Georgia Society of Health-System Pharmacists
Monthly Newsbriefs

Announcements

GSHP Annoucements

Mark your calendar... GSHP Fall Meeting October 16-18, 2015 Brasstown Valley Resort Young Harris, GA

GSHP Annual Meeting, October 16-18 Brasstown Valley Resort

Online Registration

Meeting Agenda Friday, October 16

8:00am- 12:15pm CE programming

July 2015

About GSHP

Georgia Society of Health-System Pharmacists (GSHP) is a professional society of pharmacists and related personnel practicing in organized healthcare settings.

Mission Statement
Helping our members become better practitioners.

Motto
Bringing pharmacy practice into focus.

Georgia Society of Health-System Pharmacists
3015 Shannon Lakes North
Suite 303
Tallahassee, FL 32309
(800) 913-4747

- e-mail link
- web link

ashp State Affiliate

About ASHP

12:15pm – 1:00pm Lunch and Exhibits

1:00pm –4:15pm CE programming

4:30pm – 6:30pm Reception/Exhibits

Saturday, October 17

8:00am – 9:00am CE programming

9:00am – 10:30am Exhibits/Breakfast

10:30am – 12:00pm CE programming

12:00pm – 1:00pm Lunch, Business Meeting, Awards

1:00pm –3:30pm CE programming

7:00pm – 10:00pm Dinner and Watch Football

Sunday, October 18

7:30am – 8:00am BREAKFAST

8:00am –11:30am CE programming

CE- A total of 15 hours of CE can be earned by participating in the GSHP Annual/Fall meeting.

Hotel Reservations

To make your hotel reservation, call 1.800.201.3205 or 706.379.9900. To book online reservations through the Brasstown Valley Resort website, enter block code GAS1014_001. Please note that it will show sold out unless you enter the group code. Our room rate is $165 per night.

In Memorium

Joncephine Blakely

February 1, 2015

Headlines

GSHP News

- Call for Award Nominations
- 2015 Election Results
- Stepping Beyond Just “Medication Reconciliation”
- A Summary of Revisions to the 2015 Standards of Medical Care in Diabetes for the Ambulatory Adult Population

ASHP News

- FDA Agrees to ASHP’s Request for Delay in Enforcement of Track and Trace Requirements
- ASHP Comments on USP <800>, Asks for Delay in Implementing Hazardous Drug Standards
- Provider Status Update: Oregon and Nebraska Make Gains
- Pharmacists Mull High-Dose Flu Vaccine for Seniors
- Cangrelor Approved for Use During Coronary Angioplasty

Pharmacy News

- The New Track and Trace Law Places Hospitals on High Alert

ASHP is a 35,000-member national professional association that represents pharmacists who practice in hospitals, health maintenance organizations, long-term care facilities, home care, and other components of health care systems. ASHP is the only national organization of hospital and health-system pharmacists and has a long history of improving medication use and enhancing patient safety.

American Society of Health-System Pharmacists
7272 Wisconsin Avenue
Bethesda, MD 20814
301-657-3000

- e-mail link
- web link

Calendar

2015 National Pharmacy Preceptors Conference [ASHP]
8/20/15 - 8/22/15
Washington, D.C.
web link

GSHP Annual Meeting
10/16/15 - 10/18/15
Brasstown Valley Resort
Young Harris, GA
web link

2015 Leadership Conference [ASHP]
10/19/15 - 10/20/15
web link

FDA Extends Track and Trace Deadline
- Preventing Readmissions with Help from Pharmacists
- MTF Pharmacies Provide Proactive Patient Care
- Knocking Out Pain: Hospital Pharmacists Launch New Approach to Pain Management
- Pharmacist MTM Proven to Reduce Hospital Readmissions
- New Role for Twitter: Early Warning System for Bad Drug Interactions
- Debate Over Identifying Biosimilars May be Coming to a Head
- 100 Top Hospitals: Efficient Purchasing Linked to Higher Performance
- New Breakthrough Drugs Could Cost U.S. Government Nearly $50 Billion by 2024

GSHP News

Call for Award Nominations

2015 GSHP AWARDS

CALL FOR NOMINATIONS

The Georgia Society of Health-System Pharmacists annually recognizes members for outstanding service and achievements in pharmacy. Very likely, you know someone in GSHP who is deserving of recognition. Every member of GSHP is eligible to nominate or be nominated for one or more awards. Please fill out the nominations form on the next page to nominate yourself or someone you know for the awards listed below. Awards will be presented during the GSHP Annual Meeting to be held at Brasstown Valley Resort in Young Harris, Georgia on October 17, 2015. Deadline for nominations is September 20, 2015.

Pharmacists of the Year Award

GSHP Pharmacist of the Year Award is the highest honor GSHP can bestow on any member and is presented to a Georgia health-system pharmacist to honor outstanding service and accomplishments in health-system pharmacy practice as well as participation in GSHP. All GSHP members are eligible for nomination. Nominations should include detailed information concerning the nominee's professional, civic, and other activities. Recipients of the GSHP Pharmacist of the Year Award serve on the Awards Committee for five years following receipt of the award.

25-Year Practitioner Awards

25-Year Practitioner Awards are presented to GSHP members who have actively practiced hospital or health-system pharmacy for 25 years or more. Members are encouraged to nominate peers. Also, they may also nominate themselves for this award unless they are a previous recipient.

Outstanding Pharmacy Practitioner Award

The **Outstanding Pharmacy Practitioner Award** is presented to a health-system pharmacist employed in a staff position. The award recognizes outstanding service to the profession in a non-administrative, non-managerial position.

Outstanding Residency Preceptor Award

The **Outstanding Residency Preceptor Award** is presented to a health-system pharmacy residency preceptor. The award recognizes residency preceptor for outstanding service to the profession by serving as a preceptor to pharmacy residents.

Outstanding Pharmacy Professional Representative Award

The **Outstanding Pharmacy Professional Representative Award** is

presented to a representative of a pharmaceutical manufacturer or wholesaler who has made outstanding contributions to health-system pharmacy through service to, participation in, and involvement with GSHP and those practicing as health-system pharmacists.

Outstanding Health-System Pharmacy Technician Award

The **Outstanding Health-System Pharmacy Technician Award** recognizes a health-system pharmacy technician who has demonstrated practice excellence and leadership in the support of implementing pharmaceutical care.

Community Service Award

The **Community Service Award** is presented to a GSHP member for Outstanding service to his/her community. Services rendered are not limited to those as a pharmacist, but include any activities which enhance or improve the quality of life of the community.

Outstanding Pharmacy Intern/ Extern Award

The **Outstanding Pharmacy Intern/ Extern Award** recognizes excellence in our future pharmacists. Nominations may be presented by preceptors, educators, or any other GSHP member who has had direct contact with an intern or extern who has shown exemplary service in this role.

Outstanding Young Health-System Pharmacist Award

Nominees for the **Outstanding Young Health-System Pharmacist Award** are not limited by age, but by the length of time in the profession. Nominees should have graduated from a pharmacy school within the past five years. The recipient is chosen based on exemplary service and dedication to the field of health-system pharmacy in this time period.

Outstanding Hospital or Health-System Pharmacy Newsletter Award

Recipients are selected for the **Outstanding Hospital or Health-System Pharmacy Newsletter Award** based on submission and review of the three most recent editions of their newsletter. To be eligible for consideration, the newsletter must be hospital generated and not a purchased newsletter.

Best Paper Describing a New Pharmaceutical Care Service

The award for **Best Paper Describing a New Pharmaceutical Care Service** will be presented based on publications by GSHP members in the pharmaceutical literature. Selection of the recipient is made by the Awards Committee and is based on a review of pharmacy journals and other publications for the 12-month period beginning September, 2014 through August, 2015.

GSHP Pharmaco-economics Research Award

The **GSHP Pharmaco-economics Research Award** is designed to recognize a GSHP member who has performed a pharmacoeconomic analysis in a particular area of pharmacy practice and to encourage pharmacists to investigate and report the cost benefits of pharmaceutical care through the provision of cost effective pharmacy services. Members performing an analysis or investigation in an area related to the cost effectiveness, cost benefit, or cost utility of a particular medication therapy, type of patient care delivered by pharmacists or some aspect of pharmacy services are eligible.

To nominate someone, click here

web link | return to headlines

President-elect Leslie Dotson Jaggers, Pharm.D., BCPS

Leslie Jaggers is currently the Cardiovascular Clinical Pharmacist at Piedmont Hospital in Atlanta, a role she developed and has served in for the past 16 years. She is the pharmacist team member of a comprehensive heart failure disease management program that was recently expanded to include mechanical circulatory support and heart transplant. She is extensively involved in evidence-based drug protocol development, healthcare quality initiatives, and provider education. Prior experiences include the implementation and management of an outpatient anticoagulation management service.

Leslie obtained her BS and Doctor of Pharmacy degrees from the University of Georgia in 1985 and 1987 respectively. She completed a two-year clinical pharmacy residency at the University of Kentucky Medical Center in 1989 and obtained board certification as a pharmacotherapy specialist in 1996. Prior to moving to Atlanta, she practiced for 5 years as Clinical Supervisor for Adult Medicine at Shands Hospital at the University of Florida where she was also Pharmacy Practice Residency Director and adjunct Clinical Associate Professor with the University of Florida College of Pharmacy. Leslie later worked for the American Society of Health-System Pharmacists (ASHP) in the role of Clinical Affairs Associate where her responsibilities included coordinating the development of ASHP Therapeutic Guidelines and Therapeutic Position Statements.

Leslie has been an active member of GSHP since moving to Atlanta, having served as a district director and co-chairman for the Organizational Affairs Committee. She is currently a member of the Educational Affairs Committee. Leslie is also a member of the Atlanta Academy of Institutional Pharmacy (AAIP), ASHP, and the American College of Clinical Pharmacy. She previously served for 8 years on the board of directors for AAIP, including terms as president and chairman of the board. In 2009, she was recognized as the AAIP Pharmacist of the Year. This year will mark her 15th year as a member of the UGA College of Pharmacy Advisory Board. On the national front, she has served 3 terms on the ASHP Council on Therapeutics.

Leslie is a frequent speaker at both state and local meetings. She is an active preceptor for students and pharmacy practice residents. She is also a past chairman and steering committee member of the Southeastern Residency Conference.

Leslie lives in Smyrna with her husband Rondell, who is the Executive Director of Pharmacy and Clinical Nutrition at Grady Health System. They enjoy rooting for the GA Bulldogs and KY Wildcats, traveling abroad, and making frequent visits to Leslie's hometown of Savannah.

Secretary-Trisha Branan, Pharm.D., BCPS

Trisha Branan is currently a Clinical

Assistant Professor at the University of Georgia College of Pharmacy with a practice site in critical care at Athens Regional Medical Center in Athens, Georgia.

Within these roles, she is involved in the didactic curriculum and experiential education for doctor of pharmacy students. In addition, she maintains an active practice site in the Intensive Care Unit, where she precepts students and serves on hospital committees and task forces. She has multiple peer-reviewed publications and was a previous PGY2 Critical Care Residency Program Director.

After receiving her Doctor of Pharmacy degree from the University of Georgia in 2006, she went on to complete two years of residency training. She completed the ASHP-accredited Medical College of Georgia Health System/University of Georgia College of Pharmacy PGY 1 Pharmacy Residency in 2007 and the ASHP-accredited Critical Care PGY 2 Pharmacy Residency at the University of Virginia Health System in 2008. She is also a Board Certified Pharmacotherapy Specialist. She was named GSHP Outstanding Young Health-System Pharmacist in 2009. Within GSHP, Trisha served as the CSRA District Director from 2010-2013, during which time she was named GSHP Outstanding District Director. She has been a member of the GSHP Board of Directors since 2010 and currently has been serving as Secretary since 2012.

Trisha has been a member of GSHP since 2005. She resides in Athens, Georgia with her husband, Jep, and two children, Ethan and Harper. For fun, Trisha loves to travel and is an avid supporter of UGA football.

Chattahoochee District -Mandy Mock, PharmD, BCPS

Mandy Mock, PharmD, BCPS is currently the Clinical, Education and Medication Safety Coordinator at Columbus Regional Health- Midtown Medical Center in Columbus, GA. In the Education Coordinator role she coordinates the department continuing education series, works with affiliated pharmacy schools, is the PGY1 Residency Program Director, and serves as Residency Coordinator for all Post-Graduate Pharmacy Residents of the department. She reviews all medication errors and works closely with the Quality and Risk Management Departments to review medication use opportunities. She serves as an internal TJC Surveyor and liaison to Nursing staff regarding. In addition, she serves on several process improvement committees and serves as a preceptor for Auburn, UGA, South, and Mercer pharmacy students.

She graduated from Auburn University's Harrison School of Pharmacy in 2004 with a PharmD and business minor. Since graduation, she has completed a Nutrition Support Pharmacy Residency, earned Board Certification in Pharmacotherapy and held various inpatient pharmacist roles at Midtown Medical Center.

Mandy has been a member of GSHP since 2004. She was awarded the 2007 Outstanding Young Health-System Pharmacist Award from GSHP and has been a member of the GSHP Student and Resident Committee.

Mandy lives in Seale, Alabama with Doug, her husband of 15 years. She is blessed to have three healthy children, Loretta (9), Samuel (8), and John David (4). Her parents and younger brother, Michael (13) are also close by allowing her to spend a lot of free time between many family activities.

Northeast Georgia Metro District Director-elect: Collin Lee, Pharm.D

Collin E. Lee, Pharm.D. is the Assistant Director of Clinical and Educational Services at Emory Healthcare in Atlanta. She received her Bachelors degree in Pharmacy from Purdue University and her PharmD degree from the University of Florida. She spent the first 10 years of her career at Northwestern Memorial Hospital in Chicago as a clinical pharmacist in the area of Critical Care and later in Infectious Disease; where she conducted research projects for the Centers for Disease Control and Prevention.

She joined Emory Healthcare in 2001 where she has spent the majority of her time in Drug Information, formulary management, cost savings initiatives and medication safety. During her time in Drug Information, Collin developed a passion for literature review and statistics. She teaches these skills annually to all Atlanta area residents as Chair of the APRIE (Atlanta Pharmacy Resident Information Exchange) journal club. Starting this June, she will begin as the Residency Director for the Emory University Hospital Midtown PGY-1 program.

Collin is an avid sports fan and has spent much of her free time coaching AAU and High School feeder girls basketball teams. In 2014, Collin and her High School basketball team were inducted into the Indiana Basketball Hall of Fame.

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
- Docusate 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

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 H_2 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.

web link | return to headlines

A Summary of Revisions to the 2015 Standards of Medical Care in Diabetes for the Ambulatory Adult Population

Authors: Claire Walker Rummage, Pharm. D. Candidate Class of 2016 and Maria Miller Thurston, Pharm.D., BCPS

Mercer University College of Pharmacy

Background

Diabetes mellitus is a common disease state marked by high blood glucose. Diabetes may result from problems in how insulin is produced or how insulin works. There are various types of diabetes: type 1, which occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and type 2, a disorder in which cells (usually in the muscle, liver, and fat) do not use insulin correctly. Other types may be caused by genetic conditions, diseases, or glucose intolerance that can occur during pregnancy or other illnesses.[1]

The American Diabetes Association's (ADA) "Standards of Medical Care in Diabetes" provides annual updates regarding treatment goals for diabetes care and key clinical practice recommendations. Although the 2015 clinical recommendations have remained the same, the levels of evidence of the recommendations have been revised and are detailed in the document itself. Diabetes management updates for children, adolescents, pregnancy, and diabetes care in facilities are also covered in the 2015 recommendations; however, these topics are beyond the scope of this article. With the 2015 revisions, *Diabetes Care* has divided the document into fourteen sections covering the following areas: strategies for improving care, classification and diagnosis of diabetes, initial evaluation and diabetes management planning, foundations of care, prevention or delay of type 2 diabetes, glycemic targets, approaches to glycemic treatment, cardiovascular disease and risk management, microvascular complications

and foot care, older adults, children and adolescents, management of diabetes in pregnancy, diabetes in facilities, and diabetes advocacy.[2] This article will focus on updates to the foundations of diabetes care, diagnosis and prevention of type 2 diabetes, glycemic targets, and the management and treatment of type 2 diabetes in the ambulatory adult population.

Summary of Revisions

Foundations of Diabetes Care

Improving diabetes care means including team-based care. A team is encouraged to evaluate the potential barriers for the patient such as income, health literacy, diabetes related distress, and competing demands when goals are not met by the patient. Additionally, community involvement, patient registries, and decision support tools improve diabetes care and align with the Chronic Care Model. These recommendations and revisions are supported by the Diabetes Self Management Education (DSME) and Diabetes Self Management Support (DSMS) recommendations. To ensure a healthy and productive life for those living with diabetes, advocacy is a necessity. Due to the complications associated with diabetes, patients living with diabetes are subject to restrictions concerning employment and driving capabilities. Healthcare professionals should individually assess those living with diabetes if restrictions are considered.[2]

Diagnosis, Prevention and Targets

For the prevention of type 2 diabetes, it is recommended that overweight or obese adults of any age be tested for diabetes. However, it is now recommended Asian-Americans be tested for diabetes if their body mass index (BMI) is $\geq$23 kg/m^2 (rather than a BMI $\geq$25 kg/m^2) because of the increased risk in this population. Patients with impaired glucose tolerance (IGT), impaired fasting glucose (IFG), or an A1c of 5.7 - 6.4% should establish a 7% weight loss goal to improve glycemic readings.

For those living with diabetes, the target for pre-prandial glucose has changed from 70-130 mg/dL to 80-130 mg/dL . This new goal is in accordance with the recent A1c target data. Lowering the A1c to 7% or less has been shown to reduce microvascular complications of diabetes and to be associated with long-term reduction in macrovascular disease. A less stringent target A1c of < 8% may be acceptable for patients with a history of severe hypoglycemia, those with a limited life expectancy, or the older or the more infirmed. A more stringent A1c goal of < 6.5% may be appropriate for patients with a short duration of diabetes, a treatment regimen with lifestyle or metformin only, or those with a long life expectancy.[2]

Management and Treatment

Type 2 diabetes treatment options include metformin, sulfonylureas, glucagon-like peptide-1 agonists, dipeptidyl peptidase 4 inhibitors, insulin, and the recently approved sodium-glucose cotransporter 2 inhibitors (SGLT2), among others. Metformin is the preferred first-line agent for type 2 diabetics, and it may be considered for prevention especially in patients younger than 60 years with a BMI greater than 35 kg/m^2.

Sodium glucose cotransport 2 inhibitors are the newest agents for type 2 diabetes. Agents in this class include Canaglifozin (Invokana®), Dapafliflozin (Farziga), and Empagliflozin (Jardiance®). Inhibition of SGLT2 activity reduces reabsorption of filtered glucose and lowers the blood glucose concentration at which glucose is no longer reabsorbed from the proximal tubule, but is excreted instead. This class serves as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes. Sodium glucose cotransport 2 inhibitors are used as add on therapy, but are not currently available in a combination product. Doses must be renally adjusted with a glomerular filtration rate (GFR) less than 60 mL/min. Adverse effects are in part related to the mechanism and include vaginal yeast infections, urinary tract infections, polyuria, increased serum creatinine, increased low density lipoprotein (LDL) cholesterol, and hypoglycemia when used in combination with insulin or sulfonylureas. This class

decrease A1c by approximately 0.7 - 0.8 % and has been shown to decrease body weight as well.[3] The American Association of Clinical Endocrinologists' (AACE) Comprehensive Diabetes Management Algorithm 2013 Consensus Statement lists SGLT2 inhibitors as a mono-, dual-, or triple-therapy option for patients depending on their A1c level or disease state control. The ability of SGLT2 inhibitors to provide glucose lowering without weight gain or risk of hypoglycemia is the justification for the Consensus Statement recommendation.[4] While there are advantages, the SGLT2 inhibitors remain expensive and have no long-term safety or outcomes data at this time.

Proper management and treatment of diabetes is the basis for preventing major complications. The main complications resulting from diabetes include: nephropathy, retinopathy, and neuropathy. Optimizing glucose and blood pressure control help to reduce the risk or slow the progression of these complications. The new goal blood pressure for those living with diabetes is now < 140/90 mmHg for most individuals, while in the past, the goal diastolic blood pressure was < 80 mmHg.[2] This new diastolic target is in accordance with the Eighth Joint National Committee (JNC8) guideliens.[5] If a patient's blood pressure is elevated above the goal of < 140/90 mmHg, lifestyle interventions and pharmacological therapy such as a thiazide diuretic, angiotensin-converting-enzyme inhibitor, or angiotensin 2 receptor blocker should be initiated.[5]

A lipid profile should generally be evaluated for those living with diabetes. For the treatment of dyslipidemia, the statin and statin dose recommendation is determined by a patient's cardiovascular disease risk factors.[2] Per the 2013 American College of Cardiology/American Heart Association guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults, moderate- or high-intensity satin therapy should be initiated or continued depending on 10-year arteriosclerotic cardiovascular disease (ASCVD) risk, unless contraindicated.[6] The 2015 Standards now closely agree with these guidelines and no longer support targeting a LDL goal, rather appropriate intensity of statin therapy based on risk assessment.[2]

In addition, appropriate screening and lifestyle modifications can further reduce the risk of complications. Patients with insensate feet, foot deformities, and ulcers should have their feet examined at every visit while all other diabetic patients should be examined annually.[2] Lifestyle modifications for a person living with diabetes are comprehensive in nature. A tailored diet for blood glucose control and physical activity are strongly suggested. The recommendation for patients with diabetes to limit carbohydrate and sugar intake has been consistent over the years; however, there is new direction for physical activity. Adults with type 2 diabetes are now encouraged to break up periods of more than 90 minutes spent sitting to reduce sedentary time.[2]

Further lifestyle modifications include smoking cessation and proper vaccination. It is advised for patients not to smoke or use tobacco products, and the recommendations do not support e-cigarettes in any form.[2] Vaccination recommendations are in accordance with the Centers for Disease Control and Prevention (CDC) guidelines and support an annual flu shot as well as PPSV23, PCV13 if older than 65 years, and Hepatitis B vaccination if unvaccinated and between ages 19-59.[7] PPSV23 should be given to all patients with diabetes ages 2 and older. If a patient is older than 65 years, administer the PCV13 vaccine first and then the PPSV23 vaccine 6-12 months thereafter. For patients who have not received PCV13, but have received a dose of PPSV23 at age 65 years or older, administer PCV13 at least 1 year after the dose of PPSV23 received at age 65 years or older.[2]

Conclusion

In summary, key changes noted in the 2015 Standards of Medical Care in Diabetes

include BMI cut point screenings for Asian-Americans, adoption of a less stringent diastolic blood pressure goal, a slight elevation in the pre-prandial glucose target, replacement of LDL goals with risk assessment as a driving factor for statin therapy, increased frequency of foot examinations, restrictions on sedentary time, and pneumococcal vaccination types.[8] Diabetes can be treated and controlled through healthy eating habits, physical exercise, and medications that help to lower blood glucose and A1c levels. Patients living with diabetes may benefit from patient education and self-care practices, as with this knowledge they are able to better manage their own health.

Pharmacists are vital members of the healthcare team and have the ability to help manage diabetes by providing education concerning the patient's diet, exercise, and disease state management. Disease state management includes, but is not limited to, informing the patient how to interpret and manage glucometers as well as signs and symptoms of hypo- and hyperglycemia. A pharmacist can assess the patient's health status, adherence to medication, and lifestyle modifications, as well as educate patients on drug therapy and refer them to appropriate healthcare professionals as needed. Pharmacists have the knowledge, ability, and duty to fulfill the standard of care and assist in the fight against diabetes.

References

1. U.S. Department of Health and Human Services: National Diabetes Information Clearinghouse (NDIC). Available at: http://diabetes.niddk.nih.gov/dm/pubs/causes/index.aspx.

Published June 2014. Updated August 27, 2014. Accessed January 5, 2015.

2. Standards of Medical Care in Diabetes-2015: Summary of Revisions. *Diabetes Care*. 2015;38(suppl.1):S1-93.

3. Simon JL, Timaeus S, Misita C. SGLT2 Inhibitors: A New Treatment Option for Type 2 Diabetes. Pharmacy Times. Available at: http://www.pharmacytimes.com/publications/health-system-edition/2014/September2014/SGLT2-Inhibitors-A-New-Treatment-Option-for-Type-2-Diabetes. Published September 17,2014. Accessed March 2, 2015.

4. Garber A, Abrahamson M, Barzilay J, et al. American Association of Clinical Endocrinologists' Comprehensive Diabetes Management Algorithm 2013 Consensus Statement. *Endocr Pract*. 2013;19(suppl 1):1-48.

5. 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC8). *JAMA*. 2014;311(5):512. doi:10.1001/jama.2013.28442

6. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. *Journal of the American College of Cardiology*. 2014;63(25_PA):2905.

7. Centers for Disease Control and Prevention (CDC). Vaccines that might be indicated for adults based on medical and other indications. Available at:

http://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions-shell.html. 2015. Updated February 3, 2015. Accessed February 3, 2015.

8. Standards of Medical Care in Diabetes-2015: Summary of Revisions. *Diabetes Care*. 201;38(suppl.1):S4.

web link | return to headlines

ASHP News

FDA Agrees to ASHP's Request for Delay in Enforcement of Track and Trace Requirements

6/30/2015

The Food and Drug Administration (FDA) announced today that it will delay enforcement of Track and Trace requirements that were scheduled to go into effect on July 1, 2015, until November 1, 2015. This policy change follows a formal written request by ASHP urging FDA to give hospitals and health systems more time to comply with the regulations.

In a letter sent on June 16, ASHP described significant challenges to compliance with the requirements, including the time needed by institutions to implement, test, and operationalize data collection and storage processes.

Read More

web link | return to headlines

ASHP Comments on USP <800>, Asks for Delay in Implementing Hazardous Drug Standards

6/29/2015 ASHP provided additional comments to the U.S. Pharmacopeia (USP) on the draft of General Chapter <800> Hazardous Drugs—Handling in Healthcare Settings.

ASHP's comment letter expresses conceptual support for the changes, but calls for a five-year delay in implementing the Chapter after publication, noting that it presents significant compliance challenges for many settings. Without the delayed or extended timeline, meeting the Chapter's requirements would pose an undue burden on a large number of healthcare facilities and may have a negative impact on access to care.

Read More

web link | return to headlines

Provider Status Update: Oregon and Nebraska Make Gains

6/29/2015

Oregon and Nebraska took significant steps toward increasing patient access to pharmacist-provided services with new state laws that recognize pharmacists as providers and allow for reimbursement of their patient care services.

In Oregon, pharmacists may enter clinical pharmacy agreements with physicians and healthcare organizations to provide clinical services, including smoking cessation, travel medications, and medication therapy management services. Under the new statute, pharmacists are considered healthcare providers, and payers may reimburse them for services performed as part of the collaborative agreements.

Read more

web link | return to headlines

Pharmacists Mull High-Dose Flu Vaccine for Seniors

[July 15, 2015, AJHP News]

Kate Traynor

BETHESDA, MD 25 Jun 2015—Pharmacists say a recent analysis of Medicare claims data from the 2012–13 flu season helps make the case that for seniors, high-dose influenza virus vaccine leads to better clinical outcomes than standard-dose vaccine.

The retrospective cohort study of Medicare claims data for about 930,000 recipients of high-dose influenza vaccine and 1.6 million recipients of a standard formulation found 22% reductions in probable flu infections and flu-related hospitalizations among high-dose vaccine recipients.

Read more

web link | return to headlines

Cangrelor Approved for Use During Coronary Angioplasty

Kate Traynor

BETHESDA, MD 23 Jun 2015—FDA on June 22 announced the approval of cangrelor, a $P2Y_{12}$ platelet inhibitor, to reduce the risk of thrombotic events in patients undergoing coronary angioplasty procedures.

Labeling (PDF) for cangrelor states that its intended purpose is to reduce the risk of periprocedural myocardial infarction, repeat coronary revascularization, and stent thrombosis in patients who are not being treated with another $P2Y_{12}$ platelet inhibitor or a glycoprotein IIb/IIIa inhibitor.

Read more

web link | return to headlines

Pharmacy News

The New Track and Trace Law Places Hospitals on High Alert
Pharmacy Practice News (06/23/15) Rosenthal, Marie

The Drug Supply Chain Security Act will require hospital pharmacists must maintain all the chain of custody information (inbound and outbound) that will enable product tracing. These tracking data will center around the transaction information (TI), transaction history (TH) and transaction statement (TS), called the 3Ts. “Recordkeeping will be a key component of this [process]," said Raymond Lake, RPh, MS, a pharmacist at MedStar Health, during an American Society of Health-System Pharmacists (ASHP) webinar about the new law. Unless specifically exempted, each entity in the supply chain must provide the 3Ts information to the subsequent owner who must capture and maintain it for each transaction for six years. Additionally, they must be able to respond to requests for this information by the FDA or vendor if there is a recall or investigation into a product. Joseph Hill, MA, the director of Federal Legislative Affairs at ASHP, underscored the need for pharmacists to insist upon having tracking information on hand before adding drugs to inventory. "We cannot accept a product from an authorized trading partner without the transaction history, information and statements, unless it is exempted," Hill said, "and we must provide any subsequent owner with the 3Ts." Compliance with the track-and-trace law will generate a mountain of data, industry experts warned. In the beginning, paper transactions will suffice as a documentation tool, but eventually the paper trail will end and the information must be stored digitally. This might require that hospitals increase network server space or look to cloud-based storage. As a partial solution, Hill recommended that pharmacists talk with their distributors to see if they offer cloud storage for 3Ts information.

return to headlines

FDA Extends Track and Trace Deadline
FDA.gov (06/30/15)

FDA announced Tuesday that it will give drug dispensers until November 1, 2015, to comply with federal track and trace requirements as set under the Drug Supply Chain Security Act. The original deadline was July 1, 2015. The act lists key steps for building an electronic, interoperable system by November 27, 2023, that will identify and trace certain prescription drugs as they are distributed in the United States. The system aims to improve detection and removal of potentially dangerous products from the drug distribution supply chain. Three leading pharmacy groups—APhA, National Alliance of State Pharmacy Associations, and National Community Pharmacists Association—recently asked FDA to help avoid any potential disruptions in the pharmaceutical supply chain by postponing enforcement of the July 1 product tracing deadline for dispensers.

return to headlines

Preventing Readmissions with Help from Pharmacists
Hospitals & Health Networks (06/15) Vicencio, Daniel; Silverstein, Steven

Recognizing that medication management issues tend to be one of the primary reasons behind preventable readmissions, leaders at Chicago-based Mercy Hospital & Medical Center turned to the pharmacy team to find a collaborative solution. The pharmacy leadership team recommended piloting a multidisciplinary discharge clinic housed at

Mercy's affiliate, the Mercy Family Health Center. Because of its multidisciplinary approach to care, the Family Health Center was the logical location for the discharge clinic where a team consisting of a clinical pharmacist and nurse practitioner could reduce unnecessary readmissions. The pharmacy team at Mercy Hospital worked collaboratively with the Family Health Center team to develop the right pharmacy protocol at the discharge clinic. In 2013, when the discharge clinic opened its doors for patient appointments six half days a week, with a pharmacist available for three out of the six half days. Patients were scheduled for 30-minute follow-up visits with a pharmacist and nurse practitioner. During the visit, the pharmacist conducted a comprehensive medication history and hospital course evaluation, and the nurse practitioner performed a physical assessment. On the days the pharmacist was not scheduled, the nurse practitioner conducted both assessments. The results posted within the first month of the discharge clinic's operations exceeded all of Mercy's expectations. Within the first month, readmissions of patients seen by the nurse practitioner decreased, and readmissions decreased even more significantly when the pharmacist and nurse practitioner saw the patient together.

return to headlines

MTF Pharmacies Provide Proactive Patient Care

Pensacola News Journal (FL) (06/06/15) Davis, Marketta

When it comes to choosing a pharmacy, current or former members of the military have the choice between community pharmacies or a military treatment facility (MTF). Places such as the Pensacola Naval Hospital are good representations of the differences between the two options. Cmdr. Ben Schwartz, department head of the Naval Hospital pharmacy, says that there are multiple benefits for customers who choose the MTF route. According to Schwartz, MTFs require no copays and patient wait times average 10 to 15 minutes for active duty members. The Naval Hospital also offers unique services such as inpatient services and one-on-one consultations.

return to headlines

Knocking Out Pain: Hospital Pharmacists Launch New Approach to Pain Management

Pharmacist.com (DC) (06/01/15) Erickson, Amy

A trio of pharmacists at a hospital in California's Central Valley has developed and launched an innovative pain management service and opioid stewardship program designed to help patients control their pain on the lowest possible dose. In addition to improved patient outcomes and satisfaction, the pain program has saved the hospital millions of dollars in indirect costs. Developed by clinical pharmacists Clint Brown, PharmD; Yleana Garcia, PharmD; and Richard Poirier, PharmD; the pharmacy pain management service at Kaweah Delta Medical Center in Visalia, CA, features a two-pronged approach to helping patients safely and effectively control their pain. "Our pain service is truly one of a kind and puts pharmacists on the front lines of pain management," says Brown. "Our efforts are translating into positive patient outcomes and ensuring that our physicians are more analgesically aware of their patients' needs."? Brown, Poirier, and Garcia are available 7 days a week for 10 hours per day to make recommendations to providers about how to optimize a patient's pain medication. Recommendations may include adding additional medications for untreated pain, adjusting doses, or switching medications to reduce the risk of medication-induced adverse effects. Identifying the source of the pain gives the pharmacists important information about the best type of medication to recommend. According to Poirier, since October 2013, the pharmacists have made 2,267 interventions, which equates to an indirect cost avoidance of $2.7 million.

return to headlines

Pharmacist MTM Proven to Reduce Hospital Readmissions

Pharmacy Times (06/03/15) Gilchrist, Allison

Pharmacy-based transition of care (TOC) interventions that include post-discharge medication therapy management (MTM) services are strongly linked to reduced hospital readmissions, according to a study published in the Journal of the American Pharmacists Association. The study reveals that patients who received a full range of MTM services from a pharmacist within 1 week of discharge experienced significantly lower readmissions than those who received usual care. All patients in the study were recruited

from two local hospitals and had received a diagnosis of congestive heart failure, chronic obstructive pulmonary disease, or pneumonia. Among nine Kroger Pharmacies in western Cincinnati, pharmacists reconciled medications, identified drug therapy issues, recommended changes to treatment, and provided disease self-management education to 30 patients in the MTM intervention group. At 30 days post-discharge, all patients were surveyed via phone to assess hospital readmissions and their satisfaction, and pharmacist interventions and drug-related issues were documented. Among the 90 patients who completed the study, 20 percent of those who received usual care were readmitted to the hospital within 30 days, compared with just 6.9 percent of those who received MTM services from a pharmacist. Patients who saw a pharmacist also reported greater levels of understanding about their medications and better recognition of symptoms associated with their disease states. Lead author Heidi Luder says the study shows the need to encourage patient's self-efficacy to promote self-confidence with caring for their condition to help achieve lasting behavioral changes.

return to headlines

New Role for Twitter: Early Warning System for Bad Drug Interactions
University of Vermont (06/29/15) Brown, Joshua E.

University of Vermont researchers have developed software for discovering potentially dangerous drug interactions and unknown side effects before they show up in medical databases. The researchers say the program, HashPairMiner, can efficiently search millions of tweets for the names of many drugs and medicines and build a map of how they are connected based on the hashtags that link them. "Our new algorithm is a great way to make discoveries that can be followed-up and tested by experts like clinical researchers and pharmacists," says University of Vermont computer scientist Ahmed Abdeen Hamed, who the led the program's development. He says the program's approach also could be used to generate public alerts before a clinical investigation has started or before healthcare providers have received updates. The researchers also hope to help overcome a long-standing medical research problem associated with the fact that published studies are too often not linked to new scientific findings. The researchers used the algorithm to create a website that will enable an investigator to explore the connections between search terms, existing scientific studies, and Twitter hashtags. Their approach involves building a K-H network, which is a dense map of links between keywords and hashtags, and then removing much of the "noise and trash," according to Hamed.

return to headlines

Debate Over Identifying Biosimilars May be Coming to a Head
Wall Street Journal (06/12/15) Silverman, Ed

The World Health Organization (WHO) is holding meetings to decide upon the best approach for naming biosimilars. The central question is whether biosimilars should be given the same name as biologics, and the issue has divided drug makers. WHO recently recommended a compromise that has garnered some support, but whether a true consensus will emerge is unclear. The pharmaceutical industry is working hard to influence the process. Brand-name drug makers and biotechs, for instance, argue that biosimilars should have unique names, because this would make it easier to track adverse events that might appear in patient records and in the reports that are filed with regulators. More than a dozen medical societies wrote the FDA to support this position. Generic drug makers believe that different names for biosimilars may confuse prescribers and pharmacists as they sort out whether the medicines are really the same and attempt to verify dosing and regimens. They also maintain that adverse events can already be tracked through product codes and argue that concerns over patient safety are really a smokescreen designed to blunt competition. WHO's compromise proposed adding a random four-letter suffix at the end of each biosimilar. Each country, however, is free to adopt its own system.

return to headlines

100 Top Hospitals: Efficient Purchasing Linked to Higher Performance
Modern Healthcare (06/13/15) Rubenfire, Adam

A new study determined the top 100 U.S. hospitals boast higher clinical and operational performance because they use drugs and supplies more efficiently. Lower-than-anticipated use of medical supplies and pharmaceuticals is associated with reduced rates

of mortality, lower 30-day readmission rates, and greater patient-satisfaction scores at hospitals that rank well in Truven Health Analytics' 100 Top Hospitals study. Among the 2,560 hospitals studied, a majority spent slightly less than what they expected to spend on drugs and supplies in the 2013 federal fiscal year, with an average observed/expected ratio of 0.998 for pharmaceutical products and 0.992 for supplies. Still, some studied facilities spent up to 6.9 times more than expected on drugs and 9.5 times more than projected on supplies. The hospitals' average pharmacy cost per discharge was $1,062, while the median supply cost per discharge among hospitals was $2,440. Truven discovered the hospitals that spent less than expected on drugs had fewer patient readmissions for acute myocardial infarction, heart failure, and pneumonia, and lower overall average rates of 30-day readmissions. Patients at hospitals that spent less than expected on drugs also reported more satisfaction on Medicare's Hospital Consumer Assessment of Healthcare Providers and Systems, and hospitals posted higher operating margins and lower Medicare spending.

return to headlines

New Breakthrough Drugs Could Cost U.S. Government Nearly $50 Billion by 2024

Wall Street Journal (06/08/15) Silverman, Ed

A new report from Avalere Health indicates that the U.S. government will spend almost $50 billion on 10 breakthrough drugs in the coming decade. The drugs include treatments for hepatitis C, leukemia, breast and lung cancer, and cystic fibrosis. According to the report, Medicare would pay about $31.3 billion, Medicaid would spend about $15.8 billion, and another $2.1 billion would result from subsidies through health exchange plans created under the Affordable Care Act. "There is a tremendous amount of innovation in the pipeline," says Elizabeth Carpenter, a director at Avalere. But "government programs need insight into what is coming so they can successfully balance budgets with patient access." Avalere conducted the study for America's Health Insurance plans. Robert Zirkelbach of the Pharmaceutical Research & Manufacturers of America criticized the report, arguing that it does not reflect "the potential costs savings that can be achieved by preventing other health care services, such as hospitalizations and surgery. Nor does it to take into account the offset of existing medicines going off patent, which frees up resources to pay for the breakthroughs."

return to headlines