

VSHP News Nov-Dec 2009
CE at City Center
Fall Seminar – 2009

The 2009 Fall Seminar was held at the new Marriott in Newport News City Center from October 22nd through 24th. What a great venue and program! The Marriott at City Center is located in the high-profile retail, restaurant, and business district of Newport News' stylish City Center and is near top destinations such as Colonial Williamsburg and Virginia Beach. In one weekend VSHP was able to fit 13 hours of pharmacist continuing education credit, four hours of technician continuing education, two Exhibit sessions, the ASHP Advantage Lunch Symposium, the Clinical Skills Competition, the PAC Silent Auction; a moving presentation for Reader's Digest 2008 Hero of the Year, the Award's Banquet, plus much, much more. If you missed it, you missed an outstanding seminar.

Per standard protocol, the meeting's activities began with the Political Action Committee [PAC] and the Board of Director's [BoD] Meetings. While the PAC meeting is a closed meeting, the Board of Directors Meeting is open to all VSHP members. For those members interested in organizational affairs, this is the perfect place to learn more about VSHP and to meet key members and influential pharmacists from across the state. High-lights from the BoD meeting were: 1) changes to the Spring Seminar format were discussed, decisions pending 2) the Board of Pharmacy update was provided by State Board member Bobby Ison, see the website for details, http://www.dhp.virginia.gov/Pharmacy/pharmacy_newsletters.htm 3) the results of the Membership Survey were presented. Of special interest is the fact that almost 20% of the respondents have been VSHP members for less than five years. This is a good sign showing that VSHP appeals to all age groups and is growing.

After the Board meeting, the Past President's Banquet was held. Sponsored by Roche Labs, this banquet is an annual event and is a chance for the 'corporate brain trust' of VSHP to gather, be honored for their serve to the Society, and to discuss timely topics.

On Friday morning, the educational portion of the program began with the presentation on the timely topic *Past, Present and Future of Pandemic Influenza* by Amanda Colquitt Hansen, PharmD, Infectious Diseases Clinical Specialist, Carilion Roanoke Memorial Hospital. This was followed by Robert Kidd, PharmD, PhD, Professor & Chair, Department of Biopharmaceutical Sciences, Bernard J. Dunn School of Pharmacy, who discussed *Pharmacogenomics Today. Battling Fear and Darkness (a.k.a. Anxiety and Depression)* was topic. Stephen Ingram, RPh, BCPP, Clinical Pharmacy Specialist, Department of Psychiatry and Behavioral Medicine, Carilion Clinic Saint Albans Hospital was the presenter. Wrapping up the morning session, Martin Cruz, PharmD, CGP, BCPP, Clinical Pharmacy Specialist, Hampton Veterans Affairs Medical Center gave a stirring and heartfelt talk entitled *Forever at War: The Pharmacotherapy of PTSD in Veterans*.

This talk took the meeting into lunch and the first of two Exhibit programs. The 'Lunch in the Exhibit Hall' theme was appreciated by everyone. This format gave attendees the opportunity to learn of the latest advances in pharmacotherapy and dispensing technologies, while at the same time relaxing and chatting with old, current, and newly-made friends. During the exhibit session items for the PAC Silent Auction were on display and attendees could bid on their choice from a multitude of items.

The most moving and motivating speech of the entire meeting occurred immediately after lunch. Iraqi War Veteran and Reader's Digest 2008 Hero of the Year, LTC Greg Gadson was introduced. LTC Gadson is a natural leader, but it was his accomplishments off the battlefield that made such an impact. After losing his legs following a roadside bombing in Baghdad, LTC Gadson faced his rehabilitation with such a positive attitude that it helped to inspire the New York Giants football team to turn their luck around on the field. Gadson told the team "It's not about what happens to you in life. It's about what you do about it." in an impromptu locker-room chat. His words motivated the struggling team to an unexpected win over the Washington Redskins the following day. LTC Gadson helped keep the team focused all the way to their 2008 Super Bowl victory. He provided the same motivation and inspiration to all of the pharmacists in attendance. His speech focused on doing what needs to be done. Because of his injuries and extensive rehabilitation, LTC Gadson was very knowledgeable about the role of medical professionals and their need to be caring. When he finished speaking, there was not a dry eye in the audience. LTC Gadson received a long, standing, ovation, for both his great speech and his service to his country.

The rest of the afternoon was filled with the always informative and interesting Clinical Pearls session. The presenters and topics were: Jason Sarashinsky, PharmD, BCPS, Oncology Clinical Specialist, CJW Medical Center, *Chemotherapy Induced Nausea and Vomiting- A Review*; Megan Sarashinsky, PharmD, BCPP, Psychiatry Clinical Specialist, CJW Medical Center, Chippenham Campus, *Management of Depression with Concurrent Coronary Heart Disease*; Lori Dupree, PharmD, BCPS, President, Clincomm Consulting, *Use of Inhaled Treprostinil*; Christina Olmstead, PharmD, Kidney Transplant Clinical Specialist, Henrico Doctor's Hospital, *Prevention and Treatment of Ganciclovir-Resistant CMV Disease*; Cheryl Nelson, PharmD, Pharmacy Clinical Manager, Retreat Hospital, *Evidence: Not That Everyone Requires Entereg Globally*; and finally Eve Bell, PharmD, Internal Medicine Clinical Specialist, Henrico Doctor's Hospital-Forest, *Proton Pump Inhibitors: Saving the Stomach While Busting the Bones?*

The evening's festivities began with the second Exhibit Session and wine and cheese reception. A presentation entitled *Meeting the Challenge of Today's Hospital Infections* enlightened everyone present and preceded the dinner. The banquet provided yet another opportunity to network and to meet old friends.

VSHP Award Winners

VSHP Pharmacist of the Year- Sarah Colgan

VSHP Technician of the Year- Denise Owczarski, CPhT

Clinical Practice Achievement Award- Lisa Hammond

New Practitioner Award- Julie Hughes

Student Leadership Awards:

Shenandoah University- Mikhail Arthur

VCU/MCV- Lauren Pierce

Hampton University- Brooke Ade

University of Appalachia- Megan Metivier

Excellence in Health System Pharmacy Awards [\$500 Scholarship]:

Shenandoah University- Kimberly Flynn

VCU/MCV- Paul Hansen

Hampton University- Brooke Ade

University of Appalachia- Deanna Donaldson

Saturday morning found VSHP attendees with two options for continuing education. The technician track, geared solely at the cohort, provided four hours of technician specific training. Talks included: *The ABC's of Metabolic Syndrome* by Marcia Brackbill, PharmD, Associate Professor of Pharmacy, Shenandoah University; *Antihypertensives and Treatment of Resistant Hypertension* by Brenda Clark, PharmD, PGY-2 Critical Care Resident, UVA Health System; and *Pharmacy Law for Technicians* by Mary Jo Carden, RPh, JD, President, Carden & Associates. Concurrently the pharmacists were listening to Ray Keate, MD, FACP, FACG, Vice-President, Richmond Gastroenterology Associates present *Crohn's Disease: Basic Science to Biologics*. This was followed by a talk entitled *Managing Pre-existing Conditions During Pregnancy* by Julie Kelsey, PharmD, Clinical Pharmacy Specialist- Women's Health, UVA Health System. Always a popular and in the know speaker, Janet Silvester, RPh, MBA, FASHP, Director of Pharmacy and Emergency Services, Martha Jefferson Hospital spoke on the *Environmental Scan 2009 and Healthcare Reform*. The final talk before lunch was *New Drug Therapies for Idiopathic Thrombocytopenia Purpura [ITP] in Adults* given by Morgan Snider, PharmD, Oncology Pharmacy Resident, UVA Health System. A favorite at every meeting is the annual ASHP Advantage Lunch Symposium. This year's lunchtime topic was *The Prevention and Management of Febrile Neutropenia in Oncology Patients*. Micheal Vozniak, PharmD, BCOP, Hematology/Oncology Clinical Pharmacy Specialist, Hospital of the University of Pennsylvania was the featured speaker. After a great meal and a very interesting educational presentation, the attendees returned to the auditorium for the final continuing education sessions of the Fall Seminar. Wrapping up the afternoon were Laurie Cooksey, PharmD, Acute/Chronic Clinical Pain Specialist, VCU Medical Center and Judy McClary, RN, PhD, CLNC, Center for Medical InfoSearch discussing an almost mythical topic *Understanding and Managing Fibromyalgia with a Patient's Perspective*. This presentation, especially the patient's perspective portion opened a lot of eyes to this seemingly obtuse disease. *New Updates in the Treatment of Atrial Fibrillation* was the final talk of the meeting. William Cahoon Jr., PharmD, BCPS, Acute Care Cardiology Clinical Pharmacist, VCU Health System closed the meeting in style.

With all of the presentations completed, all attendees headed for home. But they left with many more friends, happy experiences, and knowledge than they arrived with. The meeting was just another in a long line of great seminars sponsored by VSHP. Be sure you plan to attend our next meeting to be held in the Spring of 2010.

VSHP Clinical Skills Competition

by Jessica A. Jeffries, Pharm.D. Candidate
Hampton University School of Pharmacy



The second annual VSHP Clinical Skills Competition was held on Friday, October 23rd, 2009 at the recently held Fall Seminar. This year's competition had representation from all four schools of pharmacy in Virginia; Mounish Patel and Saumil Vaghela from Appalachian College of Pharmacy, Amber Joseph and Nakia Beard from Hampton University School of Pharmacy, Amber Wesner and Catherine Lee from Shenandoah University Bernard J. Dunn School of Pharmacy, and Alexis Noble and Artie Strunk from Virginia Commonwealth University School of Pharmacy.

The VSHP Clinical Skills Competition is modeled after the ASHP Clinical Skills Competition. Consisting of two parts, the teams had to create a written pharmacist's care plan and give an oral presentation of their care plan. Each team was provided materials, including reference books, for assistance with the care plans. During the preliminary round, the teams were given two hours to create a written case work-up from a given patient case. For the final round, the teams had two minutes to orally present a brief summary of all the patient's health problems and a complete treatment plan for the most urgent problem, which included therapeutic goals, recommendations for therapy, monitoring parameters, and desired endpoints. Following their presentation, the teams had to answer questions and defend their recommendations to a panel of judges. Thanks to VSHP, each student was given a Lexicomp drug information handbook as a gift for competing in the skills competition.

This year VCU School of Pharmacy kept their winning streak alive, as the team took home the title and a \$1,000 scholarship from the Jennifer E. Stallings College Bowl Fund. "The competition helped me personally develop and sharpen my clinical confidence" stated Amber Joseph, one of the competing students representing Hampton University School of Pharmacy. "It is a good preparation for the national competition and Virginia will be well represented and prepared for Midyear." Congratulations to the winners and all the teams for their hard work and success. A special thank you is extended to Francine Farnsworth, who developed the case study, and to the other judges; Stephen LaHaye, Gayle Slifka, and Carl Tullio.

This year at the 14th Annual ASHP National Clinical Skills Competition, there will be 102 schools and colleges of pharmacy, including all four schools from Virginia, competing for the national title.

PAC Silent Auction a Success

by Lisa Hammond, PAC Chairperson

The annual VSHP Political Action Committee (PAC) Silent Auction was held in Newport News at the Fall Seminar in October. We were able to raise \$2,100 dollars for the PAC. Examples of items auctioned were: original art work and prints, one week condo at Wintergreen Resort, handcrafted jewelry, gift baskets, antique pharmacy books, wine notables, and hand-blown glass and hand knitted clothing. The monies raised will be used for PAC contributions to legislators who will work to advance our organization's legislative agenda and believe in our mission with regard to issues of interest to the pharmacy profession. The PAC advocates on behalf of its membership by supporting Virginia legislative candidates' who understand the contributions pharmacists and technicians can make to health care. Thanks to all who donated and participated in the VSHP PAC Silent Auction. Your contributions were greatly appreciated. If you are interested in learning more about the PAC , you are encouraged to contact PAC President, Lisa Hammond at lhammond@valleyhealthlink.com.

President's Message

by Stephen LaHaye

Happy Holidays! I hope this message finds you and your families in good health and with a sense of accomplishment for 2009. With 2010 right around the corner (I am writing this message during the first week of December), it is time to begin the annual ritual of making resolutions for Christmas and the New Year.

Over the years, I've had the standard resolutions. Eat healthier and not as much, exercise more, go somewhere I've never been before, etc. The common thread in all of these being that they are "all about me". My wife would disagree and say it is all about her, but I digress. ☺

My resolution this year is to do something for others. I haven't figured out what yet exactly, but I've got a few ideas that might work. Feel free to use one of these ideas yourself if you are in the market for a resolution of your own. You knew there had to be a catch! The common thread in all of these ideas is time. I know, it seems like I don't have any extra time to spare either, but for a good cause, it can be time well spent.

The first idea is the easiest and least time-consuming. Find a charity that you feel follows values that are important to you and donate cold hard cash. All charities love receiving money and it only takes the time necessary to write a check. The second idea might take a little more time. Donate an hour or two at a free clinic or nursing home. This takes time, but not a lot of effort because you can go as a pharmacist. Thank goodness, a role I am comfortable in!

My final idea is the most time-consuming and may require stepping out of our usual comfort zone. Volunteer to help out at a food bank, homeless shelter, or with the Caritas program at your local house of worship. I think we'll find that most people aren't looking for a handout, just someone willing to sit with them and listen.

I hope that I am up to the challenge this year and that maybe one or two of you will be also.

“Volunteers do not necessarily have the time; they just have the heart.”

~Elizabeth Andrew

News of Members

- Congratulations are in order for **Francine Farnsworth**, Clinical Pharmacy Coordinator at the Veteran's Affairs Medical Center-Salem. She recently completed the American Society of Consultant Pharmacists – Pain Management Traineeship in Cleveland, Ohio (September 21-25, 2009). Additionally, she successfully satisfied the requirements for the Certified Pain Educator (CPE) credential (Sponsored by the American Society of Pain Educators), including having passed the written CPE examination on September 11, 2009.
- **Douglas Holroyd**, Director of Pharmacy, Augusta Medical Center, Fishersville, VA recently attended the ASHP Foundation sponsored “Pharmacy Leadership Institute”. This highly successful executive pharmacy educational program is hosted by the Executive Leadership Center within Boston University's School of Management.

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ADAMS, Susan Early, age 68, passed away October 17, 2009, at Capital Hospice in Arlington, Va., after a long and courageous struggle against colon and liver cancer. Susan was born in Harrisonburg, Va., and earned a Bachelor of Science degree in Pharmacy at the Medical College of Virginia (MCV), Richmond, Va., in 1963. During her career, she worked as a hospital pharmacist at University of Virginia Hospital, Charlottesville, Va., Richmond Memorial Hospital, Richmond, many years as Director of Pharmacy at Northern Virginia Doctors Hospital, Arlington, Va., and as a staff pharmacist at Reston Hospital Center, Reston, Va. Susan loved her work as a pharmacist, but also enjoyed

travel, gardening and keeping in touch with her many wonderful friends and associates throughout the country. **Published in Richmond Times-Dispatch on October 20, 2009**

(Editor's Note: Let VSHP Leadership know how you feel about the following editorial. Can you help? Should you help? How do you help?)

A Call to Action

by David Harlow, RPh

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The discussions have gone on for years. I remember in the late 70's when I was in orientation for my first year at the Medical College of Virginia. "The future of pharmacy is high tech and high touch."-- "Pharmacist's will be more and more involved in patient care as the complexity of therapies becomes more and more complicated." Those statements weren't new then and that vision had existed since the 1960's. The practice of pharmacy has gone through a painfully slow evolution toward those not yet fully realized goals. Meanwhile, other professions, like the physician's assistant, have gone from practically unknown in 1965 to almost completely autonomous practitioners in their own right today. That effort is to be applauded. During that very same time, pharmacy education and the body of knowledge that goes with it have virtually exploded. Today every single professional that graduates from an accredited pharmacy school is a Doctor in their own right. They are capable of DIRECT intervention in patient care, especially complicated medication regimens and chronic disease states where the primary treatment is medication. No other professional is more uniquely qualified to provide that service. We have said these things to each other for decades and yet, the practice we provide the current and next generation of pharmacists still does not remotely reflect our capabilities. Nor are we recognized as practitioners of a medical subspecialty that is deserving of privileges and rights beyond suggesting changes and matching label A with the appropriate product B. The healthcare debate will rage on in Congress and the final outcome is ambiguous at best. One thing however is certain, both parties recognize it is time to overhaul healthcare as we know it and that change is coming at some point. You can bank on that. There has NEVER BEEN a more opportune time to change how our profession is utilized to the betterment of patient care. If we do not seize upon this opportunity and challenge, we can expect to lose our talented young pharmacists to other professions whose primary focus is direct patient care.

The primary focus of the healthcare debate thus far has been "provision of coverage". That said, what happens when 15-20 million more Americans have coverage of some type? How will the system accommodate them? If we empower ourselves WE CAN be fully privileged disease state managers and begin to fill some of those voids/needs that exist. Further, that's what sets us apart from the model that the Physicians Assistant and the Nurse Practitioners have created. It is practitioner in the sense that it should come with a set of privileges but not at the expense of, or taking the place of the Physician and is simply collaboration. All the tools we need to make that today's reality are at our disposal, and yet we rarely take advantage of them. Collaborative practice regulations have been on the books for at least the last ten years in Virginia and for decades in other places in the country. And yet how many of those practices OUTSIDE of a university setting or the VA are you aware of? Very few indeed. There is nothing lacking in the definition of the practice of pharmacy or in the scope of practice as it is defined. It is in how it is viewed and implemented that has to change, from in medical circles in academia all the way to the legislator and that man on the street. That might be a tall order but together, it is attainable.

For progress to be made we must speak with one voice, we must believe in each other, and we must be unsatisfied with Status Quo.

So what does this model look like? In our institutions it means that pharmacists be privileged to participate in patient care beyond P&T allowing changes to vancomycin dosing or TPN changes or renal dosing for a select drug. It might mean that if a patient's medication reconciliation record is wrong or inappropriate that the pharmacist is empowered to change that order. It might mean deciding it's time to discontinue an antibiotic or begin one. It might mean changing the pain medication to reflect an appropriate dose or the correct product to address a neuropathic pain. It might mean a dose change based on a patient's renal function regardless of what that drug product. The point is, get beyond suggesting the change, be responsible for the change. It has been long in coming but, ASHP now advocates recognition of, ***“expansion of collaborative drug therapy management practices (CDTM) in which the prescriber and the pharmacist agree upon the conditions under which the pharmacist initiates, monitors and adjusts the patient's drug therapy...and professional initiative by pharmacist associations rather than as a government activity to develop national standards for clinical privileging systems...”and” to support the use of clinical privileging systems by hospitals and health systems”*** ASHP House of Delegates 2009.

Application of this model applies not just inside our institutions but in associated ambulatory areas also. Pharmacist lead ambulatory clinics have proven for years they can impact readmission rates, adherence and patient outcomes in Diabetes, Anticoagulation, COPD and Asthma. The Indian Health Service has been a leader and example to pharmacy for years on what can be done in DIRECT PATIENT CARE by pharmacists. Unfortunately we as a group have largely ignored their success. In a future of capitated payment arrangements our success or failure could be determined by our success in changing the current pharmacy model. In either case what is at play is the ability of the pharmacist to extend the reach of our physician staff. Simultaneously, we raise awareness of the EXPECTATION of what pharmacy practice can, and should be. This expectation should not be just at large institutions where many of these things happen informally, but even more importantly, at medium and small institutions where manpower is at such a premium and patient access issues are so dire.

We all need to be advocates. A good place to start would be to amend Virginia legislation on Collaborative Practice to stipulate that a pharmacist can initiate drug therapy once a diagnosis has been established by a physician. Thus we can fully realize collaborative practice in our ambulatory settings and become larger partners in practices such as the ***Medical Home Model***. I will be meeting with Delegate Dave Nutter who is on the VA Joint Commission on Healthcare to sponsor legislation to that effect in conjunction with physician champions. We need your voice; we need your energy and now is the time. **If you're willing to commit to that change, I need you on board and I need you to stand up and be counted as a voice for that change.**

This is not about accolades or about a particular person or institution. It is about those of us blessed to be part of this great profession leaving a lasting legacy to those that come after us. It doesn't matter if they are the next generation of pharmacy professionals or the patients that benefit from their hard work.

“References available upon request”

Hospital and Community Pharmacy: Bridging the Gap

by Jessica Wood

PharmD Candidate

VCU School of Pharmacy

Preventable medication errors are estimated to cost between \$17 billion and \$29 billion dollars every year.¹ It is a common story. Hopefully, a patient enters the hospital with a list of medications that they currently take. The patient then shows up to the community pharmacy to fill their discharge prescriptions. Ideally, the hospital staff will spend some time explaining the new medications to the patient at discharge; however, as soon as a patient is told they get to go home, they tend to tune out much of what anyone says. Even the most highly educated individual can be confused with what they are supposed to do with the discharge regimen. Unfortunately, there is no communication between the hospital and community pharmacies to reconcile which medications the patient should be taking and how they should be taking them upon discharge. An opportunity to reinforce the physician's instructions to the patient, as well as identify any therapeutic duplications, omissions or errors, is lost with this lack of communication.

Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking.² It should be done at every transition of care to minimize the occurrence of medication errors such as omissions, duplications, dosing errors, or drug interactions. Medication reconciliation has been a safety focal point in the last few years by The Joint Commission. In an ideal situation, a complete medication history would be taken upon a patient's admission, the patient would then be sent home on either the same medications they were on in the hospital, or switched back to their home medications. Who better to obtain all the needed information regarding patient's medications than pharmacists? Kaboli and colleagues³ showed that involving a pharmacist in taking medication histories as opposed to nurses resulted in more accurate medication and allergy information, more accurate patient medication knowledge and fewer missed doses. Kripalani and associates⁴ showed that having a pharmacist verify the order increased accuracy from 40 to 95 percent. What if the idea were to go a step further?

The hospital setting is stressful for the patient and not all of the information patients are given upon discharge is necessarily absorbed completely and accurately by the patient. This is where a tremendous opportunity for pharmacy exists. There has always been a large disconnect between hospital pharmacy and community pharmacy in the area of communication. Why is it not standard practice for a hospital pharmacist to follow up with a community pharmacist regarding changes to the more complicated medication regimens for their patients and vice versa? The same can be said for the community pharmacist. Why, when a new prescription is dropped off from the hospital for a patient, does the community pharmacist not follow-up with a hospital pharmacist to see why the changes have been made and what new instructions need to be reinforced to the patient or caregiver? Jack and colleagues⁵ showed that if a clinical pharmacist followed-up with a patient two to four days post-discharge, the number of re-hospitalizations within 30 days dropped from 0.451 (76 readmissions out of 99 participants during study time period) to 0.314 visits per person per month (55 readmissions out of 80 participants during study time period). In 2007, the medical community explored the deficits in physician communication between hospital and primary care pushing relationships between physicians in health care settings to improve.⁶ If the hospital physician is following up with the patient's primary care physician, does it not seem logical that the hospital pharmacist should do the same with the primary community pharmacy? Having the community pharmacist in-the-loop when the patient comes to the community pharmacy creates a reinforcing environment for any changes in medication regimens. Having the instructions repeated outside of the

hospital in the calmer setting of a community pharmacy can be beneficial to the patient's understanding.

How much extra time is involved? In the Jack study⁵, an average of 14 minutes was required by the pharmacist in the post-discharge phone call for each patient. Pharmacists in the study spent a median of 10 minutes (6 to 18) preparing for each call. While 24 minutes per patient seems lengthy, the value of reduced hospital readmissions was significant. Any myriad of filtering characteristics, such as only calling patients on three or more medications, could be used to reduce labor and to ensure that the most complicated or needy patients get the follow-ups. Schnipper and associates⁷ showed that pharmacist intervention in the form of counseling, medication review, and even a post-discharge phone follow-up reduced preventable adverse drug events (ADEs) in the 30-day period after discharge. Forty-five out of 91 patients had more than one unexplained discrepancy between admission medications and discharge medications. There were two incidents therapeutic duplication.

There is potential for the community pharmacist to decrease ADEs even further by reinforcing and clarifying the instructions given by the hospital pharmacist. The role of the pharmacist in both the hospital and the community is changing. With the advent of automation, the traditional dispensing role of the pharmacist is giving way to robotics. However, robotics have not been able to supply the cognitive role of pharmacists and provide the human element of concern and caring for the patient. President Obama identified that solving the escalating costs of healthcare is essential in fixing our nation's economic crisis.⁸ The timing is perfect for pharmacists to quickly step up to this more cognitive, communicative role with health reform. All of pharmacy's national organizations participated in drafting Pharmacy Principles for Health Care Reform. Improving communication between pharmacists can help with escalating healthcare costs and persistent gaps in quality, are two of the fundamental concepts of health reform.⁹ Opening the lines of communication between hospital and community pharmacists can help to solidify the importance of having a pharmacist physically in both locations, taking the time to counsel the patient.

I say bring it on! It is time for all pharmacists to begin making use of their community and hospital counterparts with the ultimate goal of getting the right medications to the right patients. Leave the counting to the robots; leave the counseling to the pharmacists.

References

- 1Institute of Medicine. Report Brief. To Err Is Human: Building a Safer Health System Web site. <http://www.iom.edu/CMS/8089/5575/4117.aspx>. Accessed April 17, 2009
- 2The Joint Commission. Sentinel Event Alert: Issue 35 Web site. http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_35.htm. Accessed April 28, 2009
- 3Kaboli PJ, Hoth AB, McClimon BJ, Schnipper JL. Clinical Pharmacists and Inpatient Medical Care. *Arch Intern Med*. 2006;166:957.
- 4Kripalani S, Jackson AT, Schnipper JL, Coleman EA. Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key Issues for Hospitals. *Journal of Hospital Medicine*. 2007;2:318.
- 5Jack BW, Chetty VK, Antony D, et al. A Reengineered Hospital Discharge Program to Decrease Rehospitalization. *Annals of Internal Medicine*. 2009;150:178-183.
- 6Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians. *JAMA*. 2007;297:831-841.
- 7Schnipper JL, Kirwin JL, Cotugno MC, et al. Role of Pharmacist Counseling in Preventing Adverse Drug Events After Hospitalization. *Arch Intern Med*. 2006;166:568.

8Remarks of President Barack Obama—Address to Joint Session of Congress. White House website. http://www.whitehouse.gov/the_press_office/remarks-of-President-Barack-Obama-address-to-joint-session-of-congress/ Accessed April 16, 2009.

9US Department of Health and Human Services. HealthReform Web site. <http://www.healthreform.gov/reports/inaction/>. Accessed April 17, 2009.

Should Pharmacies Be Required To Take Back Medication?

Heather Lynn McIntosh

by Pharm.D. Candidate

Hampton University School of Pharmacy

Pharmacists are already overwhelmed with work and now we may have to add on more responsibility. There is growing concern about how to properly dispose of unused and expired medications. To date, the law states pharmacies cannot accept medications that patients wish to return, for any reason. However, congress is trying to change that. The concern is ‘what is happening to all the “left over” drugs that patients have’. Some people flush them down the toilet, which is harmful to the environment; while others allow their medications to accumulate in their medicine cabinets. This pile up of drugs can lead to a much bigger concern, known as “pharming”. Pharming is the term used to describe what children and teens are doing with their parent’s medications and OTC medications¹. They are taking the drugs to parties and getting high¹. Two other areas where an overstock of unused medications is a concern are long-term-care (LTC) facilities and hospitals. Here the drugs are disappearing into the black market.

The Drug Enforcement Administration (DEA) and the Environmental Protection Agency (EPA) have started (working on) regulatory proceedings on the environmental and public health impact of prescription drugs. Both federal organizations are working on take-back programs within pharmacies. The DEA’s main focus is public health and keeping prescription drugs (especially controlled substances) out of the hands of children; while the EPA focus is on the environmental threats to all bodies of water².

This summer the House Judiciary Committee held hearings to get views on two new bills. The first bill is the Secure and Responsible Drug Disposal Act (H.R. 1359) and the other is the Safe Drug Disposal Act (H.R. 1191). The H.R. 1359 seeks to amend the Controlled Substances Act (CSA) providing for take-back disposal of controlled substances in certain instances, and for other purposes (this is an addition to a current law). Presently the CSA prohibits pharmacists and other health care professionals from accepting the return of controlled medications from household consumers for return. The CSA states that only law-enforcement personnel may receive controlled substances from household consumers³. This addition will allow LTC facilities to send back expired or unused medications, including controlled medications, to the pharmacy that initially provided them, who would then properly dispose of these drugs. The H.R. 1191 would amend the CSA to provide for disposal of controlled substances by ultimate users and care takers through State take-back disposal programs. Additionally it would change the Federal Food, Drug, and Cosmetic Act to prohibit recommendations on drug labels for disposal by flushing. The Obama administration supports the Secure and Responsible Drug Disposal Act (H.R. 1359) but not the Safe Drug Disposal Act (H.R. 1191)².

While many will agree something needs to be done about this issue, there are a number of individuals who believe such programs will be too costly. The National Community Pharmacists Association (NCPA) is concerned that costs would be imposed on the pharmacies themselves and not supported by federal funding. The American Pharmaceutical Association (APhA) states it “would not support

any mandated take-back program that would create additional costs to pharmacy.” Cost is a major concern, but not the only concern. Pharmacists are worried about the legal liability that would come up due to take-back programs, such as the storage and accountability for these medications. Some suggested means of properly disposing of medications include mixing them with household waste, such as coffee grounds or kitty litter⁴. The FDA has recommended that certain, high risk for abuse drugs are flushed down the toilet, though this is still a concern for the environment. There are many counties nationwide that have Household Hazardous Waste (HHW) facilities where consumers can safely dispose of hazardous materials³. While law-enforcement offices can legally accept medications (including controlled substances) the space they have to store them, prior to disposal is limited.

Do you have an opinion of this topic? Let your VSHP Newsletter Editor know.

REFERENCES

1. *Kids and Prescription Drugs (Pharming): Information and Prevention*. Missouri Department of Social Services. [http://www.dss.mo.gov/stat/statpres/kidsandpharming.ppt#256,1,Kids and Prescription Drugs \(Pharming\)](http://www.dss.mo.gov/stat/statpres/kidsandpharming.ppt#256,1,Kids%20and%20Prescription%20Drugs%20(Pharming)). Accessed September 25, 2009.
2. Barlas S. Pharmacy Take-Back Programs. *P&T Journal*. 2009; 34:404.
3. Lynch J, et al. The Collection and Disposal of Waste Medications. *US Pharm*. 2008; 33(6): HS-20-HS-24. <http://www.uspharmacist.com/content/t/miscellaneous/c/9785/>. Accessed September 28, 2009.
4. Illinois Poison Center. Recommendations for disposal of unwanted or expired medication. www.mchc.org/ipc/AboutIPC/News/IPC%202007%20medicine%20disposal.pdf. Accessed September 25, 2009.

Robot Rx: WMC opens new pharmacy by JESSICA J. BURCHARD The Winchester Star
WINCHESTER - The pharmacy on the ground floor of Winchester Medical Center has moved into the 21st century. In mid-April, a new 15,000-square-foot facility - complete with automated medicine sorters and organizers - opened. The new pharmacy also includes a 5,000-square-foot IV room - where clinicians can mix nutrient formulas used in intravenous tubes for patients.

WMC's former pharmacy opened in 1990 with 4,000 square feet of space. It had an older- model automation system that was retired after 12 years. The new McKesson Robot Rx stores about 200 types of medications prescribed at the hospital on alphabetized hangers of single doses. "It's for safety and efficiency. For each medication, the robot scans in a bar code," said Julie Elrick, operations manager for the pharmacy. "Not every medication we have is put into the robot. The high-risk items are what we put into the robot."

The pharmacy has nearly 2,000 medications available, and most are stored in an electronic carousel in another part of the pharmacy. The McKesson Robot Rx, a large circular machine that takes up a third of the pharmacy's main room, sits behind a technician who matches prescriptions with the bar code information to ensure that the correct medication is delivered. It now requires about 15 minutes for a medication to be entered into the robotic system through an electronic medication administration record (eMAR) - a bar code tracking system used to reduce errors in dosing prescription medication.

The medication can be entered into the system within three minutes, but additional time is needed to process the request. "We scan every product every day," said Bonnie L. Pitt, director of the

pharmacy. "We are in the process of stocking it efficiently." If any of the scanned information does not match the doctor's orders, a warning message is shown to the clinician. "Health care is just now catching up with other industries in terms of bar-coding and safety measures," Elrick said. The McKesson Robot Rx has been nicknamed "Fill 'em Right" by pharmacy staff members because of its standard 30-minute operating cycle, and the requirement that a pharmacist must check 5 percent of the medications prescribed. The robotic apparatus can also put packages of medication in its rejection bin if the bar code on the package does not match the eMAR for that rung in its system.

The high-tech machine cost about \$ 1 million. The new pharmacy's entire budget was about \$4 million, which included construction and nearly \$2 million for technology. The addition of automation to WMC's pharmacy has meant the creation of a new position, too: a bar code specialist. "This person has knowledge of safety principles for packaging patient medications and special training to load data into our pharmacy information system, so products will scan at the bedside," Pitt said in an e-mail. "This person also has a higher level of technical knowledge of the automation in order to problem solve and provide maintenance functions." Pitt said six to eight of the pharmacy's nearly 65 employees work directly with the technology each day.

These positions include someone to scan in medication bar codes, another person to organize medications in an electronic carousel, and others to help Robot Rx stock its 200 medications in single dose packages. Once a medication is in the Robot Rx's system, it can be quickly obtained for a patient in the hospital. Nearly every patient will require some type of medication, Pitt said. Our goal is to have everything ready to be scanned in at the bedside," she said. "Our goal is to send out everything accurately."

NEWS ITEMS:

With Maine on Board, Pharmacists in All 50 States Can Vaccinate

Pharmacists in Maine are preparing to vaccinate patients against influenza, as the state ends its status as the only one without a law allowing qualified pharmacists to administer vaccines.

<http://www.ashp.org/import/news/HealthSystemPharmacyNews/newsarticle.aspx?id=3199>

Florida, Illinois, Michigan Affiliates Join ASHP's Technician Initiative:

The state affiliates in Florida, Illinois, and Michigan recently joined forces with ASHP in the new Pharmacy Technician Initiative. Through the Initiative, ASHP and affiliates will push for state laws that require, as a prerequisite for registration with the state board of pharmacy, completion of an ASHP-accredited pharmacy technician training and certification by the Pharmacy Technician Certification Board. http://www.ashp.org/s_ashp/article_press.asp?CID=167&DID=2024&id=26023

The HHS Office of the Inspector General (OIG) released a report examining the FDA's process for reviewing generic drug applications. OIG examined review times for Abbreviated New Drug Applications (ANDAs), and surveyed reviewers assigned to a sample of ANDAs with review times greater than 180 days by at least one division of the Office of Generic Drugs (OGD). Three OGD divisions, Chemistry, Bioequivalence, and Labeling, review each application, which must be approved or disapproved within 180 days of receipt. OIG found that: FDA did not approve 96% of ANDAs under review in 2006 because they did not meet FDA review standards. Nearly half of Chemistry review times, and many review times in other divisions exceeded the 180-day period. In a sample of reviews exceeding 180 days, most did not begin before the 180-day period expired. FDA prioritization practices affect review times. Based on these findings, OIG recommended that FDA (1) identify deficiencies commonly found in applications and offer more guidance to industry to decrease the percentage of disapproved ANDAs; (2) increase the percentage of applications reviewed by all divisions within 180 days; and (3) implement new prioritization practices.

FDA agreed with the first recommendation but did not comment on the other two recommendations. However, FDA did note that it continues to alter its review process with the goal of reducing queue times and is implementing new measures such as providing additional industry guidance, hiring additional staff, and prioritizing some ANDAs based on potential market entry date.

<http://www.oig.hhs.gov/oei/reports/oei-04-07-00280.pdf>

src="/Livelinksupport/PolicyUpdate/arrow1.gif" width=13 border=0HHS OIG Report - "The Food And Drug Administration's Generic Drug Review Process"

The ASHP Foundation has launched a new Web site that houses the Harvey A.K. Whitney Award Lecture Collection, expanding the ability of all individuals to access the wealth of knowledge shared by past Whitney awardees. The Whitney Award Lectures Collection Web site provides access to 57 lectures that can be browsed by title, author, publication date or keyword. Each lecture has a dedicated Web page containing the awardee's biography, photograph, the lecture and a PDF version that can be downloaded.

Hospitals pass most costs of medical errors on to payers, study demonstrates

Medical errors lead to substantial adverse event costs, but shifting many of these expenses to outside payers gives hospitals little economic incentive to improve patient safety, new research shows.

The Commonwealth Fund supported a study in which researchers analyzed 14,732 discharge records from 24 Utah and Colorado hospitals in 1992 to gauge the extent to which hospitals actually absorb medical error costs. The investigators accounted for all costs from adverse events that hospitals might have to bear through the tort liability system, including inpatient and outpatient care expenses, lost income and household production, future medical costs, burial expenses and pain and suffering.

A total of 465 adverse events resulted from medical management, 127 of which were attributed to negligence. Estimated costs totaled approximately \$439 million, or an average of \$58,766 per injury or \$113,280 per negligent injury. Per average discharge, injuries cost \$2,013 and negligent-related injuries cost \$1,246.

The investigators compared costs absorbed by the hospitals--such as malpractice insurance premiums and extra inpatient care costs they could not recoup--with costs that were "passed through" to other payers. Hospitals varied in the proportion of the costs they externalized, from 0 percent to 97 percent, and did not significantly differ based on teaching status, location or other variables. On average, they externalized 78 percent of all injury costs and 70 percent of negligent injury expenses. Seventeen hospitals passed on at least 80 percent of adverse event expenses.

The authors concluded that since hospitals only bear a small proportion of these costs, they currently have little financial incentives to invest in patient safety practices. They recommended legal reforms, rewards for hospitals that meet quality and safety standards and payers' refusal to reimburse hospitals for certain adverse events.

These results were summarized online April 7 by The Commonwealth Fund's In the Literature publication. (Mello MM, et al. J Empirical Legal Studies 2008;4:835-860.)<http://www.blackwell-synergy.com/doi/abs/10.1111/j.1740-1461.2007.00108>.

The American Society of Health-System Pharmacists (ASHP) has published a new statement outlining appropriate criteria for a proposed intermediate category of medications that would be available from pharmacists in outpatient settings without a prescription. Drug products appropriate for this intermediate category would have proven public health benefits and should be identified by processes that include the input and advice of experts, such as pharmacists, physicians, and other

licensed health care professionals. Medications in this category would only be available to patients after an assessment by and consultation with the pharmacist. For more information, visit <http://www.ashp.org/import/news/pressreleases/pressrelease.aspx?id=522>.

Comparison Websites:

Something that you may want to look at, two websites for comparing hospitals that are available to the public:

Sponsored by Health & Human Services

<http://www.hospitalcompare.hhs.gov/Hospital/Home2.asp?version=alternate&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home>

Sponsored by The LeapFrog Group

<http://www.leapfroggroup.org/cp>

Clinical Pharmacists Reduced, Avoided Expenditures

A review of 21 studies shows that clinical pharmacists' interventions in hospital inpatient settings reduced and avoided expenditures, according to a June 15, 2008, review article in the American Journal of Health-System Pharmacy. Past alerts can be viewed in the policy alerts archive.

http://www.ashp.org/s_ashp/docs/files/advocacy/policy_alert/Economic_Effects_7_28_08.pdf (latest alert) http://www.ashp.org/s_ashp/cat1c.asp?CID=4427&DID=7934 (archive)

Standardization of Creatinine Assays and Its Impact on Drug Dosing

The National Kidney Disease Education Program (NKDEP) laboratory working group has implemented two changes that have significant impact on pharmacy practice: calibration of serum creatinine assays and automatic laboratory reporting of estimated glomerular filtration rate (eGFR) calculated by the Modification of Diet in Renal Disease (MDRD) equation.

Assay calibration increases the accuracy of laboratory assessments, but also results in reported creatinine levels that can decrease as much as 5 to 20% from previously reported values. Therefore, it is important that pharmacists and other clinicians know if and when their laboratory has started using the new assay.

eGFR is believed to be superior for staging renal function. Its automatic reporting is expected to improve early detection and management of patients with chronic kidney disease, and NKDEP has encouraged practitioners to use this method for estimating GFR instead of the Cockcroft-Gault (C-G) equation. However, application of eGFR to drug dosing is limited because existing pharmacokinetic formulas and dosing information from FDA-approved labeling are based on creatinine clearance calculated by the C-G equation.

ASHP has been involved in this initiative since inception and an ASHP member serves on the NKDEP working group to ensure pharmacy concerns are addressed during this transition. A guidance document is being developed by the working group. More information will be posted as it becomes available. For more information from NKDEP, go to http://www.nkdep.nih.gov/labprofessionals/estimate_report_gfr.htm

For a recent AJHP publication on this topic, go to Moranville MP, Jennings HR. Implications of using modification of diet in renal disease versus Cockcroft-Gault equations for renal dosing adjustments. Am J Health-Syst Pharm. 2009; 66:154-61. <http://www.ajhp.org/cgi/reprint/66/2/154>

Framingham Heart Study Launches New Project to Develop Blood Tests for Heart Disease

The landmark Framingham Heart Study (FHS) is launching a major initiative to discover risk factors and markers that could lead to new blood tests to identify individuals at high risk of heart disease and stroke.

The Systems Approach to Biomarker Research in Cardiovascular Disease (SABRe CVD) initiative will identify and validate new biomarkers -- such as proteins or molecules in the blood -- for heart disease. Researchers will study about 1,000 blood biomarkers. Frozen blood samples, imaging studies, and other medical test results gathered over the years from more than 7,000 FHS participants of diverse ages will be analyzed to identify which blood biomarkers are associated with heart disease, metabolic syndrome, and related risk factors. Researchers will use only materials from participants who have consented to sharing their specimens and data with commercial sector scientists, and all shared information will be de-identified to protect participants' privacy.

To learn more, go to the complete NIH News Release at:

<http://www.nih.gov/news/health/mar2009/nhlbi-12.htm>