

VSHP NEWS: Nov-Dec 2010

FALL SEMINAR HELD IN NORFOLK

by Mark Lacson
PharmD Candidate
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The 2010 Fall Seminar of the Virginia Society of Health-System Pharmacists was held from October 28-30th, at the beautiful Waterside Marriott in Norfolk, Virginia. The cool autumn weather arrived just in time to welcome the registrants for an exceptional Fall Seminar. Over 100 pharmacists, technicians, and students attended. The seminar provided 13.5 hours of pharmacist CE and 4 hours of technician specific CE. With an outstanding educational program, exhibit program, and Awards Banquet lined up, the registrants were in for a real treat.

The meeting activities commenced with the Political Action Committee [PAC] Board of Trustees Meeting. The PAC is VSHP's political branch, which uses its influence to promote Health-System Pharmacy friendly legislation to advance the profession. Also, the PAC held its Silent Auction, one of its biggest fundraising events, during this meeting. Items auctioned ranged from weekend getaways, artistic prints, to pharmacy knick-knacks. If you are interested in learning more about the PAC, you are encouraged to contact Lisa Hammond at lhammond@valleyhealthlink.com.

The VSHP Board of Directors then convened to conduct the Society's business. This is an open meeting and all VSHP members are invited to attend. This meeting provides a great chance to learn more about the organization and prospective opportunities to become more involved for all interested members. After the meeting, a Cocktail Reception was held for the VSHP Officers and Past Presidents. In addition, following the Cocktail Reception was the Past Presidents' Banquet that capped off the evening.

The educational portion of the meeting started bright and early Friday morning right after breakfast with a variety of topics set to be covered on this crisp fall day. Kathleen A. Bledsoe, PharmD, University of Virginia Health System started the day off by providing an eye-opening presentation on Updates in the Treatment of Intracerebral Hemorrhage. Diana Mack, PharmD, PGY2 Internal Medicine Resident, VCU Health System followed with her presentation on Current Practices and Future Directions in the Treatment of Multiple Sclerosis to the eager audience. She was then followed by Winston Ally, PharmD, Pharmacy Clinical Coordinator – Transplantation, University of Virginia Health System who educated the audience about a potentially problematic topic in Demystifying Pharmacotherapy in Transplantation: Recent Achievements and Future Challenges.

After lunch, Catherine Derber, MD continued the educational programming with an informative Update on the Management of Clostridium Difficile. Following her was Bryan T. Alexander, PharmD, BCPS, Pharmacy Clinical Coordinator – Infectious Disease, University of Virginia Health System with his enlightening Breakpoint Breakdown?: Assessment of Popular Empiric Treatment Regimens Against Pseudomonas aeruginosa. And the final presentation of the day was Pulmonary Arterial Hypertension: What's a Pharmacist To Do?, presented by Laura A. Duvall, PharmD, BCPS, Specialty Practice Pharmacist – Critical Care, Ohio State University Medical Center, which was very well received.

Exhibit programs were held twice on Friday, once during lunch and, again, in the evening before the Annual Awards Banquet. These sessions provided a relaxed setting and excellent opportunity to talk with colleagues and exhibitors over great food, or even a glass of wine. What better way to relax after all the top-notch educational presentations? Also with all of today's events was the annual Jennifer E. Stallings Clinical Skills Competition where one team from each of Virginia's four Pharmacy Schools competed. The night concluded with the Dinner Presentation on Nucynta, a novel analgesic agent, and Awards Banquet, sponsored by Ortho-McNeil.

Saturday promised to be a busy, but educational, day. It began with a breakfast presentation sponsored by VCU and Shenandoah Schools of Pharmacy on Growing the Profession for Now and Later. This was followed by Building an Organizational Culture of Safety presented by Sylvia Bartel, MPH, B.S. Pharm, Vice President of Pharmacy and Clinical Support Services, Dana-Farber Cancer Institute and James M. Hoffman, PharmD, M.S., BCPS, Medication Outcomes and Safety Officer, St. Jude Children's Research Hospital. Next was Christopher A. Fausel, PharmD, BCPS, BCOP, Clinical Director, Oncology Pharmacy Services, Indiana University Simon Cancer Center with a

presentation on Chronic Myelogenous Leukemia: Considerations for Selecting and Managing Therapy. Following him was James M. Hoffman, PharmD, M.S., BCPS, Initiative Chair, Medical Outcomes and Safety Officer, St. Jude Children's Research Hospital with The Future of Biosimilars in Health Care.

A lunch presentation of Ensuring the Safe Use of Botulinum Toxin was given by Evelyn Hermes DeSantis, PharmD, BCPS, Clinical Professor, Ernest Mario School of Pharmacy, Rutgers University, Director – Drug Information Service, Robert Wood Johnson University Hospital. After lunch was Philip E. Johnson, M.S., B.S. Pharm, FASHP, Pharmacy Advocacy Director, Moffitt Cancer Center and Research Institute, and James A. Jorgenson, M.S., B.S. Pharm, FASHP, Vice President and Chief Pharmacy Officer, Clarian Health and their presentation Pharmacy and the C-Suite: Managing the Interface. The final presentation of the day was Considerations for the Prevention of Stroke in Patients with Atrial Fibrillation given by Cynthia A. Sanoski, PharmD, FCCP, BCPS, Chair and Associate Professor, Jefferson School of Pharmacy, Thomas Jefferson University.

With all the presentations completed, attendees headed home after another successful seminar. If you missed it, start planning early for the Spring Seminar. You do not want to miss out! See you there!

A Student's Perspective of the Jennifer E. Stallings Clinical Skills Competition

by Mark Lacson
PharmD Candidate

MCV/VCU School of Pharmacy

The Jennifer E. Stallings clinical skills competition is quite an intimidating event for a student, but great practice. It is a chance to test the knowledge you learned in school and apply it to a patient case, testing your clinical skill against a panel of judges. It was fascinating listening to each pair's oral presentation, going from subjective to objective to the assessment of the most pertinent problems and their intended plan, all within a two-minute time limit. This was followed by a rapid-fire eight-minute question and answer period where the teams defended their recommendations, probably the most daunting portion of this ordeal. Once that was over, the judge's panel provided some feedback and the next pair came up in front of the firing squad.

The case this year was a real patient case involving a drug toxicity issue and an inappropriate drug selection that might be encountered in clinical practice today. This case was a tough one and each team made logical recommendations. The varying presentation styles and array of the recommendations demonstrated how much of an art clinical skill really is, especially with these tough cases. After hearing each team's oral presentation, it was hard to tell which team was in the lead. It was a nerve-racking experience for me as a student observer, so I can only imagine how the competitors felt. Now that the hard part was over, all we could do was wait in anticipation for the judges to announce the winner at the awards banquet and it was anyone's game. All of the teams did a great job, making their respective schools proud. Good luck at Mid-year!



(Editor's note) The winning team this year was the team from Shenandoah University; Andrew Ventura and Joseph Kalis. Andrew and Joseph each won \$500. Lexi-Comp generously donated a Drug Information Handbook to all student participants. Additionally, we thanked to each student and the teams that competed: from Appalachia College of Pharmacy; Adam Sanders and Taylor Giese; from Hampton University; Keena Segre and Ebony Ayres; and from MCV/VCU School of Pharmacy; Lauren Marston Caldas and Amy Dembowski.

PAC Silent Auction

by Lisa Hammond

The annual VSHP Political Action Committee (PAC) Silent Auction was held in Norfolk at the Fall Seminar in October. We were able to raise \$1,273.00 for the PAC. Examples of items auctioned were: original art work by Mark Pugh, a one week condo at Wintergreen Resort, two night stay in Annapolis, and a two night stay in Winchester with wine/limo tour. All money raised is 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 VSHP Political Action Committee (PAC) is a statewide, voluntary, nonprofit organization, created to enhance and support VSHP's legislative initiatives. The VSHP PAC is governed by 11

trustees who are drawn from the membership-at-large, as well as the VSHP leadership. All decisions made by the PAC trustees are bipartisan and funding is given to legislators who best support VSHP's legislative efforts. VSHP tracks all pharmacy-related legislation that comes before the general assembly reviewing and discussing the implications on the practice of pharmacy. On any given piece of legislation, VSHP will take a position to "support", "oppose", "monitor" or "amend". The discussion over each piece of legislation as well as the position taken helps VSHP's lobbyist in promoting the position that VSHP has chosen. 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.

The VSHP Political Action Committee is looking for someone to help with special events like their annual silent auction. The job comes with plenty of helpers and lots of dedicated donors. So, if you are someone who's organized, likes being in charge, doesn't mind being in the spotlight, and has a little extra time on your hands...WE NEED YOU! Contact Lisa Hammond for more details.

President's Message

by Ellie Desselle

Thank you for being a part of the Virginia Society of Health-System Pharmacists. Founded in 1955, VSHP is a community of pharmacists, technicians, and industry representatives that provides the opportunity for networking, professional growth and continuing education. Additionally, VSHP, through our political action committee, has a strong voice in Richmond when decisions are made that affect the practice of pharmacy in Virginia. We would like to alert you to a few save the dates for 2011:

VSHP Lobby Day
February 10, Thursday
St. Paul's Episcopal Church, Richmond

2011 VSHP Spring Seminar (minimum 13.0 hours of CE)
March 24-26, Thursday-Saturday
Sheraton National, Arlington

VSHP Board Retreat and Training
June 24-25, Friday-Saturday
Hampton Inn Col Alto, Lexington

2011 VSHP Fall Seminar (minimum 15.0 hours of CE)
October 27-29, Thursday-Saturday
Norfolk Sheraton, Norfolk

VSHP is also dependent on the volunteer members that make up the Board of Directors and participate in various committees and projects. By their hard work, VSHP has been able to keep membership fees to the lowest in the country while continuing to provide biannual high-quality educational seminars. This in despite of the last year's economic struggles seen across the country, as well as, the ever-changing PHARMA guidelines, which have put limitations in obtaining grants for continuing education.

VSHP has struggled with its communications infrastructure in the past year. We have had continuing trouble with our website and member database. I personally apologize for any inconvenience this has brought you. The good news is that VSHP is financially robust and we are working on solutions to the problems. Please continue to bear with us through these challenges. We have established a new email address to facilitate better communication with our members. That address is vshp1955@gmail.com.

My challenge for you during this next VSHP year is to look at your own participation in VSHP and find a way to give back. Bring a friend to your next VSHP meeting, volunteer for a committee; attend a board meeting or the biannual education seminars. It is our professional responsibility to continue the good works of VSHP and prepare the way for our colleagues in the future.

Regional Officers Announced

The final results of the 2011 election have been tabulated. (Regions 1, 6 and 7 did not submit candidates for the online process) The new VSHP Regional Officers for 2010-2011 are:

Region 2 President-elect: Colman Mulkerrins Treasurer: Fred Chatelain

Region 3 President-elect: Lisa Deal Treasurer: Julie Hughes

Region 4 President-elect: Anita Atkins Treasurer: Ericka Breden

Region 5 President-elect: Bobby Ison Treasurer: Corine Vitug

Vaccinations and Autism - Retraction

by Ankit Ghodasara, PharmD Candidate

Hampton University School of Pharmacy

The practice of vaccinating in today's world has diminished the occurrences of many diseases. Vaccinations can prevent or ameliorate the effects of a disease or infection. In the 21st century, vaccinations are, for the most part, considered a safe and cost effective method of preventing infectious diseases. Even though vaccinations have been shown to be safe and effective, there has been much debate about the use of vaccinations and autism. ^{1,2}

In February 1998, a group led by Andrew Wakefield published a controversial paper in *Lancet* ³ suggesting a link between the MMR vaccine and the development of autism. In this study, the authors noted that eight of the twelve children who were administered the MMR vaccination reported the onset of gastrointestinal discomfort followed by behavioral problems within two weeks. The authors theorized that the gastrointestinal effects were due to the measles vaccine replicating in the intestinal tract leading the bowel to become porous due to inflammation. The measles virus then spread via blood to the brain affecting the nervous system and causing autism. Although the study did not prove a causal connection, Wakefield called for stopping the administration of the MMR vaccine until further research was completed. ⁴

The paper described a new "syndrome", which could possibly be a link between bowel inflammation, autism, and the MMR vaccine. ³ The controversy began to gain momentum in the next few years after the publication of Wakefield's paper which stated that the MMR vaccine might not be safe. The use of MMR vaccine dropped to under eight percent as a result of this paper and the incidence of measles and mumps reached epidemic levels in 2005. ⁴

In March 2004, as the controversy escalated, ten of the twelve authors released a retraction in *Lancet* stating this paper showed no causal link between the MMR vaccine and autism, and concluded that data was insufficient. ⁵ More recently, the editors of *Lancet* fully retracted Wakefield's paper which linked the MMR vaccine to autism. The retraction notice stated, "...the claims in the original paper that children were "consecutively refereed" and that investigations were "approved" by the local ethics committee have been proven false." ⁶ *Lancet's* decision came after the General Medical Council which oversees doctors in Britain, ruled that Dr. Wakefield acted "dishonestly and irresponsibly." Wakefield continues to proclaim his innocence and stands by his work.

In recent years, scientists at Columbia University replicated important parts of Wakefield's study. The study was co-authored by John O'Leary, a pathologist, who was also a co-author of Wakefield's original study. ⁷ In this latest study, researchers tried to find evidence of genetic material from the measles virus in the gastrointestinal tract of children with autism who had preceding GI problems. Dr. Mady Hornig, a co-author of the study stated, "We found no relationship between the timing of MMR vaccine and the onset of either GI complaints or autism." ⁷

Many parents chose not to vaccinate their children due to their concerns of autism. The use of thimerosal, a preservative containing mercury found in vaccines, has also been a major issue in this controversy. However manufacturers of vaccines have largely eliminated thimerosal from their vaccines, so this is no longer an issue. The use of vaccinations can prevent many highly infectious diseases that result in severe and permanent complications. Therefore, health care providers are encouraged to educate parents on the importance of childhood vaccinations and their safety. (*References available upon request*)(**Addendum**) from Nov 8, 2010 ASHP News

Vaccination Rates For Children With Insurance Fall Amid Autism Fears.

The Time (11/4, Kluger) "Healthland" blog, citing data from the National Committee for Quality Assurance (NCQA), reported "vaccination rates for children with health insurance have been falling -- due mostly to fears about the widely disproven link between vaccines and autism." NCQA said "the share of children with health insurance receiving the measles, mumps and rubella vaccine (MMR) fell from 93.5% in 2008 to 90.6% in 2009." In case of "diphtheria, tetanus and whooping cough the drop was from 87.2% to 85.4%," while "for chicken pox it was 92% to 90.6%."

PERTUSSIS IN VIRGINIA

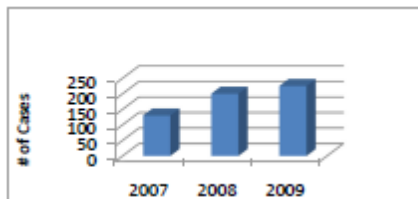
Below is an excerpt from a letter sent on 12 November 2010 by State Health Commissioner Karen Remley, MD. From January to August of 2010 there has been a 16% increase in the number of reported cases (of pertussis) in Virginia compared to the same time last year. In the northwestern region of the state there have been 47 reported cases compared to 19 cases in the same months in 2009. Many other states are showing increases as well. California declared a pertussis epidemic and has just confirmed its tenth infant death resulting from the disease.

B. pertussis is easily transmissible with an 80% secondary attack rate among susceptible close contacts. Adolescents and adults are an important reservoir and often serve as the source of infection for infants too young to be protected by vaccination. These infants represent a very vulnerable group with frequent hospitalizations, use of mechanical ventilation and even death as an outcome. Many infected healthcare workers unintentionally spread pertussis, since it is not always considered early in adults with significant cough.

Early Detection and Treatment

Often, a diagnosis of pertussis in adults and adolescents is missed because they may not have the classic symptoms. Suspect pertussis if your adult or adolescent patient presents with an unexplained, persistent cough. Consider pertussis in the differential diagnosis for any patient with prolonged respiratory symptoms, particularly:

- Paroxysmal cough of any duration.
- Cough with inspiratory whoop.
- Post-tussive vomiting.
- Cough illness associated with apnea in an infant.



For suspected pertussis cases, please consider the following suggested guidelines:

- PCR testing is preferred to rapidly diagnose patients, including those with mild illness.
 - o Specimens should be collected from the posterior nasopharynx, not the throat, using Dacron® or calcium alginate (not cotton) swabs.
 - o Serological testing is not recommended.
- Prompt treatment of patients diagnosed with pertussis can prevent severe disease and reduce disease spread.
- Advise ill patients with suspected pertussis to stay home until completion of antimicrobial therapy for five days.

Prevention and Vaccine

The single most effective way to prevent pertussis is vaccination. While there is high vaccination coverage of children, it is now recommended that adolescents and adults should be revaccinated as protection from the childhood vaccine diminishes over time.

According to a 2009 National Immunization Survey, 83.9% of children in age 19-35 months received at least four doses of DTaP vaccine by 24 months. Among adolescents age 13-17 years, 55.6% received one dose of Tdap vaccine. As for adults, a 2008 National Health Interview Survey reported that nationwide, among those ages 18-64 years, 52.0% reported receiving Tdap.

To help increase vaccination rates, please consider incorporating the following into your clinical practice:

- Encourage your adult and adolescent patients to receive a Tdap booster.
- Promote and support the use of CDC's child, adolescent and adult immunization schedules, which can be found at www.cdc.gov/vaccines/recs/schedules/default.htm.
- Remind your colleagues and health care support staff to update their pertussis vaccinations given their close contact with vulnerable patients.

• Continue to support and use the Virginia Immunization Information System (VIIS) to document and verify immunization status. If you are not currently registered and wish to do so, please call the Virginia Department of Health's Division of Immunization at (804) 864-8055 or visit www.vdh.state.va.us/viis
A toolkit with resources for talking to parents about vaccines and vaccine safety is available through Project Immunize Virginia (PIV) at www.immunizeva.org/tools/.
by Shanette Wilkerson, PharmD Candidate

FDA Bioequivalence Standards for NTI Drugs

Hampton University, School of Pharmacy

The FDA's policy on bioequivalence is currently under scrutiny by its Advisory Committee for Pharmaceutical Science and Clinical Pharmacology. The Advisory Committee has proposed tightening the FDA's bioequivalence standards which would change the way generic medications with a narrow therapeutic index (NTI) are approved.¹ Narrow therapeutic index drugs are defined as "drug products containing certain drug substances subject to therapeutic drug concentration or pharmacodynamic monitoring, and/or where product labeling indicates a narrow therapeutic range designation."²

According to the FDA's Guidance for Industry, its current process for determining bioequivalence (BE) for NTI drugs, as well as all other medications, is the same unless otherwise stated in a specific guideline. Such medications include, but are not limited to, warfarin, digoxin, lithium, phenytoin, and theophylline. Presently, NTI drugs are approved in the same manner as all generic medications. The debate focuses around the fact that NTI drugs can potentially cause more severe consequences, specifically when different brands are interchanged, thus suggesting stricter approval criteria.

² To establish BE, the manufacturer of the generic drug must demonstrate the drug is bioequivalent to the innovator drug.³ The FDA requires that the average peak plasma, serum, or blood concentration and the average area under the concentration-versus-time curve of a generic drug product have a BE range between 80-125 percent of the C_{max} and AUC values of the brand name product.¹ Bioequivalent drugs normally confer an AB rating. This rating indicates that actual or potential bioequivalence problems have been resolved with adequate in vivo and/or in vitro evidence supporting bioequivalence.⁴

All but one adviser agreed that the FDA should produce a list of NTI drugs and consider them as an independent class of medications. They also acknowledged the fact that if such restrictions were to be placed on this group of medications, manufacturer's cost of production of generic medications would ultimately increase due to the need of a larger study population to satisfy more stringent requirements.

¹ The FDA has discussed this issue several times in the past. In 1997, the National Association of Boards of Pharmacy contacted the FDA in regards to their position on generic drugs and their substitutability. Roger L. William, Deputy Center Director for Pharmaceutical Science at the Center for Drug Evaluation and Research, responded that, "because of FDA's strict bioequivalence criteria, we believe that drugs do not fall into discrete groups that would allow one to consider NTI drugs as being clearly different from other drugs for purposes of therapeutic substitution. No data has been submitted to FDA to cause any revision in the bioequivalence criteria for these products. Therefore, there has been no scientific or regulatory purpose at this time for the agency to create and implement a mechanism to designate some products as being narrow therapeutic index products, or to define any other specific group of products."

The FDA has analyzed many studies to prove that their current criterion is sufficient in determining bioequivalence, citing a disconnection between the FDA and some in the medical community. The FDA has reported that after reviewing more than 2000 bioequivalence studies, the average variation in AUC and C_{max} from the innovator drug product is a mere 5% differential. The FDA also has also analyzed studies that highlighted physicians and patients beliefs that generic products are not always equivalent to innovator drug products. The FDA noted that many physicians are unaware of the FDA's approval process for generic medications as indicated by a study that revealed less than 1 in 5 physicians could recall the FDA's bioequivalence standards. The FDA hopes to move slowly in its decision making process and has made no agreement in regards to new standards for NTI drugs.

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(References available upon request)

Proposed Changes to Childhood Disorders in DSM-5

by Adam Shelton, PharmD Candidate

VCU/MCV School of Pharmacy

Although the much anticipated Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) is not set to be published until May of 2013, the proposed draft has been made available online. Among many changes to

DSM-IV, the new addition will be identified as DSM-5, using Arabic numbers instead of Roman numerals. This change allows for updates to be released such as DSM-5.1, DSM-5.2, etc. Along with the basic name change, the DSM-5 draft has done some major revamping to the childhood disorders section. This revision creates a new category, “autism spectrum disorder,” which would replace the previous “**Pervasive Developmental Disorders**” naming. This category includes autistic disorder (autism), Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified.² Although the individual criteria to differentiate the diseases have not been established yet, the proposed change for the overall category requires patients to meet ALL three criteria. (1)- Clinically significant, persistent deficits in social communication and interactions, as manifested by ALL of the following: Marked deficits in nonverbal and verbal communication used for social interaction; Lack of social reciprocity; Failure to develop and maintain peer relationships appropriate to developmental level. (2)- Restricted, repetitive patterns of behavior, interests, and activities, as manifested by at least TWO of the following: Stereotyped motor or verbal behaviors, or unusual sensory behaviors; Excessive adherence to routines and ritualized patterns of behavior; Restricted, fixated interests. (3)- Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities).¹ In DSM-IV deficits in communication and social behaviors were defined by different criteria. This caused multiple criteria to assess the same symptom and therefore carry excessive weight in making diagnosis. DSM-5 recognizes that these symptoms are inseparable and more accurately considered as a single set of symptoms with contextual and environmental specificities and, as a result, eliminate that problem. DSM-IV requirements for meeting the criteria were complex and nonspecific, so by requiring all 3 criteria to be completely fulfilled, DSM-5, improves specificity of diagnosis without impairing sensitivity. Dr. Edwin Cook, a member of the DSM-5 Neurodevelopmental Disorders Work Group, stated in a news release, “The recommendation of a new category of autism spectrum disorders reflects recognition by the work group that the symptoms of these disorders represent a continuum from mild to severe rather than being distinct disorders.”² Although currently the recommendations for severity criteria have still not been released yet, it is expected that these changes will improve the sensitivity and specificity of the criteria resulting in clinicians more accurately diagnosing these disorders. As more is understood about these childhood disorders and their diagnostic criteria evolve, the American Psychiatric Association (APA) will be releasing updates to DSM-5 making it into a living document. These changes along with full text of the DSM-5 draft are available online at www.dsm5.org and are being continually updated as progress is made.
(References available upon request)

NEWS SHORTS

New Edition Helps Pharmacists Meet Joint Commission Standards

ASHP Publishes Eighth Edition of Assuring Continuous Compliance with Joint Commission Standards
Bethesda, Md.—Meeting Joint Commission standards for accreditation is critically important to hospitals and health systems throughout the U.S. The American Society of Health-System Pharmacists’ (ASHP) eighth edition of Assuring Continuous Compliance with Joint Commission Standards: A Pharmacy Guide, by John P. Uelton, B.S. Patricia C. Kienle, M.B.A., FASHP, and Lee B. Murdaugh, Ph.D., is the only book that covers all the latest major accreditation standards, including Joint Commission and others.

The book includes:

- Updated chapters on the Joint Commission’s survey process, medication-related National Patient Safety Goals, and Medication Management standards (with new icons to identify performance elements that require documentation);
- A new chapter on the National Integrated Accreditation for Healthcare Organizations (NIAHO) surveys of Det Norske Veritas Healthcare; AND
- Updated chapters on the Centers for Medicaid & Medicare Services medication-related Conditions of Participation and the Healthcare Facilities Accreditation Program standards

The eighth edition also includes the new Joint Commission numbering system and most current updates, revised examples of forms and documents, updated checklists, and an expanded, more complete index for easier search capabilities. The authors put this latest data into context with compliance strategies pharmacists can use in their everyday practice. In addition, the book includes checklists for each element of performance, a companion CD with nearly 50 customizable forms and documents, including a medication management and National Patient Safety Goals gap analysis application.

To place orders for the book, ISBN 978-1-58528-242-5, and view additional material, please visit www.ashp.org/cardiovascular, or, please email custserv@ashp.org or call 1-866-279-0681 (US & Canada), 001-301-664-8700 (International).

Prepare for the Board of Pharmacy Specialties (BPS) Ambulatory Care Pharmacy Specialty Certification Examination.

Prepare to take the next step in advancing your practice by earning your Ambulatory Care Pharmacy Certification. The American Society of Health-System Pharmacists and the American Pharmacists Association have teamed up to help ambulatory care pharmacists prepare for the Board of Pharmacy Specialties (BPS) Ambulatory Care Pharmacy Specialty Certification Examination. This two-day course provides a robust preparatory curriculum for the ambulatory care pharmacy professional preparing for the examination, which will be offered for the first time in October 2011.

<http://www.ashp.org/Midyear2010/Education/AmbulatoryReviewCourse.aspx>

Guideline Changes for CPR and Emergency Cardiovascular Care Science Announced

The 2010 CPR and Emergency Cardiovascular Care (ECC) Science guidelines have rearranged the basic life support (BLS) steps from "A-B-C" (Airway, breathing, chest compressions) to "C-A-B" (Chest compressions, airway, breathing). In addition, other key changes include a simplified BLS algorithm; encouragement of hands-only (compression only) CPR for the untrained rescuer; and implementation of the appropriate compression depth. For more detailed information about the revised guidelines, please go to

http://circ.ahajournals.org/cgi/content/full/122/18_suppl_3/S640

Stroke Guidelines Updated

The American Stroke Association (a branch of the American Heart Association) has released updated guidelines on the prevention of stroke and ischemic attacks. Changes in the guidelines include better control of blood pressure, diabetes, and lipids, as well as cessation of smoking and alcohol consumption.

<http://stroke.ahajournals.org/cgi/reprint/STR.0b013e3181f7d043v1>

Call for Nominations

ASHP is on the lookout for nominees to the elective offices of President; Chair, House of Delegates; and Member, Board of Directors. Individuals or affiliated state societies are encouraged to nominate ASHP members who are committed to building a strong future for health-system pharmacy. Nominations must be submitted to the ASHP Committee on Nominations, via email (ASHPCON@ashp.org), fax 301-634-5825, or U.S. mail (Attention: Committee on Nominations) no later than February 1, 2011.

<http://www.ashp.org/DocLibrary/AboutUs/NomElecAppoint/CallforNom.pdf>

Propoxyphene Withdrawn from the U.S. Market

Standard doses of propoxyphene have been shown to be harmful to patients in the form of serious or fatal heart rhythm abnormalities. For this reason, the FDA has chosen to withdraw it from the market. The drug's pain reduction effect is not enough to outweigh the heart risks.

<http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm234350.htm>

Pharmacy Leadership Institute – Apply by January 14, 2011

Do you need your leadership “batteries” recharged? There’s no better way to reignite your excitement about being a leader in health-system pharmacy than by attending the Pharmacy Leadership Institute. The Institute gives you the opportunity to spend a week with the faculty of Boston University’s School of Management, a leading U.S. business school, and pharmacy colleagues from around the country. The faculty will teach you new concepts and practices used in the business world and how to apply those to real issues you face in the medication-use process. This program is supported by the Cardinal Health Foundation. The deadline is January 14, 2011. More information about the Institute and the application process can be found at <http://www.ashpfoundation.org>.