Georgia Society of Health-System Pharmacists

Monthly Newsbriefs

| About GSHP | ASHP | How You Can Join | Contact Us |

Announcements

GSHP Webinar-June 9, 2016

June 9, 2016 – 12 noon-1:00 pm

Two presentations-30 minutes each

Title: **Biosimilars: Surfacin' in the USA**

Objectives:

1. Describe the process of biosimilar approval

2. Present analytical, pharmacokinetic/pharmacodynamic, and clinical data regarding approval of Zarxio ® as a biosimilar

3. Analyze data available from Europe regarding biosimilar use for stem cell mobilization and use after transplant

4. Identify barriers in substitution of certain biosimilars/biologic agents for Neupogen ®

Title: **The Not So Similar Biosimilars**

Objectives:

1. Define Biosimilars and differentiate between biosimilars and reference biologics

2. Discuss the regulatory processes for approving biosimilars in the United States

3. Compare the safety and efficacy data of the biosimilar, filgrastim-sndz, to the reference product, filstrasim, and discuss implications for clinical practice as well as hospital formulary management

Speakers: Jessica Gorgeis, Pharm.D., Northside Hospital

Jessica Signorelli, Pharm.D. Georgia Regents Health

® Georgia Society of Health-System Pharmacists is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a provider of continuing pharmacy education. This program is approved for 1 hour (0.1 CEUs) of continuing pharmacy education credit. Proof of participation will be posted to your NABP CPE profile within 4 to 6 weeks to participants who have successfully completed the post-test. Participants must

May 2016

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.

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About ASHP

participate in the entire presentation and complete the course evaluation within two weeks to receive continuing pharmacy education credit. UAN # 0228-0000-16-095-L01-P; 0228-0000-16-095-L01-T

This is a member service of GSHP. There is no charge for members to attend. Non-members will be charged $20.

To register: https://attendee.gotowebinar.com/register/4954690040708259074

Non-member to pay the $20 non-member fee: https://gshp.wildapricot.org/event-2234168 then register at https://attendee.gotowebinar.com/register/4954690040708259074

Headlines

GSHP News

- Summer Meeting, July 15-17, 2016 Omni Amelia Island Plantation
- Clinical Article

ASHP News

- FDA Approves New Methylene Blue Product in New Concentration
- ASHP Names 37 Members as ASHP Fellows for 2016
- California Mulls Coverage of Comprehensive Medication Management
- ASHP Urges Maine Legislators to Override Veto of Naloxone Bill
- ASHP Partner CSRxP Unveils Market-based Solutions to Address Soaring Drug Prices

Pharmacy News

- How Hospital Pharmacists Improve Care Without Breaking the Bank
- Hospitals See On-Site Pharmacies as Revenue Generators as Medication Management Pays Off
- Do Armed Guards Make Health-System Pharmacies Safer?
- Bridging Pharmacy Automation and EMRs
- Local Pharmacy Partnership to Prevent Pediatric Asthma Reutilization in a Satellite Hospital
- IU to Offer One of the First Data Science Courses to Use Real Clinical Trial Data
- EHR 'Gaps' Hinder Patient Medication Adherence
- Hospitals Dealing With Drug Price Increases
- New Naloxone Training Program for Pharmacists Takes Aim at Opioid Epidemic
- Mississippi Database Tracks Prescription Drug Abusers

GSHP News

Summer Meeting, July 15-17, 2016 Omni Amelia Island Plantation

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.

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Calendar

2016 ASHP Summer Meetings & Exhibition [ASHP]

6/11/16 - 6/15/16

Baltimore, MD
June 11–15, 2016

web link

GSHP Summer Meeting

7/15/16 - 7/17/16

Omni Amelia Island Plantation, FL

National Pharmacy Preceptors Conference [ASHP]

8/11/16 - 8/13/16

Washington Hilton, Washington D.C., August 11-13, 2016

web link

Registration Agenda

Room Reservations-The 2016 Summer Meeting will be held at the Omni Amelia Island Plantation, Amelia Island, FL. GSHP has very attractive room rates that start at $182 single/double per night for an ocean view hotel room at the Omni Amelia Island Inn and Beach Club; $155 for a resort view room. To make your reservation, click here:

Hotel Reservations

The GSHP room rate will be honored for three days prior to group arrival and three days after group departure if available.

The Plantation has a wide variety of rooms and villas and the link above can help you with any of them.

Click here for villa information, rates, etc.

If you need any assistance with rooms or need more information about the room types that are available, please contact Steve Glass at sglass@gshp.org

There is $10 daily resort service fee this year per room. The resort fee includes:

- Self Parking ($10 daily value)
- Unlimited high speed internet access in all accommodations ($9.95 daily value)
- On-property Transportation ($4.00 daily value)
- Unlimited use of health & fitness center ($20 daily value)
- In Room Coffee Service ($5.00 daily service)
- Meeting Concierge & 24 Public Safety Team
- Local & Toll Free Phone Access

Clinical Article

Ivabradine (Corlanor®): *A New Pure Heart Rate Reducing Agent*

Kevin Hall, Pharm.D. Candidate Class of 2016, Julie Patel, Pharm.D. Candidate

Class of 2016, Mike Shepard, Pharm.D. Candidate Class of 2016 and Maria Miller Thurston, Pharm.D., BCPS

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Introduction

According to a recent American Heart Association (AHA) statistical update, an estimated 5.7 million people in the United States (US) have chronic heart failure (CHF). This statistic is even more astounding when you consider the mortality of CHF; about half of the people who develop the condition die within just five years of diagnosis. The annual incidence of CHF in African-Americans is 1.5 times greater than in Caucasians. Additionally, African-Americans have a 45% increased risk of death or decline in functional status compared to Caucasians when hospitalized for CHF. Furthermore, projections show that by 2030, over 40% of the US population will have cardiovascular disease (CVD), resulting in over 8 million patients with CHF in the US.[1] Regarding economic impact, a 2009 study revealed that CHF costs the nation an estimated 32 billion dollars each year.[2] Regionally, the age-adjusted CHF mortality rate in the southeastern states (Georgia, Alabama, Mississippi, Louisiana, Arkansas, and Oklahoma), known as the 'stroke belt,' is 69% higher than the national rate, prompting the new morbid moniker of the 'heart failure belt.' The need for fully optimized CHF therapy is crucial, especially in the southeast where it is most prevalent.[3] It is essential that patients are properly diagnosed and receive evidence-based care to minimize the potentially detrimental impact of this condition as well as reduce hospital readmissions.[4]

Diagnosis and Clinical Practice Guidelines

Patients are diagnosed with CHF according to signs and symptoms, presence of structural heart disease, and risk factors, along with specific lab testing. Patients are placed in CHF stages according to the presence of structural heart disease and symptoms of CHF. The New York Heart Association (NYHA) classification is utilized when determining the functional status of CHF in the patient. Appropriate therapeutic management for patients with CHF is determined according to the stage the individual falls into, and guidance is provided by the 2013 American College of Cardiology/American Heart Association guideline. Typically, pharmacologic therapy consists of an angiotensin converting enzyme inhibitor (ACE-I) or an angiotensin receptor blocker (ARB) in addition to a beta-blocker (BB), with diuretics being used for volume overload. Additional add-on medications for more severe disease may include the combination of isosorbide dinitrate and hydralazine, preferred in African-Americans, or aldosterone antagonists.[4]

Although current guidelines recommend the use of a BB, the use of a BB is not always feasible due to the possibility of patients having contraindications or intolerance to the drug class or target doses. Therefore, additional options are needed for alternative medications in the management of heart rate (HR) when designing optimal treatment regimens for patients with CHF.[4]

To continue reading the article: https://www.gshp.org/resources.aspx?a=viewPost&PostID=30391

ASHP News

FDA Approves New Methylene Blue Product in New Concentration

Cheryl A. Thompson

BETHESDA, MD 29 Apr 2016 - FDA earlier this month approved the marketing of Provayblue 5-mg/mL methylene blue injection for i.v. use in patients with acquired methemoglobinemia.

Provayblue is the first methylene blue product to have FDA's approval, according to FDA's database Drugs@FDA.

The product, to be available only in ampules, is owned by Provepharm SAS in France and will be distributed in the United States by American Regent Inc.

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web link | return to headlines

ASHP Names 37 Members as ASHP Fellows for 2016

[May 15, 2016, AJHP News]

Kate Traynor

BETHESDA, MD 29 Apr 2016 - University of Southern California (USC) pharmacist Steven Chen is confident that data from a nearly completed multimillion-dollar project will definitively show that clinical pharmacy services are cost-effective and improve patient outcomes.

"It's practice-transforming," Chen, chair of the USC School of Pharmacy's Titus Family Department of Clinical Pharmacy and Pharmacoeconomics and Policy, said of the $12-million Centers for Medicare and Medicaid Services (CMS)–funded project's findings.

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California Mulls Coverage of Comprehensive Medication Management

[May 15, 2016, AJHP News]

Cheryl A. Thompson

BETHESDA, MD 29 Apr 2016 - A bill to have the nation's largest Medicaid program cover comprehensive medication management (CMM) services by pharmacists and primary care physicians emerged from a committee hearing on April 5 with a unanimous round of ayes by state legislators.

"In the past few years, we have added millions of Californians into Medi-Cal, making the effective management of the quality and cost of care an absolute necessity," Assemblyman Jim Wood told fellow members of the state Assembly Health Committee.

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web link | return to headlines

ASHP Urges Maine Legislators to Override Veto of Naloxone Bill

4/29/2016

UPDATE: *The Maine legislature voted 132-5 to overturn the governor's veto.* ASHP has asked Maine's legislative leaders to initiate a vote to override Governor Paul LePage's veto of LD 1547: An Act to Provide Access to Affordable Naloxone Hydrochloride for First Responders. The legislation, passed earlier this year, would allow the state's attorney general to negotiate for bulk purchase of naloxone for use by first responders. Maine is one of eight states that have not enacted legislation to increase access to naloxone.

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ASHP Partner CSRxP Unveils Market-based Solutions to Address Soaring Drug Prices

4/28/2016

This week, the Campaign for Sustainable Rx Pricing (CSRxP), of which ASHP is a member of the Steering Committee, announced the release of market-based policy solutions to curb rising drug prices. ASHP joined the Steering Committee in February as part of its continuing effort to address the impact of increasing drug costs on patients and its members.

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web link | return to headlines

Pharmacy News

How Hospital Pharmacists Improve Care Without Breaking the Bank

Hospitals & Health Networks (03/16) Aston, Geri

Health reform is motivating hospital pharmacies to improve care and expand services while curbing costs. At Lifespan, a Rhode Island health system, pharmacists visit patients who are at-risk of readmission while they are still in the hospital to discuss medications and how the drugs work in the body, says Christine Berard-Collins, director of pharmacy. A clinical pharmacist oversees the transitions-of-care program at Lifespan's Rhode Island Hospital and the Miriam Hospital, and three pharmacists make the patient visits that are followed-up by case-management nurses . Many hospitals are sending patients home with their outpatient medicines in hand to prevent the patient-provider disconnect that exists in the traditional model of hospital pharmacy services, Berard-Collins says. Mark Eastham at McKesson Pharmacy Optimization says rising interest in continuity of care into the outpatient setting is prompting more hospitals to create their own retail pharmacies. Access to patients' electronic health records means hospital retail pharmacists can check physicians' notes, what drugs a patient was on in the hospital, lab values, and the last time a patient visited a hospital clinic. Hospital-owned retail pharmacies also allow hospitals to capture revenue that otherwise would be lost to pharmacy chains. However, careful analysis needs to be done to determine whether a hospital-owned retail pharmacy is financially viable, such as by determining the baseline number of discharges and specialty services needed to cover expenses.

return to headlines

Hospitals See On-Site Pharmacies as Revenue Generators as Medication Management Pays Off

Healthcare Finance News (03/16/16) Lagasse, Jeff

More hospital systems consider on-site pharmacy services revenue generators as they seek more efficient and controllable medication delivery to patients. There are two benefits to this approach: the hospital collects more revenue from patients by letting them fill their prescriptions on-site, and it can reduce readmissions and help health systems save even more. "A lot of the initiative is more along the lines of hospitals making sure that patients can access and adhere to their medications," says Penn Medicine's Rick Demers. A key impediment for patients who want to fill prescriptions via a third-party vendor is that those pharmacies may not carry the desired medication, and this problem has grown with the pharmaceutical industry's increasing complexity. Stanford Health Care's John Cunningham says the current situation differs from the early 2000s, when hospitals with on-site pharmacies were beginning to close those operations due to medications being less costly and complicated, and there being little momentum in ambulatory care. The passage of the Affordable Care Act, which penalized hospitals for escalating readmission rates, was a driving factor in the reversal of this trend. On-site pharmacies permit more control on the hospital side, says the Medicines Company's Fred Pane. Such facilities give clinicians direct access to information such as who's prescribing which medications to whom.

return to headlines

Do Armed Guards Make Health-System Pharmacies Safer?

Pharmacy Times (02/29/16) Ross, Meghan

Slightly more than half (52%) of hospital security guards currently carry handguns, according to a 2014 International Healthcare Security and Safety Foundation report. This is an increase from a 2011 Hospital Security Survey that found 22% of respondents who

were hospital officials in charge of security had their security officers carry a firearm or were considering the use of firearms. Back then, 78% of respondents said they had "no plans to use firearms." For some pharmacists, the question of safety in relation to armed guards depends on the hospital setting. Craig Cocchio, PharmD, BCPS, an emergency medicine clinical pharmacist at Trinity Mother Frances Hospital, has also worked in hospitals both with and without armed guards. He currently works in a health system that allows security guards to carry guns. He noted that the emergency department frequently has law enforcement officers present for a variety of reasons, in addition to the armed security. "Personally, I never thought of my safety being any different with or without armed security guards," Dr. Cocchio said. Beth Lofgren, PharmD, BCPS, who has practiced in home health, long-term care, and hospital pharmacy, said she currently works in a health system that has security guards whose guns are in plain view. "I feel much safer knowing that armed guards are located on our campus," Dr. Lofgren said. A 2015 Healthcare Crime Report released by the International Healthcare Security and Safety Foundation suggested that violent crime in hospitals is on the rise. According to the report, the violent crime rate per 100 hospital beds increased from 2 in 2012 to 2.8 in 2014.

return to headlines

Bridging Pharmacy Automation and EMRs

Drug Topics (03/10/16) Vecchione, Anthony

Amid rising consolidation of hospitals and health systems, hospital pharmacy directors must now address interoperability between pharmacy automation and electronic medical records (EMRs). Challenges facing pharmacy directors include connectivity and standardization issues, a shortage of resources, and funding problems. At Southampton Hospital in South Hampton, N.Y., for instance, the hospital's old legacy computer system was not able to transfer information to a new EMR, according to Jerard West, PharmD, director of Pharmacy. As a result, predefined common orders had to be built from scratch using a 1,600-medication item master. West adds that the pharmacy department also had to design its system to incorporate current workflow practices, perform a Pyxis conversion to the new EMR, implement bar-coding technology, and assist with order set development for the medical staff. Dave Swenson at CareFusion says the company's enterprise approach is to allow health systems to standardize using a single formulary and to manage users across a health system instead of on a hospital-specific basis. Rich Berner at Allscripts' Sunrise business unit says medication management is crucial because it can help reduce errors, provide savings, and prevent fraud. Aesynt's Kraig McEwen estimates that when multiple hospitals merge, "most health systems need to take 20 percent of their cost structure out over the next several years just to remain solvent, so standardization is one of the mechanisms they use to help become more efficient."

return to headlines

Local Pharmacy Partnership to Prevent Pediatric Asthma Reutilization in a Satellite Hospital

Pediatrics (03/16/16) Sauers-Ford, Hadley S.; Moore, Jennifer L.; Guiot, Amy B.

A recent study investigated whether a partnership with community pharmacies could help reduce pediatric asthma reutilization (readmissions and emergency revisits) when hospital resources are limited. In this case, the satellite hospital lacked an outpatient pharmacy on site, so the researchers teamed up with community pharmacies, aiming to reduce asthma reutilization by providing medications in-hand at discharge. The median percentage of asthma patients who received medications in-hand rose from 0% to 82% during the study period. Expanding the medication in-hand program to all patients was a key factor, the researchers note, but other changes include expanding the team to evening stakeholders, narrowing the number of community partners, and developing electronic tools to help key processes. Following the intervention, the mean percentage of asthma patients who were discharged from the satellite hospital who had a readmission or emergency department revisit within 90 days dropped to 11% from 18%. The authors report, "When hospital resources are limited, community pharmacies are a potential partner, and providing access to medications in-hand at hospital discharge can reduce asthma reutilization."

return to headlines

IU to Offer One of the First Data Science Courses to Use Real Clinical Trial Data

IU Newsroom (03/24/16)

Indiana University (IU) will partner with Eli Lilly to offer one of the first data sciences courses in the U.S. to use real-world clinical trial data. "Our goal is for students to gain a better understanding of the overall drug development process, and specifically the human clinical trial phases," says Eli Lilly clinical data associate Sara Bigelow. "This includes gaining knowledge on the data side of the process--where the data comes from, where it goes, how it's used, and why it's so important not only to clinical trial research but also the pharmaceutical industry as a whole. Another key takeaway will be awareness about the privacy process involved in working with patient data." The IU course will be offered as a four-week summer class starting May 2 via the data science master's degree program at the IU School of Informatics and Computing. The trial data will employ anonymized information collected from human subjects during the safe testing of potential new pharmaceuticals. Students enrolled in the new course will have an opportunity to gain hands-on instruction in understanding, refining, and analyzing real-world data of the type used by drug companies in making major business decisions on drug development.

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return to headlines

EHR 'Gaps' Hinder Patient Medication Adherence
FierceEMR (03/24/2016) Hirsch, Marla Durben

Electronic health records (EHRs) and health IT are not improving patient medication adherence, according to a new report in *JMIR Medical Informatics*. Non-adherence can cost the health care industry large amounts of money, and EHRs have been considered as a possible solution. They can use certain tools to help improve adherence and better engage patients. But the report indicated four "gaps" that are stymieing efforts. First, interoperability is underdeveloped and does not allow patients to connect self-monitoring data to a doctor's EHR. Second, inconsistencies in data definitions make it difficult to determine the validity and efficiency of data sources. Third, National Drug Codes are not yet standardized in EHRs. And fourth, medication management therapy is not handled particularly well by EHRs. To fix the issues, the report outlined a system-based view of medication use, management, and patient adherence. Interoperablity should be improved and data definitions should be standardized. Doing so can create a collaborative environment that would benefit patients, physicians, pharmacists, and all others involved in the adherence process.

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return to headlines

Hospitals Dealing With Drug Price Increases
Washington Post (03/14/16) Dennis, Brady

Hospitals nationwide are being forced to address higher drug costs. The increases often involved brand-name drugs with little or no competition as well as commonly used generics around for decades. "There's been a huge consolidation of these generic companies ... everybody is buying everybody else," says Gerard Anderson, a professor at the Johns Hopkins Bloomberg School of Public Health. "If there's no competition, the prices go up. We are seeing a lot of [drug] shortages, and also price increases. That shouldn't happen, but it is." Jeff Rosner, senior director of pharmacy sourcing and purchasing at the Cleveland Clinic, says the "challenge is, you don't have a crystal ball." His organization last year faced an unexpected increase of more than $8 million after the prices of two heart therapies surged. Rosner says it is increasingly difficult to anticipate how much the institution will spend on the myriad drugs it buys annually. Hospital officials insist that even when sudden price increases occur, patients receive access to the medicines they need. However, the unpredictable increases wedge their institutions financially, as they cannot immediately pass on the cost if a drug gets more expensive because reimbursement rates for certain procedures already have been set by Medicare and private insurers. That means sharply higher prices can lead to losses.

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return to headlines

New Naloxone Training Program for Pharmacists Takes Aim at Opioid Epidemic
Newswise (03/29/16)

The University at Buffalo School of Pharmacy and Pharmaceutical Sciences (SPPS) has partnered with the Erie County Department of Health and the Harm Reduction Coalition to create an online education program for dispensing naloxone. The free course trains community pharmacists about dispensing naloxone without a prescription to the public,

including those at risk for opioid abuse, their friends, and families. "This program is a mechanism for getting the antidote out to reduce the number of deaths," says Edward Bednarczyk, PharmD, chair of the SPPS Department of Pharmacy Practice. "Rather than distributing the medication through police stations, schools, and hospitals, pharmacies provide the community with an instant, ready-made network for distributing medicine."

return to headlines

Mississippi Database Tracks Prescription Drug Abusers

Jackson Clarion-Ledger (Mississippi) (02/29/16) Fitzgerald, Robin

In Mississippi, the Prescription Drug Monitoring Program (PMP) is helping pharmacists, physicians, and law enforcement to combat the abuse of legal narcotics. Pharmacists were first to begin using the database of prescription drug records in 2005 and are the only profession legally obligated to enter information into it. At least once daily, they input details about prescriptions they have filled—data that can then help identify anyone who may be fraudulently obtaining drugs to feed an addiction or to sell on the street. Gulfport pharmacist Larry Knox, for example, contacts prescribing doctors if the PMP indicates that a person is already receiving the same medication from other providers or from multiple pharmacies. Doctors, similarly, will see the same data when mining the system themselves to check a new patient's prescription history. Prescription orders originating from outside of Mississippi also raise red flags, but the database can access records from most neighboring states. While a valuable resource for nabbing violators of prescription drug laws, the PMP also takes steps to avoid misuse of the system. Pharmacists who reach out to prescribers about suspicious orders or customers must take care not to trip federal privacy laws, and criminal investigators are prohibited from running checks unless the target is a person of interest in an active case.

return to headlines

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