You may preview your newsletter as many times as you like.

Your next publish window will be from **29-Sep-15** to **28-Oct-15**. Click on the Production Calendar tab above for details.

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**Announcements**

*Mark Your Calendar*

**Save the Date—VSHP Fall Seminar**

**October 9–10, 2015**

Kingsmill Resort, Williamsburg, VA

Hotel Reservations:

To make your hotel reservations, call 757-253-1703 or 800-832-5665. Mention you are with the Virginia Society of Health–System Pharmacists meeting. Room rate is $149 per night. **To book online**
Message from the VSHP President

How you ever wanted to get involved with ASHP? Have you considered a council or commission? Do you know the ASHP councils and commissions?

In addition to our member elected Board of Directors, ASHP also maintains the following councils, committees, and advisory bodies to assist ASHP in a variety of important activities:

Councils

The five councils are the primary bodies that initiate ASHP policies on professional issues. Policy recommendations are reviewed by the Board of Directors and, ultimately, by the House of Delegates. Councils also advise the Board on ASHP activities within their respective purviews.

Council on Education and Workforce Development

Concerned with ASHP professional policies related to the quality and quantity of pharmacy practitioners in hospitals and health systems. Within the Council’s purview are (1) student education, (2) postgraduate education and training, (3) specialization, (4) assessment and maintenance of competence, (5) credentialing, (6) balance between workforce supply and demand, (7) development of technicians, and (8) related matters.

Council on Pharmacy Management

Concerned with ASHP professional policies related to the process of leading and directing the pharmacy department in hospitals and health systems. Within the Council’s purview are (1) development and deployment of resources, (2) fostering cost-effective use of medicines, (3) payment for services and products,
Concerned with ASHP professional policies related to the responsibilities of pharmacy practitioners in hospitals and health systems. Within the Council’s purview are (1) practitioner care for individual patients, (2) practitioner activities in public health, (3) pharmacy practice standards and quality, (4) professional ethics, (5) interprofessional and public relations, and (6) related matters.

Council on Public Policy

Concerned with ASHP professional policies related to laws and regulations that have a bearing on pharmacy practice in hospitals and health systems. Within the Council’s purview are (1) federal laws and regulations, (2) state laws and regulations, (3) analysis of public policy proposals that are designed to address important health issues, (4) professional liability as defined by the courts, and (5) related matters.

Council on Therapeutics

Concerned with ASHP professional policies related to the safe and appropriate use of medicines. Within the Council’s purview are (1) the benefits and risks of drug products, (2) evidence-based use of medicines, (3) the application of drug information in practice, and (4) related matters.

Commission on Affiliate Relations

Advises the Board of Directors on standards for affiliation, implementation of the standards, methods of strengthening affiliates, and methods of building affiliate relationships that help advance ASHP’s objectives.

Commission on Credentialing

Formulates and recommends standards for accreditation of pharmacy personnel training programs and administers programs for accreditation of pharmacy personnel training programs.

Commission on Goals

Reviews trends in health care delivery and advises ASHP on broad strategic and health-policy issues that have a bearing on pharmacy practice in health systems.

ASHP President-Elect Lisa M. Gersema will appoint ASHP members to council and commissions. In making recommendations for appointments, the President-Elect takes into consideration geographic distribution, personal qualifications, and previous experience in ASHP and affiliated state societies.

Please consider the opportunity! VSHP wants to nominate members to Lisa Gersema for these roles! Deadline to apply for nomination is November 12, 2015

Lisa Deal, VSHP President 2015-2016

Clinical Article

Stepping Beyond Just “Medication Reconciliation”

Stephanie Hoge, Pharm.D. and Christina DeRemer, Pharm.D., BCPS

As healthcare professionals, we know that medication reconciliation at all transitions of medical care is essential in optimizing patient safety and, ultimately, providing excellent patient care. Yet, how do we respond if and when the medication reconciliation process is completed inconsistently or haphazardly, and concerns about the appropriateness of medication therapy remain?

Consider the following case.

A 91-year-old female was admitted to the hospitalist service at an academic medical center. Her handwritten home medication list included:

- Amlodipine 10 mg daily
- Aspirin 325 mg daily
- Calcium-Vitamin D 500 mg-200 international units daily
- Clopidogrel 75 mg daily
- Cilostazol 100 mg twice daily
- Famotidine 20 mg twice daily
- Hydrocodone-Acetaminophen 5 mg-325 mg Q6H PRN pain
- Lisinopril 40 mg daily
- Pantoprazole 40 mg daily
- Simvastatin 20 mg daily
Docusate 100 mg twice daily

When presented to the inpatient pharmacist, the patient’s medication profile contained numerous medications and obvious therapeutic duplications. However, the inpatient medical team held misguided feelings of confidence in the accuracy of the list, stating that her home medications were prescribed by her primary physician(s) in the community. As a result, the team declined to make any changes to her medication regimen. Undeterred, the inpatient pharmacist first called the outpatient filling pharmacy and was able to determine that 2 separate physicians (i.e., primary care physician and cardiologist) were prescribing the medication duplications. Subsequently, the pharmacist reached out to the primary care physician and cardiologist. Together, it was determined that the patient had been taking an H2 receptor antagonist and a proton pump inhibitor without indication as well as three antiplatelet medications since a stent placement approximately 5 years ago. The decision was made to discontinue duplicate medications, adjust dosages per guideline recommendations, and formulate an appropriate medication regimen that would be both safe and efficacious.

The Joint Commission Hospital National Patient Safety Goal 3 mandates improvement in the safety of the medication use process. Specifically, the medication reconciliation process involves comparing the medications a patient should be taking (and is actually taking) with newly ordered medications and identifying and resolving any discrepancies. This activity requires obtaining the patient’s list of prescription and over the counter medications, communicating with various healthcare professionals, distinguishing inconsistencies, establishing the optimal medication regimen based on patient-specific characteristics, and educating the patient on safe medication use. Overall, it includes coordinating information during transitions of care both within and outside the organization. Effective medication reconciliation is an interdisciplinary activity and is truly best for patients within our healthcare systems.

In summary, the strengths of varying disciplines must be used to acquire the most accurate medication history, to evaluate the appropriateness of the patient’s medication therapy, and to formulate a plan for moving forward. A patient’s handwritten medication list must not be the end point for reconciliation but rather one point of several for clarification. Healthcare professionals must work collaboratively to maintain accurate medication profiles and to successfully care for patients.

Residency Showcasse

We are pleased to announce that VSHP will be hosting a pharmacy residency showcase in conjunction with the VSHP Fall Seminar. We would like to invite you to display at the residency showcase. You will have the opportunity to advertise your program as well as speak with students who may be interested in interviewing next spring or in subsequent years.

The showcase will be held on Saturday, October 10, 2015 from 10:15 AM to 12:15 PM at Kingsmill Resort in Williamsburg, VA. There is no charge to participate in the Residency Showcase.

Residency programs interested in participating email Steve Glass at contact@vshp.org

Students interested in participating can register at the Fall Seminar webpage

Letter from ASHP
September 22, 2015

Lisa Deal, Pharm.D.
President
Virginia Society of Health-System Pharmacists
3015 N Shannon Lakes Drive
Tallahassee, FL 32309

Dear Dr. Deal:

On behalf of the ASHP Board of Directors and staff, I would like to formally extend congratulations and best wishes to the Virginia Society of Health-System Pharmacists on the occasion of the organization’s 60th anniversary.

The practice of pharmacy has certainly changed in the years since your organization’s beginning 60 years ago. It is just as certain that our professional future will continue to evolve, and that these changes will be positive because of the commitment made and delivered by the members of the Virginia Society of Health-System Pharmacists. My best wishes for a terrific celebration.

We at ASHP extend every best wish for continued success and growth. We look forward to continuing this partnership which has brought many of your organization’s members to positions of leadership within ASHP over the years.

Sincerely,

Paul W. Abramowitz

cc: Steven Glass

American Society of Health-System Pharmacists • 7272 Wisconsin Avenue, Bethesda, Maryland 20814 • 301-657-3000 • Fax: 301-664-8877 • www.ashp.org

ASHP News

Chisholm-Burns to Receive ASHP-ABHP Leadership Award

8/31/2015 ASHP has named Marie A. Chisholm-Burns, Pharm.D., M.P.H., M.B.A., FCCP, FASHP, recipient of the ASHP-Association of Black Health-System Pharmacists (ABHP) Leadership Award.

Dr. Chisholm-Burns is Dean and Professor of the University of Tennessee College of Pharmacy at its three campuses in Memphis, Nashville, and Knoxville; a renowned academic and clinical pharmacist; and an exemplary leader in the reduction of racial and ethnic disparities in healthcare.

Read More
Evolocumab Approved for Reducing LDL Cholesterol
Kate Traynor
BETHESDA, MD 31 Aug 2015—FDA and Amgen on August 27 announced the approval of evolocumab injection as add-on therapy to reduce low-density lipoprotein cholesterol (LDL-C) in patients whose blood levels of the lipid remain high despite dietary modifications and medication therapy.
Labeling (PDF) for evolocumab states that it is indicated, along with diet and maximally tolerated statin therapy, in adults with heterozygous or homozygous familial hypercholesterolemia or cardiovascular conditions that require additional lowering of LDL-C levels.

Hospital Group Takes Systemwide Approach to Antimicrobial Stewardship
Kate Traynor
BETHESDA, MD 27 Aug 2015—Pharmacists are taking a systemwide approach to antimicrobial stewardship at UnityPoint Health, a multihospital group that serves patients in Iowa, Illinois, and Wisconsin.
Brian Benson, UnityPoint’s executive director of pharmacy, said the health system’s three Des Moines-area hospitals established an antimicrobial-use committee for pharmacists several years ago. But it wasn’t until after 2012, when infectious diseases clinical pharmacist Amanda Bushman was hired and put in charge of that group, that the systemwide antimicrobial stewardship idea was born.

Small, Unverified Increase in Cardiovascular Risk Reported for PPIs
Kate Traynor
BETHESDA, MD 27 Aug 2015—FDA investigations over the years have concluded that the use of proton pump inhibitors (PPIs) may be associated with potentially serious adverse events or drug interactions, including Clostridium difficile infection and reduced activity of antiplatelet drugs.
Adverse cardiac events dropped off that list of possibilities when the agency in 2007 investigated a potential safety signal and found no link between omeprazole or esomeprazole use and the onset of cardiac problems.

AJHP Article Highlights Continuing Gaps in High-Risk Sterile Compounding Practices
Accompanying Editorial Urges Pharmacists to Adhere to USP chapter 797 Guidelines
8/11/2015
Hospital and health-system pharmacists must ensure that both internal sterile compounding staff and external sterile compounding facilities meet high standards of practice to ensure patient safety, according to an article and accompanying editorial in the August 1 issue of AJHP. A national certification or credential to verify competence in sterile compounding personnel may be needed to achieve this goal on a broad scale, according to the editorial. Ongoing, chronic national drug shortages are forcing hospitals to seek other sources for medications that meet patients’ clinical needs, including external compounding facilities. The AJHP editorial urges pharmacy managers and directors to ensure that the proper risk mitigation procedures are in place if they conduct their own compounding or outsource to a compounding facility. Pharmacy leaders also should evaluate the risks and benefits associated with switching to another commercially available product.
From Europe and Implications for U.S. Nephrologists
International Urology and Nephrology (09/01/2015) Vol. 47, No. 9, P. 1529; Covic, A.; Abraham, I.

Since 2007, the European Medicines Agency (EMA) approved biosimilar versions of the erythropoiesis-stimulating agent (ESA) epoetin alfa. A U.S. Food and Drug Administration regulatory approval process for biosimilars was legalized in 2009, so biosimilar erythropoietin products are expected to be available for prescription in the U.S. by mid-decade, at a price likely to be competitive with originator brand-name reference products. In this paper, researchers examined the status of originator and biosimilar ESAs, reviewed the clinical development and regulatory approval of biosimilar erythropoietins in Europe, and summarized relevant efficacy and safety information of biosimilar erythropoietins in relation to their reference products to provide a background for U.S. nephrologists as they appraise biosimilar erythropoietins as treatment options for renal anemia. Key lessons learned from Europe are that EMA-approved biosimilar erythropoietins have comparable efficacy and safety profiles to their reference product erythropoietin; pharmacovigilance preapproval and postapproval are critical, especially with regard to immunogenicity and vascular thromboembolic events; strict preapproval and postapproval requirements must guide the regulatory pathway for biosimilars; and high-quality manufacturing and production processes must be established to ensure quality biosimilar products. The availability of biosimilar erythropoietins in the U.S. will provide nephrologists with alternative, effective treatment options for patients with renal anemia.

FDA Approves First Fully Mobile Continuous Glucose Monitor
Medscape (08/25/15) Tucker, Miriam E.

FDA has approved the Dexcom G5 Mobile Continuous Glucose Monitoring (CGM) system for adults and children. It is the first GCM system that sends real-time glucose information directly to a smartphone using wireless Bluetooth technology built into the transmitter. Up to five "followers," such as caregivers, can check the patient's glucose levels. The system also issues alerts about readings of concern, but fingerstick blood glucose testing is still required when deciding insulin doses and for system calibrations. The G5 system is expected to ship in late September. Currently, the system only works with iOS-enabled devices, but Android applications are scheduled for early next year.

Drug-Resistant 'Superbug' Found at Los Angeles-Area Hospital
Associated Press (08/21/15)

Public health officials have been alerted after some patients at a California hospital contracted an antibiotic-resistant "superbug." In a statement, Huntington Memorial Hospital said that several patients who underwent procedures that used Olympus duodenoscopes were found to have resistant Pseudomonas bacteria. The hospital's statement did not reveal the number of infected patients or their conditions; however, media reports indicate that three patient infections have been reported to health officials after the problem was detected in June. Earlier this week, FDA posted a warning letter online that said Olympus, the market leader for duodenoscopes, took 3 years to report a cluster of 16 infections in patients who underwent procedures using the scope in 2012.

A Computerized Monitoring Program Can Help Identify Narcotic Diversion
American Journal of Health-System Pharmacy (08/15/15) Vol. 72, No. 16, P. 1365; Brenn, B. Randall; Kim, Margaret A.; Hilmas, Elora

An operational reporting dashboard was developed to correlate data to help detect potential drug diversion by automated dispensing cabinet (ADC) users. The "narcotic reconciliation dashboard" links information from a hospital's pharmacy information management system (PIMS) and anesthesia information management system (AIMS) in an associative data model, and can generate reports to find outlier activity associated with ADC dispensing of controlled substances and medication waste processing. The dashboard was evaluated by back-testing the program with historical data on an episode of diversion by an anesthesia provider that had not been detected through traditional PIMS and AIMS data monitoring. Dashboard-generated reports on key metrics, such as ADC transaction counts and PIMS–AIMS documentation mismatches, clearly indicated the diverter's outlier status relative to other authorized ADC users. Researchers concluded that such a dashboard program that correlates ADC transaction data with pharmacy and patient care data may effectively help detect patterns of ADC use that suggest drug diversion.

Boston Hospital to Help Pharmacies Increase Distribution of Overdose Medication
Providence Journal (08/08/15) Arditi, Lynn

Boston Medical Center has received a $1.3 million federal grant to study how pharmacies in Rhode Island and Massachusetts can increase distribution of the opioid overdose medication naloxone to reduce drug overdose deaths. The hospital will track and analyze data from pharmacies that distribute naloxone "rescue kits" in the two states to develop guidelines for best practices for a national pharmacy-based program. The study will be
conducted in partnership with Rhode Island Hospital and CVS Health. Traci Green, the medical center’s deputy director of the Injury Prevention Center and an associate professor of emergency medicine at The Warren Alpert Medical School of Brown University, will be the study’s principal investigator. “Pharmacies have enormous potential to expand the reach and impact of critical public health interventions, just as we have seen happen with pharmacy access to clean syringes and adult immunizations,” Green said in a statement. "But how do we do that with naloxone rescue kits? That’s what we intend to figure out here in Massachusetts and Rhode Island."

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**Model Program in Hawaii Expands Role of Pharmacists in Tracking High-Risk Patients**

*University of Hawaii (08/20/2015) Enright, Susan*

An innovative health care program is now being administered by the University of Hawaii at Hilo. The Pharm2Pharm program, which has been used over the last 3 years in various areas throughout the state, allows pharmacists to play a larger role in the medication routines of high-risk patients. Karen Pellegrin, principal investigator of the Pharm2Pharm program and director of continuing and distance education and strategic planning at the Daniel K. Inouye College of Pharmacy at UH Hilo, says the initiative is important for patients who take a lot of medication. "Through the Pharm2Pharm project, we've shown that consulting pharmacists—those who coordinate medications across prescribers and across dispensing pharmacies—can help make sure patients are on the right medications and are taking them properly," she said. Consulting pharmacists meet with patients regularly to discuss the patient’s medication plan and work with all the members of the patient's health team. The feedback has been mostly positive. Patients generally note that the services have kept their medication under control while also keeping them out of the hospital and improving their health and wellbeing.

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**Pharmacy Clinics Playing Increasingly Larger Role in Health Care**

*Las Vegas Review Journal (08/23/15) Nadler, Art*

Community pharmacies in recent years have opened clinics to treat many common, non-life-threatening illnesses. CVS Health operates 1,000 Minute Clinics in 31 states. Walgreens Healthcare Clinics numbered 50 in 2007, and have since grown to 400 nationally. Both clinics accept most insurance plans. A recent Walgreens study found that these community clinics have an increasingly important role for health care delivery across the nation. Joan Carapucci, physician assistant and clinic practice nurse in charge of all the Nevada MinuteClinics, pointed out that hospital emergency rooms can be expensive, and urgent care facilities can carry copays of about $150. The prices at MinuteClinics tend to be much lower. These clinics treat common issues such as colds, influenza, sinus infections, joint pains, allergies, and skin irritations. They also provide vaccinations and physicals. MinuteClinics and Healthcare Clinics also keep detailed patient reports that can be sent to their primary care physicians or to retail clinics elsewhere.

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**Electronic Prescribing Enlisted in Opioid Fight**

*Boston Globe (08/12/15) McCluskey, Priyanka Dayal*

The health care network Cambridge Health Alliance will stop issuing paper prescriptions for addictive analgesics in an effort to fight opioid drug abuse. Opioid abuse was linked to the deaths of more than 1,200 people in Massachusetts in 2014. Cambridge Health Alliance will be one of the first big hospital operators in the state to launch new technology that lets doctors send prescriptions for controlled substances directly to hospitals. Hospital officials say that a software upgrade next month will improve prescription monitoring and reduce fraud and counterfeiting. Cambridge Health Alliance will use software developed by Imprivata Inc. that addresses the earliest phase of the opioid crisis, said Dr. Sean Kelly, Imprivata's chief medical officer. Electronic prescriptions make it easier for hospital administrators to track prescription patterns and detect if a clinician is prescribing too many pills, Kelly said. With Imprivata's technology, Cambridge Health Alliance prescribers will be able to order opioids by entering a password, then typing a temporary code sent to their cellphones.