



Virginia Health-System Pharmacy News

Summer 2011

Fall Seminar

Make your plans now to attend the VSHP Fall Seminar that will be held at the Norfolk Sheraton, 777 Waterside Drive, Norfolk, Virginia. The dates are October 28-29 [Friday/Saturday]. There are fifteen (15) hours of ACPE accredited CE waiting for you. An official notice will be forthcoming. As an aside, if you haven't received your CE certificate from the Spring Meeting, please notify the VSHP office. The certificates were mailed in early July.

VSHP Website

If you haven't been there lately, you need to check it out. The VSHP Website (www.vshp.org) has been revamped and updated. There is plenty of legislative, medication, and society news located there. Look it over and give us your opinion. We're always open to suggestions for improving our membership benefits. Be sure to view the pictures from the 2011 Spring Seminar held in Arlington, Virginia while you're there.

Membership Renewals

At the Board of Director's meeting in June, a change in the due date for memberships renewals was made. So that the dues notice doesn't arrive during the Christmas

season with all of the hustle and bustle, it was decided that the notices would be sent out **three months** prior to renewal, i.e. September 2011. So, don't be surprised when the renewal notice arrives earlier than expected.

PAC Silent Auction

The Political Action Committee [PAC] is always looking for items to auction at its annual fundraiser. The PAC auction, always a crowd favorite, will be held during the Fall Seminar. If you've got any items [and we're talking anything] that you'd like to donate, contact Lisa Hammond at

hammond@valleyhealthlink.com to arrange pickup.

You can also contribute directly to the PAC by visiting the VSHP website. Just go to <http://www.vshp.org/vshp-political-action-committee.html> and click on the PayPal donate button.



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The 2011-2012 Board took office at the VSHP Board Retreat in June and will be officially installed before the membership at the Fall Seminar in Norfolk.

BPS Examination Registration

Registration for pharmacists interested in sitting for any one of the six Board of Pharmacy Specialty [BPS] examinations is now open online. All six exams [ambulatory care, nuclear pharmacy, nutrition support pharmacy, oncology, pharmacotherapy, and psychiatric pharmacy] will be given on October 1, 2011, at multiple U.S. and international sites. Each specialty has different eligibility requirements that must be met to be allowed to take the exam. Complete information regarding eligibility requirements is available at www.bpsweb.org.

New BPS Specialty? 'Pain and Palliative Care'

The Board of Pharmacy Specialties [BPS] announced in March that it was at a critical step in the process of deciding whether to recognize **pain and palliative care** as a pharmacy specialty area. The BPS was undertaking a role delineation study, whose purpose is to determine whether pharmacists who provide pain and palliative care services use specialized knowledge from the pharmaceutical sciences and routinely participate in specialized functions. The study instrument will be sent to hundreds of practicing pharmacists to their input, probably in September 2011.

Pharmacist running for State Legislature

Keith Hodges, owner of Gloucester Pharmacy in Gloucester, Virginia is running for State Delegate in the 98th District of the General Assembly. This is the seat to be vacated by Harvey Morgan [see below], who coincidentally is also a pharmacist. Although Keith may not be in your district, name recognition is everything in the Primary Elections. Please be cognizant of the fact

that a fellow pharmacist is running for the state General Assembly and do whatever you can to help him get elected.

Delegate Harvey Morgan: Community Servant

by Richard Byrd,
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In 2012, the Virginia House of Delegates will lose a member who is known for his hard work, dedication, and service to his community and state. A true health care leader, Delegate Harvey Morgan has announced that he plans to end his sixteen-term career in the Virginia House of Delegates by not seeking re-election. A graduate of the MCV/VCU School of Pharmacy and a pharmacist from Gloucester Virginia, Harvey served his community's health care needs until 1980 when he began to serve its legislative needs. At the age of eighty, Delegate Morgan has attended over thirty-two legislative sessions and is the second-longest serving delegate in the House of Delegates. During Harvey's tenure, he served and/or chaired such powerful committees as Appropriations, Agriculture, Chesapeake and Natural Resources, and Commerce and Labor. All of these committees made decisions that directly affected his constituents in the 98th district. Morgan is one of two pharmacists to hold a seat in the House of Delegates. A modern politician who was not afraid to speak his mind or reach across the aisle, Morgan, a Republican, sponsored bills that supported local industry, firearm rights, protection of the Chesapeake Bay, regulation of local utilities, and, naturally, health care issues. Morgan headed up many bills that directly influenced the profession of pharmacy. He sponsored bills that defined the role of pharmacy benefit managers and required

them to diligently pay pharmacy providers, required the executive director of the board of pharmacy to be a pharmacist and expanded membership to the board of pharmacy. He also was involved with bills that scheduled new drugs, bills that enabled pharmacy technicians to fill automated dispensing systems, bills that amended the Drug Control Act, bills that gave prescriptive power to pharmacists in anticoagulation clinics under collaborative agreements, bills that prohibited the discriminatory drug pricing by drug manufacturers, bills that offered guideline for antibiotic stewardship, and bills defining rural underserved areas for

scholarship and loan repayment programs. This is just a short list of the critic legislation that was lead by Del. Morgan.

Delegate Harvey Morgan serves as a shining example that health care providers, specifically pharmacists, have the skills and capabilities to impact the lives of their community, both in and out of the traditional pharmacy setting. Morgan, himself, stated, "I know of no higher calling than public service, and I cherish the relationships made possible by such a privilege...serving is truly a labor of love and the decision to step down next January has been the most difficult of my life."

Coronary Artery Calcium

by Roshanda Ruffin

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Coronary artery disease (CAD) is the progressive build-up of atherosclerotic plaque that increases the probability of having a heart attack, and is the number one cause of death regardless of gender.¹ Atherosclerotic plaque has three components: macrophages at the center, underlying layers of cholesterol and a calcified base. Heart attacks are not always accompanied by precursors (e.g. chest pain, nausea) that allow time for preventive measures; sadly enough the first sign or symptom of a heart attack may be sudden death.¹ Due to the severe consequences of heart attacks, it is vital to take precautionary measures to reduce or modify risk factors that may lead to cardiovascular events. An important method of early prevention is screening for CAD.¹ There are several patient types that are at a higher risk for having calcified plaques in the arteries such as: those with a family history of heart disease, high cholesterol, high triglycerides, low HDL, high blood pressure, diabetes,

overweight, inactive lifestyle, women over 55 and men over 45.² Measuring the calcium deposits in the coronary arteries is one of the newest promising markers for CAD risk.¹

Plaque accumulations in the arteries may cause them to harden and close, preventing adequate blood flow. The arteriosclerotic plaque is composed of macrophages, cholesterol and calcium deposits. If this plaque ruptures, the result of the thrombosis can be a heart attack or stroke.¹ Calcium, an extremely important mineral in the body, is normally not present in the arteries; however when it is, evidence of calcium can be seen in X-rays. One method for measuring the calcium accumulation is an ultra fast or electron beam computerized tomography (CT), which analyses the heart for calcium deposits.¹

The few steps to image the heart for calcified deposits may be the answer to saving millions of lives. Calcium scoring is a measure to assess the amount of calcified plaque located in the coronary arteries of a person.¹ The measure of calcified plaque accumulated within the arteries is directly proportional with the likelihood of suffering from cardiac events such as heart attacks or strokes. In a recent study, results showed

that patients without any prior cardiovascular events and receiving a calcium score of 100 have a ten times higher risk of having a heart attack or stroke.² Calcium scoring does not evaluate the individual blockage caused by the calcified deposits, but rather assesses the overall risk for heart disease.²

Cardiac calcium score is performed using a CT scanner that rotates to remit cross-sectional images of the various valves of the heart.² The calcified atherosclerotic plaques are detected from the scanner using a radioactive dye and are then evaluated and given a score.² The procedure entails the patient lying on his/her back on the CT table, while the table is positioned into a donut-shaped x-ray machine.² The x-ray machine rotates around the patient and captures roughly 64 cross-sectional images of the heart.² The procedure takes approximately 5 seconds. Following the procedure the calcium score is immediately given along with a consultation of the patient's risk.²

Coronary calcium scoring predicts the progression of heart disease by assigning a score that corresponds to the amount of plaque present. A calcium score of zero represents no plaque, a < 5% risk of current heart disease and very low risk of heart attack.² A calcium score of 1-10 signifies minimal plaque, a < 10% risk of current heart disease, and a low risk for heart attack.² At this stage the patient should consider improving diet, exercising regularly, and smoking cessation for smokers. A calcium score of 11-100 represents mild plaque, a risk for mild coronary disease and moderate risk for heart attack.² At this point the patient should take a daily aspirin supplement, while continuing diet and exercise, and smoking cessation for smokers. As the score increases to 101-400 range, there is a moderate accumulation of plaque and the intensity of heart disease increases to non-obstructive, with a moderately high risk for heart attack.² The patient should continue the aforementioned regimens as well as undergoing a physician

ordered stress test. Any calcium score > 400 constitutes extensive plaque.² At this point more than 90% plaque blocks at least one of the coronary arteries and the risk for heart attack is high. The patient should perform a stress test for further evaluation and continue the daily aspirin prophylactic therapy as well as life style changes.

Overall the calcium scoring offers a wide array of benefits for prevention and monitoring of cardiovascular risk that may ultimately decrease all cause morbidity and mortality. Coronary calcium testing is currently under investigation and has not proven to be advantageous over other testing methods. However it is a very beneficial as a diagnostic tool, as it offers a preventative measure for decreasing cardiovascular disease.

References:

1. Cardiology Associates . (2006). *What is Cardiac Calcium Scoring*. Retrieved June 28, 2011, from Cardiology Associates: www.cardassoc.com/news/WhatIsCardiacCalciumScoring.pdf
2. Quinn, R. (2004). *Underwriting Coronary Calcium*. New York: Th Legal & General America Companies: Banner Life.

The Far-Reaching Effects of California's Drug Tracking Legislation

by Richard K. Byrd
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Patients, employers, manufacturers, and legislators often influence policies regarding the practice of pharmacy. Legislation that requires changes in the practice of pharmacy are usually the hardest to comply with because the law is most often intentionally vague, and the pharmacists are left with the daunting task of trying to integrate the new laws into their practices. Recently, such legislation has been passed in California, and some are fearful that it will be adopted federally and pharmacists will be left with the huge task of compliance.

In California, a law was passed to improve the process of insuring that the medication shipped from a manufacturer is the same medication that is delivered to the pharmacy. The intent of the law is to avoid tampering and misplacement of drug shipments, thereby improving patient safety. The legislation requires all pharmaceutical manufacturers to create an e-pedigree by 2015, which will allow every item-level package to be traced back through the shipping steps to its origin. In addition, every pharmacy must be able to accept these e-pedigrees by 2017.

The e-pedigree is an improvement over current requirements. In fact, the closest system that is in place is found overseas. In Turkey and France, drug packages are labeled with a two-dimensional data matrix code, and this code is scanned when leaving the plant and again when delivered to the pharmacy. The e-pedigree system that California requires is a step up from the 2D matrix code. The e-pedigree system requires that each manufacturer assign a Standard Numerical Identifier, or SNI, to each box of items. Each item in that box will be given its own SNI, but the two will complement each other. As the package makes its way to the end user, ownership changes, and each owner's e-pedigree is added onto a digital shipment order according to Global Standard One. GS1 is a nonprofit organization that has worked to improve efficacy and visibility of supply chains across the world. This digital shipment order is called the Drug Pedigree Messaging Standard.

Another technique, known as Track-and-Trace, is very similar to the e-pedigree system except that, when the shipment changes hands, the previous owner is given a copy of any new information. This step allows an inquirer, such as a government entity, to trace the package back through its shipments or confirm delivery of packages.

Almost all participants in the drug manufacturing, shipping, and wholesaling have concerns with the legislation. Not all

drugs ordered in California are made in that state, so for the e-pedigree system to work there, all states would have to enact an e-pedigree system. Therefore, even though legislation for the e-pedigree system is only found in California at this time, all states should be wary of changes that may occur locally. Steve Drucker, the Director of Global Pharmaceutical Commercialization in Packaging Technologies and Compliance at Merck, believes that implementation of a full Track-and-Trace system would cost almost 100 million dollars. Robert Bepko Jr., a Director of Professional Services at Norwalk Hospital in Connecticut, is concerned because his hospital already has an inventory system recently purchased from McKesson and, with the new requirements on the horizon, his system may be obsolete. In 2010 the FDA got involved by issuing a guidance document for SNI formation. It is identified as a guidance document rather than a law, but it is still suggested to be as strong as a legal requirement. Because the guidance document suggests that an SNI add 20 additional numbers to the NDC code, the National Council for Prescription Drug Programs (NCPDP) would have to change how information technology systems identify drugs packages and reformat software to accommodate the extra numerals. Many retail chains, as well as the American Society of Health-System Pharmacists, have become so concerned that they have formed a work group known as the NCPDP Work Group 17 to track the outcomes and benefits of the California Project.

The future of legislation related to drug tracking is not set in stone. It is important for hospital pharmacists and administrators to understand what is being explored so that they can prepare for changes and be able to adapt to them in a timely manner.

Reference:

Abstracted from "Track-and-Trace Drug Verification FDA Plans New National Standards, Pharmacies Tread With Trepidation" Written By Stephen Barlas. P&T Vol. 36. No 4, April 2011.