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The Texas Society of Health-System Pharmacists (TSHP) is the organization representing healthcare pharmacy practice in Texas. TSHP’s membership includes pharmacists, technicians and other healthcare professionals whose goal is to optimize pharmacy practice for the public’s benefit. TSHP is an affiliate of the American Society of Health-System Pharmacists.

Mission Statement

The mission of TSHP is to enhance the growth, professional development, practice and public acknowledgement of our members’ ability to improve patient care.

TSHP EDITORIAL ADVISORY BOARD
2013 - 2014

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Next month, as the New Year dawns, TSHP will welcome Deanna Menesses, CAE as our new executive director.

The process: In July, TSHP announced and posted ads for a new Executive Director to replace Paul Davis, who is retiring after 10 years of service to TSHP and over 40 years in association management.

Our Immediate Past President Brian Cohen, Pharm.D. led the search committee in the review of more than 30 applicants. Applications were received from throughout the country from people with a variety of organizational, healthcare and even pharmacy backgrounds. Preliminary phone interviews were conducted of the top 10 applicants and 3 finalists were invited to interview face-to-face with the TSHP executive committee in early October in Austin.

The Executive Committee’s unanimous recommendation was Ms. Menesses. Deanna attended the TSHP Board of Directors October 25-26 meeting in Dallas, where she met with the board and discussed her experience, qualifications, and interest in serving the hospital pharmacists of Texas. The Board unanimously authorized bringing Deanna on board as our new executive director with an anticipated start date of January 6, 2013.

More about Ms. Menesses: Deanna has Louisiana roots that make Central Texas “close to home” for her. She brings with her a great deal of experience in association management – particularly as it relates to healthcare professions. She worked with the Louisiana Pharmacists Association, the Louisiana Academy of Family Physicians, The Capital Area Medical Society (local component of the Louisiana State Medical Society) and the Tennessee Nurses Association. Her most recent position has been the executive director of the Florida Society of Association Executives.

Please join me in giving her a hearty “welcome aboard.”
TSHP Association Announcements

TSHP Award Nominations Due
Nominations for 2014 TSHP awards and recognitions are due before December 31, 2013. Statewide awards are annually presented to individuals and departments that demonstrate exemplary support of advancing pharmacy practice. Awards will be presented TSHP’s Annual Seminar at the Westin Galleria Hotel in Houston, TX, April 11-13, 2014. Criteria for individual awards and a list of previous recipients are on the TSHP website under “Get Involved – Awards & Honors.” http://www.tshp.org/awards-information.html

Dossey Honored with TSHP Special Recognition Award
Based upon a nomination by Austin Area Society of Health-System Pharmacists President Ladan Panahi, during their last meeting the TSHP Board of Directors approved a “TSHP Special Recognition” Award for Austin pharmacist Deana Dossey for her outstanding organizational activities. According to Ladan:

Deana has been a staple and a big reason Austin Area Society of Health System Pharmacists has been successful and active for all these years. She has organized and planned all the meetings and handled all the organizational affairs and truly enjoys giving back to our profession. I have never met someone with such passion for pharmacy. I have taken on the role of President since January, 2013 and she has still remained active and always lends me a helping hand. If anyone deserves to be recognized for organizational and community service, it should be her.

Deana Dossey, Pharm.D., BCPS, is a Senior Pharmacist and the Pharmacist-in-Charge at the Baylor Scott and White Hospital Taylor location. She serves as preceptor faculty for pharmacy students from both The University of Texas at Austin and Texas A&M University Health Science Center, as well as Austin Community College pharmacy technician students. Deana is a past Secretary of TSHP. She has served as both Treasurer and President of the Austin Area Society of Health-System Pharmacists. She has also been active in archiving TSHP’s history as well has having served the Society in a variety of capacities.

Deana enjoys spending free time outdoors with her husband, Terry, and is active in the Friends of Copperfield Nature Trails in Austin, TX.

Congratulations!

Members - Front & Center

Health-System Pharmacy Week - See how TSHP members & their organizations celebrated!
TSHP encouraged members and their facilities and organizations to celebrate National Health-System Pharmacy Week, October 21 - 25, 2013.
Our members really came through, here’s a couple of highlights:

The Texas Tech University Health Sciences Center Student Society members:
• nominated their favorite preceptor and selected a winner on each of the four campuses. The winner received a certificate and a gift card. Congratulations to the winners:
  • Dallas Campus: Randy Martin, Pharm.D. (Director of Pharmacy, Harris Methodist Hospital, Fort Worth)
  • Amarillo Campus: Sherry Luedtke, Pharm.D., FPPAG (Associate Professor, TTUHSC SOP)
  • Lubbock Campus: Craig Cox, Pharm.D., BCPS (Associate Professor, TTUHSC SOP)
  • Abilene Campus: Pamela Ochoa, Pharm.D. (Assistant Professor, TTUHSC SOP)
• sent appreciation letters all faculty members who practice in a hospital or health-system setting.
• wrote thank you cards to their mentors.
• posted daily pharmacy fun facts on the Texas Tech Student Society of Health System Pharmacists chapter Facebook page.

The UT Southwestern Medical Center in Dallas employees participated by:
• having pancakes served by the director of pharmacy.
• providing staff gifts, lunches and dinner and deserts.
• playing bingo w/ prizes (all employees sent in their 3 facts that no one knows about them) - great way to learn about your colleagues.
• holding a photo guessing game for pharmacy employees (guess who’s the baby in the photo).
• setting up “meet and greet” tables to promote pharmacy - the table volunteers took blood pressure readings, and played many games with hospital visitors - spin the wheel for prizes, guess the antibiotic pill game and guess the number of pill games. They also provided handouts for different disease states, medication wastage, and poison control.
• hosting a technician appreciation day where pharmacists provided lunch or dinner and gifts to their techs.
• holding performance improvement idea raffles. Each improvement idea earned a raffle entry for the prize. The staff council will address those ideas and make recommendations for improvement.

TSHP would like to say “thank you” to everyone who participated in making National Health-System Pharmacy Week a success! Start your brainstorming for next year, National Health-System Pharmacy week is October 19 - 25, 2014!

Mark Your Calendars!

April 9 - 10, 2014
2014 Alcáldé Conference
The Westin Galleria Hotel
Houston, Texas

April 11 - 13, 2014
2014 Annual Seminar
The Westin Galleria Hotel
Houston, Texas
INTRODUCTION
For many women, pregnancy is an exciting and enjoyable experience. For others, however, it can be plagued with intense fear for the health of both mom and baby. Remarkably, nearly 3 out of every 100,000 American women who give birth to a live baby die (Stafford & Belfort, 2008b). This figure has remained relatively unchanged since 1982 for at least one reason: placenta percreta (Stafford & Belfort, 2008b). This complication contributes significantly to maternal hemorrhage, which is the leading cause of maternal morbidity and mortality (Barash, Cullen, Stoelting, Cahalan, & Stock, 2009).

BACKGROUND
Normally, a layer of decidua (endometrium) separates the placental villi and the myometrium (the inner layer of the uterus) at the site of placental implantation (Konijeti, Rajfer & Askari, 2009). This layer allows for smooth separation of the placenta from the uterus. Placenta percreta, the rarest and most severe form of placenta accreta, occurs when the villi penetrate the full thickness of the myometrium and may invade neighboring organs such as the bladder, abdominal wall and/or the rectum (Konijeti et al., 2009).

Although the exact cause of placenta percreta is unknown, it is associated with several clinical situations such as previous cesarean delivery, placenta previa, grand multiparity, previous uterine curettage, tobacco use and previously treated Asherman syndrome, which is a condition characterized by the presence of severe scarring within the uterine cavity (Poggi & Kapernick, 2007). Placenta percreta is one of the leading causes of cesarean hysterectomy and occurs in approximately 1 in 2,500 pregnancies (Konijeti et al., 2009). The average blood loss during delivery of patients with placenta accreta can range from three to five liters. One must take into account that placenta accreta is the least severe form of abnormal placentation. A recent retrospective study determined an average blood loss of 12,140 ± 8343 mL for patients undergoing Cesarean section known to have placenta percreta (Sumigama et al., 2007).

CASE REPORT
A thirty-five year old gravida 6 para 0 with a history of five failed in vitro fertilization attempts was admitted to the hospital at 36 weeks gestation with twins having the diagnosis of placenta percreta invading the bladder and anterior abdominal wall. She had no prior significant health history. The decision was made to proceed with an elective Cesarean section and possible hysterectomy. Several hours prior to the planned Cesarean section, an epidural catheter, right radial arterial line and two large bore 16 gauge peripheral intravenous (IV) catheters were inserted. The patient was then taken to interventional radiology for bilateral internal iliac arterial balloon catheter placement.

The patient was taken to the operating room in preparation of her Cesarean section. Premedication with routine aspiration prophylaxis (IV Metoclopramide 10 mg, IV Ranitidine 50 mg, and oral Sodium citrate 30 mL) was administered. Left uterine displacement was accomplished with a right hip wedge. Preoxygenation was in progress while monitors were placed. A rapid sequence induction was performed with IV Propofol 150 mg immediately followed by IV Succinylcholine 120 mg while maintaining cricoid pressure. The patient was intubated with a size 6.0 endotracheal tube (ETT) inflated to minimal occlusive pressure. Placement of the ETT was confirmed and cricoid pressure was released. A 16 French...
orogastric tube was placed to decompress the stomach as well as an esophageal temperature probe. The patient was maintained with less than one minimal alveolar concentration (MAC) of Sevoflurane during the surgery.

Cesarean delivery was performed without difficulty, and the twin neonates were handed over to the neonatologist for further assessment. Upon removal of the twins, profuse bleeding began and the balloon catheters in the internal iliac arteries were inflated by the Interventional Radiologist. IV Pitocin 40 units/liter bag was infused within five minutes. Intramuscular (IM) Mephenytoin 0.2 mg was administered as well as IM Hemabate 250 mcg for uterine atony. A total of two doses of Hemabate were given throughout the case. While replacing volume, periods of hypotension were treated with varying IV doses of Phentolamine and Ephedrine. After several minutes, the placenta was completely removed and hemostasis achieved after uterine dissection and closure. The placenta was strongly adhered to the bladder but not invading, thus a bladder resection was not performed. Insertion of an intrauterine balloon catheter as well as vaginal packing was utilized to control any additional bleeding. Estimated blood loss was approximately four liters, which was replaced with ten units packed red blood cells, six units of fresh frozen plasma, a ten pack of platelets and four liters of crystalloid. The iliac catheters were removed, and the epidural was dosed for pain control. At the end of the procedure, the patient was extubated and monitored in the PACU followed by the ICU overnight. No other complications were experienced and the patient was discharged home on postoperative day five.

PERIOPERATIVE MANAGEMENT
Pelvic artery balloon placement has been proposed to reduce blood loss and to assist in conservative management to avoid hysterectomy (Breen & Neubecker, 2002). Some investigators assessing the use of prophylactic occlusion balloons in the internal iliac arteries with selective arterial embolization have reported a greater than eighty percent success rate in controlling postpartum hemorrhage (Hansch et al., 1999). These catheters should not be inflated until after delivery as to not compromise fetal oxygen delivery. Some clinicians prefer intraoperative internal iliac artery ligation for hemorrhage prophylaxis to prophylactic catheter placement (Stafford & Belfort, 2008a).

POSTOPERATIVE COMPLICATIONS
Because of prolonged operative time combined with crystalloid infusions and transfusion, there is a risk for significant laryngeal and pulmonary edema, along with prolonged postoperative intubation and ventilation. Patients with prolonged intraoperative hypotension should be followed for evidence of renal compromise, neurologic depression, and for Sheehan syndrome, or decreased functioning of the pituitary gland secondary to hypovolemic shock (Stafford & Belfort, 2008a). Deep vein thrombosis prophylaxis is also advisable due to the high rate of thromboembolism occurrence in this patient population. Urinary tract and bowel injury, sepsis, intensive care unit admissions and death are also possible postoperative complications (Shrivastava, Nageotte, Major, Haydon & Wing, 2007). Up to five percent of patients will develop acute respiratory distress syndrome (ARDS) or acute tubular necrosis. In addition, up to seven percent of patients need surgical re-exploration for postoperative bleeding (Stafford & Belfort, 2008a).

DISCUSSION
When massive hemorrhaging occurs from placental abnormalities, it is important to know the current life-saving procedures. In the case study above, uterine salvation was strongly desired; therefore all attempts were made to avoid converting to a hysterectomy. However, in patients who do desire to have a hysterectomy, other options are available at the time of delivery to decrease blood loss.

After delivery of the fetus, no attempt is made to remove the placenta until the major supplying vessels are tied and the uterus is devascularized (Stafford & Belfort, 2008a). The umbilical cord is then clamped or tied off and placed back in to the uterus prior to uterine removal. Aortic clamping is also an option to restore hemodynamic stability. Compression of the aorta below the renal arteries can decrease blood loss and allow time for resuscitation with blood products, pharmacotherapy and additional fluid. Also, exposure of the infrarenal aorta and femoral arteries can be achieved before removal of the uterus, and these vessels can be temporarily occluded to isolate the pelvic region if massive blood loss is encountered (Stafford & Belfort, 2008a). A pelvic pressure pack is also a consideration for cases of refractory bleeding. This step has been effective in allowing time for hemodynamic stabilization and correction of coagulopathy (Dildy, Scott, Saffer & Belfort, 2006). Early use of Activated Factor VII (albeit an off-label use) may reduce red blood cell requirements by as much as twenty percent in cases of massive transfusion (Perkins, Schreiber, Wade & Holcombe, 2007). This therapy, however, can predispose the patient to a hypercoagulable state once the bleeding has subsided.

CONCLUSION
The incidence of placenta percreta has increased steadily during the past several decades and currently occurs at a rate of 1 : 2,500 pregnancies (Konijeti et al., 2009). This is most likely secondary to the rising rate of cesarean deliveries, which in the United States has risen by fifty three percent from 1996 to 2007. As the incidence of cesarean delivery rises, so will cases of abnormal placentation (Russo, Krenz,
Hart & Kirsch, 2011). It is important to remember that although extremely rare, abnormal placentation can occur even in a patient without a prior history of cesarean delivery. Anesthesia plays an indispensable role in coordinating subspecialties and fostering necessary communication. This patient population is at a high risk for massive hemorrhage before, during and after delivery. In order to have a successful outcome, early planning and a team-based approach are vital.

**REFERENCES**

On May 18, eight pharmacy students and two faculty members from the Texas Tech University Health Sciences Center School of Pharmacy left on a medical mission trip to Huancayo, Peru. All of us are members of the Foundation for International Medical Relief of Children (FIMRC), a non-profit national organization dedicated to improving the health of mothers and children and providing access to medical care to the millions of underprivileged and medically under-served children and families around the world. The TTUHSC student FIMRC chapter was formed during the 2010-2011 school year and has organized a mission trip during each of the last three summers. This summer we were afforded the amazing opportunity to visit and impact the city of Huancayo, Peru. As a chapter, we gathered donations throughout the 2012-2013 school year to support the FIMRC clinics at the international site where we would later serve during our week-long summer medical mission trip. The fund-raisers included a sand volleyball tournament in the fall, a late night snack sale during finals week and a basketball tournament in the spring. All of the proceeds from these events went directly to the community of Huancayo, Peru to help improve their healthcare. FIMRC uses this money to buy testing services and devices that the community would otherwise be lacking.

Huancayo is the capital of the Junín Region, located in the central highlands of Peru. Our journey there was quite an experience. After flying into Lima, we boarded a double-decker bus and traveled approximately 10 hours through many mountain passes. By the time we arrived in our temporary hometown of Huancayo, we had experienced a gradual rise of 11,000 feet in elevation. The fact that Huancayo is located up in the mountains so far above sea level played a significant role in the disease prevalence of this region. Many children and adults suffer from respiratory infections and chronic diseases that aren’t as common in Texas.

Religion is an essential part of any culture and an overwhelming majority of the Huancayo population is Roman Catholic. We had the opportunity to visit the awe-inspiring, historical cathedral of Huancayo. The mountains surrounding the city were a breathtaking and inspirational sight as well. We all had the privilege of staying with a host family for the entire week and we got spoiled with traditional home-cooked food for most meals, though we did delve into the Peruvian cuisine at local eateries periodically. The menus included rice, potatoes, deliciously flavored sauces, ceviche and many other local favorites. Some of us even got adventurous at a local restaurant and tried the roasted guinea pig, which is a Peruvian delicacy.

HOSPITAL EXPERIENCES IN HUANCAYO

During our time in Huancayo, we were fortunate enough to visit both private and public sector hospitals. The first
hospital we visited was the Carrion Hospital. In Huancayo, the main hospital entrances are guarded by two local police officers, so we had to be wearing our white coats to enter. After we passed through the front doors, we divided up into two groups, one of which was allowed to observe surgeries and the other attended interdisciplinary rounds in multiple wards throughout the hospital.

Upon arriving at the surgery wing, the group was surprised at the number of people lining the hallways. It was very busy and packed with patients, almost like a shopping mall. There were also wooden chairs lined up along each wall for people to sit in as they wait for the doctors, and all of the seats were taken. This was a stark contrast to hospitals in the U.S., which are generally very quiet with far fewer people out and about.

In order for us to enter the “sterile” environment of the surgery section, all we had to do was get our scrubs sterilized, wear booties on our shoes and a use a mask to cover our face. Just minutes after watching the medical team prep a patient and the room prior to surgery, it was apparent that the standards and protocol were very different than what we were used to back home. We were even allowed to be in the same room in which the surgery was taking place. We observed a below-the-knee leg amputation, saw a metal plate inserted into a man’s leg and witnessed a surgery that involved a bullet wound. During the leg amputation, we noticed that — although he did get some type of injection into his spine to numb his legs — the patient was actually awake with his eyes open during the entire procedure. It was a definitely a unique learning opportunity that we (not necessarily the patient) were fortunate to experience.

The group that went on medical rounds noticed many differences. This was a public hospital, we later learned the patients had the lowest level of insurance possible and therefore the lowest level of care as well. We immediately noticed there were roughly twenty patients to a room in beds placed about two feet apart and with no partitions separating one sick patient from the next. We encountered many patients with chronic conditions and infectious diseases such as tuberculosis and saw numerous cases of appendicitis. The rounds in Peru consisted of a team of local doctors, medical students and nurses, but there wasn’t a pharmacist in sight. We later learned there is no doctor of pharmacy program mandated by MINSA, the Peruvian Ministry of Health, and covers the majority of patients in Peru. Citizens with this type of insurance would be treated at a hospital similar to Carrion Hospital, which was described previously. The other public sector insurance is for the citizens that serve in the Peruvian armed forces and receives a slightly higher level of care than the SIS-insured individuals.

The last hospital we were assigned to observe was a private hospital. We received an official tour of the facility and were able to view the pharmacy, emergency room and the other various parts of the recently redesigned building. While at this hospital, some of us also had the opportunity to observe Cesarean sections, a brain surgery, a hysterectomy and a bladder mesh surgery. We noted that this hospital differed significantly from the previous hospitals we encountered. Overall, the conditions were much improved. The sterility regulations were much stricter and they only had one patient bed per room. This hospital was very similar to the hospitals we have here in the United States.

THE PERUVIAN HEALTHCARE SYSTEM
Our experiences in the local hospitals and medical school made it easy to see firsthand the differences in the level of care and the available technology between Peru and the United States. As a part of our experience at the Universidad Nacional del Centro del Peru, two third-year medical students explained how the Peruvian healthcare system is organized. In that discussion we learned that Peru’s healthcare is organized into public and private sectors. Within the public sector, there are two types of national insurance. Seguro Integral de Salud (SIS) is the basic, low-grade government assistance insurance for those citizens that are living in poverty. It is mandated by MINSA, the Peruvian Ministry of Health, and covers the majority of patients in Peru. Citizens with this type of insurance for the citizens that serve in the Peruvian armed forces and receives a slightly higher level of care than the SIS-insured individuals.

The private insurance in Peru is known as EsSalud. It is available to the working citizens and their families and is financially supported by individual employers. With this type of insurance, patients have access to more sanitary and safe services, better doctors, and more American-like hospitals than do those with SIS insurance. The percentage of Peruvian citizens with EsSalud insurance is, unfortunately,
extremely low.

We were also able to explore many of the problems of the healthcare system with the medical students of Huancayo. Specifically, we learned that a large percentage of Peruvian citizens receive no healthcare at all, most often due to the fact that much of the Peruvian population lives in remote locations such as the jungle or mountains, which cuts off their access to medical professionals and other healthcare services. Additionally, we were made aware of the poor access to and availability of medications, a topic we were particularly interested in as future pharmacists. We learned there isn’t much regulation or standardization on medication in Peru because they don’t have an FDA-type organization that monitors medication safety and efficacy like we do in the U.S. Many antibiotics and other medications that are only available with a prescription in the United States are bought over the counter in Peru at a very low price. One of our students actually bought five antibiotic capsules at a local convenience store for $2 (U.S.).

ADDITIONAL MEDICAL AND COMMUNITY OUTREACH EXPERIENCES

Aside from observing medical procedures and rounds during the week, our group was able to perform some important services for the children of Huancayo. Due to poor water quality and poor dental hygiene, a large percentage of the Peruvian population suffers from extensive tooth decay due to dental cavities. In fact, most Peruvians experience their first cavities as very young children. Peruvian dental students trained us on the proper techniques for applying fluoride treatments, and our group was able to conduct these treatments on children at a local preschool in Huancayo. Due to our relatively large number of volunteers, we were able to perform treatments on a large number of children in a just few hours.

Late in the week, the medical students from the Universidad Nacional del Centro del Peru designed a workshop where we could learn about and practice suturing techniques. We each were allocated a pig’s foot and stitching supplies that included scissors, a needle and thread. Over the course of a couple hours, the medical students showed us the proper method to suture a wound. We also were able to observe and assist in the cadaver lab at the local university where the first-year medical students were working on cadaver dissections. The entire week in Peru was a great experience for all of us and we are thankful that FIMRC allowed us to see and experience things that would not have been possible without this mission.

Before going on the trip, none of us realized how privileged and blessed we are in the United States. Today, we are all a little more thankful for the healthcare system, technology and regulations we have here, especially after seeing how vastly different conditions can be in other countries. This mission
trip enhanced our passion to be involved with improving the livelihood of those around us (both locally and abroad) and it was a great feeling to realize that, even as students, we can significantly impact the life and health of others.

**ADDITIONAL INFORMATION ABOUT OUR FIMRC CHAPTER**

Our chapter is also devoted to helping our local underprivileged community in Amarillo (and soon to be Abilene), Texas. Every Saturday morning, a group of members heads out to the High Plains Children’s Home, a local foster home, for tutoring services. The children are 5 to 18 years old, which means there is a wide array of subjects to be covered. Each November, we spend an evening at the children’s home making a Thanksgiving theme dinner with the residents. It is a chance for us to hang out, eat and enjoy an evening with the children we come to know through our tutoring program. We have also held a Heart Healthy Valentine’s Day party at the children’s home, during which we hand-out healthy treats and make a presentation to educate the children and house parents about the benefits and the importance of exercise and healthy foods in living a fun, healthy and long life. During the Christmas season, our chapter helps with the Eveline Rivers Christmas Project, a local charity that serves underprivileged families by supplying many children with coats, toys, school supplies and other necessities.

Another local charitable organization we help is known as Snack Pak 4 Kids. This is an Amarillo-based charity that supports more than 3,000 children in public schools throughout the Texas Panhandle by packing meals every week throughout the year for children to eat during the weekend. Without this service, many children in Amarillo and surrounding areas would not have food from the time school dismisses them on Friday until they return to classes on Monday.

For more information on how you can be involved in medical mission trip through FIMRC or start a student chapter, please visit www.fimrc.org.

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www.tshp.org
(under the Events & Education menu)
There is growing concern among Texas pharmacists over the future of internship training as well as the impact on both student education and preceptor participation. The growing number of colleges of pharmacy and the total number of students, along with the ACPE requirements for early experiential training of pharmacy students are among the reasons leading to the worries. The TSHP Internship Task-force conducted a 24 question, anonymous survey of TSHP members concerning issues relating to pharmacy student internships. The purpose of the survey was to help identify any gaps regarding rotation sites and preceptor availability. Thank you to the 243 individuals who participated, your feedback was greatly valued.

We would like to share these results with you as we work on how to improve the utilization of rotation sites and preceptors, given the current and future states of education and practice in Texas. The Task Force met with Joint Committee on Internship Programs (JCIP) to share the results of this survey, during which many opportunities were identified, including: (1) the need for a defined feedback mechanism for preceptors after rotations, (2) the development of educational tools for preceptors at varying levels of experience in precepting, and (3) a more collaborative approach in communicating rotation slot availability. The TSHP Internship Task Force is open to any suggestions and comments you may have and will keep you informed regarding our progress.

DEMOGRAPHICS
Survey respondents totaled 243, almost 50% from community hospitals, 76% from metropolitan locations and facilities greater than 500 beds (28%). Of the respondents, over 80% worked the day shift and more than 70% are currently preceptors (40% APPE & IPPE, 30% APPE and 3% IPPE). Greater than 60% have been taking interns for more than 5 years, more than 60% are taking interns from 1 or 2 Texas schools. The breakdown of types of rotations primarily precepted is: Institutional (31%), Management/Pharmacy Admin (17%), IM (14%), Am Care (7%), Critical Care (5%) and 19% other.

SURVEY RESULTS: KEY POINTS
I. Imbalance of Rotation Site Utilization:
Approximately 12% of respondents have the perception that the number of students they precept per year is “too many” or “way too many”, while 15% stated that the number is “too few” or “way too few.” This data reveals that there may be an imbalance in the distribution of rotation sites and/or preceptors that are utilized by the pharmacy schools in our state. The primary concern is that the 12% represents the potential likelihood that a group of preceptors are at risk to burn out due to an overload of students and over-utilization. The survey identified that approximately 42% of respondents had personally agreed to take P4 students but had at least 1 rotation spot that remained unfilled, which identifies an opportunity to optimize the use of all available rotation sites in a systematic approach to avoid such vacancies. More than 30% saw Institutional rotations remain unfilled and vacant. It is
important to assess, particularly from the schools of pharmacy and student perspective, what the specific limitations of those unfilled rotation spots happen to be, whether it is geographical, student preference, expectations of academic facilities versus community hospitals, or others. Finally, more than 40% of the respondents felt the number of students they personally precepted of the past 5 years has grown by “more” or “way more.”

II. Preceptor Availability & Support:
There is an increase in the number of pharmacy students in the State of Texas each year. Consequently, preceptor availability must be evaluated. One of the survey questions asked which non-Texas schools our member’s 34 total students attended, with the most frequent being Creighton, Lebanese American, and Louisiana - Monroe. Question 5 demonstrates that 25% of respondents do not currently precept pharmacy students. According to this survey, the top five reasons our members are not preceptors include (1) Time constraints, (2) Institution does not facilitate teaching environment, (3) Facility leadership does not support having interns (63% mandated or strongly suggested by leadership), (4) Lack of experience in the field, and (5) Lack of response from schools to place interns. This particular question highlights an opportunity to increase available preceptors in our state by ensuring that we provide them with adequate support and resources.

In a survey question that asked what resources would most benefit or support those respondents who are not currently preceptors, recurring suggestions included:

- Availability of library access
- Face-to-face preceptor training and CPE opportunities
- More collaboration and communication with schools of pharmacy, including ease and standardization of student evaluations
- Support in structuring and guiding rotation activities
- Education on the process of supporting a faculty member on staff

Respondents shared the following recommendations regarding how to meet their needs as preceptors:

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<thead>
<tr>
<th>Preceptor Resources</th>
<th>Schools/Colleges of Pharmacy Collaboration</th>
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<tbody>
<tr>
<td>- Live preceptor CPE meetings</td>
<td>- Standardization of evaluation forms for all TX schools of pharmacy</td>
</tr>
<tr>
<td>- Re-evaluation of compensation for rotation sites</td>
<td>- Consistent closed loop feedback to preceptors</td>
</tr>
<tr>
<td>- Pre-determined and standardized checklist of specific rotation activities</td>
<td>- Possible creation of pool of rotation sites to allow for sharing and optimal utility of available sites</td>
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<td></td>
<td>- Standardized rotation schedule among all TX schools</td>
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THE PTCB ADVANTAGE

- Improved employment opportunities
- Demonstrated value to the pharmacy team
- Validated achievement
- Future career growth options
- Prestige among coworkers
- Potential for higher salary

Certification by PTCB is the gold standard for pharmacy technicians. Many employers now require their employees to be PTCB-Certified Pharmacy Technicians (CPhTs).

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Get the PTCB ADVANTAGE
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SETTING THE STANDARD

www.ptcb.org
Thank you.

The past 10+ years as TSHP’s Executive Director have been the highest point of a fairly long career in pharmacy association management; primarily because of the leaders, members, staff, and other folks I’ve had the pleasure of working for and with since 2003.

I’ve tried to use these pages and other opportunities to irritate, encourage, nudge, promote and otherwise move health-system pharmacists and pharmacy technicians along a path that I came to believe in a long time ago – that of being a professional, responsible for patient care, who plays a valuable team role today and in the future.

In the previous issue I tried to lay out what I see ahead for our organization and profession. In this, the last issue for me, I’d like to simply look back a bit.

When Judy Turley and I came to TSHP as your first full-time professional staff, things were different:

- The organization was technically broke. We had written off most of our “assets” which were in the form of uncollectible receivables, leaving us so little money that our first decision was to go to a twice-a-month payroll, because we didn’t have enough cash to pay a full month’s payroll. We had to buy used furniture from the Texas Hospital Association (which gave us a great price on that as well as our rent!) because we had never had an office.
- Thanks to our frugal Boards, Treasurers and other leaders, we now own two 1,000 square-foot office condos clear and free. We have not only decent furnishings, but are able to regularly maintain and upgrade equipment such as computers as they become obsolete. We continue twice monthly payrolls, but we have doubled our staff to 4. Our total net assets have surpassed $550,000, which, when added to the assets that have been developed within the R&E Foundation over the same time, bring the value of operations at 3000 Joe DiMaggio in excess of $1 million.
- We had, on paper, 5 Councils and 2 Sections. The total membership of most the Councils amounted to a Chair and (if we were lucky) Vice Chair. They were dedicated, but over-extended and seldom met.
  - With the dynamic involvement of our members we have now grown to 6 councils, whose active membership consists of over 100 individuals; 5 sections, each with a full Executive Committee leading it; 3 specialty committees involving another 2 or 3 dozen members; an active Editorial Advisory Board which peer-reviews articles for our journal; as well as the TSHP PAC, R&E Foundation Board and Committees; and involvement of pharmacy students, technician and industry members in all aspects of our volunteer leadership.
- Due to a variety of reasons, TSHP membership dipped to a low of 975 total members, including 515 pharmacists in 2004.
  - This past June, we surpassed 2,250 total members, including 851 pharmacists, thanks to the efforts of our Councils and members reaching out to ask their colleagues to join.
- We had a basic, periodic hard-copy newsletter and journal that would be sent when we could muster sufficient articles to fill it.
  - Thanks to technology, our Editorial Advisory Board and our members we now have a weekly electronic newsletter; regular quarterly journal published electronically; and specialty newsletters for our Technician, New Practitioner and Student Sections. We publish a periodic “Drug Therapy Newsletter” in cooperation with The University of Texas Health Science Center/UT College of Pharmacy Drug Information Service. We have a Facebook presence and are expanding our other social media outreach.
- TSHP has had, for more than 25 years, an outstanding legislative and public policy record. We were among the first states to pass legislation to allow collaborative practice agreements, permitting pharmacists to provide...
immunizations and manage drug therapy under protocols, long before 2003. TSHP was also part of helping pass what was one of the most progressive pharmacy practice acts in the country at the time.

- Because of the dedication of our Lobbyist Brad Shields, many members of the Council on Public Affairs & Advocacy over the years and your donations to TSHP PAC, we have been the leaders in legislation to allow pharmacists in health-systems to prescribe under protocol, adding a technician to the Board of Pharmacy, defeating legislation that would have moved pharmacy practice back to the 1960s in areas such as physician dispensing, limiting the pharmacist’s ability to dispense therapeutically equivalent biosimilar products, and becoming the leaders in advancing the role of pharmacists and professional practice.

- Because of the leadership provided by our Sections, Councils and Boards, we have instituted a number of programs over the years, many of which were models for the rest of the country, including:
  - A mentor program designed to help pharmacy students (and now new practitioners) connect with more seasoned professionals to provide career guidance and support;
  - A Reverse Expo, which had paid enormous benefits to our industry partners, pharmacy director members and the coffers of TSHP;
  - A co-operative effort with 4 other state health-system societies to establish an online continuing education system. It was less than successful, but provided a great deal of knowledge that has led to the development of a new system with expanded opportunities soon to be released.
  - An active online career center that assists members in finding positions as well as employees.
  - Enhanced non-dues income from website advertising, helping keep pressure off the need to increase members’ dues.
  - Management of our sister state society in New Mexico, providing what we believe are services they could not achieve on their own, creating a new potential business model for TSHP.

We had some fun over the years:
- Trying to FIND the TSHP records and files, which had been placed in a storage unit when our management company moved to Illinois. No one realized that the storage facilities themselves would move twice during that same time.
- Carving pumpkins during one near-Halloween Board meeting, to find out that one future President has a real artistic streak buried within.
- Watching students come, develop, move on and come back to leadership positions while other leaders moved up to national seats and well-deserved recognition.
- Uncovering some long forgotten history of the organization when members came to our offices to dig through our archives.
- Sharing in the joys of births, graduations, White Coat ceremonies.

We’ve shared in some losses:
- Not all the campaigns and legislative priorities have been accomplished.
- Some outstanding leaders and supporters have been called to other states and areas of practice, losing the potential they brought to improve and advance the profession here at home.
- And tears with the passing of some good friends, family and members.

It’s been a great ride – one that I’d do again without a second thought any day, any time, any place – if y’all would be there to share it with me.

I’m Texas pharmacy’s proverbial bad penny. I keep showing up when not expected and often at strange points in time.

I’ll look forward to keeping up with the members and leaders of TSHP as you grow now to the next level that Deanna Menesses will take you to.

And I’ll look forward to seeing you next time, next place.

Paul

P.S. “-30-” is an old editorial mark to indicate “end of story.”