Volume 2, Issue 1 Second Quarter 2013

The Lobbyist

Newsletter of the District of Columbia College of Clinical Pharmacy

President's Letter

Greetings DC-CCP Members,

As I debated about what to write in this newsletter I could not help but to look at my own life and use it as inspiration. As I look at my world outside of work in the past and upcoming six months I see "change" – deaths and illnesses of loved ones, a new baby nephew due any day now, friends getting married, and an upcoming wedding (and therefore moving day) of my own. The list goes on. Likewise, if I change the perspective to that of my work-life, I still see "change" – a looming conversion in electronic medical systems, departures of co-workers, residents graduating and moving on, new residents and new hires starting. I am confident I am not alone in this. We've all heard the old adage "the only thing that is constant is change." Ironically, the reference for the quote, itself, changes with each source I find, so even the quote is not constant! Regardless, change is inevitable. It is a constant. What can be different is the way we handle the change. We have the choice to embrace what is changing with fervor and excitement, or to go into it dragging our heels, moping and complaining. The change will happen either way. What happens on the other side of the change is largely affected

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Inside This Issue

An independent chapter of the American College of Clinical Pharmacy, the DC-CCP is dedicated to improvements in pharmacotherapy practice, education, and research in the District of Columbia, Maryland, and the Commonwealth of Virginia.

DC-CCP Member Chosen to Participate in ASHP Research Boot Camp

Chelsea McSwain, PharmD Candidate
University of Maryland Eastern Shore School of Pharmacy

In May 2012, Kathleen Pincus, Pharm.D. was chosen to participate in the American Society of Health-System Pharmacists (ASHP) Research and Education Foundation's Research Boot Camp. The Research Boot Camp, held from May 16-18, 2012, involved the participation of Dr. Pincus and five other pharmacists in a research-based skills development program. The program, aimed at developing new pharmacist researchers, allows interaction with senior pharmacist researchers to develop a well-structured research plan. Participants who successfully complete the Boot Camp are then able to carry out their plans at their respective practice sites.

The three primary goals of the Research Boot Camp are to 1) foster the development of pharmacists with practice-based research skills 2) drive the advancement of translational research by providing with the expertise, tools, and support to start a practice-based research program and answer practice-based research questions and 3) enhance safe and effective medication use by promoting evidence-based decision making for individual patients and populations of patients.

Dr. Pincus had the honor of being selected among her peers to participate in this program. Please join us in congratulating her on this great accomplishment!

Kathleen J. Pincus, PharmD, BCPS

ASHP Foundation
FOSTERING SAFE AND EFFECTIVE MEDICATION USE

Introducing DC-CCP's New Officers

President: Jessica Wellman, PharmD, MBA, BCPS

President-Elect: James (Chai) Wang, PharmD, BCPS, AE-C

Secretary/Treasurer: Lisa Peters, PharmD, BCPS

Membership Committee Chair: Amol Joshi, BCPS, BCACP, CGP

Student, Resident, Fellow Chair: Kathleen (Katy) Pincus, PharmD, BCPS

Communications Chair: Deanna Tran, PharmD

Networking and Education Chair: Brad Burton, PharmD, BCOP
Doris Voigt, PharmD

2013-2014

DC-CCP joins Maryland Pharmacy Coalition for Legislative Day 2013

Chai Wang, PharmD, BCPS, AE-C
Nephrology Clinical Pharmacy Specialist
Kaiser Permanente Mid-Atlantic States

DC-CCP recently joined the Maryland Pharmacy Coalition as its newest affiliate member! The Coalition is comprised of seven full member organizations and four affiliate members, all of whom support pharmacy practice and health of Maryland citizens by advocating for important legislative issues. The signature event put on by the Coalition is the annual legislative day event.

The Thirteenth Annual Pharmacy Legislative Day in Annapolis was held on Thursday, February 14th. The member organizations distributed registration information and solicited the participation of their members. There were over 350 participants, including 51 pharmacists, who led the effort during the Legislative session. They focused not only on important bills including the expansion of the scope of practice for immunizations as well as regulation of biosimilar products, but also provided education on cardiovascular health and medication adherence with materials adapted from the Million Hearts and Script Your Future campaigns.

The Coalition meets prior to the Legislative Day event to establish consensus position statements on certain legislative bills which affect pharmacy practice. These statements must be unanimously agreed to by each organization of the Coalition before it can be incorporated into handouts and included in the talking points. A list of the bills with the consensus statement is provided in the table below with a brief synopsis of the intent of the bill.

Bill Number	Intent of the Bill	Coalition Position
SB617/HB716	Drug Therapy Management for HMOs	Supports
SB781	Biosimilar Biological Product Substitutions	Opposes
HB174	Limitations on Provider Dispensing during Workers' Compensation	Supports
SB166	Inspection Requirements for Dispensing Providers	Supports
SB401/HB179	Expanded Authority for Vaccinations	Supports
HB736	Regulation of Specialty Drugs	Supports

If you are interested in participating in the Maryland Pharmacy Coalition as a representative, please let one of the DC-CCP officers know. The next MPC meeting is April 23rd, 2013 at the Maryland Pharmacists Association headquarters at Montgomery Park.

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by our reaction to the change during the process. Resilience through and acceptance of change provides an environment for the change to become a positive and motivating process.

Regardless of where we look, change surrounds us. It is even evident within our own District of Columbia College of Clinical Pharmacy. While we're entering our second full year of official existence, and in some eyes too young for change already, there is change everywhere! Not only do we have a new officer and five new committee chairs, but we are introducing our first combined Continuing Education with the Washington Metropolitan Society of Health-System Pharmacists in May. Additionally, a committee has been formed with the sole purpose of involving our student and resident members and addressing their specific interests. We also have new social outings, networking events, and CE programs in the works. The chapter is changing, but as you can see change is not necessarily negative. Embrace the change! Join the change! And create additional momentum for change!

These are exciting times to be in the pharmacy profession and as a member of DC-CCP. I look forward to the rest of 2013 and the changes we will make together!

Jessica Wellman, PharmD
DC-CCP President

Anticoagulants in the Geriatric Population

Kalin Clifford, PharmD
PGY2 Geriatrics Pharmacy Resident
University of Maryland Medical Center

Nonvalvular atrial fibrillation is a common cardiovascular condition in adults. Of the 2 million people that have been diagnosed with nonvalvular atrial fibrillation, approximately 70% are between the ages of 65 – 85 years[1]. Nonvalvular atrial fibrillation is also a risk factor for stroke, for which this risk can intensify with additional comorbidities, such as congestive heart failure, diabetes, and hypertension. The risk for stroke increases for elderly patients diagnosed with atrial fibrillation as age is considered a risk factor in the thromboembolism risk calculators. Oral anticoagulants can be considered valid treatment options to reduce the risk of stroke if the benefit is greater than the risk of adverse effects. This brief article highlights the current risk stratification schemes for both thromboembolism and bleeding.

Did You Know?

DC-CCP has not one, but TWO, social media outlets for members to stay up to date with current events!

Like us on Facebook

Like Us on Facebook!

https://www.facebook.com/RXDCCCP

Join Us on LinkedIn!

http://www.linkedin.com/groups/District-Columbia-College-Clinical-Pharmacy-2881309?trk=myg_ugrp_ovr

DC-CCP Website:
http://dc-ccp.echapters.com

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As mentioned previously, age is one determinant in the risk for thromboembolism, but the question is how much the actual age should play a role in the overall decision. In the $CHADS_2$ score, age greater than 75 years counts as 1 point; however, in the CHA_2S_2-VASc, an age of 65-74 years count as 1 point, and age greater than 75 years count as 2 points. Previously, clinicians utilized the $CHADS_2$ score to evaluate an individual patient's risk, but now clinicians may need to use the CHA_2DS_2-VASc to identify a more exact risk for those patients who score a 0 or 1 on the $CHADS_2$. During the validation of the CHA_2DS_2-VASc, the study observed that the 22% of 16,406 individuals, who scored 0 points on the $CHADS_2$, truly had a score of 2 on the CHA_2DS_2-VASc which increased their thromboembolism risk from 1.9% per 100 person-years to 3.71% per 100 person-years[1,2]. New risk factors included in the CHA_2DS_2-VASc score are the two age categories, female gender, and vascular disease. Two age categories are necessary as in the studies with a CHA_2DS_2-VASc of 1 due to age of 65-74, the risk of stroke was 3.68% within the first year of diagnosis, as compared to a CHA_2DS_2-VASc of 2 due to age greater than 75, with the risk being 5.96% within the first year of diagnosis[3]. The CHA_2DS_2-VASc score performed better with highlighting the differences in those patients whom had a truly low risk of thromboembolism. However, a clinician needs to consider both the benefits and risks of oral anticoagulation for patients with atrial fibrillation.

As it is important to identify the risk of thromboembolism, a clinician should identify the bleeding risk to ensure appropriate use of anticoagulants in the elderly patient. There are many bleeding risk assessments, such as the Outpatient Bleeding Risk Index and the $HEMORR_2HAGES$, that can be utilized, however, this article will only discuss two assessments. HAS-BLED and ATRIA are two bleeding risk assessment tools that have been validated for use and are relatively easy to calculate. Both assessments utilize different factors including older age, bleeding history, anemia, hypertension, and abnormal renal and liver function. Both tools are specifically validated for the use with warfarin and not the novel oral anticoagulants. Three factors within the CHA_2DS_2-VASc are also considered risk factors within the ATRIA and HAS-BLED bleeding assessments.

As the risk of thromboembolism increases, so does the risk of bleeding. A patient that has a CHA_2DS_2-VASc score of 3 and a HAS-BLED score of 3 can determine that the risk of stroke is 5.92% per 100 person-years as compared to their risk of bleeding is 3.74% per 100 person-years[1,4]. When evaluating a patient for anticoagulation prophylaxis, the clinician should determine if the patient has modifiable bleeding risk factors. For example, if a patient is on aspirin 325 mg, but their CHA_2S_2-VASc score is 7 requiring an anticoagulant, then the clinician needs to discontinue the aspirin therapy to decrease bleeding risk.

In summary, a clinician should consider both the risks of stroke and bleeding when recommending anticoagulation for elderly patients with nonvalvular atrial fibrillation. Clinicians should also consider the wishes of the geriatric patient when recommending agents since different agents have different factors. Factors may include renal and hepatic function, adherence to other medications, and ability to follow up for lab monitoring. The debate for anticoagulation is still quite controversial, but this article has highlighted additional considerations for recommending anticoagulation therapy for elderly patients with nonvalvular atrial fibrillation.

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HAS-BLED Score	
Risk Factors	*Points*
H – Hypertension (uncontrolled, systolic blood pressure > 160 mmHg)	1
A – Abnormal renal function or abnormal liver function (1 point each)	1 or 2
S – Stroke	1
B – Bleeding history or predisposition to bleeding (e.g. bleeding diatheses, anemia)	1
L – Labile INRs (unstable or high INRs or poor time in therapeutic range <60%)	1
E – Elderly (age > 65)	1
D – Drugs (antiplatelet and nonsteroidal anti-inflammatory agents) or alcohol abuse (1 point each)	1 or 2

HAS-BLED Scores and Rates of Hemorrhage from the Euro Heart Study		
HAS-BLED Score	*Participants with scores in study, n*	*Rate of Major Hemorrhage per 100 Person-years*
0	798	1.13
1	1,286	1.02
2	744	1.88
3	187	3.74
4	46	8.70
5	8	12.5
6	2	0
7	0	-
8	0	-
9	0	-

CHA_2DS_2-VASc Risk Factors		
Letter	*Risk Factor*	*Points*
C	Congestive heart failure or left ventricular dysfunction	1
H	Hypertension	1
A_2	Age >/= 75	2
D	Diabetes mellitus	1
S_2	Stroke, transient ischemic attack, or thromboembolism	2
V	Vascular Disease (prior MI, PAD, aortic plaque)	1
A	Age 65 – 74	1
Sc	Sex category : female	1

Danish National Registry Data with CHA_2DS_2-VASc Scores	
Score	*Event Rate of Hospital Admission and Death due to Thromboembolism per 100 Person-Years*
0	0.78
1	2.01
2	3.71
3	5.92
4	9.27
5	15.26
6	19.74
7	21.50
8	22.38
9	23.64

References:

1. Zarraga IGE, Kron J. Oral anticoagulation in elderly adults with atrial fibrillation: integrating new options with old concepts. *JAGS* 2013.61:143-150.

2. Gage BF, Waterman AD, Shannon W, et al. Validation of clinical classification schemes for predicting stroke: results from the national registry of atrial fibrillation. *JAMA* 2001;285:2864-2870.

3. Olesen JB, Lip GY, Hansen ML et al. Validation of risk stratification schemes for predicting stroke and thromboembolism in patients with atrial fibrillation: nationwide cohort study. *BMJ* 2011;342:d142.

4. Pisters R, Lane DA, Nieuwlaat R, *et al.* A novel user-friendly score (HAS-BLED) to assess 1-year risk of major bleeding in patients with atrial fibrillation: the euro heart survey. *Chest* 2010;138:1093-1100.

Student Corner

Dispensing of Schedule II Controlled Substances in Emergency Situations

By Namrata Thakkar, Class of 2014
University of Maryland School of Pharmacy

Emergency situations constitute an exception to the requirement that a pharmacist may dispense schedule II drugs only pursuant to a written prescription. In an emergency situation a pharmacist may dispense a schedule II drug on the oral authorization of an individual practitioner, provided that:

1. The quantity prescribed and dispensed is limited only to the amount necessary to treat the patient for the emergency period.

2. The prescription must be immediately reduced to writing by the pharmacist and shall contain all required information, except the signature of the prescriber.

3. If the prescriber is not known to the pharmacist, the pharmacist must make a reasonable, good-faith effort to determine that the oral authorization came from a registered individual practitioner. This reasonable effort could include a call back to the prescriber using the phone number in the telephone directory, rather than the number given by the prescriber over the phone.

4. Within 7 days after authorizing an emergency oral prescription, the prescriber must deliver to the dispensing pharmacist a written prescription for the emergency quantity prescribed. The prescription must have written on its face "Authorization for Emergency dispensing," and the date of the oral order. The written prescription may be delivered to the pharmacist in person or by mail. If delivered by mail, it must be postmarked within the 7-day period. On receipt, the dispensing pharmacist shall attach this prescription to the oral emergency prescription previously reduced to writing. If the prescriber fails to deliver the written prescription within the 7-day period, the pharmacist must notify the nearest office of the DEA. Failure of the pharmacist to do so will void the prescription. Note: Although the regulation specifies "oral authorization," the DEA has indicated in the Pharmacist's Manual that a faxed prescription from the prescriber would also be acceptable.

Questions:

1. A prescriber must deliver a written prescription to the dispensing pharmacist for the emergency quantity of schedule II drug prescribed within 72 hours.
   True
   False
2. A patient comes in to the pharmacy asking for his Percocet prescription to be filled today that is dated to be dispensed 2 days after today's date. This is considered an emergency situation and Percocet may be dispensed.
   True
   False

Answers:

1. False; The requirement is that within 7 days after authorizing an emergency oral prescription, the prescriber must deliver to the dispensing pharmacist a written prescription for the emergency quantity prescribed. (The requirement used to be 72 hours before March 28, 1997.)

2. False; An emergency situation is defined as a situation in which:

- Immediate administration of the controlled substance is necessary for the proper treatment of the patient.
- No appropriate alternative treatment is available.
- It is not reasonably possible for the prescribing physician to provide a written prescription to the pharmacist before dispensing.

References:

1. Abood, R. Pharmacy Practice and the Law. 6th edition. Sudbury, MA: Jones and Bartlett Publishers: 2011.

2. Pharmacist's Manual: http://www.deadiversion.usdoj.gov/pubs/manuals/index.html

2013 WMSHP and DC-CCP SPRING MEETING

WASHINGTON METROPOLITAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS

SHARPENING UP YOUR CLINICAL SKILLS: UPDATE ON CLINICAL KNOWLEDGE

SATURDAY, MAY 18, 2013

(WMSHP AND DC-CCP FIRST JOINT MEETING!)

NATIONAL 4-H YOUTH CONFERENCE CENTER
7100 CONNECTICUT AVENUE
CHEVY CHASE, MD 20815
301-961-2801

youth conference center

Please Remember to Renew Your Membership for 2013!

If you registered as a member or renewed your membership on or after 10/01/2012, your membership is paid through 2013.

You can pay via check or cash mailed to:

DC-CCP
c/o Lisa Peters, PharmD
5325 Westbard Ave, Apt 815
Bethesda, MD 20816

OR

You can pay via credit card or PayPal at the "Join Us" tab at http://dc-ccp.echapters.com/

Full Member: $50

Resident Member: $10

Student Member: $5

DC-CCP and ACCP Upcoming Events

Sharpening Up Your Clinical Skills: Update on Clinical Knowledge
May 18 Chevy Chase, MD

2013 Oncology Pharmacy Preparatory Review Course
May 2 - May 4 Chicago, Illinois

2013 ACCP Annual Meeting
Oct 13 - Oct 16 Albuquerque, NM

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