New and Noteworthy

Over the course of the last few months there have been a few additions to the School of Pharmacy family. So let’s roll out the red carpet for Patricia A. Chase, Ph.D., the Dean of the School of Pharmacy and Gina Carbonara, Pharm.D. Director of Introductory Pharmacy Practice Experiences (IPPE).

Mark Your Calendar

Please mark your calendar for the following upcoming dates and deadlines:

**APPE**
- Block 7: November 13, 2006 – December 15, 2006
- Student Assessment Forms from Block 7 are due on or before December 22, 2006
- Block 8: January 8, 2007 – February 2, 2007
- Student Assessment Forms from Block 8 are due on or before February 9, 2007
- Student Assessment Forms from Block 9 are due on or before March 9, 2007

**Community IPPE**
- First year students (P1) will complete 20 hours in the community setting between January 8, 2007 and May 5, 2007 at the same site where they completed their 20 hours in the fall.

Patricia A. Chase, Ph.D.

In July Patricia A. Chase, Ph.D. took the post of dean of the West Virginia University School of Pharmacy vacated by George Spratto, Ph.D. She served as dean and the Edward and Margaret Rowe Decanal Chair of the College of Pharmacy and Health Sciences at Butler University, Indianapolis.

“Dr. Chase is a leader in her profession, an advocate for patients and for students, and an accomplished and energetic person,” said Robert M. D’Alessandri, M.D., who made the appointment. “We expect her to continue the tradition of excellence that has been the hallmark of the WVU School of Pharmacy for a century, and to bring it to new levels of achievement in education, research and service to the state.”

Chase led Butler’s pharmacy school from 2000-2006. She holds a bachelor’s degree from Albany College of Pharmacy, a master’s degree from the University of North Carolina-Chapel Hill, and a Ph.D. from the University of Colorado. Her research has focused on topics such as innovative curriculum development, programmatic assessment, programs to enhance faculty leadership, and on the design and implementation of health and wellness programs.

In recognition of her research to improve the heath of the people of Indiana she has been named to the Governor’s Council for Fitness and Sports.

At Butler, under her leadership, the number of faculty and staff doubled in five years. Private donations also doubled, allowing the school to renovate teaching and laboratory facilities, enhance the student experience with laptop computers, and establish health and wellness programs for students, faculty and staff.

Working with health providers and other institutions in Indiana, she was successful in securing more than $5 million in free medication for people with unmet pharmaceutical needs in four rural communities.

“I am extremely honored to be selected as the dean of the School of Pharmacy,” Chase said. “I look forward to continuing the excellent work that Dean Spratto, the faculty, staff, students, and alumni have achieved. I am inspired by the quality of the human spirit in West Virginia and I am excited to be a part of this wonderful university.”

As chair-elect of the Council of Deans of the American Association of Colleges of Pharmacy, Chase will be a national voice on issues in the profession, Dr. D’Alessandri said. “West Virginia University will be providing leadership in an important area of health scholarship and health professions education.”
Greetings! I am excited to introduce myself as the new Director of Introductory Pharmacy Practice Experiences (IPPE) at the West Virginia University School of Pharmacy. My first day at the School of Pharmacy was October 2, 2006, and it has been a very busy time trying to get up to speed with the first and second year students!

I am a graduate of the University of Pittsburgh, School of Pharmacy, and I began my career as a retail pharmacist with Wal-Mart in Mt. Pleasant, Pennsylvania. Prior to joining the Faculty at WVU, I was a Clinical Pharmacy Specialist for UPMC Health Plan, a large Managed Care Organization in Southwestern Pennsylvania. My experiences at UPMC Health Plan included leading the quarterly Pharmacy & Therapeutics (P&T) Committee meetings, developing the formularies for the commercial products, developing the communication materials for providers and members for all pharmacy initiatives, preparing the pharmacy department for accreditation by NCQA (National Committee for Quality Assurance), and reviewing prior authorization requests.

My favorite role during my years at UPMC Health Plan was serving as a preceptor and mentor for pharmacy students from the local universities. I served as a preceptor for the fourth professional year (P4) students from the University of Pittsburgh and Duquesne University. I coordinated the internship program for the summer months, and we were fortunate last year to have students from Pitt, Duquesne, and Wilkes-Barre. I also assisted with the student chapter of the Academy of Managed Care Pharmacy (AMCP) at various functions throughout the year, as well as represented the area of managed care pharmacy at student career roundtable events.

Therefore, I have been involved with Experiential Education both as a pharmacy student and as a preceptor. My experiences during pharmacy school with service learning and experiential education made such a positive and lasting impact on me that I was thrilled to begin serving as a preceptor. I wanted to be able to provide guidance to students and teach them to be positive influences within the community. Therefore, I truly applaud all of you for serving as preceptors for WVU School of Pharmacy and providing a learning environment for our students outside of the classroom.

My position at WVU will allow me to work with the pharmacy students during their first three years of Experiential Education. I will work with various faculty members to coordinate the community pharmacy practice experience for the P1 students and the service-learning experience for the P2 students. I will also be assisting with the development of the 2-week Capstone Institutional Rotation for the P2 students and the practice experiences for the P3 students. As you can see, it is a busy and exciting time for our IPPE program!

I look forward to meeting all of you over the next several months. I truly appreciate all of your efforts, and by working together, I know that we can make the IPPE program a true success!

Sincerely,
Gina Carbonara, Pharm.D.

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**Library Resources**

User login to computers at the WVU Libraries or to remotely access the Libraries’ electronic resources changed as of Sunday, Oct. 8. Under the new policy username and password are required. If you do not know you login for the WVU Libraries please call 304-293-1933 and ask to speak with a Staff Member. You will need to tell them that you are an adjunct faculty preceptor for the WVU School of Pharmacy. For everyone, passwords are the two-digit day of an individual’s birth and the last four digits of his WVU ID. For example: If someone’s birthday is July 2, 1980 and his WVU ID is 700000000, he would enter 020000. You can find your WVU ID at [https://centralid.wvu.edu/wvuid/](https://centralid.wvu.edu/wvuid/). If you continue to have problems access the WVU Library resources, or if the Library is unable to find user information for you, please contact Jenny Ostien, Program Specialist for Experiential and External Education at 304-293-1464 or jostien@hsc.wvu.edu.
Welcome New Preceptors and Sites!

With the inception of the new IPPE program and the ever expanding APPE program, we have gained several new preceptors and sites. We apologize for any that may have been left off of this list.

- Jackson General Hospital – Ripley, WV (Sherri Adams, R.Ph.)
- Alaska Native Medical Center – Anchorage, AK (Anne Bott, Pharm.D.)
- Walgreens Pharmacy #9343 – Morgantown, WV (John Buracchio, R.Ph.)
- Rite Aid Pharmacy #1407 – Craigsville, WV (Amanda Carpenter, Pharm.D.)
- WVU Hospitals, Inc. – Morgantown, WV (Kelly Collins, R.Ph.)
- Walgreens Pharmacy #1073 – West Columbia, SC (Jim Cordan, R.Ph.)
- CAMC – General Division – Charleston, WV (Jeremy Fox, Pharm.D.)
- CVS Pharmacy #6281 – Parkersburg, WV (Kathy Gibbs, R.Ph.)
- St. Mary’s Hospital – Huntington, WV (Rupert Hay, R.Ph.)
- Highland Pharmacy – Webster Springs, WV (Jeff Kesecker)
- Walgreens Pharmacy #4387 – Oakland Park, FL (Natachia Lawrence, Pharm.D.)
- Three Springs Village Pharmacy – Weirton, WV (Patsy Longhi, R.Ph.)
- Walgreens Pharmacy #7942 – Whitehall, OH (D. Rich Miller, R.Ph.)
- Walgreens #9804 – Uniontown, PA (Tim Rakas)
- CVS Pharmacy #5957 – Elkview, WV (Chanda Saucerman, Pharm.D.)
- Walgreens Pharmacy #6159 – New York, NY (Suzanne Tamer, R.Ph.)
- CVS Pharmacy #7604 – Parkersburg, WV (Sally Lane, R.Ph.)

Newsletter Name Vote Now!

Over the course of the last several months (and issues of the newsletter) we have been taking suggestions for an official name for our preceptor newsletter. After a lot of hard work three names and designs have been decided upon and now it is time for you to vote!

The three choices are listed below and have also been attached to the e-mail containing the newsletter as a Word document. They will also be posted on SOLE with the newsletter. Please e-mail your vote to Jenny Ostien (jostien@hsclwvu.edu) by January 3, 2007.

The next edition of the newsletter will be out in February and will introduce the official name!!

Choice 1: The PEN Preceptor-Educator Newsletter

Choice 2: Preceptor Today

Choice 3: The Pharm Report
Diabetes Pearls

Glyburide is a second generation oral sulfonylurea agent commonly used in the management of type 2 diabetes mellitus. Recent evidence suggests that the drug may pose a risk for persons with ischemic heart disease thru interference with a normal physiologic defense (or adaptation) mechanism called ischemic preconditioning. During short periods of cardiac ischemia, various mediators including activation of ATP-dependent potassium channels confer protection upon the myocardium preserving function and perfusion. These same channels are found in the beta cells of the pancreas whose blockade by oral sulfonylureas results in the release of insulin. Likewise, blockade of these channels in the myocardium can prevent ischemic preconditioning. Whether gluburide poses an added cardiovascular risk for persons with type 2 diabetes (with or without underlying heart disease) or interferes with the diagnosis of acute myocardial infarction remain controversial. However, some experts have called for the elimination of glyburide from our therapeutic armamentaria. Interestingly, glipizide and glimiperide have not been shown to adversely affect ischemic preconditioning. Before considering stopping glyburide or substituting it for another agent, you and/or the patient should discuss this issue further with his/her primary care provider.

Charles D. Ponte, PharmD, CDE, BCPS, BC-ADM
Professor of Clinical Pharmacy and Family Medicine

Preceptor Pearls on Alzheimer’s Disease

1. Patients with dementia should be managed by a team of caregivers.
   
   The needs of patients with dementia are complex but they may or may not be capable of participating in decisions. All patients with dementia will have some sort of a caregiver who assists with their care and healthcare decisions. Additionally, there usually is not just one way to manage these patients. So unless we ask, we won’t know what goals are appropriate for a patient’s care. Communication among those who participate in the care of patients with dementia is critical to ensure that the desired outcomes can be met.

   The American Geriatrics Society promotes the role that an interdisciplinary team can play in providing quality care to all seniors, including those with dementia. We must realize that we are part of a team that is providing care, even if we never see the other team members. Family and professional caregivers (including prescribers) need to receive information from us and they are a source of information for us. We need to take the initiative to contact other members of the “team” when we have concerns or suggestions.

   At least one group that advocates for the needs for seniors has recognized the potential role that pharmacists can play through providing Medication Therapy Management Services to patients with dementia. In order for our work to benefit patients, however, we need to work with the team.

2. Not all dementias respond equally to drug therapy.

   Common forms of dementia include Alzheimer’s disease (AD), multi-infarct dementia, and Dementia with Lewy Bodies. Drugs used to prevent disease progression (e.g. aspirin for multi-infarct dementia), improve cognition (e.g. cholinesterase inhibitors), and control behavioral problems (e.g. atypical antipsychotics) do not work the same in these different disease states. Therefore, we need to find out what the patient’s presumptive diagnosis is before we can make recommendations about their therapy.

3. AD is a chronic, progressive illness that is often fatal.

   Patients with Alzheimer’s disease will progress from the date of diagnosis until the time of death. We should re-evaluate a patient’s overall drug regimen in this context. Should a patient continue to receive a drug that may take several years to provide benefit? (e.g. a bisphosphonate for osteoporosis, a statin for primary prevention of cardiovascular disease)

4. All patients with AD should be considered for treatment with a cholinesterase inhibitor with or without memantine.

   Most clinical practice guidelines recommend that patients with AD receive a trial of a cholinesterase inhibitor. It is reasonable to recommend that a prescriber consider one of them (donepezil, galantamine, or rivastigmine) if we know that a patient has never been tried on one. However, many patients do not tolerate the adverse effects of these drugs and don’t improve on therapy. As a result, not everyone with dementia needs to be receiving one of these drugs.

   Memantine is effective alone but the drug is more likely to be effective when used in combination with a cholinesterase inhibitor. It is reasonable to consider recommending memantine in patients in whom it has not been tried, whether or not they are receiving a cholinesterase inhibitor.

5. No drug therapy has been shown to be effective for all patients with AD. All therapy should be started on a trial basis and only continued if the perceived benefits to the patient outweigh the potential risks.

   Drugs from a variety of therapeutic classes (including antidepressants, antipsychotic, anticonvulsants, and anti-anxiety agents) are used to manage a variety of symptoms associated with AD. No drug is universally effective for this...
Each drug that is started needs to prove its value in maintaining or improving the quality of life of the patient. Since the patient is not able to evaluate the response of the drug, those who live or work with the patient must be asked. We need to ensure that information is being obtained regarding a patient’s response to therapy. Otherwise, these patients tend to have very complex medication regimens full of drugs that might not be helping them.

Patients with AD change with time. Therapy should not be static but should be adjusted based on the needs of the patient.

AD is a chronic progressive disorder. The fact that a patient started receiving a drug six months or a year ago and seemed to respond does not mean that the drug is helping today. We need to regularly consider whether it would be reasonable to recommend a trial dosage reduction or discontinuation of a drug that was started to manage a patient’s symptoms.

Cholinesterase inhibitors and memantine are the exceptions to this rule of thumb. There is no clear consensus about when it would be reasonable to consider withdrawing these forms of therapy. Many people consider stopping these drugs if a patient develops adverse effects or if there is little risk of negative consequences with drug discontinuation. For example, a situation where it would be reasonable to re-evaluate the role for these drugs is for a patient with very advanced AD. It is likely that such a patient can no longer communicate with those around her, and is not able to participate in any aspect of her care. She may no longer be receiving any benefit from the cholinesterase inhibitor and the potential negative impact of discontinuing the drug might be little if any.

**Summary**

There are many ways to treat patients with AD. Perhaps the most important pearl for us to remember is that the key to quality care is communication. Effective communication with caregivers and among healthcare professionals is necessary to optimize care for these patients.

David P. Elliott, PharmD
Director, Clinical Pharmacy Programs-Charleston Division
Professor of Clinical Pharmacy

**References**


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**Oscillometric Wrist Blood Pressure Measuring**

Emily DeVault, PharmD
Pharmacy Practice Resident, West Virginia University-Rite Aid

Home blood pressure monitoring is becoming increasingly popular and offers several advantages over office-based measurements. As the trend toward patient blood pressure monitoring grows, health care providers are not only seeing improvements in the diagnosis of hypertension, but also in the treatment and management of patients currently taking blood pressure medications.1 Two types of home monitoring systems are available to patients, the conventional blood pressure device and the oscillometric wrist blood pressure measuring device.

Wrist devices are becoming very popular among patients due to their size and ability to use without undressing.2 However, there are some factors that may hinder proper use of wrist devices. Appropriate hand position is essential for accurate use of the device.2 The patient needs to understand the importance of identical arm positions for each blood pressure reading. In addition, differences of up to 10 mmHg have been reported because of small changes in arm position.2 Differences can also occur due to palmar flexion or palmar extension of the hand.2 Palmar flexion can result in higher readings.2

Elderly patients may have a particularly difficult time positioning their arm and may not have the dexterity and flexibility to hold this position for the time that the wrist cuff requires. In a student blood pressure lab held recently at the WVU School of Pharmacy, wrist cuffs were compared to conventional arm cuffs. Students and instructors noted the difficulties encountered when attempting to obtain a wrist measurement using Omron’s wrist cuff, which is thought to be the highest quality product on the market. Many students were unable to position their arm correctly or were unable to hold it in the correct position for the time required and could not obtain a blood pressure reading. Many students noted that the wrist cuff felt cumbersome and placed it on the wrong wrist without calibrating it for the correct wrist. These issues
could create problems in compliance if such cuffs were used in a large-scale blood pressure monitoring program.

A study was conducted comparing wrist blood pressure measurements with conventional methods. The results observed a significant difference in blood pressure readings between each mode of measurement. Lower blood pressure readings were observed using the conventional method, as compared to the wrist device.

Although the size and availability of the wrist devices may be appealing to patients, accurate results may be hindered due to inappropriate use and difficulty in obtaining appropriate arm position. Traditional automatic arm cuffs remain the more practical and reliable tool for at-home blood pressure monitoring for most patients.

References:

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**From the Director's Chair**

**APPE Student Remediation Plan**

The new APPE student assessment form has been well-received by preceptors. The form is comprised of six competency areas: professionalism, communication, pharmacy knowledge, patient care, drug information/evidence based pharmacy practice, and pharmacy systems based practice.

Because it is possible for the student to satisfactorily complete the rotation but receive an unsatisfactory evaluation on individual competencies, we are finding that preceptors are providing us with more accurate feedback on the competencies in need of improvement. If needed, this allows the SOP to remediate students on a particular competency or competencies during subsequent rotations instead of them being required to repeat a particular type of rotation and delay their graduation. This remediation may be accomplished by the following:

- the preceptor(s) providing the student with experiences that will enhance and strengthen areas in need of improvement or
- changes to the student’s rotation schedule that will enhance and strengthen areas in need of improvement

Recognizing that some students may require additional assistance to master a particular competency or competencies, other options for remediation may include:

- removal from rotations until the student can successfully complete academic work assigned by the SOP or
- remediate an entire rotation.

**Please note that if a student must remediate a rotation, they will not be assigned to the same preceptor.**

Preceptors are encouraged to contact Carla See if a student receives a score of less than 5 on any competency at the two-week evaluation. Preceptors should contact her immediately when a student will receive a total score of less than 5 at the four-week evaluation.
Student Professionalism on Rotations

A joint task force involving the American Pharmaceutical Academy of Students (APhA-ASP) and the American Association of College of Pharmacy Council of Deans resulted in a white paper on student professionalism. The purpose of the article was to raise awareness and lead to action on the issue of student professionalism. A copy of the article has been attached as a PDF document.

In preparing the white paper, the task force used the following definitions of a professional and professionalism.

**Professional**: A member of a profession who display the following 10 traits:

1. Knowledge and skills of a profession.
2. Commitment to self-improvement of skills and knowledge.
4. Pride in the profession.
5. Covenantal relationship with the client.
6. Creativity and innovation.
7. Conscience and trustworthiness.
8. Accountability for his/her work.
9. Ethically sound decision making.
10. Leadership.

**Professionalism**: the active demonstration of the traits of a professional.

This white paper is relevant to preceptors because the first competency on the APPE student assessment form deals with “professionalism.” Students are evaluated by the preceptor on responsibility and citizenship, self-learning, and time management. Please note this means the SOP definition of professionalism goes beyond the traditional issues such as promptness, appearance and general good manners.

Preceptors are encouraged to review the student assessment form and be cognizant of the criteria used to evaluate student professionalism. The SOP will not tolerate unprofessional behavior of students and will work with the preceptor to either resolve the student issue or, if necessary, provide remediation for the student. Our goal is to work with preceptors to graduate competent pharmacists who positively represent the profession and the School of Pharmacy.

Preceptors who have identified a professionalism issue with a student, should contact Gina Carbonara (IPPE rotations) or Carla See (APPE rotations) to discuss options for assisting the student in improving in the competency of professionalism. The earlier we can assist the preceptor with an intervention, the less likely the behavior(s) will continue in subsequent rotations.


**Contact Information**

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<tr>
<th>Carla J. See, M.S., M.A.</th>
<th>Gina Carbonara, Pharm.D.</th>
<th>Mrs. Jenny Ostien</th>
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<tr>
<td><strong>Director of Experiential and External Education</strong></td>
<td><strong>Director of Introductory Pharmacy Practice Experiences</strong></td>
<td><strong>Program Specialist, Experiential and External Education</strong></td>
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<tr>
<td>West Virginia University School of Pharmacy</td>
<td>West Virginia University School of Pharmacy</td>
<td>West Virginia University School of Pharmacy</td>
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<tr>
<td>P.O Box 9520</td>
<td>P.O. Box 9520</td>
<td>P.O. Box 9520</td>
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<tr>
<td>Morgantown, WV 26506-9520</td>
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<td>Morgantown, WV 26506-9520</td>
</tr>
<tr>
<td>(304) 293-5104</td>
<td>(304) 293-1471</td>
<td>(304) 293-1464</td>
</tr>
<tr>
<td>(304) 293-7672</td>
<td>Fax (304) 293-7672</td>
<td>fax (304) 293-7672</td>
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<td><a href="mailto:csee@hsc.wvu.edu">csee@hsc.wvu.edu</a></td>
<td><a href="mailto:gcarbonara@hsc.wvu.edu">gcarbonara@hsc.wvu.edu</a></td>
<td><a href="mailto:jostien@hsc.wvu.edu">jostien@hsc.wvu.edu</a></td>
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