

Pharmacists and DVT

The outpatient use of low-molecular-weight heparin (LMWH) to treat acute deep vein thrombosis (DVT) in appropriate adult patients is just as safe and effective as traditional inpatient therapy with unfractionated heparin, according to a new therapeutic position statement released by the American Society of Health-System Pharmacists (ASHP).

“The good news is that DVT can be treated very easily and cost-effectively in an outpatient setting with the use of LMWH,” said Cynthia LaCivita, Pharm.D., director of clinical standards and quality in ASHP’s Practice Standards and Quality Division. “This means that patients can spend less time in the hospital, and costs for care go down dramatically.”

Daniel M. Witt, Pharm.D., manager, Clinical Pharmacy Services, Kaiser Permanente of Colorado, pointed to the growing number of health-system pharmacists who have successfully developed and implemented outpatient DVT treatment programs. “These programs are invariably win-win because patients get effective therapy in a more comfortable setting and scarce financial resources can be preserved and allocated to other important health-care initiatives,” Witt added.

Often called a “silent killer,” DVT can lead to deadly complications such as pulmonary embolism (PE). According to the American Heart Association, more than two million Americans are diagnosed with DVT each year, and it has been estimated that PE may cause up to 200,000 deaths annually. Some of the top risk factors for DVT include:

- Age
- Stroke
- Prolonged immobility
- Cancer and its treatment
- Major surgery
- Prior DVT
- Varicose veins
- Obesity

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Virginia Health-System Pharmacy News

November/December 2004

ASHP Policy on Affiliation

On behalf of the ASHP Board of Directors, I wish to thank you for providing the many insightful comments about ASHP affiliation for the Board to consider at its recent strategic planning retreat. As promised, I am following up to report on our discussions and action.

The Board reaffirmed the principle that ASHP is a specialized pharmacy organization representing the interests and needs of pharmacists who practice in hospitals and health systems. ASHP will continue to focus its efforts on serving the interests of pharmacists who practice within this distinct area of pharmacy.

In the past, ASHP’s affiliation has been with independent health-system pharmacist organizations, health-system pharmacist components of broader state pharmacy organizations and with merged state pharmacy organizations. The ASHP Board of Directors believes that affiliation is a special partnership arrangement. As an outcome of the retreat, the Board concluded that affiliation should be based on a close alignment in the mission, scope, and membership focus between ASHP and the affiliate.

New affiliation guidelines will be developed that clearly define the specific organizational requirements for affiliation. State affiliates will have an opportunity to comment on these guidelines before they are finalized. Until the new guidelines are finalized, current affiliation arrangements will be maintained but no new petitions for affiliations will be entertained.

As an additional outcome of our discussion at the strategic planning

retreat, ASHP will undertake a thorough examination of how ASHP’s role can be enhanced in fostering the success of affiliates. The Board welcomes your ideas about this.

The following is the policy approved by the Board at its meeting on April 15, 2004:

- To reaffirm that pharmacy practice in hospitals and health systems is a distinct area of the profession and that practitioners in this area have unique interests and needs; further,

- To reaffirm that ASHP’s mission is to serve the interests and needs of pharmacists who practice in hospitals and health systems; further,

- To declare that ASHP has no interest in merging with other pharmacy organizations; further,

- To reaffirm ASHP’s desire to cooperate with a variety of organizations both inside and outside of pharmacy in ways that serve its members and help it achieve its objectives; further,

- To reaffirm that affiliation is a formal relationship in which ASHP collaborates with organizations whose purposes and priorities are aligned with ASHP’s mission, scope, and membership focus; further,

- To revise the ASHP affiliation guidelines to be consistent with the above points; further,

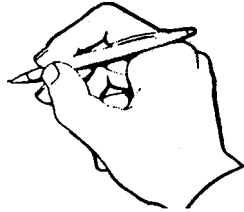
- To enhance ASHP’s role in fostering the success of its affiliates.

(Note: While the ASHP affiliation guidelines are under revision, ASHP will maintain the status of currently affiliated organizations and will not consider any new applications for affiliation.)

Affiliation Policy • continued on page 4

From The President

Robert F. Guanci



I'm sure that many, if not most, of you are familiar with ISMP, JCAHO, and ASHP. Some of you may even be familiar with the American Hospital Association (AHA) and the Institute for Healthcare Improvement (IHI). One thing that all of these agencies have in common is the recommendation or requirement for accurate medication histories.

In ASHP's 2015 Initiative (which I outlined for you in the last newsletter), Objective 1.1 states that *Pharmacists will be involved in managing the acquisition, upon admission, of medication histories for 75% of hospital inpatients with complex and high-risk medication regimens.*

As part of JCAHO's 2005 National Patient Safety Goals, goal number 8 states that all hospitals should develop (by January 2006) *a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.*

In 2002, Pathways for Medication Safety was published, which was a collaborative effort between AHA, ISMP and the Health Research & Educational Trust. It demonstrates how a complete medication history is one of the first elements that should be in place to reduce risk associated with the medication use process.

Most recently IHI announced the launch of their "100,000 Lives Campaign" which seeks to enroll 1500 to 2000 hospitals in an effort to extend or save 100,000 lives by July 2006. One of their specific goals is to *Prevent adverse drug events (ADEs) by implementing medication reconciliation at all transition points starting with the reconciliation of admission orders with home medication lists.* They go on to state that:

- Forty-six percent of all medication errors occur at transition points (e.g. admission to hospital, transfer between units, discharge from hospital)
- Medications not reconciled at transition points may account for up to 20% of ADEs seen both in the hospital and later in outpatient settings.
- Medication reconciliation ensures that patients receive all intended medications and no unintended medications following transitions in care locations.
- Medication reconciliation can virtually eliminate errors occurring at transitions in care.

When a patient is admitted to the hospital, the list of all medications ordered upon admission must be compared with the list of medications the patient was taking before the admission. If any pre-admission medication is neither ordered nor explicitly declared to be inappropriate, the physician should order the medication or formally confirm that the omission was deliberate by providing a reason.

Tips for designing the medication history form include:

- space must be provided for patient allergies, the dose and frequency of each medication, the date and time of the last dose, as well as instances and reasons for non-compliance with prescribed dosages and frequencies. Also space for indications would assist with compliance for other JCAHO requirements.
- provide additional space to list not only prescription and OTC medications, but also herbals, vitamins and other supplements (perhaps with default instructions not to continue them while in the hospital but to be re-evaluated upon discharge).
- space should be provided for the physician to document reasons for omitting medi-

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VIRGINIA HEALTH-SYSTEM PHARMACY NEWS

*Official Publication of the
Virginia Society of
Health-System Pharmacists*

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Virginia Health-System Pharmacy News is published six times a year by the Virginia Society of Health-System Pharmacists, P.O. Box 2344, Falls Church, VA 22042; 800/613-VSHP (8747); Fax 703/323-5233; E-mail VSHP@aol.com, web site <http://www.vshp.org>. Subscription to the Virginia-Health-System Pharmacy News is a benefit of membership in VSHP. All articles published represent the opinions of the authors and do not reflect the policy of the Virginia Society of Health-System Pharmacists or the authors' institution unless so specified.

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Calendar

- February 2:** VSHP Lobby Day, St. Paul's Episcopal Church, Richmond, www.vshp.org
- April 1-2:** VSHP 50th Anniversary, 2005 Spring Seminar, Williamsburg, VA www.vshp.org
- April 10-13:** ACCP Spring Forum, Myrtle Beach, SC www.accp.com
- April 20-23:** AMCP Annual Meeting, Denver, CO www.amcp.org
- June 11-15:** ASHP Annual Meeting, Boston, MA www.ashp.org
- June 17-18:** VSHP Board of Directors Annual Retreat, Richmond
- October 13:** VSHP 50th Anniversary Past President's Banquet, Norfolk, VA
- October 14-15:** VSHP 50th Anniversary 2005 Fall Seminar, Norfolk, VA www.vshp.org
- December 4-8:** ASHP Mid-Year Clinical Meeting, Las Vegas, NV
- December 5:** VSHP Mid-Year Reception, Las Vegas, NV www.vshp.org

Welcome VSHP New Members

Region 1

UVA Health System

Bethany Lilly Jones
Jennifer Neal

Region 2

Inova Fairfax Hospital

Melinda Alam
BethAnn Bloomer
Hong Nguyen

Virginia Hospital Center

Belynda Kinney

Region 5

Admiral J.T. Boone Clinic

Reba Sadr

Aventis

Beverley Casper

Chesapeake General Hosp

Randy Lee Schepler

Children's Hosp of King Daughters

Mary Bryce
Kimberly Clawson
Audra Kelli Johnson

Eckerd

Christine Curcio

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Marco Salgado

Sentara Norfolk Gen

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Walgreens

Fred Ghaffari

Region 7

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DVT • continued from page 1

The new “ASHP Therapeutic Position Statement on the Use of Low Molecular Weight Heparin for Adult Outpatient Treatment of Acute Deep Vein Thrombosis” highlights opportunities for health-system pharmacists to dramatically reduce the cost of treating DVT, maintain clinical outcomes, and improve patients’ quality of life. ASHP’s Board of Directors approved the document, produced through the Society’s Commission on Therapeutics, April 16, 2004.

The recommendations contained within the position statement are also supported by a new antithrombotic pharmacotherapy traineeship sponsored by the ASHP Research and Education Foundation. The traineeship’s primary goal is to prepare pharmacists to offer

specialized services for managing antithrombotic therapy.

ASHP is a member of the Coalition to Prevent Deep-Vein Thrombosis, a group comprised of more than 35 representatives from key health care organizations such as the American College of Chest Physicians, the American Public Health Association, and the Society of Hospital Medicine. The Coalition’s mission is to reduce the immediate and long-term dangers of DVT and PE, which together comprise one of the nation’s leading causes of death. For more information on the “ASHP Therapeutic Position Statement on the Use of Low Molecular Weight Heparin for Adult Outpatient Treatment of Acute Deep Vein Thrombosis,” go to www.ashp.org/bestpractices/ and click on “New Guidance Documents.”

President’s Message • continued from page 2

cations.

- design the medication history form to be used simultaneously as an order form.

According to *hcPro*’s Briefings on Patient Safety “A (Massachusetts) group, called the Reconciling Medications Collaborative...has worked for the past two years to identify the most effective ways to reduce medication errors by reconciling medications.” During this time frame, the following best practices were identified:

- The primary duties for reconciling medications should be assigned to someone who has sufficient expertise and accountability. Although they identified that floor, triaging, or admission nurses tended to be the best candidates, some hospitals found that the pharmacist was their best choice. Another option that was identified was to only involve a pharmacist, case manager or special consultant for high-risk patients (e.g. patients on high risk medications or elderly patients on 5 different types of drugs).
- Medication reconciliation must be completed within specified time frames. Many hospitals required that high risk patients have their medications reconciled within 4 hours of admission.

As part of VSHP’s commitment to the 2015 Initiative, the VSHP Board of Directors will consider issuing a grant to

partly fund the development of a pilot program that demonstrates a clinical and cost effective benefit to the patient and the hospital. The details for securing a grant will be made available shortly after the February VSHP Board meeting.

In the mean time, VSHP will be handing out blank medication history forms with an explanation of the reasons and benefits for completing these forms during our Lobby Day activities on February 2nd. Please join us at St. Paul’s Church from 8:30 to 12:30 to participate in Lobby Day. The church is located on Church Street next to the Capital.

See you there!

SAVE THE DATE

VSHP 50th Anniversary
2005 Fall Seminar

October 14-15, 2005
Norfolk Waterside Marriott

Affiliation Policy • continued from page 1

(Note: This action supersedes Board Voted 17, April 27, 2000.)

The new Board policy still allows for an affiliate to exist within another organizational structure, but establishes that ASHP’s affiliation will be with the health-system pharmacist component of that structure. The Board of Directors looks forward to working with you as we move toward developing guidelines to implement the new policy on affiliation. We will be discussing next steps at the upcoming Regional Delegate Conferences and at the State Affiliate Leadership Conference at the Summer Meeting.

— Daniel M. Ashby, MS, FASHP
April 28, 2004

JCAHO NOTES

Interpretive Guidelines Released for JCAHO Safety Goals

JCAHO has issued its interpretive guidelines for the 2005 National Patient Safety Goals. Included in the guidelines is information on the expectations of JCAHO surveyors, such as the use of “name alert” stickers in areas where look-alike or sound-alike medications are stored. http://www.jcaho.org/accredited+organizations/patient+safety/05_npsg_guidelines.pdf

JCAHO Releases Safety-Goal List of Look-Alike, Sound-Alike Names

The list of look- and sound-alike drug names that accredited groups must consult in adhering to the 2005 National Patient Safety Goals was released by JCAHO. Each accredited group’s list must contain at least 10 drug-name combinations. http://www.jcaho.org/accredited+organizations/patient+safety/05+npsg/look_alike_sound_alike_drugs_list.pdf

JCAHO Gears Up to Survey Sterile Compounding Practices

When a surveyor from the JCAHO visits a hospital pharmacy after June 30, one of the first things he or she evaluates may be the apparel of persons in the intravenous admixture room. <http://www.ashp.org/news/ShowArticle.cfm?id=5535>

Tentative **2005 SPRING SEMINAR AGENDA** *Tentative*

50 Years in the Making

Thursday, March 31

- 12:00-1:00 pm VSHP PAC Board of Trustees Meeting
- 1:00-5:00 pm VSHP Board of Directors Meeting
(Open to all members)
- 5:30-6:00 pm Cocktail Reception
- 6:00-7:00 pm Topic to be determined
ACPE #108-000-05-000-L01 (.10 CEU)
Sponsored by Ortho McNeil
- 7:00-9:00 pm Opening Night Banquet
- RAFFLE DRAWING
(Must be Present to Win)

Friday, April 1

- 7:00-8:00 am Continental Breakfast
- 8:00-9:30 am Critical Care Therapeutics
ACPE #108-000-05-000-L01 (.15 CEU)
- 9:30-9:45 am Break
- 9:45-11:15 am Drug Allergies and Cross Sensitivities
ACPE #108-000-05-000-L01 (.15 CEU)
- 11:15-1:00 pm Lunch
The History of ASHP and VSHP
ACPE #108-000-05-000-L04 (.10 CEU)

8:00 - 11:15 Practice Management Forum

- 8:00-9:30 High Cost Drugs:
Forecasting and Managing Cost Drivers
ACPE #108-000-05-000-L01 (.10 CEU)
- 9:30 - 9:45 Break
- 9:45 - 11:15 Joining Together to Implement
Safe Medication Practices
ACPE #108-000-05-000-L01 (.10 CEU)

- 1:00-2:30 pm Clinical Pearls
ACPE #108-000-05-000-L01 (.15 CEU)
- 2:30-2:45 pm Break
- 2:45-3:45 pm Integration of Personal Digital Assistants
into Pharmacy Practice
ACPE #108-000-05-000-L04 (.10 CEU)

- 3:45-4:45 pm Appropriate Use of
Intravenous Proton Pump Inhibitors
ACPE #108-000-05-000-L01 (.10 CEU)
- 5:30-7:30 pm Reception/Exhibit Program
- Dinner on your own

Saturday, April 2

- 7:00-8:00 am Christian Pharmacists Fellowship
International Prayer Breakfast

8:00-11:15 Technician Symposium

- 8:00-9:00 Professionalism Among Technicians
ACPE #108-000-00-000-L01 (.10 CEU)
- 9:00-10:00 Multiple Sclerosis:
Challenges and New Advances
ACPE #108-000-00-000-L01 (.10 CEU)
- 10:00-10:15 Break
- 10:15-11:15 The Drug Approval Process, Drug
Safety, and the FDA
ACPE #108-000-05-000-L01 (.10 CEU)

- 8:00-10:00 am New Drug Update
ACPE #108-000-05-000-L01 (.20 CEU)
- 10:00-10:15 am Break
- 10:15-11:15 am Update on the Seventh American College
Of Chest Physicians Consensus Conference
on Antithrombotic and Thrombolytic Therapy:
ACPE #108-000-05-000-L01 (.10 CEU)
- 11:15-12:15 pm NCEP Guidelines
ACPE #108-000-05-000-L01 (.10 CEU)
- 12:15-1:45 pm Lunch/Exhibit Program
- 1:45-3:15 pm Art of Active Listening
ACPE #108-000-05-000-L01 (.15 CEU)
- 3:15-4:15 pm Drug Use in Pregnancy and Lactation
ACPE #108-000-05-000-L01 (.10 CEU)

The is a tentative agenda. We will post the final agenda with presentation titles, speakers, and objectives by January 1 to our website at www.vshp.org.

MEMBERSHIP APPLICATION

Personal Data

Name _____
(First) (MI) (Last) (Jr/Sr/III)

Address _____
(Street Address) (Apt. #)

(City) (State) (Zip Code plus four)

Home Phone Number () _____ Email Address _____

Date of Birth ____/____/____ Social Security ____ - ____ - ____ Sex: M / F
(MO) (DA) (YR)

VA State License Number _____ Recruited By: _____

Practice Site

Name _____
(Name of Practice Site)

Address _____
(Street Address) (Suite)

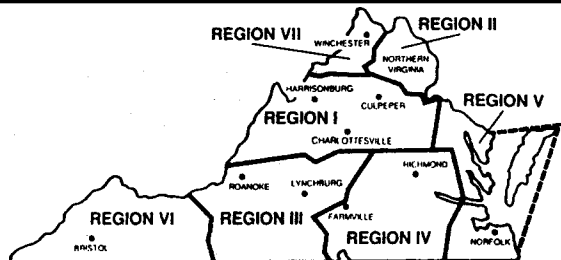
(City) (State) (Zip Code plus four)

Phone () _____ Fax () _____ Email _____

Type of Practice Site <small>(please select one)</small> <input type="checkbox"/> Hospital <input type="checkbox"/> Managed Care <input type="checkbox"/> Home Health Care <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Community Pharmacy/Retail <input type="checkbox"/> School of Pharmacy <input type="checkbox"/> Government <input type="checkbox"/> Industry <input type="checkbox"/> Other: _____	Job Title <small>(please select one)</small> <input type="checkbox"/> Director of Pharmacy <input type="checkbox"/> Assistant or Associate Director <input type="checkbox"/> Staff Pharmacist <input type="checkbox"/> Clinical Coordinator <input type="checkbox"/> Other Supervisory Position <input type="checkbox"/> Clinical Pharmacist - Specialist <input type="checkbox"/> Consultant Pharmacist <input type="checkbox"/> Faculty <input type="checkbox"/> Resident/Fellow <input type="checkbox"/> Technician <input type="checkbox"/> Student/Intern <input type="checkbox"/> Other: _____	Specialty Area of Practice <small>(please select one)</small> <input type="checkbox"/> Acute/Critical Care <input type="checkbox"/> Admin/Management <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Clinical <input type="checkbox"/> Consulting <input type="checkbox"/> Disease Management <input type="checkbox"/> Drug Information <input type="checkbox"/> Endocrinology <input type="checkbox"/> Geriatrics <input type="checkbox"/> Home Health/Infusion <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Inpatient <input type="checkbox"/> Long Term <input type="checkbox"/> Mental Health <input type="checkbox"/> Nuclear Pharmacy <input type="checkbox"/> Oncology <input type="checkbox"/> Pediatrics/Neonatology <input type="checkbox"/> Pharmacotherapy <input type="checkbox"/> Research <input type="checkbox"/> Sales <input type="checkbox"/> Women's Health/OBGyn <input type="checkbox"/> Other: _____
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Membership Category <small>(please select one)</small> <input type="checkbox"/> Active \$ 75.00 <input type="checkbox"/> Joint* \$125.00 <input type="checkbox"/> Associate \$ 75.00 <input type="checkbox"/> Resident/Fellow \$ 35.00 <input type="checkbox"/> Technician \$ 25.00 <input type="checkbox"/> Retired \$ 25.00 <input type="checkbox"/> Student* \$ 10.00 Anticipated year of graduation: _____	Local Chapter <small>(please select one)</small> <input type="checkbox"/> Region 1 <input type="checkbox"/> Region 2 <input type="checkbox"/> Region 3 <input type="checkbox"/> Region 4 <input type="checkbox"/> Region 5 <input type="checkbox"/> Region 6 <input type="checkbox"/> Region 7 <input type="checkbox"/> Region 8 (Students)
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*If applying for joint membership, please complete an application form for self and spouse. If applying for student membership, please include a photocopy of current student I.D.

Send completed application and check made payable to VSHP to P.O. Box 2344, Falls Church, VA 22042.

Polio Update

The World Health Organization recently released a report on the progress of its Global Polio Eradication Initiative. The results were both encouraging and discouraging at the same time. Some of the highlights include:

- At the end of 2003, only 6 countries in the world still were polio-endemic, the lowest number ever: Nigeria, India, Pakistan, Niger, Afghanistan, and Egypt.
- Somalia passed a full calendar year without polio. Its last case was reported in October 2002. Somalia's success is testimony that WHO's strategies are working, even in the most challenging country-settings.
- In 2003, 784 polio cases were reported worldwide (there were 1,918 reported cases in 2002). 90% of the cases originated in just three countries: Nigeria, India, and Pakistan.
- In spite of having a large percentage of the reported cases, India showed a sig-

nificant reduction by achieving the lowest number of cases ever reported. Further, the country launched the largest-ever health campaign in history, immunizing more than 165 million children in just six days in February 2003.

Challenges

- An acute cash shortfall in early 2003 forced scaling back of the immunization programs and a major tactical change; concentrating on endemic countries while abandoning polio-free countries. This leaves their populations vulnerable to potential poliovirus importations.
- In Nigeria, a number of northern states suspended polio immunization campaigns when public figures voiced safety concerns with the polio vaccine. Subsequently, a new outbreak occurred and reinfected previously polio-free areas within Nigeria, as well as eight previously polio-free countries across west and central Africa.

· For the first time ever, the number of countries suffering polio due to imported virus was greater than the number of endemic countries. 52 cases of polio following importations into previously polio-free countries were reported in 2003.

The world is close to becoming polio-free, as wild poliovirus is now restricted geographically. However, as 2003 ended, the polio outbreak in west and central Africa was continuing to spread to additional countries, some of which were affected by the change in tactics due to the acute cash shortage. "It is increasingly evident that this outbreak could require a much larger, multi-country 'emergency response' in 2004. It is time for the final push against polio, with the goal of interrupting transmission by the end of 2004." To review the full report, see WHO's website at www.polioeradication.org.

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HEALTH-SYSTEM PHARMACISTS

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