local Associations and make sure that we appoint motivated members to these committees to move these initiatives forward. I am counting on our Locals to pull through in this endeavor.

Lastly, we just finished holding the CPhA Synergy meeting in Irvine, California. It was a great opportunity to get all of our leadership from the Board of Trustees (BoT), Academies, Local Associations, Student Pharmacist Chapters, and Committees together in order to strategize and set goals for the upcoming year. The meeting showcased a review of CPhA Governance and Structure, the newly revised Strategic Plan, legal and financial responsibilities, President-Elect Kenny Scott’s plans for the upcoming year, Jon Roth’s vision for CPhA, and PFC’s upcoming initiatives. We also had a great leadership workshop hosted by Landmark, which many attendees found very valuable, and we had a great brainstorming session regarding prioritizing and creating strategies regarding Emerging Issues that were identified. I received a lot of positive feedback from this meeting and I hope that we can formalize our plans for the year and keep making progress towards our goals to move the Association forward.

In addition to these major activities, we have been busy attending “CPhA Days” at various universities, attending Local Association meetings, and developing member benefits that we hope to unveil in the near future. It has been an exciting time since August, and I am looking forward to the transition process over the next few months and handing over the reins of our beloved Association to President-elect Scott at CPhA Outlook in Palm Springs. Hope to celebrate with you there!
E ach year the California Pharmacists Association and the Pharmacy Foundation of California host a program for pharmacy leaders and stakeholders from all practice settings known as the Synergy Leadership Conference. In total, there were more than 125 CPhA leaders present to learn about CPhA operations, governance, and the strategic plan.

Attendees included Board of Trustees members, and representatives from the Academies, Local Associations, the CPhA Committees and Student Leaders.

Throughout the weekend, leaders listened to outstanding presentations and, then broke out into their respective workshops to focus on issues pertinent to the CPhA academies, Local Associations, Committees and Student Pharmacists. On day one of the meeting, Immediate Past President Jeff Goad, President Eric Gupta, CPhA Attorney John Cronin and Treasurer Ed Sherman presented critical information about how CPhA is structured and governed, as well as the legal and financial responsibilities leaders are required to follow. In addition, a town hall forum was held with Jon Roth, the new CEO of CPhA, and Michael Negrete, CEO of the Pharmacy Foundation of California. The forum provided members with an opportunity to learn more about Mr. Roth’s background, and future plans for the Association, as well as an opportunity to hear more about the Foundation’s initiatives. Next up was a guest speaker from the Landmark Forum who led a presentation on how to be an effective leader. Armed with all of this important information, leaders went off to their workshops to discuss the purpose of their groups in relation to the CPhA strategic plan.

The second day of the meeting allowed attendees to dig deeper into the previous day’s work and to develop goals for each of their respective groups that would effectively contribute to the CPhA strategic plan. But first, they were treated to two, highly motivating presentations by the incoming President, Kenny Scott, and CEO, Jon Roth. Both men are equally optimistic about the opportunities that the year ahead holds, and presented detailed plans about where their priorities will lie. Attendees were impressed and energized by their visions.

Synergy effectively brought leaders together, got them all on the same page and developed exciting ideas to move the profession forward. In the coming months, Jon Roth and Kenny Scott will develop an implementation plan to actualize these goals in order to improve the CPhA membership experience overall. For those members who plan to attend the Outlook 2011 meeting in Palm Springs over the February 10-13 weekend, you will hear more about what’s in store for the future.
To kick-off American Pharmacists Month, on October 8, 2010 CPhA held a Senior Health Fair event in Sacramento, co-sponsored by Sacramento Valley Pharmacists Association, Pucci’s Pharmacy, the Pharmacy Foundation of California, Rite Aid, and the Partners in D Program. The event began with a press conference that featured several speakers, one of whom was Dr. Glennah Trochet of the Sacramento County Department of Public Health, who took the opportunity to thank pharmacists for their role in providing influenza vaccinations and talked about the importance of annual flu shots. Also in attendance were Dr. Lucy Saldaña, Region IX CMS, and representatives from LifeScan and I-Guard, an online medication safety organization. Additionally, many members from the Sacramento Valley Pharmacists Association, the California Northstate College of Pharmacy and the Sacramento State Pre-Pharmacy program volunteered to assist. The health fair provided flu shots, diabetes and blood pressure screenings, medication risk assessments, brown bag medication reviews and Medicare Part D counseling.

This was just one such outreach event held by CPhA organizations throughout the month of October that capitalized on the American Pharmacists Month theme of “Know Your Pharmacist, Know Your Medicine.” The celebration was marked by a letter from Governor Arnold Schwarzenegger acknowledging the value of pharmacists.

The Sacramento Valley Pharmacists Association hosted a blood pressure screening clinic at a local church, and was instrumental in promoting American Pharmacists Month with a billboard on a very busy freeway.

The San Mateo County Pharmacists Association hosted its 15th Annual “Talk with a Pharmacist Day.” It is estimated that over 300 people took advantage of the free health screenings for hypertension, diabetes, bone density and more. In addition, student pharmacists from the UCSF School of Pharmacy provided health care education by exhibiting posters on a variety of health topics such as diabetes, smoking cessation, etc.

The Marin County Pharmaceutical Association participated in its county’s Annual Senior Information Day. The fair was very well-attended by seniors and their caregivers, who consumed a wide array of health information, food and entertainment provided at the Marin County Fairgrounds.

The Schools of Pharmacy in California also actively participated in American Pharmacist Month outreach activities. Specifically, the Thomas J. Long School of Pharmacy at University of the Pacific was instrumental in hosting a billboard inside a Bay Area Rapid Transit (BART) station, where it is estimated that 4.5 million people saw the advertisement in October. In addition, the students were successful in getting publicity by attending the Price is Right game show, and Good Day Sacramento.

The combined efforts of students and pharmacists to promote the value of pharmacists and the life-saving skills they contribute to the health care arena were effective once again. Congratulations to all for a job well done.
Compounders Day and Long Term Care Weekend

More than 140 participants attended Compounders Day and Long Term Care Weekend, held in Huntington Beach October 16-17, 2010. The event was so highly regarded that one pharmacist who attended Compounders Day on Saturday, and the Federal and State Regulatory Update for LTC Weekend on Sunday, proclaimed these were the “best and most informative continuing education programs I’ve ever attended!” Many attendees expressed similar sentiment about the weekend including the ALTC Trustee, Lee Meyer who said, “I will say that I always look forward to talking with long-time friends and colleagues, meeting some new people, and finding out what is going on in their lives, both inside and outside of work. I learn as much from the dialogue as I do from the education programs. This year’s weekend was especially rich in good work. I learn as much from the dialogue with my colleagues, and finding out what is going on around me, as I do from the education programs. This year’s weekend was especially rich in good work.”

Academy of Pharmacy Educators Survey

The CPhA Academy of Pharmacy Educators (APE) is relatively new to the Academy offering within CPhA. Their mission is to serve the needs of the growing number of pharmacists practicing in academia and to improve the quality of pharmacy education in California through better communication and collaboration between pharmacy faculty and pharmacy practitioners/preceptors. Formerly known as the Academy of Pharmacy Specialties, the APE was formed in 2009.

The APE board of directors is eager to develop meaningful benefits for its members and recently sent out a survey by email to determine needs. Over the next several months, they will be working diligently to develop and implement an action plan that generates a high quality membership experience uniquely suited to the needs of academicians.

In addition to serving as the liaison between CPhA and the Schools of Pharmacy, the APE will be the liaison group for the American Association of Colleges of Pharmacy (AACP). It will be their charge to maintain two-way communication and represent CPhA’s voice with the academic community at the national level.

To learn more about the CPhA APE, contact the Chairperson by email, Karl Hess, khess@westernu.edu. You may also contact the APE Trustee, Sam Shimomura by email, sshimo@westernu.edu.

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Practice settings. They are also grateful for the hard work of their fellow board members; and the generosity of the sponsors and exhibitors. If you are interested in attending this outstanding event next year, mark your calendars for a weekend date in mid-September.
You're Invited to the Largest State Pharmacy Convention!

Palm Springs Convention Center | Palm Springs, CA | February 10 - 13, 2011

OUTSTANDING FEATURED PRESENTATIONS:

“CPhA 2011 and Beyond”
Jon Roth, New CPhA CEO
Opening Session HoD
Thursday 2/10/11

“What’s Up With Pot?”
The Ongoing Marijuana Debate
Panel Discussion - Controversial
Great Speakers
Opening Session HoD
Thursday 2/10/11

“Traversing Challenging Terrain: Creating History”
Mary Anne Koda-Kimble,
Dean, UCSF School of Pharmacy
2010 Winner, APhA Remington Honor Medal
Opening General Session Keynote
Friday 2/11/11

Image credit: © majedphoto.com
Section 1: Attendee Information

Last Name  First Name (Given Name)

Nick Name (To appear on name badge)  E-Mail Address

Pharmacy, Company, or School Name  Pharmacist/Technician License Number

Mailing Address

City  State/Zip

Work Phone  Cell Phone  Fax

Emergency Contact  Emergency Phone Number

Section 2: Registration Fees

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I will be attending CE classes & request that syllabus materials be provided to me via:

- 300 page book
- CD/Booklet
- Online/Download

Section 3: Included Events

Included Events

- McKesson Presidents’ Reception, Silent Auction & Wine Tasting (Thursday, 2/10)
- Pharmacy Foundation of California Awards and CE Program - Seating is limited (Friday, 2/11)
- Rite Aid Young Professionals’ Night (Friday, 2/11)
- CVS Caremark Student Pharmacist Reception (Students & Residents Only, Saturday, 2/12)
- Pharmacy Foundation of California Film Festival - Seating is limited (Saturday, 2/12)
- AmerisourceBergen Party (Saturday, 2/12) Visit booth for required ticket.
- William R. Bacon Memorial Breakfast (Sunday, 2/13)

Section 4: Special Programs & Ticketed Events (All programs/events listed below require pre-registration and an additional fee.)

- Pharmacy Foundation of California Leadership Networking Breakfast (immediately precedes the PFC Awards and CE Program)... No. attending _____ x $40 (Seating is limited)
- School Breakfast:  Touro  UCSF  UOP  USC  WesternU ................................................................. No. attending _____ x $40
- McKesson Presidents’ Reception, Silent Auction & Wine Tasting (Additional tickets for guests)......................................................... No. attending _____ x $40
- APO Dinner & Legislative Forum......................................................................................................................... No. attending _____ x $50
- Support the Pharmacy Foundation of California’s Fundraising Event .......................................................... $______ Donation
(Donations are not required to attend the event, but your support will help tournament competitors meet their pledge goals.)

- Sponsor a CPhA Student Pharmacist Member........................................................................................................... No. of Students _____ x $100

School

Section 5: Spouse/Guest Program Registration

No. of Guests: _____ x $175  Guest Name(s)__________________________

Section 6: Payment (Make checks payable to: California Pharmacists Association).

- __________ Section 2 totaled
- __________ Section 4 totaled
- __________ Section 5 totaled

= __________ Total Amount Due

I accept these terms. Failing to check this box may delay your registration.

Register Online Today: www.cpha.com
CPhA Members Earn a 10% Dividend!

The California Pharmacists Association (CPhA), Marsh and the American Automobile Insurance Company, one of the Fireman's Fund Insurance Companies®, are pleased to announce the declaration of a 10.1% dividend* for CPhA members enrolled in the sponsored Workers' Compensation Insurance Program during the policy year December 2007–December 2008.

With this dividend, members will have received $3,340,655* in returned surplus premiums simply by buying insurance they are required to purchase by law. It reduces the net cost of insurance for members. If those $3,340,655* reasons aren’t enough to ask for a quote, here are a few more:

- Low, competitive rates for workers’ compensation insurance.
- The Fireman's Fund RiskAdvisor℠ Web site provides members with online access to policy and claim information, loss control and workplace safety advice.
- Small pharmacies receive additional premium discounts through a special Merit Rating Program.
- Loss control visits with experts from Fireman's Fund help improve pharmacy safety.
- Members receive an extra 10% premium discount on the Business Owners Package policy when also insured through the Workers’ Compensation program.
- Please take advantage of this opportunity to reduce your business expenses now by calling a Marsh Client Service Representative at 888-926-CPhA or e-mailing CPhA.Insurance@marsh.com.

*Additional qualifications also apply. Payment of future dividends cannot be promised or guaranteed. Past dividend performance is no guarantee of an insurer’s future dividend performance. Under California Law it is unlawful for an insurer to promise the future payment of dividends under an unexpired workers’ compensation policy or to misrepresent the conditions for dividend payment. Dividends are payable only pursuant to conditions determined by the insurer’s Board of Directors or other governing board of the Company following policy expiration.

The insurance policy, not this communication, forms the contract between the insured and the insurance company. The policy may contain limits, exclusions, and limitations that are not detailed in this communication. Coverage may differ by state. Fireman’s Fund Insurance Company, Novato, CA.

Marsh Representatives
Thanks to our partners at Marsh for their continued support.
Roy Lyons, Executive Director
Sam Baxter
Kimberly Brame
Liz Fogle
Lisa McGinty
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Gary Thomas, Chair
Gary Basrai
Frank Cable
Kathy Hillblom
Rich Kane
Ken Ross
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www.cpha.com
They say a picture is worth 1,000 words...

This picture is worth $3,340,655!

With this year’s 10.1% dividend declaration by the American Automobile Insurance Company, one of the Fireman’s Fund Insurance Companies®, CPhA members will have received $3,340,655 in returned surplus premiums over the past five years simply by buying insurance they are required to purchase by law*. CPhA members enrolled in the sponsored Workers’ Compensation Insurance Program during the policy year December 2007–November 2008 qualify for the 10.1% dividend.

If those 3,340,655 reasons aren’t enough to ask for a quote, here are a few more:

- Low, competitive rates for workers’ compensation
- The Fireman’s Fund Risk Advisor® Web site provides members with online access to policy and claim information, loss control and workplace safety advice
- Small pharmacies receive additional premium discounts through a special Merit Rating Program
- Loss control visits with experts from Fireman’s Fund help improve pharmacy safety
- Members receive an extra 10% premium discount on the Business Owners Package policy when also insured through the Workers’ Compensation program

Please take advantage of this opportunity to reduce your business expenses by calling a Marsh Client Service Representative at 888-926-CPhA to schedule an appointment with one of our advisers (on the phone or in person) or just to receive a premium indication to see how your current policy compares.

*S Additional qualifications also apply. Payment of future dividends cannot be promised or guaranteed. Past dividend performance is no guarantee of an insurer’s future dividend performance. Under California Law it is unlawful for an insurer to promise the future payment of dividends under an unexpired workers’ compensation policy or to misrepresent the conditions for dividend payment. Dividends are payable only pursuant to conditions determined by the insurer’s Board of Directors or other governing board of the Company following policy expiration. The insurance policy, not this communication, forms the contract between the insured and the insurance company. The policy may contain limits, exclusions, and limitations that are not detailed in this communication. Coverages may differ by state. Fireman’s Fund Insurance Company, Novato, CA.
National Preparedness Month

In an ongoing effort to raise awareness about the importance of emergency preparedness for pharmacists, the CPhA Emergency Preparedness Committee participated as a coalition member in promoting the Federal Emergency Management Agency’s (FEMA) “Ready Campaign” for the second year in a row.

National Preparedness Month takes place in September each year and encourages citizens to prepare for emergencies in their homes, businesses and communities. The Ready Campaign developed a purpose-driven theme to motivate citizens to action: “Resolve to be Ready.” Citizens across the United States were called to get an emergency supply kit, to make an emergency plan with their family, to get informed about community groups that can provide disaster resources and emergency response training, and finally, to get involved with those community groups. In addition, CPhA has called on pharmacists to get registered with the Disaster Healthcare Volunteers of California in order to become available as a resource for their local governments. Should you desire to volunteer your services, this is an absolute MUST of a first step to take. Visit www.healthcarevolunteers.ca.gov for more information.

CPhA was one of 4,859 coalition members to help promote National Preparedness Month throughout the country. To educate pharmacists in California, the Committee put several pharmacy-specific plans into action including:

- Fax and email blasts to owners regarding sales of emergency supplies
- Discussions with the Board of Pharmacy on listserve access for emergency communications
- Continuing education programs for local associations
- Educational programs for pharmacy students
- New connections made with local Medical Reserve Corps chapters throughout CA
- Press release at beginning of month
- Voice broadcast from Eric Gupta to all CPhA members

With some advanced planning, pharmacists need not become victims of disasters themselves and can assist the public in any way possible during large-scale emergencies. In spite of preparedness messages from numerous agencies, we know that 42% of Americans report that they would not be prepared if a disaster of any sort were to strike today. In California, we know those disasters can come in many forms, most notably, major storms, fires, floods, and earthquakes. If you need help to get prepared, visit www.ready.gov for more information and access to resources. If you prefer to order ready-make emergency kits, you can get a 20% discount from an organization called Your Safety Place (www.yoursafetyplace.com). The question is not IF an emergency will occur, but WHEN.
Pharmacists Needed IMMEDIATELY!

Finding the perfect job has never been easier. The CPhA Career Center is custom tailored to our business.

JOB SEEKERS:
- POST YOUR RESUME TODAY
- ACCESS PREMIER JOB POSTINGS
- RECEIVE JOBS VIA EMAIL
- LAND THE PERFECT JOB

EMPLOYERS:
- POST JOBS
- RECEIVE RESUMES VIA EMAIL
- SCREEN RESUMES
- HIRE QUALIFIED TALENT

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Careers in Pharmacy—Introduction and Overview
Finding Your Fit is a Matter of Making Choices

by Guest Editor – Glenn Yokoyama, PharmD, FCSHP, FAPhA

Where are you regarding your pharmacy career: at the beginning, in the middle or at the end? Are you happy where you are?

This article, along with the series of following articles on “Careers in Pharmacy,” are designed to help you make pharmacy career choices to help you find “your place in the sun.” If you’re not happy or satisfied in your current position, try to make or suggest changes, and if that doesn’t work, move on. If you’re not happy, you’re probably going to make others unhappy as well.

Whether you’re a student, a resident/fellow, just starting your career as a pharmacist or one that has been in the field for years, reading this series will remind you that you do have many, many choices – some might even say too many choices. If you want to work, have the qualifications and experience, and are flexible, there is a job for you. If you’re a student, we would recommend you consider doing a residency and/or fellowship, as that increases your marketability and choices. For someone who has been in practice, you should consider a leadership position (e.g., manager, supervisor), as this area has a shortage and the demand is high. In my opinion this leadership is the area of greatest need, especially at the Director level. I had spent some 33 years as a Director of Pharmacy and can tell you it was very satisfying – developing people and programs with a very flexible schedule. My current faculty position, going on seven years, is very similar. It is extremely satisfying to develop students and also has a flexible schedule. Pharmacy is blessed by the fact that even in a down economy, there are still jobs available for pharmacists.

The following are some pertinent questions to ask regarding a pharmacy career:

• What are the outlook and opportunities?
• How marketable are you?
• What is the best path?
• What are my short term and long term goals and objectives?
• What is my plan or strategy?
• What are my options or choices?
• What is the typical job profile of the position I have in mind?

The good news about pharmacy is, even in the current economic downturn, the outlook and opportunities are there – if you’re flexible and open minded. There are so many career choices in pharmacy, there is a place for everyone. If you can’t find something that fulfills your need, perhaps you’re someone who doesn’t know what he or she wants or needs. I believe that it is virtually impossible not to find a position that coincides with your likes and dislikes.

About the Author
Glenn Yokoyama, PharmD FCSHP, FAPhA, is Associate Adjunct Professor UCSF Department of Clinical Pharmacy (6+ years), and, previously Director of Pharmacy and Residency Director, Prescription Solutions (2+ years), Director Inpatient Pharmacy (2+ years), Kaiser Permanente Sames, Director of Pharmacy and Residency Director (23+ years), Huntington Memorial Hospital, Director of Pharmacy (9+ years) St. Vincent’s Hospital, Sar-On and Clark Drugs (6 months), National Institutes of Health (NIH 2+ years), Keiro Nursing Home (1 month), Gardena Pharmacy (3+ years) as intern pharmacist. Served as President California State Board of Pharmacy, President of CPhA, and, President of CSHP.
Recruitment of Pharmacists

In general, jobs for pharmacists have been plentiful, even in this “down” economy where the unemployment has been high. The job market in California has been especially hard hit. Your job will come from either networking or being recruited – sometimes you’re looking and sometimes you’re not. There are certain areas where the demand exceeds the supply and other areas where it’s the reverse. We have three guest writers who speak to the recruitment of pharmacists from their perspective. We start out with Molly Richardson, a “headhunter” who hires for institutions which are usually looking for specific hard-to-find positions, such as Directors of Pharmacy. Then we have recruitment perspectives from Theresa Taylor, PharmD, who writes about a staffing agency looking for pharmacists to fill in for “extra help,” and the last article by Christine Fukunaga, PharmD, addresses recruitment from the perspective of a large employer.

Interactions with executive recruiters are key to your career network and development. Recruiters may work directly for the hiring organization or be affiliated with external firms that have a contractual relationship with the hiring organization to identify top talent. External recruiters share information about a job opportunity on web sites, in ads with professional groups or by networking with colleagues who know you professionally.

As a start, it’s helpful to understand how the recruiter works. Firms maintain large databases of candidate data and access online network sites. When contracted to recruit for a specific position, recruiters use these
tools to contact potential candidates who might have an interest in the role or might know someone who has the skill set. Even if you aren’t interested in the position, use the opportunity to establish a relationship with the recruiter and expand your career network. Your network is only as strong as the contact information you maintain.

Candidates are wise to have their resumes with many recruiting firms. Research recruiting firms online or have friends recommend firms or recruiters. Check the firm’s website for directions on how best to submit your resume. Some firms have online profile information that must be completed with a resume submission. At a minimum, email information as a paper copy of your resume can be overlooked. If you email a resume, include information about your availability and relocation preferences.

Firms receive dozens of resumes in a day. After you submit your resume, don’t expect a reply. The firm may not be actively working on a search that matches your background but will store your data and contact you about future opportunities. Therefore, it’s critical to keep your contact data current. Update your colleagues and recruiters of email, cell number or address changes. If the recruiter can’t find you, you may miss out on a golden opportunity.

I imagine readers rolling their eyes and thinking ‘of course I’ll keep my network updated’. Even seasoned professionals promise to stay in touch regarding their contact changes but about 1% follow through with their intentions. Your career network is directly tied to your career development. Don’t let it grow stale.

My next piece of common sense advice relates to underestimating the recruiter… don’t!

Your resume or a recommendation from a colleague may get you the initial contact with the recruiter. Assuming the hiring manager is the primary decision maker, candidates of all experience levels can undervalue the recruiter’s screening skills. Your goal is to get an interview with the hiring manager and your initial interactions with the recruiter are critical to reaching that end. From the start, you want to establish a professional level of communication. Your initial interaction maybe by phone and will require you to convey positive energy and communication skills. The recruiter may also schedule an in-person interview before presenting you and your credentials to the hiring manager.

The recruiter understands the position, its challenges and the corporate culture. Tap their knowledge to give yourself a leg up in future interviews. Feel free to ask the recruiter about their professional background to assess their ability to understand clinical specifics. Many recruiters are former healthcare executives or clinicians.

The recruiter plays multiple roles in the hiring process. They are the initial screener and as the process continues, they will function as a bridge between the hiring manager and the finalist. The recruiter will typically do reference checking and needs to be aware of red flags before you disclose them to the hiring manager. Letters of recommendation are nice but recruiters will call references specifically asking how you might function in terms of the job specifics. They will ask references about your strengths and limitations. Keep this in mind when you prepare reference lists and make sure you have current contact information for your reference (no eye rolling…you wouldn’t believe our experiences). Give your reference a heads-up about the role and potential call. You want the reference to respond quickly to the recruiter’s request and directly speak to the context of the position.

The recruiter will also be involved with any financial and criminal background checks. If you know something negative will surface, let the recruiter know before it becomes a hiring issue. The job application is a legal document and the recruiter will make sure yours is complete but you need to make sure it’s accurate. Even minor errors can be grounds for dismissal or reason to not hire.

The characteristics the recruiter is seeking depend on the job specifications and the organizational culture. The recruiter is challenged to find the candidate who will succeed in the role. Candidates can become future clients, so good recruiters follow successful candidates throughout their careers.

About the Author

Molly Richardson, Ed.D. is a San Francisco based healthcare executive recruiter. For the past 15 years, she has placed candidates on a national-level with managed care and provider organizations. She previously held senior-level positions with PacificCare (United Healthcare) and Homedco (Apria Health).
Getting Started in a Pharmacy Career
The Advantages of Working with a Staffing Agency

by Theresa Taylor, PharmD

The pharmacy profession is faced with an ever increasing role resulting in a growing need for pharmacists. As the medication delivery system continues to expand, pharmaceutical care must be delivered by highly trained licensed pharmacists.

Employers have met this requirement through various methods, some pharmacies employ pharmacists as direct-hire staff; while others contract the services of a pharmacy staffing company on an as-needed basis to complement and augment employee shortages. Replacements of pharmacists are for short or long term periods of time, or for chronic needs on an intermittent and ongoing basis. By combining their internal staffing resources with the staffing firm’s resources, pharmacies are able to achieve the required employee needs to meet the required staffing ratios.

The healthcare and pharmaceutical sectors are among the noted sectors for the post recessionary staffing needs to expand. Post recession, companies generally resort to using temporary staffing prior to adding direct-hire staff. However, as the unemployment rate remains high, small and large companies have adapted to working with less and the new buzz word is “sustainability,” doing more with less resources. Companies within the pharmacy profession have approached sustainability in various ways, such as budget cuts, staff cuts by attrition, decreased benefits, etc.

Many retail chains and hospitals have resorted to decreasing their reliance on...
Working with a staffing firm exposes you to a variety of clinical practice settings, allows flexibility in your schedule, and enables you to achieve your personal and career goals.

outsourced staffing as they have met with an expanded float pool over the last two recessional years. Dips in 401Ks and pension plans result in pharmacists placing their retirement and vacation plans on hold, and leaving little to no job openings for the graduating class of 2009. The class of 2010 is in the same situation with less positions open for them. Currently, there are about 120 pharmacy schools (in the U.S.), with about five more scheduled to open in 2011, and another five scheduled to open in 2012. The situation will only get worse as more pharmacy schools graduate record numbers, thereby increasing the surplus of pharmacists. This shift in supply and demand results in more available pharmacists for less available positions.

Planning for your future: Benefits of working with a staffing firm

If you are a pharmacy student or newly licensed pharmacist, you are faced with questions about what’s next – What do you want to do – a simple, yet a very complex question. First, determine the practice setting you will be most comfortable within. The options are varied and wide ranging from hospitals, industry, research, retail chain stores, independent pharmacy, long term care pharmacies, specialty pharmacies, and home infusion pharmacies, as well as the varied subspecialties within each of the practice options mentioned.

Second, determine which geographic location you are most interested in; this is a critical factor in your job selection process. Being a nationwide company, we (Asereth Medical Services, Inc.) observed that flexibility and willingness to support the geographical areas with the greatest needs are critical factors in career advancement.

Third, find ways to brand yourself by providing value to your employer. You have invested in gaining a wealth of knowledge in pharmacy school; use it by extending yourself to your patients and employer. Be open minded to all possibilities. This is a very important characteristic that will differentiate and set you apart. As a new grad, your character is your trademark, and your competency is your armor, keep it well shined.

Your first job does not define your entire professional career. However there are qualities you must look for in your first job to enhance your career. The largest or most well known companies are not always the best places to gain a broad experience. They may enhance your resume but not always meet your professional expectations.

Remember, you must strategically plan your career, and planning for your future is a continuous process. Should you decide you want to make a change, broadening your scope of practice is always helpful and makes you a more competitive applicant. Seasoned pharmacists, looking for more schedule flexibility or just a change of pace, can easily achieve this by working with a pharmacy staffing firm.

Any substantial long term investment such as a car requires pre-evaluation, planning and assessment based on safety, likeability, and long term satisfaction. A similar set of criteria should be applied towards your search for employment. Generally, one would “test drive” a car prior to purchase. This same opportunity is available when working with a pharmacy staffing firm. With a staffing firm, you are able to gain firsthand experience in a variety of practice settings.

Which career path is for me?

Currently there is a shift in the market towards client facilities preferring to work with healthcare staffing firms who have earned their Joint Commission certification. This affords the client a smooth transition between client’s staff and the registry’s staff because they meet the same ongoing standards of clinical competencies. The logic behind this preference is that healthcare facilities are required to be accredited and so should the staffing firms that provide them with services. When selecting a staffing firm, become familiar with the reputation and lineage of the company. Make sure that they are also visible and branded within the industry, as this drives their client pool and affects the practice settings in which you have the opportunity to be placed.

Working with a staffing firm exposes you to a variety of clinical practice settings, allows flexibility in your schedule, and enables you to achieve your personal and career goals. Pharmacists with a desire to exercise their skills, to become leaders in their profession, and to explore their sense of adventure will find working with a pharmacy staffing firm one of the fastest paths to uncompromised clinical and professional growth. There is great potential for this experience to be the most rewarding aspect of their professional career.

About the Author:

Theresa Taylor, PharmD graduated from the USC School of Pharmacy in 1979, worked as a hospital staff pharmacist and later in the position of Director of Pharmacy Services for several years. In 1990, she founded Asereth Medical Services, Inc., a nationwide Joint Commission Certified pharmacy staffing firm where she currently leads daily operations.
Hiring, retaining and developing great employees are the keys to success for all organizations including Kaiser Permanente (KP). As a large employer in California that employs over 3,000 pharmacists statewide, recruitment of highly skilled and knowledgeable pharmacists is vital.

Although the current economic challenges have impacted job growth for pharmacists across the nation, recruitment strategies for pharmacists continue to be an important focus.

According to the most recent U.S. Bureau of Labor Statistics (BLS) projections, “Employment of pharmacists is expected to grow by 17 percent between 2008 and 2018, which is faster than the average for all occupations.” The BLS report notes that there are many reasons for this including an aging population who has a greater need for multiple medications. Prescription drugs are also becoming more complex, resulting in pharmacist, having greater involvement in patient care. With healthcare reform, it is predicted that there will be an increase in people with prescription coverage. According to data from the Aggregate Demand Index survey, there is currently a moderate unmet demand for pharmacist across the United States. This is a project sponsored by the Pharmacy Manpower Project Inc, and has been measuring the unmet demand for pharmacists for over ten years. There are a few states that have a moderate to high demand where there are difficulties filling open positions; e.g., Wisconsin, New Mexico and Washington in the latest surveys. In California, there has been a downward trend in unmet demand since 2007; however, currently, it is moderately difficult to fill vacancies. Specialized Ambulatory Care positions, especially in Oncology and Anticoagulation continue to provide opportunities.

Pharmacist recruitment strategies include attending recruitment events at professional association meetings such as exhibiting at CPhA Outlook, CSHP Seminar, ASHP Midyear and various other local, state and national meetings. Many organizations also attend career fairs and interview days at the various California pharmacy schools. At Kaiser Permanente, it is essential that our pharmacy managers attend these events, allowing candidates an opportunity to ask questions and learn about actual job duties, work environment and opportunities for growth in their careers. By offering pharmacy practice experiences to pharmacy students, Kaiser Permanente pharmacy managers not only provide valuable instruction and experience, they have additional opportunities for recruitment of interns, residents and future pharmacists. KP Pharmacy offers American Society of Health-System Pharmacists (ASHP) accredited residency programs which brings many residency trained pharmacists into our organization annually. As with most companies, internal recruitment processes allow employees opportunities to change location and/or positions. However, should positions not fill internally, career websites provide another avenue where external candidates can search for open vacancies and apply online. Positions can also be advertised through external websites, publications or social media. By far, the most effective recruitment tool has been employee referral. Our employees, able to practice what they believe, are successfully recruiting their friends, classmates and associates.

Prospective employees with an excellent knowledge base and strong work ethics are necessary qualities for any organization. Excellent communication skills are also essential in all practice settings. As an integrated healthcare delivery organization, not only must you communicate with patients but also with other members of the health care team. This is vitally important. Another important characteristic is the ability to work as part of a team. Teamwork is needed in order to provide high quality pharmaceutical care and service. Finally, a critical attribute is that the applicant possesses compassion and the ability to empathize with patients in a healthcare setting. Kaiser Permanente looks for prospective employees who can treat patients as they would their family, friends and loved ones.

Valuable information can be obtained from an applicant’s curriculum vitae (CV) or resume. The job history gives an idea of the skills, training, experiences and accomplishments that the candidate possesses. It also provides information reflecting their involvement in community service and professional organizations giving employers an idea of a possible “fit” with their departments. Pharmacy managers are encouraged to conduct reference checks in order to determine past work performance. Although letters of recommendations are preferred for staff pharmacist positions, they may also...
be required when applying for a residency program. The letter should be personalized, describing your character, leadership ability, accomplishments, etc. This is valuable information in the selection process.

One of the most important tools in the hiring process for the employer is the interview. There are a variety of interview styles that includes individual, panel, serial, group and phone screenings. When interviewing, the individual should be prepared with knowledge of the company and the position of interest. An updated resume should be provided. During the interview, standardized questions may be used. Practice possible questions with colleagues or friends and be prepared to ask questions of the prospective employer. This is an important opportunity for not only the prospective employer to consider if the individual might be a good fit for their organization, but also for the individual to evaluate whether the organization is a good fit for them.

It is difficult to predict the future. Trends in pharmacist supply and demand can change with economic performance, technological advances, changes in government policies and programs and the number of pharmacy schools producing graduates. As an employer of a large organization, Kaiser Permanente continues to focus on recruitment and retention. There is an ongoing need to replace the positions that open due to retirement, job movement, etc. In this current job market, there are more opportunities for those who are flexible in their location preferences and practice settings. At Kaiser Permanente, we offer diverse practice settings and diverse locations. With your unique perspective, you can truly make a difference and practice what you believe.

About the Author
Christine Fukunaga, PharmD, is the Administrative Services Manager for Kaiser Permanente Pharmacy Strategy & Operations in Southern California. Her responsibilities include overseeing Pharmacy recruitment for California, developing relationships with the Pharmacy schools and the professional organizations. Christine is also involved in assisting Pharmacy Managers with personnel issues and grievances, participates in negotiating union contracts and is a faculty member in a Management training program.

Christine’s pharmacy career began as an Intern at Kaiser West Los Angeles. After graduating from USC School of Pharmacy, she became an Outpatient Pharmacist at the 24-Hour Pharmacy. A few years later, Christine became a Pharmacy Manager and went on to manage several other pharmacies. She later had the responsibility for overseeing all the Outpatient pharmacies in West L.A. Throughout the years, Christine had the opportunity to develop and implement the first Managed Care Residency Program in Kaiser Permanente, participate as a consultant to improve Pharmacy operations in Southern California and lead initiatives to improve quality and service to Kaiser members.

References
Traditional Positions in Pharmacy

Over the years, there have been two primary practice settings where most pharmacists practice and, they are acute care and outpatient care (community pharmacy). Over 80% of all pharmacists practice in these two areas, with some 65% in community (independent and chain pharmacies), and over 20% in Acute Care (hospitals). Of these two areas, community pharmacy is growing at a much faster rate due to ambulatory care, Medicare Part D, and growth in the over 65 population. Arash Dabestani, PharmD, MHA, FABC speaks to the opportunities in acute care.

Next, John Tilley addresses the opportunities in community pharmacy practice from the unique viewpoint of an owner. Compounding pharmacy could be placed in the community category because pharmacists have been compounding for hundreds of years.

The general understanding among new grads was that a staffing pharmacist role in a hospital would offer more clinical opportunities then a retail position at a drug store. I was fortunate enough to have experienced the thrills of the hospital setting at an academic medical center first hand. This experience convinced me to pursue a career in the acute

The Current Hospital Pharmacy Job Market: An Employer's Perspective

by Arash T. Dabestani, PharmD, MHA, FABC
care arena, even with the challenges of the then limited pharmacist job market and the very limited number of hospital pharmacist job vacancies. After multiple attempts and interviews at urban hospitals in Charlotte N.C, I was able to land a hospital staff pharmacist position on the outskirts of Charlotte, a complicated 60 minute drive from home. Fortunately, this was not a deterrent as my goal was simply a job in any hospital. Within six months of my first job as a staff pharmacist, I decided to pursue an administrative career in pharmacy and healthcare by obtaining a Masters degree in Health Care Administration. This long journey included four years of attending night classes and simultaneous jobs as a staff pharmacist in the hospital and clinical pharmacist in a specialty pediatric home health care setting.

Today, as an Associate Director of Pharmacy at Stanford Hospital and Clinics, I’m involved with all aspects of employee management from recruitment, interviewing, selection, on-boarding and talent management. At Stanford, more then ever, we are in need of pharmacists with a solid foundation and understanding of clinical pharmacy as the traditional staffing tasks of order entry have been replaced by more clinical functions of chart review and electronic order verification. This is due to multiple factors and developments in our inpatient pharmacy department. First, Computerized Physician Order Entry (CPOE) has eliminated medication order transcription and drastically reduced the amount of time “staff” pharmacists spend on order processing. On the other hand, CPOE has increased the number of order sets, protocols, and formulary restrictions. As a result, it is pertinent that all pharmacists possess a profound knowledge and full understanding of hospital order sets, protocols and formulary restrictions and recommendations. Additionally, the hospital administration and medical staff’s expectations for pharmacists has grown to the point where each expect a comprehensive and clinical review and evaluation of patients’ medication record and history, and rightly so.

The nationwide pharmacist shortage and hiring frenzy that began in the mid-nineties and brought us significantly higher salaries and increasing demand for our skills has arguably come to a halt. In the future, demand for pharmacists will undoubtedly fluctuate based on the final accepted version of the Healthcare Reform Bill and other national and state specific initiatives. The current environment will encourage new pharmacy grads to pursue post-graduate training, the enhancement of skill sets and additional certifications in order to increase their marketability. This is the natural course for a rather competitive environment. In the long run, the current oversupply of pharmacists should advance the profession as more pharmacists pursue post-graduate training and education than before.

The growing supply and lower demand for pharmacists allow future employers more flexibility in hiring and to demand higher productivity from new employees. In lieu of that, State, Federal and other regulatory agencies continue to pass laws and regulations that require pharmacist involvement for compliance. This results in formation of contemporary pharmacist positions such as Medication Safety Officer, Compliance Officer, IT Pharmacist, Med Reconciliation Pharmacist or in the case of our institution, a Clinical...
A career in a large medical center or healthcare system can offer the candidate many avenues for advancement in multiple practice settings and specialty positions.

**Special skill sets and the interview process**

Each time a pharmacist position is posted for a hospital, the particular institution will be searching for a specific set of skills, particular experience, or even personality type. This is generally due to the institution's goals and objectives (both short and long-term), in addition to the strategic plan the institution has identified for its pharmacists. For example, an institution with a very low rate of pharmacist turnover and a high average of tenured pharmacists will be more inclined to hire new grads simply due to the availability of senior pharmacists and mentors. In contrast, a “revolving-door” institution with a higher rate of pharmacist turnover will most likely prefer experienced pharmacists to improve staffing stability. It is imperative for the candidate to research and identify the hiring institution's goals and objectives as they apply to the posted position once the candidate has been selected for an interview.

An applicant may accomplish this task by simply contacting the human resources hiring manager and the pharmacy manager in charge of the posting. Applicants are highly encouraged to visit and thoroughly search the hiring institution's website. This will familiarize the candidate with the institution's accomplishments, goals, objectives and perhaps even culture. Additionally, the applicant is encouraged to research the pharmacy portal and familiarize him/herself with the pharmacy department's structure, personnel, sub-departments and accomplishments. I routinely quiz candidates on our institution's mission and vision statements. This information is readily available on the world wide web. The candidate is encouraged to locate the interview location at least one hour prior to interview time. This will allow the candidate ample time to prepare for the interview and absorb some of the organizational culture by simply walking around the campus. A visit to the cafeteria is highly encouraged as many candidates will experience a dry mouth during the interview process. Additionally, this will provide the applicant with ice-breakers during the interview process as he/she will be able to ask questions about the facility or an encounter.

All interested applicants, including new graduates are encouraged to monitor the career section of their potential employer's website for timely job postings. These postings will likely contain a job description which may or may not provide the candidate with the specificities of the position. Salary information may occasionally be posted. The majority of institutions have a set salary range for posted positions. It is important to understand that there is little to no room for salary negotiations as these rates have already been set by the human resource compensation department of the organization. In addition, most organizations have multiple applications for each posting hence are less willing or inflexible to negotiate on the salary.

In summary, the very basic rules of supply and demand can be applied to the current pharmacist job market. Pharmacy students are highly encouraged to identify and research area(s) of interest and pursue available post graduate training in order to remain competitive, highly skilled and sought after in the current market.

**About the Author**

Arash Dabestani is the associate director of pharmacy at Stanford Hospital and Clinics in Palo Alto, CA where he is in charge of daily inpatient and outpatient pharmacy operations. Arash received his Doctor of Pharmacy degree from Campbell University in North Carolina. Following the completion of his PharmD degree, he earned a masters in health administration from the University of North Carolina in Charlotte and completed a fellowship with the Advisory Board in Washington, D.C. Prior to joining Stanford, he was the Director of Pharmacy Operations for Potomac Hospital in Virginia.

**References**


Effectiveness Manager. Larger organizations have the capability to identify and promote internal pharmacists for such specific positions and roles which ultimately result in availability of entry level pharmacist positions ideal for new grads. A career in a large medical center or healthcare system can offer the candidate many avenues for advancement in multiple practice settings and specialty positions, in addition to research, multi-disciplinary collaborations, projects and publication opportunities.

ASHP Health-System Pharmacy Initiative 2015 objective 4.7 states, “90% of new pharmacists entering hospital and health-system practice will have completed an ASHP accredited residency.” Please note that this objective applies to the nearly 5,000 hospitals in the U.S. This objective and the hiring practices associated with it have already been adopted by the majority of academic medical centers and teaching hospitals. In our institution, there is no specific policy mandating the completion of an ASHP accredited residency for new hires. However, it is unlikely for a new pharmacy grad to be selected for a position given the abundance of residency trained applicants.

**Company or Employee Name**

**Employment Application**

**Your Name:**

**Address:**
Are you considering a career in community pharmacy? Have you ever dreamed of owning your own pharmacy? Let’s look at the positives, and the potential negatives of becoming a community pharmacy owner.

Making the decision to become your own boss in a pharmacy practice can be quite challenging, and requires a lot of time and commitment. There is planning involved, hard work, having the required clinical skills needed to provide proper patient care, plus understanding the business aspects of running a pharmacy. In addition, having good people skills, managing staff, and working well with the public are also vitally important.

So, assuming you are interested in owning your own pharmacy, you should ask yourself the following question: How do I get started, and should I buy an existing pharmacy, or start a new business from scratch?

Many students in the Colleges of Pharmacy have developed business plans, and competed nationally in the NCPA Pruitt-Schutte Business Plan competition. It has been a fantastic way for students, and young entrepreneurs to develop their pharmacy plans on paper, and then carry it forward a few years later. Developing a good business plan is vital, and should be an integral part of beginning your pharmacy business venture. The ideas are endless, as to what you would like your pharmacy practice to include, e.g., Physician IPAs, Specialty Pharmacy Practices, and many other areas where one can focus their efforts.

There are positives and negatives to either buying an existing pharmacy, or starting up a new business. If you choose to open a new pharmacy practice, you are starting without patients, and it may take some time and effort on your part to build up the business practice. However, the start-up costs will typically be less because you are not buying an existing practice with patient files. I typically prefer to buy an existing pharmacy practice, as you are already buying the seller’s prescription files and inventory. And, although slightly costlier, there is typically an easy transition...
Owning Your Own Pharmacy (cont.)

between you and the previous owner. In either case, financing is usually needed. In buying an existing pharmacy, sometimes the seller may help finance the business, as he or she wants to insure your success.

To those students or other pharmacy practitioners wishing to purchase or start their own pharmacy business, they should probably consider the following: Ask yourself in which type of pharmacy practice do I have an interest? Sometimes gaining on-the-job experience at a particular practice can help you decide what type of pharmacy you are interested in. Find a community and a pharmacy where you have an interest. Make an appointment, and go talk to the current pharmacy owner. Tell him or her your desires and your goals in pharmacy. If both parties are interested, perhaps there will be an opportunity to work at that location and develop a program that you envision helping that particular community. If the pharmacy owner is approaching retirement age, express your desire to work at the pharmacy and purchase the store. You can possibly do a Junior Partnership arrangement with the current owner, and acquire stock in the business over the next few years before making the purchase.

Students, as well as employee pharmacists, have often approached me about purchasing a pharmacy. My advice would be to:

1. Attend local CPhA pharmacy meetings, and get to know the pharmacists, and pharmacy owners, and find out who may be wanting to sell their store.
2. Assess your financial situation, and the amount of capital you may have to invest. Talk to banks, and other lenders, and know what your start-up costs and legal fees might be.
3. Make certain you have sufficient assets or collateral to secure the debt.
4. Choose the type of pharmacy you are interested in purchasing, then find the right pharmacy to buy. Consider whether you want to go this alone or partner with another person.
5. Consider working with a pharmacist who is ready to retire, and buying in as a junior partner, or working with the pharmacy owner to help finance the purchase for you.
6. Think about relocating. Sometimes a rural pharmacy can be very attractive.
7. Obtain the services of a pharmacy broker. This may help find the right match for you, and may help you establish the market price for a particular pharmacy, when evaluating the business.
8. Conduct a thorough financial analysis of the business before making any financial decisions. Make your decisions based upon financial facts, and not necessarily on emotion.
9. Hire an accountant familiar with pharmacy practice. That person should also be able to assist you with some long-term planning.
10. Identify potential areas of growth and niche markets, building upon the previous owner's patient base to develop those things you want to see in your pharmacy practice.

Once you own your own pharmacy practice, do something with it. Be active in your community. Get involved in community service organizations such as Lion's Club, Rotary, etc. Get to know the doctors in the community, and speak with them at various functions. Go to senior centers, and volunteer your time. Be active in your Chamber of Commerce, run for City Council or Mayor, and be politically active.

As policies in Washington D.C. and Sacramento dictate new regulations that affect our pharmacy practice, make sure to voice your opinion with your representatives; otherwise, the politicians will assume we agree, and vote the way they choose. Being successful, is not just about working in the pharmacy, it’s about being out in the community, and being pro-active on the issues.

Owning your own pharmacy, although rewarding, can have its challenges. As a pharmacy owner, you should have good people skills, and be able to manage personnel. Your former co-workers may now become your employees, so understanding their needs is also essential. There are also other commitments to consider. Becoming a good business manager is a must. Owning any type of business requires meeting the bottom line. Controlling expenses and inventory, ensuring reimbursements are being paid correctly, and in a timely manner, are just a few critical areas of pharmacy operations that require careful management. This can lead to longer work hours at the pharmacy, as you as the owner now have complete responsibility.

Should owning a community pharmacy be in your future? NCPA has pharmacy ownership workshops, in various parts of the country, offered two to three times per year. They are designed to help potential pharmacy owners who have questions about buying, or starting their own pharmacy. The workshops provide the potential pharmacy owner with the necessary tools to start their venture.
In conclusion, I would ask you to find your passion in pharmacy. If your passion is to become your own boss, develop your pharmacy practice the way you like, determine your work environment, and decide the patient care services that you want to offer, then you should strongly consider a career in pharmacy ownership. Pharmacy ownership is a risk, but I firmly believe that with greater risk comes greater rewards. I personally can’t imagine my pharmacy career without owning a pharmacy. It’s just my passion in our wonderful profession.

Find your passion, and build upon it!

**About the Author**

John Tilley is a 1977 graduate of Idaho State University, College of Pharmacy. In 1984, Tilley bought the three-store chain of Zweber Apothecary in Downey, CA.

In 2000, Tilley started the pharmacies inside all of the Stater Bros. Markets.

By 2005, Tilley had 23 pharmacies, covering five California counties.

Tilley has served on many committees of CPhA, and served as CPhA’s President in 1997. He has also received the Bowl of Hygeia Award in 1994, and the Pharmacist of the Year award in 2002. Nationally, Tilley has been a member of APhA, and a Regional Director for the American College of Apothecaries, and served as an officer and Executive Committee member of NCPA for 15 years. In 2007, Tilley served as President of NCPA.

Mr. Tilley served on the California State Board of Pharmacy from 2001 to 2005, and has also served on many advisory committees. Mr. Tilley has also been President of the Downey Chamber of Commerce, and coached his children’s Little League, Pony Tail, and Soccer teams. Today, Tilley owns four pharmacies, and remains active in local, state, and national pharmacy issues.

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california pharmacists association
Non-traditional Pharmacist Positions

The advent of the pharmacist specialist has blossomed over the past 20 to 30 years. The profession is rich with a variety of opportunities which include: teacher (faculty), pharmaceutical industry, long term care, nuclear, pediatrics, ambulatory care, and government agencies such as FDA/USPHS. They are amongst the oldest specialty fields.

Other newer practice areas include oncology, infectious disease, critical care, surgery, anticoagulation, mail order, and psychiatry. The newest specialty areas are in ER (emergency room), technology, transplant, pain management and hospice, women's health, and neurology. In some of these areas, such as the pharmaceutical industry, we find pharmacists in marketing, research, drug and medical information, legal regulatory, pharmacoeconomics, managed care, etc. aside from the traditional sales positions. In my opinion, the most urgent needs and growth in the future will be in ambulatory care, technology, ER, oncology, teaching/research, and leadership (director level). The following articles are examples of some of these practice areas Robert Kwan writes about nuclear pharmacy, Joyce Lin speaks to anticoagulation/ambulatory care, and Anne Wong-Beringer writes about infectious disease. In addition, David Yu and Florence Wong provide perspective for oncology inpatient/outpatient, Christine Joseph writes about ER, and Carly Paoli speaks to pharmacoeconomics.

When entering pharmacy school in the fall of 2005, I had already graduated with a Bachelor's degree in Health Promotion & Disease Prevention and a Master's in Public Health. Due to my educational background, I knew I was interested in population health. I sought out any opportunities in pharmacy school which were in line with a non-clinical career.

I joined AMCP (Academy of Managed Care Pharmacy) and got the opportunity to explore different career paths, attend a variety of lectures by pharmacists doing non-clinical work and also participated in the AMCP's P&T Competition (with my team placing third nationally in 2006). Although, it was not until my last year in pharmacy school when I went on rotations that I really got to explore what it was I wanted to do for my career.

Fortunately my school gave me three elective rotations and for these I selected Pharmacoeconomics in academia, Medical Affairs at a pharmaceutical company and Managed Care at a consulting firm. It was from these rotations that I got an opportunity to explore what I wanted to do after graduation and decided to pursue a fellowship in health economics and outcomes research.

While applying and interviewing for fellowships, I was also exploring managed care pharmacy residency opportunities as well. Early in my fourth year I decided to apply for both a health economics fellowship and a managed care residency. After interviewing for both, and decided on the fellowship program which I believe will give me transferrable skills to work in industry, managed care, consulting or academia when finished.

My specific fellowship is a two-year program sponsored by the UCSF Department of Clinical Pharmacy and Amgen's Global Health Economics (GHE) group. I will spend the first year at UCSF working with a researcher who specializes in health economics and the second year I will be at Amgen as a member of the GHE team. Here at UCSF, I am involved in various projects which have to do with analyzing the costs of various health states from surgery to drug costs and everything in between. I spend most of my days at my desk in front of my computer, designing, executing and completing studies. I currently work on three major projects and my focus this year has been to publish as much of my research as possible.

Pharmacists who would be good at this type of job have excellent analytical skills: statistics, epidemiology and study design. If you didn't enjoy or excel in statistics, this career path would not be for you. If you are interested in direct patient care then this is also not a career path for you. However, there are several benefits of this type of career. You conduct your own research and can have much autonomy in your daily work. You also have a regular 9-5 work schedule, although some people choose to take on more. There are also many opportunities for growth and promotion in this field.

If you have any questions about health economics and outcomes research, please feel free to contact me at paolic@pharmacy.ucsf.edu. ISPOR (International Society for Pharmacoeconomics and Outcomes Research) is the best organization and resource for jobs and fellowships in pharmacoeconomics: www.ispor.org.

About the Author
Carly J. Paoli, PharmD, MPH, is a second-year postdoctoral fellow in health economics, outcomes and policy research at the UCSF, School of Pharmacy, Dept. of Clinical Pharmacy, Program for Outcomes, Pharmaceutical Economics and Policy Studies (PO-PEPS). Her fellowship program is in conjunction with Amgen, Inc.
A Day in the Life of an
Emergency Department
Clinical Pharmacist

by Christine Joseph, PharmD

What does an adult with new-onset chest pain which develops into a NSTEMI in minutes, a pediatric patient with a rare congenital metabolic syndrome with dehydration due to intractable vomiting, a solid-organ transplant patient with a high fever and body aches, a combative teenager with suicidal tendencies, a pregnant woman with vaginal bleeding, a child with an allergic reaction and an adult with a broken arm have in common?

They are all patients at any given time in the Emergency Department (ED).

The Emergency Department is a unique setting where the immediate care of urgent and life-threatening conditions found in the critically ill and injured patients takes place. The ED is also an important entry point for those without other means of access to medical care.

The fast-paced, limited drug options, variety of patients, and the need for immediate and sometimes temporary solutions with limited information can be challenges to providing safe and effective medication therapy. As pharmacists, we are positioned to ease many of the above challenges.

On a typical day I come to the ED, take a look at our census for the day and round on patients starting from highest to lowest acuity. At any moment a code may arrive. When this happens, I take the lead on procuring and preparing all necessary medications, ensuring appropriate dosing and anticipating and recommending further therapy. If the patient does not have a patent airway I would assist in dosing and preparing the rapid sequence intubation (RSI) medications. If the patient is in cardiac arrest, I would prepare the ACLS medications. In most cases with limited patient information, it can be very difficult to assess for appropriateness of medications. Regardless, decisions for the immediate stabilization of the patient are made.

When medication therapy is ordered in the ED, a diagnosis may not yet be confirmed. As an ED pharmacist I need to rationalize whether the medication in question is appropriate based on the presentation of the patient. Most patients present to the ED at the height of their illness and may require higher than normal doses of certain medications.

Many patient complaints in the ED are associated with medication-related adverse events as a result of drug interactions, inappropriate dosing or inappropriate use. In these cases, I review the patient’s medications, past-medical history and recent dose changes, and recommend therapy changes to the medical team.

Between codes I prospectively process and verify medication orders, expedite urgent medications to the patient, assist in procedures that require patient specific medication dosing (i.e., alteplase in stroke cases and ketamine in pediatric procedural sedation), provide drug information to physicians, nurses and patients, provide discharge counseling for high-risk patients (newly initiated on warfarin/enoxaparin), assist with medication reconciliation for complicated admitted patients, monitor and report adverse drug reactions and follow-up on microbiology data for outpatients.

The Emergency Department is a rewarding area for pharmacists. I would recommend this specialty to anyone who is comfortable in a fast-paced environment with patients of all ages and disease states, and enjoys a challenge!

About the Author

Christine Joseph, Pharm.D. is Health Sciences Associate Clinical Professor of Pharmacy and clinical pharmacist at the University of California, San Francisco (UCSF). Dr. Joseph has worked in a variety of settings which include hospice and palliative care, critical care, solid-organ transplant and most recently emergency medicine. Dr. Joseph and her colleague founded the Emergency Department Clinical Pharmacy program at UCSF in September 2009. Please feel free to get in touch with questions via email at Christine.joseph@ucsfmedctr.org
Clinicians are increasingly challenged with the “Bad Bugs No Drugs” crisis when managing hospitalized patients with an infection. Mortality attributed to hospital-acquired infections caused by antibiotic-resistant bacteria such as MRSA, Pseudomonas, Acinetobacter currently affects 100,000 patients each year, costing the U.S. healthcare system $21 to 34 billion annually.

In particular, some strains of Pseudomonas, a leading cause of nosocomial infections, have developed resistance to all available antimicrobial agents. Adding to the gravity of this situation is the lack of novel agents anticipated to reach the market at least in the next five years. Pharmaceutical industry has severely curtailed antibiotic research and development over the past decade due to poor economic incentives, regulatory hurdles, and extraordinary genetic pliability of bacteria to circumvent antimicrobial action. Until novel antibiotics become available, the effectiveness of our existing antibiotic arsenal must be regarded as a “non-renewable” resource that needs to be protected.

Overuse and misuse of antibiotics have facilitated the development of antibiotic resistance as well as compromised patient safety. In this light, the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America jointly called for the implementation of an antimicrobial stewardship program at acute care hospitals in which a clinical pharmacist with infectious diseases training is recognized as a core member. In addition, the Joint Commission requires the prevention of hospital-acquired infections due to multidrug-resistant organisms as a National Patient Safety Goal. Specifically in California, each acute care hospital is being assessed for their compliance to CA Senate Bill 739 approved in September 2006 which mandates that each hospital develops a process for evaluating the judicious use of antibiotics.

The goal of antimicrobial stewardship program (ASP) is to promote the appropriate use of antimicrobials through proper selection, dosing, route, and duration of therapy that optimize clinical outcomes while minimizing toxicity, selection of pathogenic organisms, the emergence of resistance, and treatment costs. Core activities of the ASP include but are not limited to: 1) tracking of antimicrobial resistance patterns, 2) prospective audit of antimicrobial use with direct interaction and feedback to clinicians.
prescribers, 3) formulary management and guideline development, 4) dose optimization, 5) parenteral to oral conversion, and 6) education.

The appropriate use of antimicrobials has become a patient safety focus along with medication errors, allergy identification, and drug-drug-interactions. We have shown that in addition to impacting the care of individual patients through antimicrobial therapy interventions, an infectious diseases-trained pharmacist can take on a leadership role to positively change antimicrobial prescribing practices at the institutional level and improve patient outcomes. (Pharmacother 2009;29:736) Typically on a daily basis at the acute care setting, an antimicrobial stewardship program identifies patients who are receiving antimicrobial therapy in a systematic fashion (i.e., computer printout of all patients receiving antibiotics). Recommendations to optimize antimicrobial therapy for selected patients are made after thorough workup of the patients by the infectious diseases pharmacist and/or consultation with the infectious disease physician. Members of the medical staff and pharmacy staff may also refer patients to the infectious diseases pharmacist for consultations particularly in cases involving multidrug-resistant bacteria, suboptimal response to standard therapy, or presence of significant drug-drug interaction potential. In addition, the infectious diseases pharmacist performs regularly antimicrobial use evaluation of prescribing trends to identify areas for improvement and provide feedback to prescribers individually and by reporting to medical staff committees, newsletter etc. The specialist also works closely with microbiology to develop and update an institutional antibiogram (typically on an annual basis) to inform prescribers the local pattern of resistance at the institution and make empirical antibiotic selection guidelines. As such, the infectious diseases specialist interfaces between medical and pharmacy staff, as well as other members of the health care team (microbiologist, infection control practitioners) providing consultation, feedback, and education on antimicrobial therapy. Therefore, excellent oral and written communication skills are paramount for the individual to be effective in this role.

Specialty training in infectious diseases is attained by completion of PGY2 Residency or Fellowship in Infectious Diseases following PGY1 Pharmacy Practice Residency. Notably, infectious diseases affect broad patient populations from pediatrics to geriatrics and otherwise healthy to immunocompromised individuals and across practice settings from community to intensive care unit. Therefore, having a strong foundation in internal medicine is a prerequisite to specializing in infectious diseases in order for the individual to have an appreciation of disease interactions that impact selection of antimicrobial regimen and infectious disease outcomes. While most infectious diseases specialists practice in general acute care setting, some further sub specialize with practice in areas such as critical care, transplant, oncology, or HIV.

With support from various professional and accrediting organizations, there is a definite and increasing demand for pharmacists specializing in infectious diseases. They have tremendous opportunities to impact on the care of patients and educate others. During this public health crisis of “Bad Bugs No Drugs”, a pharmacist with training in infectious diseases must seize this unique opportunity for our profession to respond to this urgent call for action.
I recently joined the San Francisco Veterans Affairs Medical Center as an outpatient anticoagulation clinical pharmacist. My position centers around telephonic care of VA patients in the rural health community of Eureka, CA.

As this clinic is still relatively new, we are still in the process of developing the most efficient and effective workflow. On a daily basis, I generally interview 10-15 patients to identify any adverse events related to warfarin and to account for any changes in INR, and to determine the need for any warfarin dose adjustments and time for follow-up. Days are often a mix of “simple” encounters (e.g., patients with therapeutic levels and no other changes/complaints) and “complex” encounters (e.g., patients who have acute changes in health or start new medications, or patients who are going to undergo invasive procedures which will require adjustment of anticoagulation therapy). It is also important to perform an ongoing re-assessment of a patient’s need for warfarin given the risks and benefits of anticoagulation therapy.

I did not always envision that I would specialize in anticoagulation management. After graduating from pharmacy school, I completed a general pharmacy practice residency (at my current site of employment), and then went on to a second year, managed care residency at the Palo Alto Medical Foundation, which is a large, multi-specialty outpatient medical group. There, much of my effort was devoted to incorporating a pharmacist into an already-developed nurse-run anticoagulation clinic. Upon completing my residency, I was offered a full-time position at PAMF, and I practiced there for the next four years. While I primarily served as an anticoagulation clinic pharmacist at PAMF, I also had the opportunity to work with other clinicians to develop protocols regarding diabetes, hyperlipidemia, and hypertension treatment, and was actively involved in quality improvement projects and development of anticoagulation tools for PAMF’s electronic health record.

It was not always clear to me what path in pharmacy I wanted to pursue, so it was very important to me to keep my options open. I have, however, seemingly found my niche in ambulatory care. I am passionate about working directly with patients and establishing a relationship with them as part of their health care team. Through my experiences, I have also recognized that I also enjoy being involved in the big picture – quality improvement, development of new clinics and protocols, ways to make our health system more effective and efficient.

One challenge about working in a specialty clinic is the narrow focus, so I try to stay engaged in other areas of pharmacy as well by attending lectures/grand rounds, participating in pharmacy student/resident projects, etc., and working to understand what other pharmacists do. And in reality, even though I may be focused on anticoagulation management for my patient, I cannot ignore their other health issues or complaints, and am often able to draw from my pharmacy background to help provide education or serve as a liaison between the patient and their primary care provider.

The face of anticoagulation management may be evolving as alternatives to warfarin become available, but anticoagulants will always remain high-risk medications that require follow-up and ongoing risk/benefit assessment.

About the Author
Joyce Lin, PharmD, CACP, has been working in the outpatient anticoagulation field for the last five years, and is currently a clinical pharmacist at the San Francisco Veterans Affairs Medical Center. There she is responsible for anticoagulation management of VA patients in the rural health community of Eureka, CA, and serves as a preceptor for University of California, San Francisco School of Pharmacy students and the University of the Pacific School of Pharmacy students.
nuclear pharmacy seeks to improve and promote public health through safe and effective use of radioactive drugs for diagnostic and therapeutic purposes. As a member of the nuclear medicine team, a nuclear pharmacist specializes in the procurement, compounding, quality control testing, dispensing, distribution, and monitoring of radiopharmaceuticals.

Additionally, a nuclear pharmacist provides consultation regarding health and safety, patient care, and the use of non-radioactive drugs.

To become a nuclear pharmacist you must graduate from pharmacy school, be a licensed pharmacist, and have a minimum 750 nuclear pharmacy instruction hours which includes 250 hours of classroom work and 500 hours of formal structured, supervised experiential laboratory coursework. Classroom work is largely done online through Nuclear Education Online, referred to simply as NEO.

Some advantages or disadvantages of nuclear pharmacy, depending on your preferences, include working weekends, night shifts, and taking call. A nuclear pharmacist does not directly deal with insurance companies and works behind the scenes of the general public.

A typical day for a nuclear pharmacist entails compounding radiopharmaceuticals. Compounding is performed in a sterile environment with aseptic technique. The process begins by ordering radioactive material from manufacturers to procure technetium-99m (Tc-99m), the primary isotope for imaging which comes in the form of a generator. Different drugs carry the purely diagnostic Tc-99m to distinct body organs to achieve a more dynamic analysis. Radiopharmaceutical compounding requires eluting the generator to obtain the Tc-99m and combining it with cold drug kits (vials), which are supplied by the manufacturer. A sample is pulled to perform quality control testing (Q.C.) which ensures that a sufficient amount of radioactive material (Tc-99m) is bound to the drug (cold drug). After the kit passes Q.C., the nuclear pharmacist verifies the correct dose is drawn from the proper kit. Once drawn, it is placed inside a lead lined tube that holds a single unit dose of radioactive material, known as a pig. The pig is checked for radioactive contamination and if clear of contaminants, placed in a carrying bag. A driver delivers the dose to the ordering hospital where a Nuclear Medicine Technologist, who placed the order, checks the label for the right drug and the amount of radiation in the syringe. Once the drug and amount of radiation is verified, it is administered to the patient and a scan is performed. Tc-99m is purely for diagnostic imaging, nuclear pharmacy does about 10% of dispensing with therapeutic isotopes.

In addition to compounding, a nuclear pharmacist is also responsible for monitoring radioactive material within the scope of our practice. The Department of Transportation, Nuclear Regulatory Commission, State Radiation Department, Federal Drug Administration, Occupational Safety and Hazard Agency, Environmental Protection Agency, and the Board of Pharmacy inspect and monitor nuclear pharmacy to certify execution of health and safety regulations. Throughout the year a representative from any of these agencies will audit nuclear pharmacy laboratories to determine the practices are in compliance with their license.

If you are interested in becoming a nuclear pharmacist most companies are willing to provide training. The major companies in the U.S. are Cardinal Health Nuclear Pharmacy Services, G.E. Healthcare, and Triad Isotopes; check the company websites for employment opportunities.

About the Author
Robert Kwan, PharmD, BCNP, is a Clinical Preceptor and Staff Pharmacist for Cardinal Health Nuclear Pharmacy Services. Dr. Kwan improves and promotes public health through the safe and effective use of radioactive drugs for diagnosis and therapy, servicing the Bay Area since 2007.
With health care reform focusing on cost, a predicted oncology workforce shortage, and an ever-growing level of complexity in chemotherapies, providing high quality services to cancer patients is indubitably a challenging yet rewarding pharmacy specialty.

Oncology pharmacists play an important role in the multidisciplinary team that assists in individualizing the best treatment plan for each cancer patient.

Oncology pharmacists are recognized as highly skilled clinicians, capable of practicing in a variety of acute, ambulatory care, and private settings, which include outpatient infusion centers, sterile compounding services, and investigational drug services. In explaining how to manage side effects from chemotherapy treatments, oncology pharmacists are able to allay patients’ fear and anxieties on the job. By using newer supportive care drugs, oncology pharmacists can help patients cope with their disease and treatment-related complications and maintain a better quality of life.

Prior to each treatment cycle, oncology pharmacists validate the physician’s orders, facilitate optimal drug dosing, avoid potential drug interactions, and ensure the safe preparation and timely administration of drugs to patients. By communicating with patients or attending rounds with the team, oncology pharmacists have the opportunity to provide drug information to oncologists, educate nurses, and at the same time, to assess efficacy of the treatment. By identifying chemotherapy errors, oncology pharmacists enhance patient safety. To promote the safe and appropriate use of oncology drugs, oncology pharmacists evaluate novel agents for formulary consideration and develop pre-printed chemotherapy order forms and usage guidelines.

Investigational oncology pharmacists play an active role as protocol reviewer on the Institutional Review Board; they also coordinate the acquisition, maintenance and distribution of drugs and provide drug information to the research and care teams on each approved protocol. Ambulatory care oncology pharmacists can help reduce drug
expenditures by working with insurance payers on pre-authorization of therapies, by identifying inappropriate prescribing practices and by improving patient compliance to oral antineoplastic agents with patient education.

Specializing in oncology pharmacy requires years of clinical experience and postgraduate training. Interested students are advised to take oncology electives during pharmacy school. Moreover, they should volunteer to shadow an oncology pharmacist to explore the field, get involved in local, state-based, national or international networks or oncology focus groups (Table 1) and find mentors who can be valuable sources of information and support.

Exposure to different practice settings helps individuals decide whether oncology pharmacy is the right path for them. Upon graduation from pharmacy school, students are recommended to complete a PGY1 residency program in general pharmacy practice and, subsequently, a PGY2 oncology specialty residency. This PGY2 program provides residents with advanced training in oncology pharmacy practices with an emphasis on patient care in various cancers, clinical research and education. After completing this training, residents gain sufficient experience and knowledge to practice independently as an oncology clinical specialist.

Practitioners who consider specializing in oncology will benefit from the growth of their knowledge in oncology based on hands-on experience. This involves attending courses and conferences, undertaking self-directed learning through websites, getting involved in professional networks, and pursuing opportunities to work in oncology settings. An excellent resource for clinical support is the Hematology/Oncology Pharmacy Association (HOPA), which provides an on-line discussion forum for its members. The Oncology Patient Care Traineeship program offered by the ASHP Research and Education Foundation also provides training to practitioners who have not completed a specialized residency in oncology and are developing or expanding their oncology services.

To obtain the designation of Board-Certified Oncology Pharmacist (BCOP), licensed pharmacists have to meet certain criteria such as spending more than 50% of their time in an oncology practice setting for at least four years or completing the PGY2 oncology specialty residency in addition to one year of practice in the field before they can take the comprehensive certification exam.

Each oncology pharmacist has a high level of job satisfaction in knowing that he/she can make a difference in patient care. Likewise, there is no greater gratification than seeing cancer patients in remission. Oncology is an exciting field that is intellectually challenging. Individuals need to be exceptionally self-motivated to be able to keep up in a constantly evolving field. For instance, a challenge for the oncology pharmacist arises whenever a drug that has insufficient data to support its use is ordered for an off-label use to treat cancer. This specialty is highly respected by our peers. In addition to cancer, oncology patients often have other comorbidities requiring the oncology pharmacist to manage their diseases with drug therapies. The demand for oncology pharmacist is growing as the role is expanding in providing disease and supportive care management in the next few decades.

### Table 1. Organizations with Oncology Resources

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<thead>
<tr>
<th>Organization</th>
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<tr>
<td>American Society of Health-Systems Pharmacists</td>
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<td>American College of Clinical Pharmacy</td>
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<td>Hematology/Oncology Pharmacy Association</td>
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<tr>
<td>International Society of Oncology Pharmacy Practitioners</td>
<td><a href="http://www.isopp.org">www.isopp.org</a></td>
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<tr>
<td>Board of Pharmacy Specialties</td>
<td><a href="http://www.bpsweb.org">www.bpsweb.org</a></td>
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<td>American Society of Clinical Oncology</td>
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<td>American Society of Hematology</td>
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<td>Multinational Association of Supportive Care in Cancer</td>
<td><a href="http://www.mascc.org">www.mascc.org</a></td>
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<tr>
<td>Oncology Nursing Society</td>
<td><a href="http://www.ons.org">www.ons.org</a></td>
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As an oncology pharmacist with the Board of Pharmaceutical Specialties since 2000, he currently practices as an Oncology Pharmacist at Huntington Memorial Hospital in Pasadena, California, where he developed and implemented pharmacy practice guidelines on the use of growth factors and collaborated with colleagues to develop pre-printed order forms including antimicrobrial therapy for neutropenic fever in cancer patients. He is a preceptor for the 3rd and 4th year pharmacy students and the primary preceptor for residents during their oncology rotations. Additionally, he regularly provides education to oncology nurses.

Florence H. Wong, PharmD, received her PharmD degree from the University of California, San Francisco, in 1987. She completed a general pharmacy practice residency at VA Medical Center Long Beach and went on to work for Owen Healthcare, Inc which later became Cardinal Health as Director of Pharmacy for almost 15 years. During this time, she served as Assistant Clinical Professor of Pharmacy for UCSF. In 2003, she joined the University of Southern California as Assistant Professor of Clinical Pharmacy and as Pharmacy Manager for USC Norris Comprehensive Cancer Center and Hospital in Los Angeles. In her academic role, she precepts pharmacy externs, 4th year clerkship students, and residents. She also provides didactic lectures in oncology topics to pharmacy students and education to oncology fellows. Her research interests include complementary and alternative medicine use in cancer patients. In her clinical role, she developed and implemented various best practices in oncology including the venous thromboembolism risk assessment and prophylaxis program in cancer patients.

About the Authors

David K. Yu, PharmD, received his PharmD degree from University of Southern California in 1989. He has practiced clinical pharmacy at a teaching hospital for 20 years, has served as an Adjunct Assistant Professor of Pharmacy Practice at University of Southern California since 1995 and as a Clinical Assistant Professor of Pharmacy Practice at Western University of Health Science since 2004. He has also been certified as an oncology pharmacist with the Board of Pharmaceutical Specialties since 2000. He currently practices as an Oncology Pharmacist at Huntington Memorial Hospital in Pasadena, California, where he developed and implemented pharmacy practice guidelines on the use of growth factors and collaborated with colleagues to develop pre-printed order forms including antimicrobrial therapy for neutropenic fever in cancer patients. He is a preceptor for the 3rd and 4th year pharmacy students and the primary preceptor for residents during their oncology rotations. Additionally, he regularly provides education to oncology nurses.
Please allow me to introduce myself; I am Dr. James J. Gasper, a psychiatric clinical pharmacist with San Francisco County’s Community Behavioral Health Services (CBHS). CBHS is the county mental health plan for indigent patients with severe mental illness or drug addiction. We serve about 25,000 patients at neighborhood based clinics throughout the city of San Francisco.

My job, as many clinical positions, is a blend of direct patient care, consultation, and formulary management. I also oversee a drug information service which offers consultation to our community psychiatrists and mental health providers.

In preparation for my current position, I obtained a Doctorate of Pharmacy degree followed by a PGY1 general practice residency and a PGY2 specialty residency in psychiatric pharmacy. Because the field is relatively new, many current practitioners have only completed a general practice residency with specialty experience occurring on the job. This approach often requires several years of practice to develop the same skill set derived from a specialty residency and therefore is less favorable to prospective employers. Another cohort or current psychiatric pharmacists have completed only a psychiatric specialty residency. This approach allows for specialty expertise but limits experience in dealing with the medical conditions (namely obesity, diabetes, dyslipidemia, and hypertension) that are pervasive in mental illness. For residency accreditation purposes, this “specialty only” track is no longer an option. Beyond residency, psychiatric pharmacy practitioners who have met the requirements may also apply for board certification. The specialty has been recognized by the Board of Pharmaceutical Specialties since 1992. Candidates for the certification exam must complete either a one year specialty residency plus one year of practice or four years of practice, primarily doing psychiatric pharmacy activities. Certification is another mechanism for ensuring competency above and beyond residency training.

There are a wide variety of settings in which psychiatric pharmacy activities occur including inpatient (acute care), outpatient, managed care, and government institutions. Academic, research, and regulatory roles are also possibilities. Primary responsibilities include evaluating neuropsychiatric disorders, developing medication treatment plans, initiating medication regimens, and monitoring for response or adverse effects. The setting often dictates the pharmacist’s responsibilities. For example, in the acute care psychiatric setting, pharmacists serve primarily as consultants, working collaboratively with a team of psychiatrists, nurses, occupational therapists, social workers, and case managers. The objective is to ensure that the most effective and appropriate combinations of medications are being used to a rapid response. A pivotal role provided by pharmacists in acute psychiatric care settings is to ensure continuity of medication treatment at discharge which is needed to prevent readmission. In the outpatient setting pharmacists work with an equally diverse mental health team; however, the goal is on achieving remission of symptoms and improving adherence. Pharmacists can see patients with medication issues by referral from a treating physician, serve as the primary provider of medication management, or to conduct medication groups for education and monitoring purposes.

Regardless of the setting or practice type, providing care for psychiatric patients is extremely gratifying. Effective treatment has a dramatic and often immediate impact on how patients feel, relate to others, and cope with life’s challenges. These observable benefits can be appreciated by pharmacy students and practicing pharmacists alike even in non psychiatric settings. The only need is to consciously engage their current patients with mental illness.

For more information about the specialty of psychiatric pharmacy please see the College of Psychiatric and Neurologic Pharmacists website at www.cpn.org.


About the Authors
Dr. Gasper is a Psychiatric Clinical Pharmacist and Coordinator of the Drug Information Center for San Francisco Community Behavioral Health Services. Dr. Gasper provides direct patient care at the San Francisco AIDS Foundation, Stonewall Project, treating adults with comorbid psychostimulant dependence and mental illness. Dr. Gasper also serves as an Assistant Clinical Professor (AFOS) in the Department of Clinical Pharmacy for the University of California at San Francisco.
There are numerous residency programs for pharmacy students to choose from if they wish to further specialize and advance their pharmacy career. Each residency program caters to a specific individual with particular interests and goals, which makes choosing a residency program a challenging task. In this model case, we follow the unique path of a resident through the Kaiser Permanente residency program.

Yong Kim, PharmD, is currently the Kaiser Permanente Ambulatory Care Pharmacy Supervisor overlooking ten Ambulatory Care programs at the Kaiser Permanente South Bay Medical Center. His success started during his years as an intern pharmacist at Kaiser Panorama City while he pursued his Doctor of Pharmacy degree at the University of California School of Pharmacy. His experience as an intern pharmacist, involvement with pharmacy organizations on the state and national level, and his post-graduate experience as a resident allowed him to learn the skills necessary to excel and advance his career.

The Tri-Central Pharmacy Practice PGY1 Residency Program offered by Kaiser Permanente is an American System of Health-System Pharmacists (ASHP) accredited general practice residency with an emphasis in clinical pharmacy. The “Tri-Central” aspect of this residency program allows the resident to experience different Kaiser Permanente facilities around southern California, including Baldwin Park, Downey, and the South Bay. This all-encompassing component is a unique aspect of the program, allowing the resident to see different perspectives of each facility and how they all work to achieve a common goal.

Rather than focusing on one aspect of pharmacy, this program provides the resident an opportunity to experience the three main aspects of being a clinical pharmacist: inpatient, outpatient, and ambulatory care. The resident is extensively trained for approximately ten weeks at each aspect. During the inpatient rotation, the resident rotates throughout various floors and units within the hospital. A unique component of the inpatient rotation allows the resident to choose which hospital facility they want to train at or a specific floor or unit they have a particular interest in. For example, the Downey facility offers a neonatal Intensive Care Unit (ICU) rotation, which is a rare experience. If neonatal ICU is your particular interest, you can choose to spend the majority of your inpatient rotation at this site. In other words, the residency program caters to the resident’s interest, and allows the resident to focus on their career goals.

The outpatient rotation also offers a unique management training experience. Residents are challenged with various projects, including the establishing and developing a new outpatient pharmacy facility. The resident is involved in the setup,
inventory planning, and pharmacy equipment installation, all of which are important to maximize the workflow of an outpatient pharmacy. In addition, the outpatient rotation trains the resident on the duties of a pharmacy manager, which encompass staffing, budgeting, and administrative duties in order to maintain a successful outpatient pharmacy. The ambulatory care rotation offers a wide variety of ambulatory care clinics to choose from, including renal, cardiovascular disease, oncology, infusion, chronic heart failure, and anticoagulation. Extensive training is offered at each ambulatory care site, which further enhances the resident’s direct patient care skills.

There are some notable advantages unique to the Kaiser Permanente Tri-Central Pharmacy Practice Residency program. The first advantage, as mentioned before, is that it is very flexible and accommodates to the resident’s interest. Residents can choose to allot their time during the residency to focus on particular clinical and therapeutic areas of interest. Another advantage of the program is that it focuses more on learning and gaining advanced skill sets. Lastly, this program offers unique ambulatory care experiences that may not available through other residency programs. For example, there are Medication Therapy Management (MTM) clinics, New Member Program Clinic, Neonatal ICU, and Pain Clinic that are exclusive to the program.

There are also some limitations to this residency program. Although the program allows for numerous rotations in various pharmacy settings, there is no advanced staffing experience offered. In other words, the residents are not intensively trained at a single aspect of pharmacy, but rather are exposed to the bigger picture of how pharmacists play a role in various settings within the Kaiser Permanente system. Another limitation to the program could be the block scheduling of rotations, which may not allow the resident to get an in-depth view of patient care at each practice setting.

In the model case, Dr. Kim utilized his residency to help him network with key individuals at Kaiser Permanente. He was also able to explore various pharmacy practice settings within the Kaiser system, which helped to open up doors to countless career paths. Currently, Dr. Kim is the ambulatory care pharmacy supervisor in the South Bay area overlooking ten ambulatory care programs.

This is just one example of numerous pharmacy practice residency programs that are available to pharmacy students today. Each residency program affords the pharmacy student different experiences and it is up to the student to determine which program best suits their immediate needs to fulfill their future career goals.

About the Author

Tim Chou is a 2012 PharmD Candidate at the University of Southern California School of Pharmacy. He is involved with CPhA, AMCP, SLA, Alpha Iota Pi Professional Pharmacy Fraternity, and a current intern pharmacist at Kaiser Permanente East Los Angeles.
The VALOR program is a pre-residency program for student pharmacists interested in hospital-based practice. The program is designed to develop skills in clinical practice, critical thinking and analysis, research design, communication and leadership.

Candidates must be willing to commit to a one-year program correlating with their last year in pharmacy school. The intent of the program is to provide advanced training and experience to better prepare student pharmacists interested in pursuing a residency program and a career in hospital pharmacy practice.

**Description of the Program**

The VALOR program is a national pre-residency program for pharmacy interns during their rotational year. The program is targeted towards individuals interested in a career in hospital-based pharmacy practice, either in the inpatient or ambulatory care setting. The VALOR program does not replace the Advanced Pharmacy Practice Experience (APPE) that schools of pharmacy provide at clerkship sites; rather, the program is meant to augment that experience and provide advanced clinical exposure to pharmacy practice. Various VA facilities participate in the VALOR program across the country; however, each program varies in length of commitment and focus.

The VALOR program at the VA San Diego Healthcare System (VSDHS) is a year-long program, beginning the summer just prior to the start of clinical rotations. The application period begins each January, and submissions are due in March. Only those candidates qualifying for interviews are invited for an on-site visit, which is conducted in April.

The primary intent of the VALOR program is to prepare individuals for a successful residency experience and possible future career within the VA system. To that end, the program is very selective of candidates based on their potential to develop professionally as clinicians and as leaders in pharmacy. The VSDHS program focuses mainly on the inpatient care setting; however, facets of specialized practice such as oncology, emergency medicine, infectious disease, spinal cord injury and pharmacy administration are incorporated into the program based on the intern's areas of interest. The program is conducted based on a series of modules utilizing a systems-based approach.

Upon completion of the program, interns will be able to clinically assess patients and perform disease management activities, dose patients based on pharmacokinetics, conduct patient assessment and discharge interviews and be proficient in providing presentations. The intern will also complete an original research project with the goal of presenting a poster at a state or national pharmacy meeting and will also participate in various medication safety and/or quality assurance projects throughout the year. The intern is also encouraged to participate in pharmacy organizations at the local or state level to further develop their leadership skills.
Resource Requirements

VALOR interns are federal employees under the Department of Veteran Affairs and receive a competitive hourly salary.

Description of Anecdotal and Measurable Successes

The pharmacy VALOR program was implemented in 2007, and VASDHS was fortunate to be one of the first sites selected to offer the program. Since then, all VALOR graduates from VASDHS have successfully matched into very competitive PGY1 residency programs in California and Oregon, with the majority of individuals garnering their first choice. Twenty-five percent of the graduates have also pursued a PGY2 program, specializing in critical care, emergency medicine and oncology.

“VALOR was my first exposure to the emergency department and was the reason why I developed my own ED rotation as a resident and have started working as an ED pharmacist.” — Jennifer Lai, VALOR Class of 2009

Carol Huang, VALOR Class of 2010, is currently a PGY1 Pharmacy Practice Resident at VASDHS. When asked about the strengths of the San Diego VALOR program, she stated, “The VALOR program has developed my clinical, technical and critical thinking skills and provided me with a strong foundation in diverse patient areas.” The clinical training obtained through the VALOR program focuses on applied learning. Their patients are no longer textbook examples; they have non-standard doses, hidden drug-drug interactions and other challenges that need to be addressed, and the interns are given the task of identifying, assessing and solving these problems as part of their training.

The VALOR program at VASDHS is meant to be demanding in order to prepare interns for their residency training. Sophia Pak is a VASDHS VALOR graduate from the Class of 2008 and is currently employed as an infusion center pharmacist for Kaiser Permanente in Los Angeles. When she was asked to describe what she had gained from the program, she replied, “The program challenged me to work hard and manage time well, which also helped me to prepare for the rigors of life as a (pharmacy) resident.”

VASDHS has been successful in developing a program that is both rigorous in its clinical content and purposeful in cultivating both professional and leadership abilities. The purpose of the VALOR program is not only to prepare individuals to become excellent clinicians but also to prepare them to become the mentors and leaders of tomorrow.

Limitations of the Program, if Any

The number of VALOR positions available each year depends on funding availability allocated by VA headquarters. Typically, VASDHS is granted four (4) VALOR positions each year.

Legal or Regulatory Requirements of the Students Entering the Program

Because this is a federally funded program, candidates applying for the VALOR program must be U.S. citizens.

Future Plans and Direction

As the program continues, there are plans to formalize a mentoring program with VALOR alumni from VASDHS. As summarized by one graduate, “In addition to the incredible, high caliber learning opportunities available through the San Diego VALOR program, another aspect that I enjoy is that we are a family. As an alumna, I have gotten to know, mentor and precept other VALOR interns since completing the program, which is a very rewarding feeling. I will always reflect fondly on my time as a VALOR resident and get excited as I see the program improve and become stronger with each passing year.”

About the Author:

Dr. Helen K. Park is the Director of Inpatient Pharmacy and VALOR Coordinator at the V.A. San Diego Healthcare System. She also serves as an Adjunct Clinical Professor for the University of the Pacific TLJ School of Pharmacy and UCSD Skaggs School of Pharmacy and Pharmaceutical Sciences.
Goals:
The goals of this lesson are to review USP’s contributions to the provision of information supporting rational therapeutic decision-making and safe medication use, focusing on the general topic of drug information and use standards.

Learning Objectives:
At the conclusion of this lesson, successful participants should be able to:
1. Recognize the role USP has played in providing drug information.
2. Describe new opportunities that USP is exploring for drug information and use standards.

Introduction
As a standards-setting organization for medicines and other healthcare articles, the United States Pharmacopeial Convention (USP) has contributed broadly and deeply to the provision of information supporting rational therapeutic decision-making and safe medicine use. USP’s Council of the Convention Section on the Quality of Patient Care provides a situation analysis of these and allied contributions, focusing on the general topic of drug information and use standards. Standards generally apply to people, processes/practices, and/or products. USP now provides an extensive array of product standards for drug and food articles in the United States Pharmacopeia (USP), National Formulary (NF), Food Chemicals Codex (FCC), and allied compendia. These product standards support testing to assure identity, strength, quality, and purity of foods and...
These product standards support testing to assure identity, strength, quality, and purity of foods and drugs.
a “large share” of healthcare web portal and hospital web site segments with USP DI branded content. However, changes in some state pharmacy regulatory requirements in 2001 resulted in a sharp decline in the number of pharmacies ordering the product. In addition, the chain pharmacy market was demanding a single vendor for all electronic solutions, which the Thomson USP DI could not provide. USP and Thomson explored a variety of strategic options over the next few years, but ultimately it made the most financial and operational sense for USP to exit the business completely.

In 2004, the USP DI Volume I and Volume II became the responsibility of Thomson Healthcare. Under the agreement, Thomson could edit, create content, and publish these texts under the USP DI name until the 2007 edition, after which Thomson’s right to use the name ceased. USP DI Volume III continued to be owned in its entirety by USP. Thomson continues the USP DI product under the name DrugPoints.

Many other entities have provided drug information in various compendia to support sound therapeutic decision-making. An analysis of these types of compendia appeared in a series of three articles earlier this year in the Annals of Internal Medicine; a summary editorial references the three articles.1 Overall these articles and summary editorial are generally critical of the various compendia in terms of their currency, consistency, and other factors.

3. Model Guidelines

The Medicare Modernization Act (MMA) of 2003 defines the role of USP (Section 1860D-4(b)(3)(C):

(ii) MODEL GUIDELINES – The secretary shall request the United States Pharmacopeia to develop, in consultation with pharmaceutical benefit managers and other interested parties, a list of categories and classes that may be used by prescription drug plans under this paragraph and to revise such classification from time to time to reflect changes in therapeutic uses of covered part D drugs and the additions of new covered part D drugs.

In addition, Section 1860D-11(c)(2)(D) creates a “safe harbor.”

(iii) USE OF CATEGORIES AND CLASSES IN FORMULARIES – The Secretary may not find that the design of categories and classes within a formulary violates clause (i) if such categories and classes are consistent with guidelines (if any) for such categories and classes established by the United States Pharmacopeia.

With this legislative mandate and on behalf of the Secretary of the Department of Health and Human Services, the Centers for Medicare and Medicaid (CMS) awarded USP a cooperative agreement to develop and revise the Part D Prescription Drug Benefit Model Guidelines. A new Model Guidelines Expert Committee was formed to accomplish the task. While the MMA did not specify the frequency of updates to the Guidelines (“... from time to time...”), the Expert Committee and CMS agreed that an annual update was appropriate given the rapidly evolving nature of pharmaceuticals. Version 1.0 was a large effort, involving a review of how other formularies are categorized and presented.

At its highest usage (2006), 74% of health plans were using the USP Model Guidelines (Version 1.0). The Model Guidelines Categories and Classes provided a formulary structure that helped ensure beneficiary access while preserving needed flexibility for pharmacy benefit managers (PBMs) and health plans. USP developed an additional component to the Model Guidelines: Formulary Key Drug Types (FKDT), which offered additional protection for beneficiaries and a useful tool for CMS in reviewing formularies.

Although not mandatory, the FKDT have been utilized by CMS as part of its Formulary Review Guidance, and serve as standards that promote consistency, fairness, and ease of administration. Usage of the Model Guidelines lessened in subsequent years, primarily due to plan consolidation and a broader use of internal classification systems due to plans’ comfort with the CMS process. Nevertheless, the guidelines contributed substantially to the availability of a comprehensive, yet affordable, benefit. As with all its standards, USP actively solicited and welcomed participation and input on Guidelines development from interested stakeholders, including manufacturers, drug plans, practitioners, and patients. USP’s experience with the Model Guidelines was summarized in a report published in Annals of Internal Medicine in 2006.2 Its work on behalf of the Federal government followed a primary activity where USP participated in a consortium of interested organizations to produce a document entitled “Principles of a Sound Drug Formulary System” (2000).3

By 2008, CMS decided that the Guidelines had achieved a significant level of success and stability. Based on this, USP and CMS agreed to move from an annual revision timeline to a three-year cycle. CMS continues to use the current Model Guidelines and FKDT through plan year 2011, and USP is maintaining the current versions on its web site. The goal is for USP to start work on Version 5.0 in 2010.

Exploration of New Opportunities

1. Drug Information Consultations

In 2005 and again in 2006, USP convened special meetings, called Drug Information Consultations, where individuals and organizations gathered to discuss the feasibility and advisability of developing practice standards associated with drug information. In these meetings, USP sought a clear understanding of the current gaps in
drug information and where its standards-setting expertise might be used to augment information used by practitioners, plans, and patients in decision-making about rational drug use. At the time of these meetings, USP was engaged in the development of Model Guidelines for the Medicare Prescription Drug Benefit and was considering how that activity might also be supported with additional drug information for the healthcare community. Despite a number of useful suggestions from a broad range of participants, these consultations did not generate any specific activity (notes of meetings are available). A Board Task Force (2005-2010) was formed to monitor USP’s interests in the topic.

2. Applied Drug Information Resource

Working with the American Medical Association, the American Nurses Association, and the American Pharmacists Association, USP led a series of meetings that explored the concept of an Applied Drug Information Resource (ADIR). The general idea for the ADIR was to advance “personalized medicine” concepts, in which general information about a medicine would be adjusted by patient-specific characteristics. The product would yield information directed to diverse practitioner and patient constituencies. The opportunity did not progress.

3. Comparative Effectiveness

Comparative effectiveness (CE) studies of specific treatment approaches—including various pharmacotherapies, lifestyle changes, imaging procedures, and surgical interventions—have great current and potential value. They add to the body of knowledge that helps health care practitioners, as well as patients and their families, make treatment decisions. The infusion of funds (through the American Recovery Reinvestment Act of 2009, also known as the “Economic Stimulus” Legislation) that will support additional research is a welcome development. The bill provides $1.1 billion for CE research:

- $300 million to the Agency for Healthcare Research and Quality (AHRQ).
- $400 million to National Institutes of Health (NIH) and
- $400 million to the Department of Health and Human Services (DHHS).

Observations about this funding that are relevant to USP include:

- Organizations can make proposals for CE project funding (the process is still being determined by agencies).
- According to the conference report, funding is not to be used to mandate coverage decisions, but instead is for generating useful research comparing clinical outcomes.
- The law also establishes the Federal Coordinating Council for Comparative Effectiveness Research, made up of high-level government officials, for the purpose of coordinating healthcare research across the Federal government.
- IOM has engaged the community in a better understanding of the types of CE studies needed.
- AHRQ has conducted workshops and engaged in other tasks to generate evidence-based information and engage the community in understanding how database analyses can generate useful CE information.

CE studies per se will be valuable and must, more frequently, become one of the inputs used by practitioners and patients to guide therapy following diagnosis, despite the fact that CE is sometimes linked in public discourse to rationing of healthcare. Diagnosis and treatment can be aided by development of a treatment model—captured and presented as a generally applicable set of process standards—that addresses key aspects of the decision-making process that are often considered in an ad hoc fashion, if at all. In turn, these process standards support treatment programs (protocols) to guide the practitioner and patient/consumer alike. These treatment programs themselves are also process standards that are frequently lacking for the individual patient when he or she leaves the immediate healthcare provider's setting.

4. Pharmacotherapy Guidelines

Comparative Effectiveness results could be put into action through extended pharmacotherapy treatment standards. USP could serve as a convenor of organizations to 1) develop an innovative, multidisciplinary, patient inclusive approach for integrating CE research study outcomes into pharmacotherapy standards/guidelines—treatment program standards—and 2) apply this approach to two separate, established, model standards or guidelines for particular disease treatments.

Aspects/features of the approach include:

- AHRQ-funded evidence-based studies, including CE studies.
- Conferences and Webinars.
- Disease/condition candidates for which a wide range of treatment therapies exist, the cost of therapies varies widely, and which are part of a discrete patient population that would be affected.

In all cases, transparency of work would be emphasized, partners would represent the interdisciplinary health care team (including patients and payors), and USP committees and members would be part of the process.

5. Specialty Medicines

Specialty medicines are the product of innovative technologies (often, but not solely, biotechnology engineered molecules) that target unmet medical needs and are expensive because of limited patient populations, high cost of manufacture, and the increased risk and cost of development programs. In addition, the forced evolution of the pharmaceutical industry business model from reliance on historically successful but fading "blockbusters" to larger numbers of innovative specialty medicines requires higher prices to fuel growth.

Exacerbating the cost problem is that, as a consequence of structural and financial realities in the approval process and the costs and risks of development, these medicines are often used for unapproved indications for which evolving data sets are suboptimal when compared with data supporting their use in approved indications. Such use is generally for chronic, inadequately treated diseases with high morbidity and mortality, creating compelling demand for utilization and making it difficult to deny access. Access may seem arbitrary, depending upon the sophistication of the practitioner and patient in confronting the payor, which contributes to a growing sense of unfairness.

The payment for these medicines varies considerably among plans. Medicare covers specialty pharmaceuticals under Parts B and D, depending upon seemingly unrelated factors, including the route and place of administration. Therefore, care may be driven by reimbursement rather than clinical considerations. Both private and public (Medicare) payors use tier structures (essentially a cost shift to patients) to reimburse for these medicines. Since Medicare Part B (and most private plans) lacks out-of-pocket maximums and these medicines can cost tens of thousands of dollars per year, they are simply unaffordable for many under the current system.

To effectively allocate scarce health care resources, standards are needed to support rational therapeutic use of specialty medicines. These standards are now left to individual pharmacy and therapeutics committees, their health plans, and/or individual practitioner and patient decision-making. The question arises whether a
national process could lead to standards to better inform these decisions.

The sensitive and inevitably controversial nature of these standards requires that this process be inclusive, transparent, and objective. USP possesses a structure and history that uniquely position it to achieve these objectives.

6. Information Standards

USP’s Information Expert Committee chairs have advocated that USP provide information standards rather than the information itself. Such standards would serve as a framework within which others could create information. This concept relates directly to USP’s standards-setting and practitioner-based character and links the quality of patient care to the quality of the information used by healthcare professionals and patients. Examples of information standards (as distinct from information) could include the adequacy of research study design, methodology, analysis, and communication of results. Other standards could include:

- Linguistic competency for verbal or aural messaging and comprehension targeted at specific audiences, e.g., level of language used, languages available, visual depictions, words presented per minute.
- Cultural sensitivity in messaging: ethnicity, gender, age, etc.
- Ethics in targeting vulnerable populations: elderly, children, terminally ill.
- Competency in decision-making: use of duress, undue influence, physical and mental capacity, etc.
- Patient–provider relationships and conflicts of interest.
- Direct to patient advertising: “free” samples.
- Requirements for post-regulation marketing surveillance.

7. National and International Approaches

Through its Essential Medicines List, the World Health Organization (WHO) has sought to provide a limited list of medicines to decrease inappropriate prescribing and promote rational use. The WHO Essential Medicines List is used by many nations throughout the world to create national formularies that expand and/or contract the WHO list to meet local needs. In principle, USP’s Model Guidelines provides a “table of contents” for a U.S. national formulary. Combining the approach with the AMA-DE in evaluating individual medicines within each category and class of the Model Guidelines further supports a U.S. national formulary, which does not now exist. The opportunities and challenges of such an approach are generally well known. An essential medicines list speaks to the best medicines within a country, region, or even the globe. In this context, it speaks to official medicines in the United States Pharmacopeia, which were always intended to be the best medicines. The National Formulary in the United States provided quality standards for non-official medicines. It was adopted by USP in the 1970s and has evolved into a book of excipient monographs. A seminal paper by
In the current state of healthcare reform and crisis, it may be time to call upon USP again.

T. Donald Rucker, Ph.D., argued that USP should advance a “true” national formulary in the U.S.

Summary
At the outset, this article asked the following questions:

■ In an era of health care crisis and reform, what are societal needs for drug information and use standards to support rational therapeutic decision-making?

■ If these needs can be defined and USP, by virtue of its structure and history, can uniquely fulfill them—with availability of adequate resources—does it have a responsibility to do so?

The U.S. Federal government has turned to USP’s standards-setting activities and expertise on many occasions over more than 100 years, not only when it recognized USP and NF as official compendia of the United States, but also for purposes of reimbursement on two occasions and, more recently, to assure beneficiary access in the Medicare Part D legislation. In these cases, USP was recognized as a trusted, neutral organization that could bring together diverse stakeholders and make objective, science-based decisions through an open and transparent process. In the current state of healthcare reform and crisis, it may be time to call upon USP again. There is a deep logic, expressed in many countries over many years, for governments to seek non-governmental practitioner experts to achieve a public health good, such as drug information and use standards. But even if the U.S. Federal government does not turn to USP at this juncture, this does not mean that USP should not act. While USP has a need for sufficient financial resources to set drug use and information standards, it has access to the greatest resource of all: a cadre of healthcare experts from around the world who have, can, and could set, through activities of the Council of Experts, drug information and use standards in ways that would speak profoundly to patients and practitioners in a time of great need. The Council of the Convention Section on the Quality of Patient Care seeks creative thinking about a strengthened role for USP in setting drug use and information standards.

Comments on this white paper may be submitted to CoC@usp.org.

About USP and NASPA
The United States Pharmacopeia (USP) is an official public standards-setting authority for all prescription and over-the-counter medicines and other health care products manufactured or sold in the United States. USP also sets widely recognized standards for food ingredients and dietary supplements. USP sets standards for the quality, purity, strength, and consistency of these products—critical to the public health. USP’s standards are recognized and used in more than 130 countries around the globe. These standards have helped to ensure public health throughout the world for close to 200 years. More information can be found at www.usp.org.

The National Alliance of State Pharmacy Associations (NASPA) promotes leadership, sharing, learning, and policy exchange among state pharmacy associations and pharmacy leaders nationwide, and provides education and advocacy to support pharmacists, patients, and communities working together to improve public health. NASPA was founded in 1927 as the National Council of State Pharmacy Association Executives (NCSPAE). More information can be found at www.naspa.us

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About the Authors
Kalen Dunican is an assistant professor of pharmacy practice at Massachusetts College of Pharmacy and Health Sciences School of Pharmacy-Worcester/Manchester. She received both her BSPharm and her PharmD from MCPHS- Boston in 1996 and 2006 respectively. She coordinates the Professional Pharmacy Practice Lab and the Self Care Therapeutics course; she has also developed an elective course in self care. Dr. Dunican maintains practice sites with both CVS and Rite Aid Pharmacies and precepts advanced community pharmacy students at these locations. Dr. Dunican is a certified immunizing pharmacist and self care advisor.

Kelly Orr, PharmD, is a Clinical Associate Professor at the University of Rhode Island, College of Pharmacy. She serves as a course coordinator and lecturer for the 3-credit required Self Care 1 course and elective, Self Care 2. In regards to self care, Dr. Orr has published articles on evidenced based use of vitamins, pediatric use of nonprescription drugs, emergency contraception, and virtual patients in self care teaching. Dr. Orr co-authored the Natural Products chapter for the APhA Handbook of Nonprescription Drugs, 16th edition. She also serves as a member of the Nonprescription Medicines Academy (NMA). Steering Committee. In addition to self care responsibilities, Dr. Orr is coordinator and lecturer for the pulmonary therapeutics classes. Her teaching and practice interests are the areas of smoking cessation and asthma management, also obtaining the National Asthma Educator Certification (AE-C).

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Opportunities for Drug Information and Use Standards

1. USP provides an extensive array of product standards for all of the following except:
   a. National Formulary
   b. Food Chemicals Codex
   c. Allied compendia
   d. They provide for all of the above

2. Who produced the first Dispensatory of the United States of America (USD) in 1832?
   a. George B. Wood
   b. Franklin Bache
   c. A+B
   d. None of the above

3. When was the last edition of the USD published?
   a. 1973
   b. 1983
   c. 1993
   d. 2003

4. Which volume of the USP Drug Information resource (USP DI) is Drug Information for the Health Care Professional?
   a. 1
   b. 2
   c. 3
   d. 4

5. Which volume of the USP Drug Information resource (USP DI) is Advice for the Patient?
   a. 1
   b. 2
   c. 3
   d. 4

6. Who launched the USP DI Desktop Series CD ROM?
   a. Thomson Healthcare
   b. Carepoint
   c. American Medical Association
   d. Medicare

7. The highest usage of the USP Model Guidelines was in 2006, representing what percentage of health plans?
   a. 70%
   b. 72%
   c. 74%
   d. 76%

8. Which of the following is true regarding the Formulary Key Drug Types (FKDT)?
   a. It offers no additional protection
   b. It was established prior to the Model Guidelines
   c. It is mandatory
   d. It has been utilized by CMS

9. Which association(s) did USP work with to lead a series of meetings to explore the concept of Applied Drug Information Resource (ADIR)?
   a. American Nurses Association
   b. American Medical Association
   c. American Pharmacists Association
   d. All of the above

10. The American Recovery Reinvestment Act of 2009 provided which of the following?
    a. $300 million to National Institutes of Health
    b. $300 million to the American Medical Association
    c. $400 million to Department of Health and Human Services
    d. $400 million to Agency for Healthcare Research and Quality

11. Medicare covers specialty pharmaceuticals under:
    a. Parts A and D
    b. Parts B and D
    c. Parts C and D
    d. Parts B and C

12. Who is responsible for the Essential Medicines List?
    a. United States Pharmacopeia
    b. Food and Drug Administration
    c. World Health Organization
    d. Agency for Healthcare Research and Quality

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How do you rate this course? (Excellent) 5 4 3 2 1 (Poor)

Did this article meet its stated objectives? yes no

Was the material biased in anyway? yes no

Comments/future topics welcome.

Name:

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The contributions of pharmacists throughout history are legendary. Many famous pharmacists have been honored and decorated for their contributions to society – most of them for deeds and offerings other than pharmacy.

The first professional pharmacies were probably in Baghdad in the 13th century. Modern pharmacies developed in the 18th century. And by the 21st century, pharmacies resembled 13th century markets and bazaars.

Many famous people got their start in a pharmacy, either as a pharmacist, chemist, apothecary, assistant, apprentice, clerk or owner.

Before Ben Franklin became a famous printer and author, he was a clerk selling herbs and medicines. He must have been selling vitamins, too, because in Poor Richard’s Almanac he came up with, “An ounce of prevention is worth a pound of cure.” How many times have we said that when we counsel a patient at the front counter? We can certainly see how, “This one pill a day keeps the doctor away,” became his famous, “An apple a day …”

At the end of the 13th century, Dante joined a Florentine apothecary guild. He certainly didn’t do that so he could renew his chariot license. Was he dispensing drugs, too? Maybe Dante’s Inferno had more to do with the consequences of taking more than the prescribed dose than it did with his encounters in the afterlife.

In 1881, William Porter (whom we know as O. Henry), was, at 19, a licensed pharmacist in North Carolina. That was before he went to prison for embezzlement and before writing all those famous short stories, including, “The Gift of the Magi.” No doubt an idea he got in the drugstore when a young woman didn’t have enough money to pay for her prescription!

Every wonder why Agatha Christie goes into such detail with all the poisons in her various mysteries? She worked in a hospital pharmacy during both WW I and II, probably as a pharmacist assistant. There is no doubt in my mind that the original title of one of her most famous stories was “Murder and the Over-the-Counter Event.”

Now most pharmacy schools never mention it, but Benedict Arnold owned an apothecary shop in New Haven, Connecticut, before the Revolutionary War. Was he really a traitor? Maybe, but since when does anyone make such a big deal about switching wholesalers during a pricing war? Obviously, the old established British offered something like cost less 1%, instead of the new upstart Americans with only cost less ½%.

Norwegian playwright Henry Ibsen and US Vice President Hubert Humphrey were pharmacists. Sir Isaac Newton was an apprentice. Other influential pharmacists included Friedrich Serturiner, who discovered morphine; Herbert Haft and Paul Beiersdorf became industrialists; and Cornelius Jadwin, Oscar Rennebohm, George Ryan, and Harve Tibbott became congressmen and governors. You will notice that I did not include my name in this list of famous pharmacists. (No need to complain or write in, as this was done intentionally.) I wanted the names of these distinguished pharmacists of the past to sink in. I felt that if I were included it would diminish their importance.

Pharmacists were responsible for many retail innovations such as the concept of franchising and the shopping cart. However, this article is about opportunities in pharmacy and there is one major category – one major pharmacy career specialty – that has been overlooked and is rarely mentioned in discussions of famous or influential pharmacists. That career specialty is recognized by almost every American and every citizen in each developed nation in the world, and overlooked pharmacists Bradham, Pemberton, Hires, Alderton, and Vernor are rarely, if ever, mentioned.

What is this lost pharmacy specialty? Soft drinks. Pharmacists invented the modern soft drink industry: John Pemberton invented Coca-Cola; James Vernor invented Vernor’s ginger ale; Charles Hires was responsible for Hires Root Beer; Charles Alderton created Dr. Pepper; and Caleb Bradham invented Pepsi-Cola. A pretty impressive list of nobodies – don’t you think?

In 1876, Philadelphia pharmacist Charles Hires (1851-1937) developed and was marketing a 25-cent packet of powder, which yielded five gallons of root beer. I wonder what was in the under-the-counter 50-cent bag? At any rate, by 1884 he began producing liquid extract and syrup for soda fountains. By 1890, Hires began supplying Hires Root Beer in small bottles. Hires promoted his drink as “the greatest health-giving beverage in the world” and began advertising aggressively. He believed that “doing business without advertising is like winking at a girl – in the dark.”

Confederate veteran and pharmacist John Pemberton (1831-1888) developed his drink, Pemberton’s French Wine Coca, in 1886 while working behind the counter at a drugstore in Columbus, Georgia. It probably started out as “a little something” to carry him to the end of his shift. On May 8, 1886, Coca-Cola, the non-alcoholic version, was on sale at the soda fountain at Jacob’s Pharmacy in Atlanta for 5-cents a
Dr. Pepper, or was it named after a tonic served at the drug store — “D Peppers Pepsin Bitters?” Those old guys really had a flair for marketing, didn’t they?

So, when thinking about a future in pharmacy, don’t forget that pharmacists have the power to change the world. And if and when you’re tired and run down, grab a soft drink — look at it -- you are holding our history in your hands. And if you are really clever and smart -- you could be holding our future too.

Disclaimer — Although this article contains considerable factual material, some liberties have been taken with people, historical events, and/or conversations. Unlike our current news and media coverage of political events; the truth in this article is easier to find and understand. However, since our profession is so paranoid, the CPhA is afraid to represent any of the views presented or reach for the validity of anything in the article. The descriptions might be exaggerated a little but they are actually real and mostly factual. Lastly, the CPhA and the editorial staff are just as surprised as you are that this article is actually backed by research, facts, and intense cerebral involvement — some of it by me.

Reader Comments
“I can see Russia when I drink Coke,” former Alaska Governor, Sarah Palin

“Barry, will vodka be undetectable in your new soda?” performer with an alcohol detection bracelet, Lindsay Lohan

“I paid cash for everyone of my free Pepsis,” former USC running back Reggie Bush

“If you add vitamins to your new soda I will add it to the Healthcare Bill,” President Barack Obama

About the Author
Famous and loved pharmacist
Barry Pascal owned Northridge Pharmacy for 32 years and is now retired. He was the Honorary Mayor of Northridge from 2003 to 2005 and the Honorary Sheriff from 2005 to 2008. Even though he no longer holds honorary political positions he would like all to know he still accepts invitations to any and all free dinners. Pascal has written seven comedy books, and, in addition to this journal series, writes a humorous monthly newspaper column. At least that is what it is supposed to be.
As I am approaching my 90th birthday, I suppose it is normal that I find myself thinking about the past and particularly those portions of the past that I was involved as a participant. Additionally, I have found it troubling that so much of what happened appears to have been lost to the present generation. And I am seeing accounts written of what had happened that I know are not correct. Many of those accounts were by well-intentioned people who were given incorrect information.
I want to make it clear from the start that this is written from memory and not from reference material. It is information that I was either involved with or happened during my days in related fields and was known to me. As such, I take full responsibility for its contents.

Also I find that many of the present generation are not interested in what happened in the past and how their present fields of endeavor started and developed. It has always seemed to me that knowledge of the history of one’s chosen field has to be of importance in guiding its growth for the future. Knowledge of the past helps both present and future planning and decisions.

I was both involved in and, to a great degree, responsible for the creation and development of prescription drug plans in the 1960s.

There is a lot of history that has not been adequately described and saved for those that come later. Knowledge of that history can and will help in understanding what has happened and will aid in not repeating mistakes that were made in the past.

It is not my intention to make this an academic quality work but to furnish enough information to understand what happened and why.

Part One

A third party payer as it relates to health care is someone other than the patient who pays the bill.

It is certainly a simple concept and yet it was not widely seen until after World War II. There was a wage freeze during that war imposed by the government and labor unions were not able to negotiate for increased wages for their members. However, benefits were not restricted and they were the focus of labor unions during negotiations with the employers. Most of these benefits translated into so many cents per hour and the benefits received by the employees reflected what could be purchased for that amount of money. Specific benefits were spelled out in these labor contracts and these included hospitalization, medical, dental, vision, and prescription drugs.

With each new benefit, the employee found that someone else was paying for all or part of the cost. As each of the major labor unions negotiated these benefits, there was a surge in the number of employees that were receiving some of these benefits. This caused a major impact on many areas involving the delivery of healthcare and its related organizations.

The early health service plans for hospital and medical benefits started in the 1930s when the states passed enabling legislation that allowed first hospitals to form nonprofit service plans and then physicians to form nonprofit service plans.

These were mainly Blue Cross plans for hospital benefits and Blue Shield for physician benefits. These individual plans were organized in each state and were for a specified geographical area. Some were statewide and others for smaller areas.

Each plan had its own list of benefits and reflected local needs. The existing problem of a covered member obtaining benefits when the member was in a different plan area was first addressed by Blue Cross. The Blue Cross Association formed a clearing house whereby local Blue Cross plans could provide benefits for members of other Blue Cross plans when not in their home area. This gave Blue Cross members the ability to use their benefits when not actually in their home area.

In addition to these early health service plans, several areas of the country saw consumer sponsored comprehensive health plans. These plans, now called HMOs, were mainly nonprofit and were also supported by organized labor. These included HIP and GHI, both of which recently changed to a for profit status, among others. Kaiser Permanente had its roots in the Kaiser Shipyards during World War II and now is available in many areas of the United States.

Other such comprehensive plans were formed in different local areas. The plans by the dental associations were called Delta Dental. The nonprofit service plans provided specified benefits on what was called Community Rating. This meant that everyone covered paid the same premium.

The insurance companies were anxious to protect their relationship with their clients, both in corporate accounts and in groups, such as associations, etc. There was concern that they might lose the pension and other insured plans if they let other insurers or health plans cover the newly added benefits. These insurance companies understandably were interested in protecting their business relations with their clients. The result was their introduction of policies for health insurance on an Experience Rating basis. This allowed the insurance companies to compete by charging a lower premium for those individuals that they deemed to be better risks. They were not restricted to Community Rating as then required of many of the nonprofit plans.

In addition, since the total amount of money that was being negotiated or budgeted for health benefits, usually so many cents per hour per employee, was a specific amount, there was a concern by each provider of a benefit that their share of the total amount available for premiums be protected to be sure that they would be able to have enough money available for their needs. The hospitals were concerned that the Blue Cross plan was able to charge an adequate premium to protect the needs of the hospitals as an example.

Also, many corporations were self-insured. They would budget a specified amount per employee for health benefits and pay the claims from their own funds. The administration of claim payment was usually contracted to their insurance carrier who also frequently provided stop loss insurance in the event that claims exceeded the amount budgeted. This stop loss insurance usually related to both individual employees and to the total of the claims. This was referred to as specific and aggregate stop loss insurance. Many insurance companies set up elaborate administration facilities to provide this service. These facilities were used for both self insurance administration and their own insurance policies.

The corporate decisions by these insurance companies to invest heavily in such administration facilities made it difficult for their management to utilize other options, even if it made sense to do so. So we find...
that each health care provider group, such as hospitals, medical, dental, vision and pharmacy were becoming aware of the growth of the third party payers for their services and were attempting to determine how their individual needs could be best protected in this rapidly changing world. Once a benefit was negotiated by a labor union for its members, the labor contract usually specified that an amount of money, usually a specified number of cents per hour worked, be paid by the employer to provide that benefit.

There were two main methods for the administration of this added benefit. In the case of larger corporations, the benefit was administered by or on behalf of the corporation itself. This was the case where the corporation was the sole employer. Where the labor contract involved multiple employers, such as the building trades including laborers, carpenters, etc., that payment was made by the employer to a Taft Hartley Trust, which then provided the benefit. The Taft Hartley Trust was structured in accordance with the federal law bearing its name that required the trust be administered by an equal number of employer and labor trustees. These trusts were created for each labor union to provide for negotiated benefits for the members of that union. The options for the trusts to provide benefits were as broad as those of single employer corporations and they ranged from fully insured to self-insured and self-administered plans.

For most of the early health benefits, such as hospital and medical, the amount of money represented by each claim was large enough to justify the cost of administration needed to effectively manage and make payment for that claim. However, as other benefits began to be examined, especially by labor unions, as new or additional benefits to be included in collective bargaining, it became evident that claim payment procedures as currently employed would not work for claims with relatively small dollar amounts where the cost of the claim itself would be less than the cost of paying it. This was an added reason for the insurance companies to resist adding these new benefits. Without an acceptable means of administration and financing a new benefit, it would certainly not be chosen. Some of the unions, such as the United Auto Workers, had their own research departments staffed with experts that studied all such aspects of prospective new benefits. Their research in these areas was an important factor in the decisions of the union regarding items to be included in future collective bargaining. Many of those individual researchers were highly respected and an important influence in the decision making of other unions.

Part two

In the early 1960s, certain pharmacy leaders expressed concern that prescription drug benefits would be passed over and the profession would not be able to benefit from an increase in the number of prescriptions filled that would follow the inclusion of prescription drugs as a covered benefit.

At that time, national pharmacy organizations included the American Pharmaceutical Association (APhA) and The National Association of Retail Druggists (NARD). There were others but these are the ones that were mainly associated with this issue.

The American Pharmaceutical Association membership included the individual pharmacist. The National Association of Retail Druggists membership included the independent community pharmacy. Pharmacists also worked in hospitals, chain drug stores and for pharmaceutical drug companies. However, at that time the American Pharmaceutical Association and the National Association of Retail Druggists were the organizations best organized to study this problem.

Each state had an association of pharmacists that was associated with The American Pharmaceutical Association. The California Pharmaceutical Association was one of those state associations. There were leaders of both APhA and NARD that kept the issue alive and provided a platform for information to its membership. Dr. William Apple was the executive head of the APhA and a proponent for improving the professional status of pharmacists and pharmacy.

In California, the executive head of the California Pharmaceutical Association was Cecil Stewart and the general counsel was James Nielsen. The participation of these two would be important for what was to come in the area of prescription drug plans. In addition, the elected President of the California Pharmaceutical Association in 1963/1964, Benjamin Kingwell, and myself would become the catalysts for action.

I became interested in the need for a structured prescription drug benefit that would meet the needs of both pharmacy and the world of third party payers in early 1963. It seemed to me that pharmacy would suffer if it was not included in this growing development in the greater health field and needed to be able to be its own voice. I understood that you could not spend $25 to pay a claim for a $5 prescription. There had to be some way to provide what was needed in a way that was efficient and cost effective.

At that time, the oil companies were providing their customers with a plastic ID card which they could use at the company gas stations for the purchase of gasoline. The gas stations were furnished with a machine from Addressograph that allowed them to swipe the card onto a standard form in lieu of cash and the forms were sent periodically to the oil company for a single payment to the gas station.

The gas stations were pleased with the arrangement and some told me that they felt it resulted in the sale of more gasoline as well as eliminating the need to handle so much cash.

It seemed to me that this could be the basis for a solution to the third party payers dilemma for pharmacy. Each pharmacy could be furnished an Addressograph machine and a supply of standard forms. The covered employees receiving the prescription drug benefit could be furnished a plastic ID card showing the amount that the employee would pay to the pharmacy for each covered prescription. When that employee had a covered prescription filled, the pharmacy would swipe the card and collect the amount shown on the card. That would be all the employee would have to do. There would be no claim forms to submit and wait for reimbursement.

The pharmacy would know the prescription would be paid and not have to be concerned with collecting for each prescription from the patient. Then the pharmacy would submit all of the forms periodically for one payment instead of individual payments. In addition, this process could be automated using the IBM computers then in use, further reducing the cost of administration to pennies per prescription. It would be easily understood and easily utilized. The covered employee would know exactly what a prescription would cost and there would be less resistance to having all written prescriptions filled.

At that time, in the early 1960s, prescriptions were much less expensive for the consumer than they are today. Also, prescriptions were priced by the pharmacy on a markup basis starting with the cost of the ingredients. A chart, which was distributed by the NARD, was frequently used as a guide in such pricing. There was little uniformity in the price of a prescription among pharmacies. This was also complicated by the fact that most prescriptions did not identify the ingredient(s) on the label, which was not required at that time and seldom shown. Prescriptions were not viewed by patients at that time as
they are now. There was little known by patients about their prescribed medications and little opportunity to find out. All of this contributed to the attitude regarding prescription drug coverage by the third party payer community and consumers.

I prepared an outline of what I felt needed to be done and discussed it with Ben Kingwell, the incoming president of the California Pharmaceutical Association. He was supportive of the concept and encouraged me to continue. I also discussed this with James Nielsen, the general counsel for the California Pharmaceutical Association. He felt that it may be possible to form a nonprofit corporation under the California statutes for hospital and medical nonprofit service plans.

The concept was approved by the California Pharmaceutical Association and the details were created with the assistance of James Nielsen, Ben Kingwell, Cecil Stewart (the executive of the Association). On August 11, 1963, California Pharmaceutical Services, Inc. was incorporated in the State of California as a nonprofit corporation and sponsored by the California Pharmaceutical Association. I was the President of the corporation.

In keeping with the general structure of the hospital and medical service plans then operating in California, California Pharmaceutical Services was an insurer. The prescription drug plan it created and offered for sale was called Paid Prescriptions. That name eventually became the corporate name and California Pharmaceutical Services, Inc. as the corporate name was changed to Paid Prescriptions. This was done to eliminate confusion and to focus on the plan itself.

The plan involved all the aspects that I had visualized. Participating pharmacies were provided an Addressograph machine and standard forms. The covered employees were provided a plastic ID card, which showed that the employee would pay $2 for each covered prescription. The pharmacy would submit all forms periodically to the administrative office of Paid Prescriptions for a single payment for all submitted valid forms.

Payment to the pharmacies was to be on the “usual and customary” fee that that pharmacy would charge to any customer. Marketing of the plan was started and several small groups were enrolled. Then the issue of expansion to a national plan was started. It became evident that the time and effort required to create a duplicate plan for each state would not be feasible. Therefore, it was decided that Paid Prescriptions, a California nonprofit corporation, would operate nation-wide as a single entity. Upon discussion with national pharmacy leaders, there was no opposition and that was decided.

Shortly after this change was effected, the United States Department of Justice sent Paid Prescriptions a letter advising that we were in violation of antitrust provisions. If we continued as we were, we faced prosecution. That put us in a difficult position as the publicity alone would effectively destroy what had been created. At the same time, there was much discussion within Paid Prescriptions regarding the issue of how prescriptions were priced. There had been much discussion at the national level by Dr. Apple and the American Pharmaceutical Association regarding the matter of professional image and actions. There was support for actions that would improve the professional image.

We also had discussions with Dr. Robert Abrams, a pharmacist who had been employed in both the academic area, and with a major pharmaceutical manufacturer. Dr. Abrams was promoting the concept that pharmacies should price their prescriptions based on a professional fee plus the cost of the ingredients. We felt this approach would both be supported and accepted and also help Paid Prescriptions with its administration needs. Dr. Abrams was eventually recruited by Paid Prescriptions and succeeded me as President when I stepped down.
Part 3

Paid Prescription now found itself in a position that it was no longer an insurer and not able to define the benefits and rules for administration as a prescription drug plan. It was now an administrator and adviser to those who would be providing the plans. Consequently, its needs were very much different and its nonprofit status became a problem regarding its ability to expand and invest in improved administration and marketing. There was great and growing interest in prescription drug plans. Paid Prescriptions could not stand still and survive and needed to grow to stay on top and in a position to be effective in the structure of future plans. Growth required capital and the ability to keep abreast was becoming more difficult.

Finally, in 1970, the board of directors of Paid Prescriptions decided that it would change to a for-profit status and look for an appropriate buyer for the company that could provide the needed resources. Such a buyer was found and Bergen Brunswig acquired Paid Prescriptions. Dr. Robert Abrams was then the president of Paid Prescriptions and I had retired with a consulting agreement. Paid Prescriptions was subsequently sold to Computer Sciences Corp and then to Merck. It has remained the largest company of its kind and the basic concept and operation of Paid Prescriptions has largely remained the same.

Paid Prescriptions started an industry that has mirrored the growth in the importance of pharmacy and pharmaceuticals in the health fields. But it is important that history shows this part of the story and how it happened.

Part 4

If we make the leap forward to the present, the question is asked as to what this means to the pharmacist and to pharmacy.

When I started as a student in Pharmacy at the University of Michigan in 1938, we were still taught about tinctures, elixirs, fluidextracts, and how to make them. We learned how to compound and prepare individual powders, pills, capsules and suppositories. There was emphasis on the study of botanicals and individual chemicals. One needed to be able to identify by sight, feel and odor the individual botanicals and to know their country of origin, part used, when collected and botanical name. Pharmacy was a vastly different profession. Even chemistry, both organic and inorganic, were very different than today’s courses.

Pharmacy followed the development of the advances in prescription drugs and medical procedures. Many of those advances involved pharmacists and pharmacists remain an integral part of the pharmaceutical industry. These advances also resulted in a huge increase in the cost of prescription drugs. And it also became more important in the eyes of the patient as there was an increased reliance on these new drugs in medical treatment. Today, it is frequently reported that some patients are quoted as saying they must choose between paying for prescription drugs and other necessities. This both demonstrates the need for these prescriptions and the high cost for many. Many pharmacists are faced daily with the issue of the high cost of some drugs and their patients ability to pay for them. All of this is understood by the world of third party payers for prescription drugs. And it has become a political issue in both the public sector and the private sector.

Pharmacy’s involvement in third party payers has become an important issue within the profession. As in the other health professions in the early days, there was some resistance within the
individual professions to participating in the development of the third party payers for their professional services. This resistance resulted in the ability of some programs and entities that would have been otherwise rejected to be created and implemented over the objections of the profession. Many have been successful because they filled a need as perceived by the public but without the advantage of meaningful input by professional pharmacy and others.

If we allow ourselves to project in the future, it seems that the cost factor for many prescription drugs may well increase. The reliance by the patient for access to prescriptions will certainly not diminish. The need to meet this challenge and to maintain the high standards for pharmacy will continue.

It should be kept in mind that the beginning of the development of third party payers for prescription drugs was understood and undertaken by pharmacy.

While some aspects of its development in recent years appears to be contrary to what was wished by many in pharmacy, I do not feel that time has run out. Pharmacy is again becoming more and more involved in this aspect of the profession. If it is understood by the individual pharmacists, wherever they practice, the future will see real benefits for everyone involved.

What first started as an experiment to lead and to assure that the highest professional standards were met, has become an integral part of professional life for pharmacy. Full involvement by pharmacy and individual understanding and support by the pharmacist in the entire spectrum of third party payers for prescription drugs can be an important factor in improving the delivery of pharmaceutical services. It has become a professional necessity.

The issue of how the profession can have a leadership role in the world of third party payers for prescription drugs remains an important one.

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**About the Author**

Sydney Aronson received his pharmacy degree from the University of Michigan in 1942. He practiced as a licensed pharmacist in California from 1947 to 1972, and was a community pharmacy owner from 1951 to 1968. He served as President of Paid Prescriptions from 1963 to 1969 and as a member of an Ad Hoc Committee appointed by Governor Pat Brown from 1963-1965 (until passage of Medicare). The purpose of the 15-member committee was to improve the health care provided by California to welfare recipients under Medical Assistance to Aged and Aid to Families with Dependent Children programs. He represented pharmacy on committees which included all health disciplines, insurance and public health representatives.

In addition, Mr. Aronson was an Adjunct Professor for the California State University, Northridge from 1972 to 1978, teaching a graduate course in Third Party Payers. And finally, he was a member of several HEW task forces in Washington, DC in 1965 related to the implementation of Medicare.

After leaving Paid Prescriptions in 1970, Aronson served as a consultant regarding third party payers for health care from 1970 to 1976. He then became the Co-founder and chairman of NAS Ltd. and NAS Insurance Services, Inc. in 1976. Companies were Surplus Line Brokers that served as Coverholders for Underwriters at Lloyds, London, for specific insurances and reinsurances in the United States, including issuing and administering insurance policies on behalf of Underwriters at Lloyds, London. Their offices were located in Chicago and Los Angeles. There, he developed new insurances in conjunction with certain Underwriters at Lloyds, London. In 1986, Aronson retired, although he keeps fairly current with developments in the health care field.

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### Third Party Players and Prescription Drug Plans (cont.)

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<td>1. Publication Title: California Pharmacist</td>
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<tr>
<td>3. Filing Date: 10.13.10</td>
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<tr>
<td>4. Issue Frequency: Quarterly</td>
</tr>
<tr>
<td>6. Annual Subscription Price: $80</td>
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| 7. Complete Mailing Address of Headquarters or General Business Office of Publisher: California Pharmacists Association, 4030 Lennane Drive, Sacramento, CA 95834 |
| Contact Person: Cathi Lord Telephone (916) 779-1400 |

| 8. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Publisher: Lynn Rolston, 4030 Lennane Drive, Sacramento, CA 95834 |

| 9a. Editor Lynn Rolston (same) |
| 9b. Managing Editor: Cathi Lord, 4030 Lennane Drive, Sacramento, CA 95834 |
| 10. Owner: California Pharmacists Association 4030 Lennane Drive, Sacramento, CA 95834 |
| 11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities: None |

| 12. The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: Has Not Changed During Preceding 12 Months |

| 13. Previous Title: California Pharmacist |
| 14. Issue Date for Circulation Data: Spring 2010 |

| 15. Extent and Nature of Circulation: Members and Subscribers |

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