The official newsletter of the Pharmacy Association of Nova Scotia

The PHARMACIST

May 2016

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Pharmacy Association of Nova Scotia
170 Cromarty Drive, Suite 225, Dartmouth, Nova Scotia B3B 0G1
902-422-9583 (phone) 902-422-2619 (fax)
pans@pans.ns.ca www.pans.ns.ca

Have an interesting story idea or know of a pharmacist we should profile, we want to hear about it. Email amy@pans.ns.ca or call 422- 9583, ext 4.

PANS
PHARMACY ASSOCIATION OF NOVA SCOTIA

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Chair's Message

By: Sandeep Sodhi, Chair of the Board, PANS

On April 20, PANS hosted it's seventh MLA reception.

The idea for the event came out of the realization that the best way to educate the decision makers in our province and advocate for our profession was to invite them to a casual event where they could interact with pharmacists on a one-on-one basis, learning about how pharmacists contribute to our communities, the health care system, and overall patient outcomes. The MLAs, including our Health Minister, have told us that our event is one of their favourite (if not favourite) events of the year.

I had the opportunity to address the attendees, from all three political parties, and I wanted to share with you my message.

Chair's Speech: 7th Annual MLA Reception

My name is Sandeep Sodhi, as Chair of the Pharmacy of Association of Nova Scotia's Board of Directors - it gives me great pleasure to welcome you to our seventh annual MLA reception.

A lot has happened in the past seven years. But some things have stayed the same. Pharmacists continue to be the most trusted health care providers in this province. We are the experts on medications and their effects on the body. And we are the most accessible health care providers in Nova Scotia.

There are more than 1500 practicing pharmacists in Nova Scotia. They are vital members of health care teams in our hospitals. They work in the 308 community pharmacies in Nova Scotia - located throughout the province. In many communities, they do not have a hospital - but they do have a pharmacy.

This is why pharmacists embraced the opportunity to expand the services they can provide to their patients. And our patients embraced us. This is good news.

Three years ago pharmacists were included in the publically provided flu vaccine program. Since pharmacists were included in the program, almost 300,000 flu shots were given to Nova Scotians by their pharmacists. More Nova Scotians got their flu shot than ever before. This is good news.

Why were we so successful? Because we were ready, well-trained, had trusted relationships with our patients, and it was easy for our patients - we there on weekends and evenings and throughout the day to give them their flu shot - when and where they wanted it.

We know immunization rates amongst adult Nova Scotians are low. This is bad news. But - based on the success of the flu program, we know pharmacists can help raise that rate if you called on us to help. You just have to ask.

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From the Desk of the CEO

By: Allison Bodnar, Chief Executive Officer, PANS

As a professional organization, PANS is also an advocacy organization. Based on a survey we conducted last year, our members have identified advocacy as the number one priority for PANS. With this in mind, staff members at PANS spend a lot of time on advocacy initiatives.

Here's a list of just some of the things we do:

- Organizing and running the Annual MLA Reception
- Organizing the Take Your MLA to Work Day
- Creating documents and letters for members to send to elected officials
- Meeting with legislators, government department staff, drug manufacturers, third party insurers, regulators, other associations, educators, researchers, seniors groups, other community groups, and more
- Developing proposals for government and other stakeholder groups in support of pharmacy services
- Working with media to ensure pharmacy is represented positively
- Organizing and implementing activities for Pharmacy Awareness Month

Some of the advocacy work PANS engages in is very visible, such as the ad PANS placed in the Chronicle Herald during the last provincial election, but much of PANS advocacy work is behind the scenes.
Your PANS membership pays for this important advocacy work, however, how can you put a dollar value on advocacy?

For PANS member discounts on gym memberships and hotels, it's easy to see your savings. A subscription to RxFiles has a dollar amount attached. But what about advocacy?

The Harvard Family Research Project has stated that, "While many foundations and nonprofits are interested in measuring their advocacy and policy work, currently no accepted evaluation approach or practice exists."

The Global Research Firm McKinsey & Company has noted that most not-for-profit track their performance by metrics such as dollars raised, membership growth, number of visitors, people served, and overhead costs. They state, "These metrics are certainly important, but they don't measure the real success of an organization in achieving its mission."

PANS stated mission is to "support the professional and economic interests of its members to advance the practice of pharmacy and improve the health of Nova Scotians."

Chair's Speech
7th Annual MLA Reception

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We know that there are huge stresses on our health care system. This is bad news. We want to work with you to reduce those stresses.

I wanted to share with you tonight some ways pharmacists have been used in other provinces to help improve patient health outcomes.

It is estimated that around one in ten adults in Canada are affected by chronic kidney disease. More bad news, I know. And, many of these adults are undiagnosed. But, here's some good news. If at risk patients are recognized earlier, and the correct medications are prescribed and lifestyle changes made, the progression of their disease can be slowed - and in many cases stopped. Knowing these facts, a interdisciplinary team of medical practitioners decided to conduct a study where pharmacists were used to identify at risk patients, screen them for Chronic Kidney Disease, help manage those patients already diagnosed, and collaborate with the physicians of patients' who had the disease. The outcomes were interesting. Of the patients screened by pharmacists in the study, 16 percent were found to have Chronic Kidney Disease but had no idea they had the disease. Pharmacists were able to intervene and put the patients on the road to better health. Pharmacists were able to do this because they were accessible, trusted, and they had the tools they needed at their disposal - which included the ability to order lab tests.

The good news is - pharmacists in Nova Scotia also have the legal authority to order lab tests. The legislation was passed. The Standards of Practice released.

Now the bad news. There is no process in place for us to do this. We are working hard to make this happen. Representatives from the PANS, the labs, hospital IT, the Nova Scotia College of Pharmacists, and Dalhousie University are working together to make this happen. The missing ingredient is a decision on how these tests will be paid for. We need this decision before we can move forward. And we want to move forward.

Right now, if a pharmacist indentifies a need for a patient to have a lab test - the patient must go back to their doctor to get the referral and then have this test. This takes extra time and costs more. It's not very efficient.

Do you know who loves efficiencies? Insurance companies love efficiencies. They love to save money and are always looking at ways to do so. One insurance company, Green Shield, partnered with the Ontario Pharmacists Association to see how pharmacists could help to improve the health outcomes of patients with high blood pressure. And guess what they found? With pharmacist intervention, the number of patients whose blood pressure was under control quadrupled. Medication adherence increased by 15 per cent. And the amount of money spent on high blood pressure medications was reduced by more than 31 per cent. And patients were very happy to have their pharmacists involved in managing their health. Twenty-five per cent of them said they were more productive at work because of their involvement in the study.

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Healthier patients, more productive workers, less money spent on healthcare - I think we can all agree that these are great achievements.

As we all know, our province has more than our share of patients with chronic diseases, such as diabetes, COPD, high blood pressure. That's the bad news. The good news is pharmacists are well trained and positioned to help these patients. We just need programs in place to help them. We are just finishing up our Minor Ailments Demonstration Project. It's been a collaborative project between the Department of Health and Wellness and PANS. If the final results are anything like the results of our mid-term results, they are going to be excellent. Patient satisfaction is high, health outcomes were improved, and there was cost savings to the system. This is the good news.

Now for the bad news. This is a temporary project that was only open to Pharmacare recipients, limited to three minor ailments, and it will end. Patients will still be able to access the service but they will have to pay out-of-pocket. This is a significant barrier.

Some patients cannot afford the cost of the service.

Some patients are philosophically opposed to paying for a service that is offered by other health care providers and is covered by MSI.

We've been told by patients that they do not want a two-tiered health care system. According to a study conducted by research firm Abacus - Nova Scotians believe all health care providers who are legally authorized to provide a service should have that service publicly funded.

This same study found that Nova Scotians trust and value their pharmacists more that those living in other parts of Canada. Why not? We have some of the broadest scope of practice, we are highly trained, accessible, and we develop strong and lasting relationships with our patients. Okay. We're pretty awesome.

Despite our broad scope, we also have some of the fewest publically funded pharmacy services in the country. We are ahead of the country and behind the country at the same time. Good and bad.

I want to close with a personal story.

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Not too long ago, I had a mother take her child into the pharmacy for a minor ailment assessment. The child was not in school because she was ill and the mother had taken the day off work to be with her. When the mother discovered that there was a cost to have a minor ailment assessment, she decided against the assessment and the pair went home.

My pharmacy is attached to a medical clinic. The way it is laid out, I can see the waiting room of the clinic from my pharmacy. The next day, I saw the same child sitting in the clinic's waiting room. This time with her father. She was missing another day of school and , this time, it was her father missing a day of work. Two days of school missed, two days of work missed, because they didn't want to- or couldn't afford to - pay $22.50 for an assessment by a pharmacist.

This saddens me. I want to help my patients. I cannot do it for free because Nova Scotia Power, my bank, my suppliers, and the taxman all want to be paid. In fact, they demand it. I do my best. I love what I do. But I need help. We need help. My ask tonight is this: work with us. We want to help the system, because this helps our patients. I am a pharmacy owner and a frontline pharmacist. I want to focus on the good - and I really believe there is more good than bad - so let's work together so there is even more good and even less bad.

Here's to healthier Nova Scotians and a sustainment health care system.

Thank you for coming.

From the Desk of the CEO

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Being able to negotiate a competitive fee with the Province of Nova Scotia for the provision of the publically funded flu shot by pharmacists is a measurable outcome. Nova Scotia pharmacies received $12 per flu shot given, versus Ontario, where pharmacies received $7 a flu shot. Additionally, vaccination rates in Nova Scotia have increased. All measureable, but as an association, we cannot really put a dollar amount on this.

Yes, pharmacies can measure the return on their investment. Pharmacists can measure a sense of accomplishment of being able to improve the health and wellbeing of their patients. Yet, this was years in the making. Was not receiving the authority for pharmacists to provide the publically funded flu shot a year earlier a failure? How can it be, when PANS representatives were working to have more and more doors opened, which ended in achieving the ultimate goal?

The Stanford Social Innovation Review states that, "The typical approach to a successful measurement strategy in direct service - developing a (linear) theory of change and measuring in increasingly rigorous ways until you can prove your model's effectiveness - simply doesn't work in most advocacy contexts. Neither does waiting to measure until the "end outcome" is achieved, since it could be decades away."

In advocacy, it's the steps you make along the way that are important. Sometimes an Association will feel like it is taking two steps forward only to take two steps back, but the constant advocacy work is making progress for the long term. You can find benchmarks of achievement, but you still cannot put a dollar value on the achievements.

How do you put a dollar value on raising public awareness? This is also an area that takes time. Yes, businesses can measure how many new services they have performed but that is only part of the picture.

PANS tries to show the government that there are measureable savings through studies such as the Minor Ailments Demonstration Project. But how do you put a dollar value on improving access for a patient, or the strong relationships built on trust between a patient and his pharmacist?

I suggest that you cannot put a dollar figure on quality of life and improved feelings of wellbeing. You cannot put a dollar amount on a feeling of pride in your profession, of knowing that you helped someone have a better day or even a better life.

It is equally as hard to put a dollar value on having a Cabinet Minister say to you that they look forward to the PANS MLA reception every year and never miss it because it is both fun and educational, thus giving pharmacists the opportunity to have meaningful conversations with this province's decision makers.

Advocacy is about building relationships. It is about working towards a common goal as a team. You cannot put a dollar sign next to it because it is so much more than a line item on a ledger at the end of a fiscal year.

Advocacy is priceless. You cannot put a price tag on priceless.

The more engaged our membership is, the stronger advocates we are. Members are encouraged to stay in touch and get involved in PANS. This is your organization.

PHARMACY PRACTICE

THE NEXT CHAPTER

Nova Scotia Pharmacy Conference
October 21 - 23, 2016
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Cape Breton Kitchen Ceilidh

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Awards Gala

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Medical Cannabis
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for more information visit pans.ns.ca/conference

PHARMACY CONFERENCE 2016

CPR Training: A Legendary Waste of Time

by: Kyle Mohler, Business Owner at LifeShield

"Welcome to your CPR class. I will be your instructor. - Please open your books.

Follow my instructions word for word. This is very important.

Step 1: Do this and then do that.
Step 2: Place one hand here, not there.
Step 3: Assess yes or no, for 10 seconds.
Step 4: If YES to step 3, see step 4A. If NO, repeat step 2 three times, and then refer to page 12.
Step 5: Push this many times, not that many times. Breathe now. Reposition, push X inches unless below 66 lbs...

...and don't forget to pass the written test, otherwise you fail."

Sound familiar? – I'm willing to bet that it does.

Cardiac arrest = dead. - Clinically dead, to be precise.

While clinical death is reversible in modern times, survival rates are embarrassingly poor, Canada being no exception. This abysmal reality is not your fault, nor the fault of EMS, nor that of the Emergency Room Physician. It's my fault. - I am your CPR instructor.

If you like numbers, here's the first one worth noting: 80%.

Approximately 80% of death occurs in the Canadian home. Not at work, not at the bus stop and not in an ambulance. Statistically, the person you love most in the world will die at home. - Your home, on your watch.

Here's another number: 8%.

Approximately 8% of out-of-hospital cardiac arrest patients in Canada will survive. Got that? 8%. That leaves an overwhelming 92% who do not. The reality is that your loved one will likely stay dead. There will be no trip to the hospital. The medical examiner will send a representative and your loved one will be placed in a large, white, vinyl bag. This is my fault. – I am your CPR instructor.

Let's be honest with each other. – The average Canadian can't stand CPR training and I feel they've got a legitimate beef. "Is it 15 or 30 chest compressions, this year?" she says. "I thought it was 5. Yup, definitely 5!", someone else proclaims. "Are we breathing into people these days, because Facebook told me not to. Do we pump first or breathe first this year? What if it's a kid? Why do they keep changing it?" – I hear these questions on a weekly basis, often with a well justified tone of futility. – People are disenfranchised and they hate CPR class, because they're fed up with the ever changing minutia, which we as instructors sell you as Gospel.

The good news: At the public level there has been no change in the "numbers" since 2005 (it's almost 2016 so stop complaining). Consistency at last! Since 2005, those who are not breathing should receive a combination of 30 chest compressions and 2 ventilations. Repeat until help arrives. This makes the dying brain happy. Enter the defibrillator (AED) to coax the hysterical heart back into rhythm and (cue the applause), - your loved one wakes up.

Side note: It doesn't matter if you source your training from agency X or Y, in Canada, the US or Europe. All training agencies take their cue from a single international liaison committee. This ensures that the global community is singing from the same hymn sheet.

The 30:2 recipe, unchanged for a decade, has been scientifically shown to be most conducive to best outcomes. Allow me to repeat that: the evidence suggests that 30:2 is most conducive to best outcomes. That's what we teach, and that what we hope comes to fruition. Pretty simple, right? - Until reality hits you.

Do you have kids? – I do. I have 3 kids, aged 10, 9

and 5 (they're awesome). If you don't have little kids, I trust you have someone that you care for very much. You think you've committed 30:2 to memory? – Good for you. I think I know it by heart. – Good for me.

Here's the part no one wants to talk about:

Heaven forbid I walk into the bathroom, and my 5 year old daughter is floating face down in the tub, vital signs absent. Her shoulder-length brown hair is floating above her flaccid body, which is the color of an eggplant. When I pick her up and her dead, naked body slips from my arms and hits the floor, what will I know about 30:2? – I'm going to suggest that I'll know very little in that moment. I'll suggest that, despite my CPR certificate, I'll go "scrambled eggs" right then, and am unlikely to consider compression to ventilation ratios. – You can forget about other minutia such as beats per minute, compression depth and the other details that the instructor made to sound really important. You can also forget about relying on your 200 page (largely useless) textbook for any direction. - Good thing that book formed the basis of you course.

As mentioned, most cardiac arrest happens at home. Frustratingly, I often hear the following statements made in hindsight. "Dad was blue and not waking up so we called 9-1-1. He looked really sick but I couldn't remember exactly what the instructor said 3 years ago. He made those details sound really important and I didn't want to make things worse. EMS would be quick. I'm going to hold off and pray" – Hopefully the funeral was nice.

What if, as instructors, we dispensed reasonably with the specifics? While I feel that health care professionals such as paramedics need know their sequences cold, I feel that the public will do better with broad concepts and minimal details . Otherwise said, move blood to the brain and put air in the lungs.- Period. By all means, let's teach and practice to the evidence, but equally as important let's motivate Canadians to do SOMETHING:

76:4 cause you're scared and don't recall details? - Great job!

Not sure what a 2 inch compression feels like? - Who cares, push really hard.

Compression-only CPR because breathing into humans is gross? - Good for you!

You lost count because you're normal? – Me too!

This leads me to another interesting point. The following, fundamental point is seldom made during a CPR class for fear of making someone upset. Too bad, say I, so here's the cold truth: If your heart stops, your brain will die faster than an ambulance can arrive to fix you. Got that? Without bystander intervention, the person having the bad day is usually brain dead upon EMS arrival.

I don't want to hear about the "yeah but" or the "what if?" or the "I heard about a frozen guy in Sweden once, who made it". – No one cares. I'm here to reiterate the average Canadian circumstance, which is the 60+ year old in full arrest on your bathroom floor. – That brain is toast after 10 minutes, which is typically when EMS is walking up your driveway. Sure, they might get a heart back (heck, muscle is easily recovered after 10 minutes of down time), but it's beating inside a brain dead body. A body without brain function is a body in revolt. Without the brain, the body does not secrete important hormones needed to keep biological processes — notably kidneys — in proper working order. For example, vasopressin is a hormone that's needed for the kidneys to retain water. Normal blood pressure, which is also critical for bodily functions, often cannot be maintained in a brain-dead person. Hospitals sometimes provide mechanical support (a ventilator, hormones, fluids, etc.) for several days if organs will be used for donation, or if you and your family need more time to say good-bye. - But make no mistake, given the lack of bystander CPR you will be saying goodbye.

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CPR Training: A Legendary Waste of Time

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There is a misunderstanding among the average Canadian that whilst in cardiac arrest, those that matter to you, in order of importance are:

1: The Emergency Room Physician, followed by:

2: The ER Nurse

3: The paramedic

4: The firefighter / first responder

5: The bystander

A cold reminder that resources 1 through 4 are not standing next to your loved one in the first 10 minutes of their dilemma. Accordingly, (gasp), they don't matter within the context of this conversation. – You, on the other hand, matter very much.

At the end of the day, many CPR instructors are making an easy thing hard, compounding the problem of poor survival rates. We need to abandon the traditional checklist approach of 17 things that have to happen in order. Instead, instructors should concede that bystanders will mess up the details and to please be OK with that. Pink is good and blue is bad. Blood goes round and round and air goes in and out. Any deviation from this is bad and must be corrected immediately. Although there's a proven best practice, don't ever let your forgetfulness of specific details stop you from seeing the bigger picture. Oh, and if you fail the silly test, you're still plenty capable of helping the blue guy on the pavement. - Get in there.

In closing, bystander CPR is the backbone of surviving a cardiac arrest. Without public intervention, there will be a negative outcome. On the other hand, public CPR and timely access to defibrillation sets the stage for survival. As I tell those in my class "beat the heart a ton, and if you're feeling keen, please breathe for them too. If you're lucky enough to have an AED, use it yesterday. You can pick your textbook up on the way out the door."

Let's give folks the science, but more importantly, let's give them a license to deviate from the centerline. Empower them with flexibility and the public will start coming out of the woodwork. Since bystander CPR matters more than EMS intervention ever will, I suggest that we as instructors, need to start changing our collective tune. – My mentors have been blazing that trail for years, and for that, I thank them.

Kyle Mohler is a First Aid Program Instructor-Trainer with the Canadian Red Cross society. Professionally, he is a Firefighter and Paramedic in Halifax, Nova Scotia, Canada.

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Pharmacy Services - A New Direction In Health Care

By: Chris Matthews, CJM Solutions+

Under the present system it is clear that the health care system is in somewhat of a crisis. Everyone feels stressed, too many patients without a doctor or patients unable to get an appointment within a reasonable time for their Doctor or not being able to get in to see a specialist for months. The doctors are stressed because they have too many patients, and not enough time to give each patient adequate care. The average doctor's visit is 6 minutes for a male doctor and 8 for a female doctor. While reducing the wait times for specialists is a much longer fix there is something that can be done to help the Family physician. We, as Canadians, are living longer and getting sick rather than dying; the current system is just not equipped to look after our health care needs adequately.

Many patients are in the habit of going to their pharmacist if they have a minor issue because it is not always convenient to go to the doctor. Up until recently advice by pharmacists was and still is, in most cases, freely given and over the counter medications dispensed. If the patient needed a renewal or had an emergency need he/she would have to return to the family doctor. Now prescribing pharmacists are able to do so much more and up until recently if they wanted to get paid they would have to bill the patient, something that pharmacists, understandably, had trouble explaining to patients.

Now we are entering into a different world: pharmacists can not only prescribe they can diagnose minor ailments, give injections and provide an in-depth review of a patient's medications for those patients who are on multi medications. Government programs are already providing some reimbursement for services provided by pharmacists. Private Insurers while initially slow off the mark are starting to realize the importance of pharmacists in the health care equation. Medavie Blue Cross, Green Shield and Sun Life have all agreed that if the employer sees a need for these services they can provide it; with provisos of course.

So why would a pharmacy want to add all this paperwork for very little return, no pharmacy owner will get rich on pharmaceutical services alone. However these initiatives do three things for pharmacy:

1. Establish the pharmacy as a health centre rather than just another retailer. Patients (I use this word not customers) will view the pharmacy as it should and not go to another store because they have cheaper Kleenex. The relationship will be patient/pharmacist which is a professional relationship.
2. This should encourage more people to come to the pharmacy instead of going to their doctor for minor ailments and med reviews etc. This will allow Doctors to spend more time on patients that need more detailed help and hopefully take new patients.
3. Positive patient outcomes because a patient will be able to see a qualified health professional much earlier, and the communication with the doctor can only enhance a collaborative environment. All of which should benefit the patient.

Yes there are obstacles and yes there will be doctor push-back and you, as a pharmacist, will not feel you are being reimbursed properly for the work done but this is the way of the future and any positive change is fraught with pain and problems. It is a start.

So how do we push these initiatives forward? Simply through educating the following groups

April 1st 2016 Medavie Blue Cross added pharmaceutical services to the Pharmacy Association of Nova Scotia group benefits plan a great first step into this new world.

cjm+ Solutions
Insuring Your Financial Health

not necessarily in this order

1. *Employers,* by adding pharmacy services to their plan. How much employee time would they save since employees would not necessarily have to take time off to see the doctor. I use the very simple example of myself getting a Zostavax vaccination. In the past, I would have to go to the doctor to get a prescription, go to the pharmacy to get it filled, and then back to the doctor to get the injection. Thanks to Andrew Buffet's advice I got it all done in 20 minutes and my plan paid for it. Formerly it would have taken three visits and I would have waited an hour each time in the Dr.'s office. As an employer if I can cut down on my employee's absenteeism and assist in my employee's health it is worth doing. Not to mention that if an employee sees a health professional early it can reduce his/her stress and improve productivity. I should add here that a number of employers already have Health Spending Accounts and these can be used for pharmacy services.
2. *Insurers and their representatives*. Insurers are concerned about one thing and that is the bottom-line, basically banks that deal with employee benefits. The more claims dollars they process the more premiums they have to collect from employers. Some Insurers have taken some steps to show they are on the wellness bandwagon and offer on-line or telephone advice. Occasionally, they will do a wellness initiative which may involve a nurse and drawing blood. I did one survey which told me I needed to lose weight and slow down my driving, (I had had a recent speeding ticket) neither suggestion was earth shattering. Insurers will respond to employers' requests and what other Insurers are doing and once evidence can be shown that pharmacy services have an effect on the well being and the overall health of the patient, then they will start adding pharmacy benefits as a matter of course. (like physiotherapists and massage therapists) Much progress has been made already through representations to Insurers by PANS.
3. *The public* - despite the multi-layered advertising that has gone on, there are a number of patients who are just not aware of the services provided by pharmacy. People do not read, or read only when they need to. We have the same issue with Employee Assistance Plans; people do not know they have them until they need them.

So how do we get the message across?

1. For the *pharmacy owner*: talk to any employer that you may golf with or do business with in any way. Tell your friends about the new services that are available through pharmacy. Promote it within your pharmacy.
2. For the *pharmacist:* make the public aware by offering the service to your patients, with the boss's permission of course.
3. As a *benefit consultant:* we are adding pharmacy services to all our Medavie Blue Cross Plan members and other carriers as the groups renew. It is a gradual process. "Rome was not built in a day" and not without pain and suffering as pharmacists you are uniquely positioned and are the most knowledgeable on medications, younger doctors will be more open to collaborative practices and I believe this is the way of the future.

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P.A.A.P.

Pharmacists' Addiction Assistance Program

Ask a Drug Information Pharmacist

Question:

Divalproex is currently backordered. How would you convert the dose if you're switching the patient to valproic acid?

Valproic acid is an anticonvulsant with a relatively high incidence of gastric adverse effects. Enteric-coated divalproex was introduced to decrease the incidence of these side effects.[1] Divalproex sodium is comprised of valproate and valproic acid in a 1:1 molar ratio 1,2 and both valproic acid and divalproex sodium are converted into valproate in the body.[1,2] The bioavailability of valproic acid and divalproex is equivalent[1-3]; however, because of the enteric-coating, absorption of divalproex is delayed by approximately an hour when compared to valproic acid.[2] Upon discussion with the prescriber, patients previously receiving divalproex may be switched to valproic acid at the same daily dose and dosing schedule without loss of therapeutic effect.[1] The switch, however, should be accompanied by increased monitoring of plasma concentrations of valproate and other medications, as well as the patient's clinical status.[2,3] In addition, the pharmacist should counsel patients that they may experience more gastric side effects when taking valproic acid.[1]

References:

1. New Drugs/Drug News May/June 2002. Frequently Asked Questions: What are the differences among valproic acid, divalproex sodium, and valproate?
2. eCPS 2016: Epival® Product Monograph. Date of Revision: January 8, 2016
3. eCPS 2016: Depakene® Product Monograph. Date of Revision: January 8, 2016

Disclaimer: The Drug Information and Resource Centre (DIRC) of the Ontario Pharmacists Association provides this material to health professionals for informational purposes only. It is provided without warranty of any kind by DIRC and DIRC assumes no responsibility for any errors, omissions or inaccuracies therein. It is the responsibility of the health professional to use professional judgment in evaluating this material in light of any relevant clinical or situational data. This information is up to date as at the date of publication. Readers are encouraged to confirm information with additional resources.

Your Comprehensive Malpractice Insurance

By: Angela Walton, Wilson Insurance

Wilson Insurance Ltd. is pleased to be the provider of Malpractice Coverage to the Members of PANS through the carrier, Wynward Insurance. This coverage offers a competitive package with extended coverages to meet the needs of Pharmacists and your industry.

- Occurrence Based Policy provides coverage for an incident when it occurs, regardless of when it is reported.
- 2 Million guaranteed limit with higher limit option available
- Minimum policy aggregate limit is 2,000,000 per person
- New policy has no restricted reporting period and it will be retroactive to Dec 31,2002 to cover any incidents not reported in the past
- Coverage is for everything in the scope of pharmacy as regulated by NSCP
- Individual certificates are issued for each pharmacist
- Legal defense costs are covered in excess of the liability limit
- No deductible
- Choose to increase your limit option!

As a result the E&O Liability policy is broader than traditional E&O Policies as the changes made created a policy specific to Pharmacists' needs.

Proactive Practices help reduce claims….

1. Have a system in place that all prescriptions are double checked to ensure proper drug and dosage has been dispensed.
2. Check a/o screen for possible interactions with other medications.
3. If the prescription is not legible, call the doctor to confirm details.
4. Keep all data notes for a period required by NSCP and not less than 6 years.
5. Ensure that up to date product monograms, package inserts and patient counseling sheets are provided on all prescriptions.
6. Make computer entry notes to document conversations of relevance.

Educate your team on the when and how to Report a Claim….

1. When you first notice an error has been made the first thing to do is: document the details of the incident in your log book. This is a good practice as it reduces the likelihood of important information being missed or misconstrued. Write it out while it is fresh in your mind.

2. Next, tell your Employer, Insurance Company and licensing body.

For additional information or to discuss the program in further detail contact Angela Walton at Wilson Insurance waltona@wilson.nb.ca

Exclusive Retail Pharmacy Insurance Package

By: Angela Walton, Wilson Insurance

Wilson Insurance Ltd. in partnership with Wynward Insurance Group offer an exclusive Pharmacy Package policy with unique coverages and endorsements designed to address the Property and General Liability needs of Pharmacy Retail Stores.

Automatic discounts are added to stores that are:

- Camera's / Alarmed
- Tobacco free
- Claims free
- Supporting business

The Pharmacy Retail Package offers the following:

- 25% of additional coverage up to $100,000.00 limit of extra stock protection during peak seasons
- A limit of $25,000.00 on/ for signs is included within the package
- Crime limit of $ 10,000.00 at no additional premium
- Computers coverage limit of $ 10,000.00 included
- 3D Crime, the broadest coverage available.
- Includes Contingent Business Interruption in addition to regular business interruption
- Equipment Breakdown including stock spoilage
- Shop malpractice for no additional premium.

This coverage is extremely important as it covers your non- professional employees.

Your Wynward program provides many "Extras" written within your program at no additional cost to you. The business income wording is also broader to cover; actual loss sustained, mortgage rate guarantee, extended indemnity period and ordinary payroll coverage including extended period.

It is recommended that insurers complete a business income worksheet to ensure accurate values/ limits in the event a loss should occur. (Worksheets are available from Wilson Insurance).

For additional information or to discuss the program in further detail please contact Angela Walton at Wilson Insurance.

Wilson
ASSURANCE·INSURANCE
The RISK DETECTIVES™

ONTARIO PHARMACISTS ASSOCIATION
Drug Information & Resource Centre

PANS
PHARMACY ASSOCIATION OF NOVA SCOTIA

Therapeutic Options

FOCUS ON TRANSGENDER HEALTH

By Christine Elliott, BScPhm, RPh

BACKGROUND

Recognition and acceptance of transgender people is a relatively recent phenomenon. As the nomenclature for this topic varies across cultures and among references, some common terms are defined in Box 1.[1,2]

Not everyone who experiences gender nonconformity seeks or requires treatment. For those who experience significant gender dysphoria, there are a number of therapeutic options available including drug therapy, surgery and psychological therapy. Others not experiencing a high level of distress may still require some hormonal treatment to develop characteristics of the opposite sex without losing all of their phenotypic sex characteristics. A therapy plan needs to be individualized according to the patient's needs, desires and goals.[3,4]

BOX 1: DEFINITIONS

- Gender nonconformity is the extent to which a person's gender identity, role or expression differs from his/her biological sex.
- Gender dysphoria is the distress that an individual experiences as a result of his/her gender nonconformity.
- Transgender is an umbrella term for people who identify with a different gender from what is typically associated with the sex with which they were born.
- Transsexual refers to individuals who have already, or intend to change their bodies to a different gender permanently through surgery or hormone therapy. This is an older term and one with which not all transgender individuals identify. For the purpose of this article, the umbrella term transgender will be used.

EPIDEMIOLOGY

Epidemiological studies generally have not been done to evaluate the incidence or prevalence of transgenderism.[1] Cultural disparity in recognition and acceptance of gender nonconformity make it difficult to conduct such studies and capture specific incidence across multiple populations. The Netherlands and Belgium have calculated a transgender prevalence of 1:11,900 for males and 1:30,400 for females or a ratio of approximately 3:1 between the sexes. As these numbers are based on persons who have had sex changing surgery, they likely do not capture the entire transgender population. A further study of 8,064 people in the Netherlands suggested 4.6% of men and 3.2% of women shared some ambivalence regarding their sexual identity; while 1.1% of men and 0.8 % of women described their sexual identity as definitely different from their biologic sex. Only 0.7% and 0.2% of men and women respectively underwent gender reassignment surgery.[1,4,5]

ETIOLOGY AND PATHOPHYSIOLOGY

Pathologic studies suggest that transgenderism may be related to changes in the brain. Typically, an area of the hypothalamic bed nucleus is significantly larger in males. In an autopsy study of male-to-female (MTF) transgenders, this nucleus was found to be female sized. Nontransgender men taking supplemental estrogen for prostate cancer did not have a female sized nucleus, suggesting that hormonal therapy is not the cause for reduction in nucleus size.[1] In addition, identical twins are more likely to share transgenderism compared with fraternal twins, indicating there may be a genetic component.[1]

Studies have not demonstrated that transgenderism is caused by hormone changes in utero, nor correlated to geography; it occurs world-wide and across many different cultures.[1]

Gender dysphoria presenting in children does not necessarily persist through adulthood. Studies in prepubertal boys and girls, showed that only 20-25 % of those with childhood dysphoria continued to experience it into adolescence and

adulthood.[6] Dysphoria that continues after the initial hormone changes of puberty is a more reliable predictor that it may be permanent.[4,5,7]

Both children and adolescents who express discomfort with their gender are more likely to have coexisting anxiety, depression, oppositional defiant disorder and autistic spectrum disorders than the general population.[5] The Endocrine Society Practice Guideline outlines the DSM-IV diagnostic criteria for gender identity disorder (now referred to as gender dysphoria) that provides context as to what this behaviour may look like in children.[6] The recently published DSM-V devotes a chapter to gender dysphoria and includes revisions to the diagnostic criteria in DSM-IV.[8]

MANAGEMENT

There are many therapeutic options available for patients seeking treatment for gender dysphoria. Each patient should be assessed and a therapeutic plan developed that may include the following:

- Lifestyle change in gender expression (e.g., modifying dress, gait and/or voice consistent with one's gender identity)
- Hormonal therapy
- Surgery
- Psychotherapy

PSYCHOTHERAPY

The goal of psychotherapy is not to cure gender nonconformity but to provide a diagnosis, support, education and treatment for gender dysphoria. Indeed, the literature confirms that attempts to suppress or alter gender identity will fail, regardless of the biological sex.[9]

The World Professional Association for Transgender People Standard of Care recommends that a qualified mental healthcare professional makes the diagnosis of gender dysphoria. The assessment by the therapist may include:[6]

- Evaluation of the individual to assess if DSM-V-TR or ICD-10 criteria for gender dysphoria is met,
- Discussion of the possibilities and limitations of gender reassignment therapy to set realistic expectations,
- Assessment of potential psychological and social risk factors for unfavourable results of medical intervention,
- Counselling on reproductive options before undergoing hormone therapy for adults of child-bearing age.[5]

Since gender dysphoria in children often does not persist into adulthood, a reasonable strategy is to take a 'wait and see' approach.[10] Permanent treatments should be limited, and other diagnoses like schizophrenia, delusional disorder or body dysmorphic syndromes should be ruled out.[7]

Most adolescents with gender dysphoria do not have severe underlying psychotic disorders but commonly have anxiety, depression or oppositional defiant disorder.[5] Relationship problems with parents are also quite common, reported in up to 75% adolescents at one clinic.[6] Concurrent psychiatric illness and poor community/family support prevent good treatment outcomes, therefore, treatment of children and adolescents with gender dysphoria should include family counselling.[5]

Adults with gender dysphoria can present with mental health issues that may or may not be related to the stress accompanying the dysphoria. Concerns such as anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders need to be addressed.[5] Psychotropic medications may be required to treat the dysphoria or concurrent mental health conditions.[5]

Before undergoing permanent changes to gender, whether hormonal or surgical, some treatment centres require patients to have a 'real-life experience' by living the role of their new gender for a period of time, often up to a year.[6]

PHARMACOTHERAPY

Hormonal Therapy

The Endocrine Society Guidelines state there are two goals of hormone therapy. The first is to reduce endogenous hormone levels and thereby reduce the sexual characteristics of the patient's biological sex. The second is to replace those hormones with those associated with the reassigned sex as if the patient is starting from a hypogonadal state. The cross-sex hormones should be maintained at a physiological level consistent with the reassigned sex.[6] A list of hormonal treatment regimens can be found in Table 1; the choice of therapy will depend on whether treating an adolescent or adult.

GnRH Analogues

Adolescents who have started puberty (Tanner stage 2, usually aged 12 to 14 years) can be initiated on puberty suppression therapy with a GnRH analogue like leuprolide. This therapy is reversible and can decrease emotional and behavioural problems and improve functionality. It also allows more time to assess if hormonal therapy will be required. Lastly, this treatment can prevent development of irreversible sex characteristics that would later require surgery if the adolescent persists with gender reassignment at a later date.[5]

In a male-to-female (MTF) adolescent, these drugs will suppress testosterone significantly, with an effect similar to a bilateral gonadectomy. At around age 16 years, estrogen therapy can also be started: only 1 to 2 mg of estradiol is needed to achieve feminization. Estrogen therapy reduces erections, and libido, prevents facial hair development and voice deepening, but allows for breast development and more feminine development of facial bone structure and overall height.[1] If the cost of a GnRH is prohibitive, a progestin such as medroxyprogesterone may be an alternate choice.[5]

Adolescent female-to-male (FTM) individuals can be treated with a GnRH analogue to prevent full puberty and menses from occurring. Reversible prevention of puberty with the GnRH analogues prevents full breast development that would require surgery in the future. At around age 16 years, weekly testosterone cypionate or enanthate (50-75 mg per dose) injected subcutaneously or intramuscularly can be started. Menses will be suppressed, male characteristic body and facial hair will grow, vocal pitch will lower and breast formation will be prevented.[1] Again, one limitation of the GnRH analogues is the high cost. Alternately, individuals may be treated with a progestin like medroxyprogesterone. Continuous oral contraceptives or depot medroxyprogesterone can be given to suppress menses.[5]

Treatment to suppress puberty may be continued for a few years then either discontinued altogether or transition made to the standard adult feminizing/masculinizing hormone regimens listed in Table 1.

Use of suppression therapy does not imply future social transition or that sex reassignment will follow.[5]

FEMINIZING HORMONES

The goal of using hormone treatment in MTF adults is to suppress endogenous androgen and increase estrogen levels.[2] This activity will promote feminine characteristics like breast development, skin softening, and typical female fat distribution. It also decreases testosterone serum levels via a negative feedback loop, and in turn, reduces erections, libido and male-pattern hair growth. Combination therapy of an anti-androgen or GnRH analogue with an estrogen is the usual approach. Effect and onset of these treatments can be seen in Table 2.

Transgender women who have not had an orchiectomy, require estrogen doses four to eight times greater than a non-transgender woman.[1] These high doses increase the risk of venous thromboembolism (VTE). To reduce this risk, one strategy is to use transdermal preparations, especially in transgender women >40 years old or with comorbid risk factors.[2] Alternately, intramuscular injections avoid the hepatic first pass effect, providing higher estrogen levels with less risk of VTE compared to oral formulations.[1,3] If oral estrogen is to be used, estradiol is preferred over synthetic or conjugated estrogens as it has a better safety profile and can be monitored by blood tests.[2,6] Serum estradiol should be maintained at a level consistent with premenopausal women (<200 pg/ml) and the serum testosterone should be within a female range (<55ng/dl).[6] There are no studies comparing the efficacy of the different dosage forms of estrogen; however, observations suggest there is no significant difference. The selection of dosage form should be determined by safety profile, dose required, and patient preference.[3]

The addition of anti-androgens to estrogen therapy will also reduce the dose of estrogen needed. The most commonly used agents are spironolactone and cyproterone.[3] Spironolactone inhibits testosterone secretion to a minor extent and mainly acts as an androgen receptor blocker. It does not significantly lower blood testosterone levels and may cause hyperkalemia.[2,6] Cyproterone is a progestational compound with anti-androgen properties. It may have a faster suppression of testosterone than spironolactone; however, it can cause liver toxicity and depression so it should be used carefully.[2,6] GnRH analogues, like leuprolide, are effective at decreasing testosterone levels but tend to be expensive. Finasteride or dutasteride, 5-alpha reductase inhibitors, block the conversion of testosterone to its more active form and may have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin.[5]

With the exception of cyproterone, the use of progestins in transgender women remains controversial. Although progestins decrease androgen production and have been prescribed to assist with full breast development and to improve

TABLE 1: HORMONE REGIMENS AVAILABLE IN CANADA[2,7,11]

Medication	Dosage
Antiandrogens	
Spironolactone	100 to 200 mg daily
Cyproterone	25 to 100 mg daily
GnRh agonist (leuprolide)	3.75 mg subcutaneously monthly
Finasteride	1 to 5 mg daily
Dutasteride	0.5 mg daily
Male to Female individuals	
Estrogens	
Conjugated Estrogen	0.625-1.25 mg daily
Estradiol (oral)	2 to 6 mg daily
Estradiol (transdermal)	0.1 to 0.4 mg twice weekly
Estradiol valerate (parenteral)	10 mg weekly or bi-weekly
Female to Male Individuals	
Testosterones	
Testosterone cypionate or enanthate (parenteral)	100 to 200 mg every 2 weeks OR 50 to 100 mg every week
Gel 1% (transdermal)	2.5 to 10 mg daily
Patch (transdermal)	2.5 to 7.5 mg daily

TABLE 2: ONSET OF FEMINIZING HORMONE EFFECTS.[2,6,7]

Effect	Onset (months)	Maximum	Reversible
Feminizing effects of estrogen			
Redistribution of body fat	3-6	2-3 yr	Yes
Decreased muscle mass	3-6	1-2 yr	Yes
Skin changes	3-6	Unknown	Yes
Decreased libido	1-3	3-6 months	Yes
Decreased spontaneous erections	1-3	3-6 months	Yes
Male sexual dysfunction	Variable	Variable	
Breast growth	3-6	2-3 yr	No
Decreased testicular volume	3-6	2-3 yr	No
Decreased sperm production	unknown	>3 yr	Yes
Decreased body/facial hair growth	6-12	>3 yr	Yes
Scalp hair	No regrowth	NA	NA
Voice changes	None	*	NA

* Unlike adolescents, adults starting hormone therapy will not experience change in vocal pitch. Voice training with a speech pathologist is the most effective therapy.

libido, there are concerns about side effects (depression, weight gain, and lipid changes). Progestins are also suspected of increasing cardiovascular risk and breast cancer risk in women.[2,5]

Masculinizing Hormones

The primary hormone therapy for transgender men is testosterone. The goal of therapy is virilization, that is, the development of male secondary sexual characteristics. The expected effects and onset is listed in Table 3; the degree of physical change will depend on dose and route of administration.[2] Exogenous testosterone should be supplemented as it would for a hypogonadal male, with target testosterone serum levels in the therapeutic range of 320-1000 ng/dl.[6] Oral testosterone results in lower serum levels than parenteral or transdermal testosterone, and may not suppress menses. Transdermal testosterone may have a slower onset of effect than parenteral, but evidence suggests they achieve similar masculinization.[5] If cessation of menses does not occur with transdermal or low dose testosterone, a progestin can be added.[2] In circumstances where cessation of menses is desired, without significant virilization, a progestin injection contraceptive may be used or a levonorgestrel-releasing IUD can be inserted.

TABLE 3: ONSET OF MASCULINIZING HORMONE EFFECTS.[2,6,7]

Effect	Onset (months)	Maximum (years)	Reversible
Masculinizing effects of testosterone			
Skin acne	1-6	1-2	Yes
Facial/body hair growth	6-12	4-5	No
Scalp hair loss	6-12	---	No
Increased muscle mass	6-12	2-5	Yes
Fat redistribution	1-6	2-5	Yes
Cessation of menses	2-6	*	Yes
Clitoral enlargement	3-6	1-2	No
Vaginal atrophy	3-6	1-2	Yes
Deepening of voice	6-12	1-2	No

* Menorrhagia requires diagnosis and treatment by a gynecologist

SURGERY

Transgender individuals who have not had pubertal suppression therapy early in life, may require surgical intervention to achieve optimal masculinization or feminization goals. This surgery is not elective but medically necessary for some to alleviate their gender dysphoria.[3] Patients should be fully assessed by qualified mental health professionals and surgeons before making irreversible changes to their bodies.

For MTF patients, surgical procedures may include:[1,5]

1. Breast/chest surgery: augmentation mammoplasty
2. Genital surgery: penectomy, orchiectomy, penile inversion or creation of a vagina from a section of the colon
3. Non-genital procedures: facial feminizing surgery, liposuction, lipofilling, voice surgery, Adam's apple reduction, hair reconstruction, and other aesthetic procedures

For FTM patients, surgical procedures may include:[1,5]

1. Breast/chest surgery: mastectomy
2. Genital surgery: hysterectomy/ salpingo-oophorectomy, vaginectomy, scrotoplasty, implantation of erection and/ or testicle prosthesis
3. Non-genital procedures: voice surgery, liposuction/lipofilling, pectoral implants and other aesthetic procedures

Gender reassignment through hormone treatment and surgery results in a high level of patient satisfaction (87% of MTF patients to 97% of FTM patients), and relatively few regrets (1-1.5%MTF and <1% FTM).[5]

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Reviewed by: Joanne Deshpande, BScPhm, RPh and Lisa Sunstrum, BScPhm, RPh

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Home Insurance: Beyond Basic Coverage

Depending on where you live, if you work from home, and what you own, you may want to consider topping up your coverage for an extra level of protection. Here are some ways to tailor your policy:

Water Damage

Basic home insurance does a good job of covering water damage, but you may need more. Depending on your province or territory, you may be eligible to buy additional coverage:

- Sewer back-up coverage. Offers protection against back up, discharge or overflow from a sewer, septic tank, storm drain or sump pump.
- Aboveground water damage coverage. Provides roof water damage protection caused by ice damming, weight of ice, snow or sleet on the roof, and back up, overflow or discharge of water from eaves, downspouts, gutters or roof drains.

Oil Damage

The primary source of oil damage to your home and property is a leaking oil tank. If you have one on your property, you can avoid the potential cost of an expensive indoor or outdoor cleanup with additional protection. Generally, this includes:

- Loss or damage to your property
- Cleaning or decontamination of your premises

Oil damage can also be costly since you may have to decontaminate soil on your property.

Here's how the coverage works. If you have an oil tank on your premises, your home insurance policy does not cover oil damage. That's why it's a wise choice to get this coverage. Here's what's included in our new endorsement:

Coverage for loss or damage caused to your property by the sudden and accidental overflow or escape of fuel oil from a tank or apparatus or supply pipes connected to a heating system in use.

- Cost of cleaning and decontamination or remediation of your premises.
- Up to $25,000 for trees, shrubs and plants, subject to a maximum of $1,000 per item, including debris removal for any one tree, shrub or plant which is part of the landscaping of your premises.
- You are not covered if you have loss or damage caused by repeated escape or overflow of fuel oil, or the damage occurs while the building is under construction or vacant.

Who's eligible?

- You must have a home insurance policy with us and satisfy its conditions.
- This coverage is available on our homeowner/tenant/condo policies: Platinum Plus, Platinum, Gold, Silver, and Bronze.
- You have an aboveground exterior tank which is less than 14 years old or an interior tank which is less than 19 years old. If your tank is near our designated age limit, you may be asked to replace it.
- Your tank is in perfect working condition;

this means there are no signs of leakage or spills, no evident fumes or odours.
- Your tank is inspected/serviced annually by a certified or licensed heating contractor.
- Your tank is located on a non-combustible, level support.
- For exterior installations both your tank and fuel supply line are protected from vehicle impact.
- You reside in Canada.

In case of discrepancy between the information provided on this website and your insurance policy, your insurance policy prevails. Remember, the exclusions and limitations specified in your policy apply in all circumstances.

Damage from Earthquakes

Buying additional earthquake coverage will offer protection from direct losses or damage caused by an earthquake (but not if caused by tidal waves, floods or waterborne objects resulting from an earthquake). If you're eligible, this coverage includes living expenses (accommodation and food) and transportation while your home is being repaired.

Learn more: Is your property at risk of damage from earthquakes?
Home-based businesses

If you're a freelancer or run a business from your primary residence, you may be eligible for added coverage for:

- Business property (on premises and while away from the office)
- Expenses to keep your business running following loss or damage
- Clients or colleagues who injure themselves on your property

Identity Theft Protection

Identity theft is a real and growing problem. Added coverage includes up to $30,000 per incident to reimburse expenses and $5,000 for loss of income. If you have a current home insurance policy, you can add this protection at any time.

Your policy spells out coverage limits for your valuables including your jewellery, furs and bike. If you need more coverage you have options:

- Expensive bike. Your policy probably limits the coverage for your bike and includes a deductible. If you have an expensive bike, you can "schedule" it by adding a special clause to your policy to get the full replacement value.
- Jewellery and furs. Most insurance companies limit basic coverage to about $3,000 each. But you can buy extra coverage for a piece that is worth more or use it to itemize your more expensive pieces and rely on the basic amount to cover the rest. When you buy extra coverage for valuables, there is usually no deductible.
- Fine art. Buying extra coverage will depend on a number of factors, including the type of art, if it was bought or is on loan, and where it will be displayed or stored.

#inDISPENSEable: Pharmacy Awarenes Month 2016 - A Recap

Pharmacy Awareness Month was the first time PANS deployed a significant social media strategy. The results were outstanding. Here's an overview.

Twitter

107,000 impressions

Top Tweet earned 2,008 impressions

The CTV Morning Live team did a great job on our quiz this morning! They know how pharmacists are **#inDISPENSEable**
pic.twitter.com/EmH7CG9e0J

Facebook

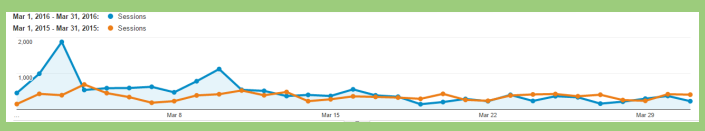
54,407 people reached

11,676 people were engaged (shared a post or commented on a post)

Website Visits

Up 67.16 over March 2015
Up 198.35% over March 2014

72% of users were new visitors, vs previous years when 50% were new visitors.



Contest Entries: 2,069

Contest Winners

Public Contest
Bernard Hillier, New Glasgow

Pictured:
Kevin MacKay from Medical Hall Pharmasave with winner Bernard Hillier from New Glasgow

see page 30 to read some of the reason patients said their pharmacist was #inDISPENSEable

Pharmacist Winners (tie)
Heather Barkhouse, Shoppers Drug Mart, Wyse Road
Wendy Coffin, Guardian, Dartmouth Gate

Profiles

23 pharmacists and pharmacy technicians were profiled.

TV/Radio

PANS representatives appeared on CTV TV, CBC TV, and News Talk Radio during PAM promoting pharmacy.

Building on the strength of our 2016 campaign, PANS will use the #inDISPENSEable theme in 2017.

New Member Benefits 2016

Hotels

Prince George Hotel/Cambridge Suites, Sydney and Halifax

Fantastic rates are available for members of PANS at the Cambridge Suites Hotel in Halifax and the Cambridge Suites Hotel in Sydney.

The Cambridge Suites Hotel in Halifax rooms are equipped with kitchenettes for those that like the conveniences of home when traveling for business or leisure. Studio Rooms are $129. Rates include complimentary buffet breakfast and Wi-Fi.

Contact: 1-800-565-1263 or use your corporate code to book online PHARMNS at the Cambridge Suites Hotel in Halifax

The Cambridge Suites Hotel in Sydney offers One Bedroom Suites which have kitchenette and a separate bedroom and living room space. These rooms are at a rate of $134 and include a complimentary buffet breakfast and Wi-Fi

Contact: -800-565-9466 or use your corporate code to book online PANS at the Cambridge Suites Hotel in Sydney

PANS is our company of the month in May at the Cambridge Suites in Halifax and Sydney. We will provide a complimentary welcome treat in your room when you visit!

Holiday Inn Harbourview

PANS members are able to enjoy a discounted rate at Holiday Inn Halifax Harbourview.

Rates are: May 1- September 30: $125 per night, October 1- April 30: $115 per night

This rate is available on Rooms with 1 King or 2 Doubles and includes complimentary hotel parking along with complimentary passes to the Dartmouth Sportsplex

Cineplex Movie Certificates

As a PANS member, you can purchase either a four-pack or a ten-pack of Cineplex® movie certificates and save. The savings to you is almost $13 off the suggested retail price on the four-pack and almost $35 off the suggested retail price on the ten-pack. Certificates may be used individually or you can treat your whole family to a night out at the movies. The choice is yours. 4-Pack: $35+HST ($8.75/certificate), 10-Pack: $85+HST ($8.50/certificate)

OPA Continuning Edcuation Programs

PANS members can now take OPA programs at the same rate as OPA members.

QiD - Pharmacist Forum

QID.io is a community exclusive to Canadian pharmacists, technicians, and students.QID allows you to easily and securely communicate with pharmacists across the country in dozens of Communities of Practice; collaborate on difficult cases, request and share advice on best practices, and easily keep pace with medical news. What's more, when you sign in to QID you'll have immediate unlimited access to a world-class decision-support tool. Find evidence-based answers to therapeutic questions, accredited CE, and more than 20,000 videos, algorithms, tables – all when you need them most.

For more information on all PANS member benefits, visit: pans.ns.ca

Employment Opportunities

Below are the highlights of the lastest career posts on the PANS website. To see the full details of each posting log-on to the PANS website and visit the Careers on the Pharmacy Professionals section of the website. The direct link to the page is: https://pans.ns.ca/pharmacy-professionals/careers

Pharmacist: Permanent part time - Eskasoni, Nova Scotia

We are looking to hire a permanent part time pharmacist, 2 to 3 days per week plus vacation coverage. The dispensary is located in the Eskasoni Health Centre where we are an integral part of a collaborative practice with a full health care team comprised of physicians, nurses and other health care professionals.

Relief Pharmacist: Part-time - Metro Dispensary, Halifax, Nova Scotia

We currently have an opening for a part-time pharmacist to work one day per week and to be available to cover vacations periodically throughout the year. Our pharmacy is very unique in that we are not open to the general public.

Pharmacy Assistant / Pharmacy Technician: Part Time (25-40 hours/week) - Dartmouth, Nova Scotia

Costco Pharmacy is looking to add a part-time Pharmacy Assistant or Pharmacy Technician. Applicants must have a diploma/certificate from a formal training program. Minimum 1 year experience in a retail setting is considered an asset. Position includes benefits package and competitive starting wage.

Pharmacist: Full/Part Time - Liverpool, Nova Scotia

We are looking for an enthusiastic, self-motivated individual with a passion for the ever-changing world of pharmacy. We are a customer service-oriented company and have great relationships with our patients and fellow health care providers. An interest in expanded scope services (medication reviews, injection administration, etc.) will be considered an asset

Links of Interest

Alzheimer's Society - Canada
http://www.alzheimer.ca/en

Asthma Society of Canada
http://www.asthma.ca/

Canadian Celiac Assoication
http://www.celiac.ca/

Canadian Dermatology Association
http://www.dermatology.ca/

Canadian Diabetes Association
http://www.diabetes.ca/

Canadian Lung Association
http://www.lung.ca/

Canadian Paediatric Society
http://www.cps.ca/en/

Canadian Pharmacist's Association (CPhA)
http://www.pharmacists.ca

Cancer Care Nova Scottia
http://www.cancercare.ns.ca/en/home/healthprofessionals/stp/default.aspx

Crohn's and Colitis Canada
http://www.crohnsandcolitis.ca/site/c.dtJRL9NUJmL4H/b.9012407/k.BE24/Home.htm

Health Canada - Advisories and Warning
http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/index-eng.php

Health Canada - Tobacco Information
http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/index-eng.php

Mayo Clinic
http://www.mayoclinic.org/

Medication InfoShare
http://medicationinfoshare.com/

Medline Plus (U.S. National Library of Medicine)
https://www.nlm.nih.gov/medlineplus/druginfo/herb_All.html

Mother Risk (Hospital for Sick Children, Toronto)
http://www.motherrisk.org/

National Center for Complementary and Integrative Health (U.S. Dept. of Health & Human Services)
https://nccih.nih.gov/

Osteoporosis Canada
http://www.osteoporosis.ca/

Sleepwell Nova Scotia
http://sleepwellns.ca/

PANS **www.pans.ns.ca**

facebook.com/PharmacyNS

twitter.com/PharmacyNS

YouTube **youtube.com/pharmacyassocns**

THEY ANSWER ALL THE DIFFICULT QUESTIONS AND UNDERSTAND MY NEEDS

I feel safe and comfortable that he is looking out for the best interests of my family.

HE STAYS AROUND LATE ON A SNOWY NIGHT

EXTREMELY KNOWLEDGEABLE AND HELPFUL

THEY GIVE ME GOOD ADVICE AS WELL AS KNOW MY MEDS

They know my husband's meds better than me

HE TAKES THE TIME TO ENSURE THINGS ARE WORKING FOR ME

QUICK TO LET ME KNOW THINGS I NEVER WOULD HAVE THOUGHT OF

MAKES YOU FEEL COMFORTABLE

THEIR INFORMATION IS ABSOLUTELY INVALUABLE!

ALWAYS MAKES SURE YOUR EVEY NEED IS MET

SHE GIVES GREAT ADVICE

#inDISPENSEable

THEY HAVE GONE THE "EXTRA MILE" FOR ME A FEW TIMES WITHOUT BATTING AN EYE!

HE'S THERE WHEN YOU NEED HIM

THEY ARE THE BEST THERE IS

THEY'VE HELPED ME THROUGH MY PREGNANCY. COULDN'T HAVE DONE IT WITHOUT THEM.

SHE KEEPS ME HEALTHY

SHE MAKES ME FEEL CONFIDENT GIVING MY KIDS MEDICINE

PROVIDES ME WITH GREAT INFORMATION

THE ADAGE MAKING YOUR COMMUNITY A BETTER AND HEALTHIER PLACE IS CERTAINLY OBVIOUS BY OUR PHARMACIST.

HE HELPED ME TO SAVE MY DADS LIFE

We are in a very rural community and our pharmacist plays a valuable role as part of the network of our health care service which includes more than just prescriptions!

I seriously don't know what my family would do without her.

VERY KIND AND HAS THE PATIENCE OF A GOD.

She is one of the kindest people you will ever meet.

It is #inDISPENSEable to have more information than a doctor provides!

TREATS ME AS A PERSON NOT A PATIENT

The below resolution was passed in the Nova Scotia Legislature on April 28, 2016. PANS CEO Allison Bodnar was in attendance.

House of Assembly
Nova Scotia

DEBATES AND PROCEEDINGS

Speaker: Honourable Kevin Murphy

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Second Session

THURSDAY, APRIL 28, 2016

MR. GLAVINE « » : Mr. Speaker, in the gallery today we have Allison Bodnar, Chief Executive Officer of the Pharmacy Association of Nova Scotia, and if everyone would give her a warm welcome. (Applause)

MR. SPEAKER « » : The honourable Minister of Health and Wellness.

RESOLUTION NO. 3417

HON. LEO GLAVINE « » : Mr. Speaker, I hereby give notice that on a future day I shall move the adoption of the following resolution:

Whereas pharmacists are valued and trusted health care providers in communities across the province; and

Whereas pharmacists are able to give flu shots, prescribe medication for minor ailments or refills for regular medications, review medications, and provide valuable health information to patients; and

Whereas pharmacists work in hospital settings, in community pharmacies, and with other regulated health care providers to improve the health of Nova Scotians;

Therefore be it resolved that all members of this House thank pharmacists and the Pharmacy Association of Nova Scotia for the good work they do every day on behalf of Nova Scotians.

Mr. Speaker, I request waiver of notice and passage without debate.

MR. SPEAKER « » : There has been a request for waiver.

Is it agreed?

It is agreed.

Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

The PHARMACIST

PANS

PHARMACY ASSOCIATION OF NOVA SCOTIA

170 Cromarty Drive, Suitee 225
Dartmouthn Nova Scotia
B3B 0G1

www.pans.ns.ca