District of Columbia
College of Clinical Pharmacy

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THE LOBBYIST

President's Letter

To our valued DC-CCP members,

Allow me first to say that I am excited and privileged to have the opportunity to serve as your incoming president for the upcoming year. Having been involved with the organization since its first year, I believe DC-CCP to be a vibrant group with many opportunities for its members. Thanks to the vision and leadership of our founding members, the hard work of our volunteers and committee chairs, and the enthusiasm and interest shown by our members, DC-CCP has established a sustainable footprint in the DC Metropolitan region.

The future of this chapter depends on you, our members who contribute time and energy to making this organization successful. Keeping our members in mind at our recent strategic planning meeting, I believe we must focus on developing effective sustainable infrastructure which serves ultimately to bring enhanced value and accessibility to you. I am pleased to announce that a number of enhancements and goals were unveiled at the first business meeting. We are particularly excited to introduce web-based conferencing as a means of engaging more of our members in our broad geographic region. A projected annual calendar of events has also been released to encourage all of our members to actively participate.

Our new committee structure makes it easier for you to contribute to your organization, with each of our three committees aligned with our strategic goals. If you are interested, I encourage you to become involved with one of these committees. Otherwise, your thoughts, comments, and ideas are always welcome, as I am only an e-mail or phone call away.

We are celebrating our birthday as an organization with a Founder's Day New Membership Special during the first week of February. Check out the details of this promotion in your e-mail as well as our second spring collaborative continuing education event with WMSHP on May 10th, 2014! We hope to see you at more of our events!

Best wishes for the new year,
James Chaifu Wang, PharmD, BCPS, AE-C
President, DC-CCP 2014-2015
Chaifu.Wang@gmail.com

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.

Outgoing President's Letter

Greetings DC-CCP members,

2013 has come to a close, and we are off to a new beginning with 2014. In the past year, we saw the introduction of our newest committee for students, resident and fellows; our first formal engagement with WMSHP to co-sponsor an event; Student Night to welcome new and returning pharmacy students; and a continuation of projects we had already started such as our networking events, Fall Forum, and the Richard Parrish Lecture Award. Along with the New Year comes the transition of DC-CCP officers, including myself. Thank you for providing me the opportunity to serve as your 2012 President-Elect and 2013 President; it has truly been an honor. Back in the fall of 2011, I sought the office as an opportunity to serve a local organization whose ideals are so close to my own. However, I feel that the membership served me more than I served you. I have gained ten-fold in the past two years. I appreciate the effort of so many of our talented members who have served the chapter in speaking engagements, committee coordination, event-planning, and attendance at meetings and events. It is my honor to entrust the presidency to Chai Wang, the 2013 President-Elect. Many exciting ideas were shared at the chapter's December strategic planning retreat, coordinated by Chai, and I look forward to the great work that is to come in 2014 and beyond!

Best,

Jessica (Wellman) Merrey, PharmD, MBA, BCPS, BCACP

Welcome New Officers!

President:
James Chaifu Wang, PharmD, BCPS, AE-C

President-Elect:
Lisa Peters, PharmD, BCPS

Secretary-Treasurer:
Tim Rocafort, PharmD, BCACP

DC-CCP Membership

Continuing education opportunities on a wide variety of timely topics to help sharpen your clinical knowledge and improve pharmaceutical care for patients.

Networking with fellow pharmacists and pharmacy trainees who practice within the Washington, DC Capital Region.

Social gatherings with fellow members and other professional organizations.

Participation in pharmacy advocacy initiatives on a governmental level… and more!

Please contact Tim Rocafort (trocafo1@jhmi.edu) if you or anyone you know is interested in joining DC-CCP.

Interpretation of HbA1c in patients with hemolytic and iron-deficiency anemias

Namrata Thakkar, PharmD Candidate 2014; University of Maryland School of Pharmacy

Asha L. Tata, PharmD, BCPS; University of Maryland Medical Center

Hemoglobin A1C (HbA1c), also called glycated hemoglobin (GHb) is a routinely used biochemical marker for individuals with diabetes mellitus (DM) to monitor long-term glycemic control and assess the risk of developing complications[1]. HbA1c reflects the mean blood glucose levels of the previous three months. The American Diabetes Association (ADA) determines an HbA1c ≥ 6.5% as one of the diagnostic criteria[2]. In addition to blood glucose levels, HbA1c is also dependent on a normal erythrocyte life span in the assays and methods used. Although alterations in HbA1c levels due to factors affecting hemoglobin levels have not been adequately studied, some limitations for interpreting HbA1c results in patients with hemolytic and iron deficiency anemias are summarized in this article.

Red blood cells are continuously exposed to circulating glucose in the blood. As a result, hemoglobin, a major content of the red blood cells is exposed to continuous glycation[3]. The structure of hemoglobin consists of two α and two β subunits for a total of 4 globin chains. One molecule of glucose binds to the N-terminal valine of the hemoglobin β chain during the non-enzymatic process called glycation. This process occurs during the entire life span of red blood cells (120 days). There are many factors which influence HbA1c. In iron and vitamin B12 deficiency, bone marrow suppression in pregnancy and alcoholism, and decreased erythropoietin production in chronic kidney disease, the mean age of erythrocytes increases due to decreased erythropoiesis and an increase in HbA1c may be seen[4]. A rise in HbA1c may also be seen in patients with splenectomy due to increased erythrocyte lifespan[4]. On the contrary, in settings of administration of erythropoietin, iron or vitamin B12, chronic liver disease, splenomegaly, and administration of drugs such as antiretrovirals, ribavirin and dapsone, decreased mean age of circulating erythrocytes causes a lowering in HbA1c[4]. Case reports below focus on effects of both auto-immune and drug-induced hemolytic anemias and iron deficiency anemia on HbA1c.

HbA1c may be falsely lowered due to a decreased life span of erythrocytes

In patients with hemolytic anemia, HbA1c may be falsely lowered due to a decreased life span of erythrocytes. A case report published by Debard et al reported severely lowered HbA1c despite the average blood glucose remaining high in a patient with diabetes[5]. In March 2008, Debard et al were presented with a patient with past medical history significant for primary dilated cardiomyopathy (known and treated since September 2004) and type 2 diabetes mellitus (T2DM) (known and treated since January 2006). In addition, the patient also had a past medical history significant for immune thrombocytopenic purpura without hemolysis in February 2006 for which the patient was treated with corticosteroids for three months. Three weeks following the start of corticosteroid treatment, the patient's platelet count returned to normal and the patient remained in remission for the following two years. In March 2008, this patient was sent to the internal medicine team for management of pancytopenia (platelets 110 billion/L, hemoglobin 10g/dL) and a sharp decrease in glycosylated hemoglobin below normal values while fasting glucose levels remained high. Upon additional tests and workup, patient was diagnosed to have Evans syndrome. The association between immune thrombocytopenic purpura and autoimmune hemolytic anemia defines Evans syndrome[5]. The authors discovered that any form of hemolysis can lead to falsely lowered HbA1c values in patients whose blood glucose readings remain high[5].

A case report from Lai et al showed lowering of HbA1c due to dapsone induced hemolytic anemia[6]. In July 2005, a male patient presented with purpura over his lower limbs. A skin biopsy was performed in December 2005 and the patient was diagnosed with leukocytoclastic vasculitis,

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and was initiated on dapsone 100mg daily. In June 2006, his fasting plasma glucose measurement was obtained as 144mg/dL, postprandial plasma glucose as 141mg/dL and HbA1c as 4.4%. The estimated average glucoses derived from an HbA1c was 79.58mg/dL; however the patient did not report any hypoglycemic symptoms. In September 2006, patient's leukocytoclastic vasculitis improved and dapsone was discontinued. Three months following discontinuation of dapsone without any changes in the patient's antidiabetic agents or lifestyle, his HbA1c increased to 6.2%. For the following 6 months, the patient's fasting plasma glucose ranged from 103 to 112 mg/dL, postprandial plasma glucose ranged from 109 to 117 mg/dL and HbA1c ranged from 5.7% to 7.6%. In August 2007, new purpura lesions recurred and patient was restarted on dapsone. Three months following re-treatment of dapsone, the patient's HbA1c was reported as 4.1% when fasting plasma glucose was 123mg/dL and 2-hour postprandial glucose was 110mg/dL. The estimated average glucose derived from this HbA1c was 70.97mg/dL. In February 2009, dapsone was discontinued again due to short supply. Two months following discontinuation, the patient's HbA1c was increased to 6.2% with fasting plasma glucose at 132mg/dL and postprandial plasma glucose at 137mg/dL. The authors concluded that dapsone -induced hemolysis can cause a decrease in HbA1c and that clinicians should be aware of it when patients with diabetes are placed on dapsone or other medications causing hemolytic anemia.

Iron status must be considered during the interpretation of HbA1c

On the other hand, in patients with iron deficiency anemia, HbA1c values may be falsely elevated due to several mechanisms. Tarim et al discuss some proposed mechanisms in their study. First, iron deficiency might alter quaternary structure of the hemoglobin molecule leading to easier glycosylation of hemoglobin β chain[7]. Second, emergence of young erythrocytes in the circulation after iron therapy for iron -deficiency treatment may lead to diluting and lowering of the concentrations of previously formed HbA1c[7]. Tarim et al conducted a prospective controlled study enrolling 37 patients with type 1 diabetes mellitus (T1DM) between October 1996 and September 1997. Patients were divided into two groups: iron deficient (ID) and iron sufficient (IS) with 11 and 26 patients in each group, respectively. Two non-diabetic control groups were also selected for the ID and IS groups. Patients with diabetes were monitored for glycemia at home by glucometer before breakfast and supper. All patients who were ID in both diabetic and non-diabetic groups were treated with oral iron 6mg/kg/day for 3 months. HbA1c was measured in all subjects at the beginning and the end of the study. The authors found that before iron therapy, the mean HbA1c concentration in ID T1DM patients (10.6 ± 2.6%) was higher than that in ID non-diabetic patients (7.7 ± 1.3%) ($P=0.005$), as expected. Moreover, the HbA1c in ID non-diabetic patients (7.7 ± 1.3%) was significantly higher than in IS non-diabetic patients (5.9 ± 1.3%) ($P<0.05$). In contrast, after iron treatment, mean HbA1c decreased from 10.6 ± 2.6% to a mean of 8.3 ± 2.6% ($p<0.05$) in ID T1DM patients, and from 7.7 ± 1.3% to 6.4 ± 1.2% ($p<0.05$) in ID non-diabetic patients. Thus, while an increased concentration of HbA1c is seen in iron deficient patients, iron replacement therapy leads to a drop in concentration of HbA1c in both diabetic and non-diabetic patients[7]. The authors concluded from their research that although the mechanisms behind falsely elevated HbA1c remain unclear in iron deficient patients, patients' iron status must be considered during the interpretation of HbA1c.

FA levels are unaffected by disorders of red blood cells and have an advantage of accurately reflecting short-term changes

Above mentioned limitations of use of HbA1c in patients with anemia warrant the use of additional glycosylation markers for monitoring diabetes, such as fructosamine (FA). FA is a measure of glycated serum proteins, most commonly being albumin[8]. FA levels are unaffected by disorders of red blood cells and have an advantage of accurately reflecting short-term changes (10-14 days) in glyce-

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mia[8]. Additionally, FA is an inexpensive and yet underutilized assay in clinical practice. Studies conducted in dogs have identified a positive correlation between albumin and FA where FA values have been found to be low in hypoalbuminemic patients[9]. In a study done by Chon et al, patients with hypoalbuminemia were excluded; hence further studies are warranted to determine the effect of hypoalbuminemia on FA measures in humans[8].

In summary, health care professionals should be cautious with interpretation of HbA1c values in patients with anemia. In hemolytic anemia HbA1c may be falsely lowered whereas in iron deficiency anemia HbA1c may be falsely elevated. Additionally, patients being treated with iron supplementation therapy may have a decrease in HbA1c concentrations. Alternate methods are available such as measuring blood glucose and fructosamine to monitor glycemic control in patients with altered hemoglobin due to variable causes.

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Dimethyl fumarate (Tecfidera™)

Andrea Gauld, PharmD, BCPS; Assistant Professor, Notre Dame of Maryland University

Alice Chong, Pharm.D. Candidate; Notre Dame of Maryland University

Class: Fumaric acid derivative, systemic immunomodulator

Indication: Relapsing forms of multiple sclerosis

Dose: Starting: 120 mg administered orally twice daily for 7 days. Maintenance: 240 mg administered orally twice daily. Dimethyl fumarate may be taken with or without food. Capsules must be swallowed whole.

Common adverse effects: Flushing, dyspepsia, nausea, vomiting, diarrhea, abdominal pain

Serious adverse effects: Neutropenia

Multiple sclerosis (MS) is an autoimmune demyelinating disease of the central nervous system. There are no symptoms that are unique to MS but it is common for patients to experience sensory, visual and gait disturbances. A majority of patients with MS tend to undergo periods of relapses and remissions of the disease throughout the course of their life. There is currently no cure for MS and the mainstay of therapy is to prevent relapses and manage symptoms.[1] For many years the first line treatment options for multiple sclerosis included only injectable agents (glatiramer acetate, interferon β-1b, and interferon β-1a) which could be bothersome for patients. However, since 2010 three oral agents have been approved by the United States Food and Drug Administration (FDA) as potential first line treatment options: figolimod (Gilenya™), teriflunomide (Aubagio™), and dimethyl fumarate (Tecfidera™). Each agent offers a unique mechanism of action to decrease relapses in MS patients. Fingolimod and teriflunomide both have effects on T-cells and B-cells leading to anti-inflammatory processes. Dimethyl fumarate directly inhibits pro-inflammatory pathways and has cytotoxic effects against oxidative stress.[2] It was approved by the FDA on March 27, 2013 as first line therapy for patients with relapsing forms of multiple sclerosis.[3]

Approved by the FDA on March 27, 2013 as first line therapy for patients with relapsing forms of multiple sclerosis

The approval of dimethyl fumarate was based on the DEFINE and CONFIRM trials; which were both double-blinded, randomized, placebo-controlled trials. Patients taking dimethyl fumarate had fewer MS relapses compared to patients taking placebo in both trials.[4,5]

The DEFINE trial compared dimethyl fumarate 240 mg twice and thrice daily to placebo in 1,234 patients with relapsing-remitting MS. Patients in both dimethyl fumarate groups had significantly lower proportions of relapses compared to placebo (27% with twice daily and 26% with thrice daily vs. 46% with placebo, $P<0.001$ for both comparisons). Reductions in disability progression was also significant in the dimethyl fumarate groups compared to placebo ($P<0.01$ in both comparisons).[4] The CONFIRM trial, which included 1417 patients, had similar treatment arms with the inclusion of a group receiving glatiramer acetate 20 mg subcutaneous daily. The annualized relapse rate in both dimethyl fumarate groups and the glatiramer acetate group was significantly lower compared to placebo (0.22 with twice daily, 0.40 with thrice daily, 0.29 with glatiramer acetate vs. 0.40 with placebo, $P<0.01$ for all comparisons).[5] Reductions in disability in the three treatment groups were not statistically significant compared to placebo.[4,5] While

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Dimethyl fumarate (Tecfidera™)

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there has not been a clinical trial that directly compares the three oral agents, an indirect comparison of the reduction of relapse rates versus placebo of the different oral agents for MS can be seen in Table 1.

Dimethyl fumarate is recommended to be initiated with a starting dose followed by maintenance dosing. The starting dose is 120 mg by mouth twice daily for seven days followed by a maintenance dose of 240 mg by mouth twice daily. Dimethyl fumarate may be taken with or without food. The capsules should be swallowed whole and intact. Capsules should not be crushed, chewed, or sprinkled on food. Dimethyl fumarate should be protected from light by storage in the original container. Opened dimethyl fumarate should be discarded after 90 days.[6]

There are no contraindications for dimethyl fumarate. However, there are warnings and precautions of lymphopenia and flushing. Patients should have a complete blood cell count (CBC) within 6 months of initiation of therapy, annually, and as clinically indicated. Flushing was the most common side effect in the CONFIRM and DEFINE trials occurring in 31% and 38% of patients, respectively.[4,5] Flushing usually improves or resolves over time, but the incidence may be reduced by taking dimethyl fumarate with food.[5] Severity and incidence of flushing may also be reduced by administering non-enteric coated aspirin by mouth 30 minutes prior to dimethyl fumarate.[67]

Patients should be counseled on the warnings and precautions, along with possible gastrointestinal (GI) side effects. In clinical trials, GI side effects occurred in up to 13% of patients. Possible GI side effects are dyspepsia, nausea, vomiting, diarrhea, and abdominal pain. The GI side effects usually decrease over time.[4,5,6] Patient tolerability is of concern with dimethyl fumarate as 16% of patients in the DEFINE trial and 12% of patients in the CONFIRM trial cited adverse effects as the reason for subject discontinuation.[4,5] For a comparison of adverse effects of the different oral agents for MS please see Table 1.

Dimethyl fumarate is pregnancy category C and should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Women exposed to dimethyl fumarate during pregnancy should be encouraged to enroll in the Tecfidera Pregnancy Registry at 1-800-456-2255. It is unknown if dimethyl fumarate is excreted in human milk and caution should be used when it is administered to nursing women.[6]

Dimethyl fumarate is not metabolized by the cytochrome P450 (CYP) system. It is metabolized by esterases and the metabolite is metabolized by the tricarboxylic acid cycle. The major metabolites include fumaric acid, citric acid, and glucose. There are no CYP or P-glycoprotein drug interactions with dimethyl fumarate.[6]

For patients prescribed dimethyl fumarate therapy, prescribers can send prescriptions directly to a specialty pharmacy in the Tecfidera Pharmacy Network. A specialty pharmacy is needed for the distribution of dimethyl fumarate to patients due to the high cost of the medication and the complexity of multiple sclerosis. The pharmacy can mail the prescription directly to the patient. There is a $10 co-pay program available through Tecfidera *ActiveAccess*. There is no income requirement, time limit, or waiting for the program. Participation is only limited by federal law, state law, and insurance provider policy. The manufacturer also offers Tecfidera *ActiveVoices* and Tecfidera *ActiveNurses* which provides the opportunity for patients to speak with a peer mentor or a registered nurse. These services can be accessed through MS *ActiveSource* at 1-800-456-2255 8:30 am – 8 pm (ET).[8]

In summary, it is currently an exciting time for multiple sclerosis therapy with the introduction of new oral therapies. Dimethyl fumarate is a viable alternative to injectable medications for treatment of multiple sclerosis with few adverse reactions and infrequent monitoring.

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Dimethyl fumarate (Tecfidera™)

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Table 1: Comparison of disease modifying oral agents for multiple sclerosis

Generic name	**Fingolimod[9]**	**Teriflunomide[10]**	**Dimethyl fumerate[6]**
Brand name	Gilenya	Aubagio	Tecfidera
Place therapy	Relapsing forms of MS	Relapsing forms of MS	1st line for relapsing forms of MS
MOA	Sphingosine 1-phosphate receptor modulator	Pyrimidine synthesis inhibitor	Unknown, but it activates Nuclear factor (erythroid-derived 2)-like 2 pathway which is involved in the cellular response to oxidative stress
Dosing	0.5 mg daily	7 mg or 14 mg daily	120 mg BID for 7 days than 240 mg BID
Adverse Events	Headache (25%) Influenza (13%) Diarrhea (12%) Back pain (12%) Liver transaminase elevations (14%) Cough (10%)	ALT increase (14%) Alopecia (13%) Diarrhea (18%) Influenza (12%) Nausea (14%) Paresthesia (10%)	Flushing (40%) Abdominal pain (18%) Diarrhea (14%) Nausea (12%)
Annualized relapse rate vs. placebo (p-value)	0.18 vs. 0.40 (<0.001)	7 mg: 0.370 vs. 0.539 (0.0002) 14 mg: 0.360 vs. 0.539 (0.005)	0.172 vs. 0.364 (<0.0001)
Relative risk reduction	55%	7 mg: 31% 14 mg: 33%	53%

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Richard Parrish Lecture Award

Second Annual Richard Parrish Lecture Award Presented To

Doris Voigt

This award is DC-CCP's highest distinction, and is awarded to an individual who has made significant and sustained contributions in or for clinical pharmacy and has provided influential leadership in clinical pharmacy at the regional or national level.

Dr. Doris Voigt earned her Bachelors of Science in Pharmacy Degree from Albany College of Pharmacy then went on to attain her PharmD from the University of Maryland School of Pharmacy. She was awarded Alumnus of the Year from Albany for "Contributions to the Profession of Pharmacy" and has been named "Preceptor of the Year" from both Kaiser Permanente and University of Maryland School of Pharmacy. She has been a very involved member of eight pharmacy professional organizations, serving on committees of four. She recently worked for Kaiser Permanente Health Plan of the Mid-Atlantic States as their Academic Affairs coordinator. In her role at Kaiser Permanente, she facilitated the student experiential learning for up to 30 Pharmacy and Pharmacy Technician programs and over 70 preceptors in addition to the coordination of internal continuing educational opportunities for pharmacy personnel. She has a long history of supporting impaired pharmacy professionals, serving as a Monitor for over 10 years with the Maryland Board of Pharmacy's partner, the Pharmacists Education & Advisory Council (PEAC).

Thank you for your outstanding contributions to the chapter and to the profession, Dr. Doris Voigt!

Schools of Pharmacy Updates

University of Maryland School of Pharmacy

Submitted by: Adrienne Herman, SCCP-UM DC-CCP Liaison and Jueli Li, SCCP-UM President:

The University of Maryland School of Pharmacy is currently in the process of establishing a Student College of Clinical Pharmacy chapter! Our main mission is to provide unique resources and opportunities to our student members, to promote interest and knowledge of clinical careers, and to allow for networking with other student chapters, faculty, and regional and national clinical pharmacists. We hope to act as a resource for students to advance their clinical careers and to advocate for clinical pharmacy as a whole. The new executive board is currently focusing on its membership drive and on planning new and established events for the upcoming spring semester such as the Clinical Roundtable and the Clinical Pharmacy Challenge. As an executive board, we are extremely thrilled to be a part of this exciting transition with establishing our new student chapter. We hope to use this opportunity to build a closer relationship with DC-CCP!

Schools of Pharmacy Updates

Notre Dame of Maryland University School of Pharmacy

Submitted by: Min Kwon, PharmD, BCPS, Assistant Professor at Notre Dame of Maryland University

Thank you to Christie Dunton and Brittany Eisamann, P4 Pharmacy students, for leading the discussion on "Interpreting Lab Data: Mystery Diagnosis" as part of the student track at the DC-CCP Fall Forum.

University of Maryland Eastern Shore

Submitted by: Dr. Su Young Lee, PharmD, MS, BCPS-AQID, Associate Professor at the University of Maryland Eastern Shore

The Accreditation Council of Pharmacy Education (ACPE) announced in June that the University of Maryland Eastern Shore's Doctor of Pharmacy Program had been awarded Full Accreditation.

The students, faculty and staff of the University of Maryland Eastern Shore School of Pharmacy (UMES-SOP) rolled up their sleeves and reached out to the community for the 3rd Annual Service Day on Wednesday, March 27, 2013. Collectively, we have provided almost 6000 hours of community service since the matriculation of the first class in Aug. 2010.

Congratulations to Dr. Cynthia J. Boyle, for being elected as President of the American Association of Colleges of Pharmacy.

Congratulations are in order to Matthew Balish and Keith Larson, who won the first place in the Clinical Skills Competition at UMES ASHP student chapter and represented UMES at the Clinical Skills Competition at Midyear 2013.

Miraj Patel, Jinxiang Xu, and Gillian Ndi, class of 2014 students, along with Drs. Freeman and Parmar, presented and won second place award for their poster during the Maryland Public Health Association (MdPHA) Annual Meeting held in Silver Spring.

Dr. S. Victor Hsia, associate Professor of Pharmacology/Immunology in the School of Pharmacy and Health Professions, received the award for securing the competitive R01 research grant from National Institute of Neurological Disorders and Stroke (NINDS) at NIH for conducting biomedical research at UMES.

Dr. Miguel Martin-Caraballo was promoted to Associate Professor with Tenure as the first faculty member with this achievement in the history of the school (UMES-SOP).

Dr. Harbester was installed as President of the Delaware Pharmacists Society (DPS).

Congratulations are in order to Dr. Patrice Ayotunde-Jackson. Her proposal entitled Synthesis and Evaluation of Novel Enaminones as Potential Agents for Partial Epilepsy has been selected as a winner (and will be funded) of the 2013-2014 AACP New Investigator Award (NIA).

Events of DC-CCP

Back to School Night

During the first year of this committee, we were proud to host our first annual DC-CCP Back to School Night. It was a pleasure to meet so many students from different area schools of pharmacy. At the event, students were able to ask a panel of current residents and clinical pharmacists a variety of questions about residency applications, interviews and daily activities. It was exciting to see the enthusiasm the students who participated had for their future pharmacy careers. It was also fun to run into some of the participating students at the recent ASHP Midyear Clinical Meeting.

November Fall Forum

Committee Updates

Education/Networking Committee

Thank you to the Education/Networking Committee members for your time in putting together our 2nd DC-CCP Fall Forum.

We are busy planning our Spring CE Dinner focusing on Antimicrobial Stewardship. More information soon to come. It will be posted on our DC-CCP website.

Also, please contact Thao Tran (thao.muse@gmail.com) if you are interested in joining the committee!

Student Resident Fellow

The student, resident, and fellow committee would like to thank everyone who participated in the committee this year. During the first year of this committee, we were proud to host our first annual DC-CCP Back to School Night. In 2014, we have merged our committee with the Education/Networking Committee. We have plans to continue offering programming and networking events aimed toward DC-CCP members who are students, residents and fellows.

Please contact Thao Tran (thao.muse@gmail.com) if you are interested in helping with our newly merged Education/Networking committee!

Communications Committee

It has been this committee's honor and pleasure to deliver Volume 2 of The Lobbyist for the 2013 year! Thank you so much to the following committee members for their dedication, long hours, and hard work to make this newly revamped newsletter come true!

Committee Chair and Editor of *The Lobbyist*: Deanna Tran, PharmD, BCACP
Reviewer and Newsletter Developer of *The Lobbyist*: Andrew Haines, PharmD
Reviewer and Newsletter Developer of *The Lobbyist*: Chelsea McSwain, PharmD
Reviewer and Newsletter Developer of *The Lobbyist*: Andrew Phan, PharmD

Membership Committee

We thank all the members of the Membership Committee this past year for their hard work. The Membership Committee is now merged with the Communications Committee and Education/Networking Committee.

Please contact Tim Rocafort (trocafo1@jhmi.edu) if you or anyone you know is interested in DC-CCP.

Membership application and fee structure available via DC-CCP website: http://dc-ccp.echapters.com/

A Final Farewell to 2013

Thank You!

To the brave and motivated founders who created DC-CCP then stayed on to ensure it's success: thank you. To the inspired and dedicated members who stepped up to grow the chapter, as well as the profession: thank you. 2013 has been a tremendous year for all of us in DC-CCP and would not have been possible with each and every one of its members' contributions.

Communications Committee – Deanna Tran

Thank you so much for the opportunity to deliver Volume 2 of *The Lobbyist* for the 2013 year! I would not have been able to do it without our amazing committee members, Andrew Haines, Chelsea McSwain, and Andrew Phan. I would also like to recognize Jarjeet Singh for revitalizing our Facebook page.

> **"Thank you so much"**

Student Resident Fellow Committee — Katy Pincus

It was a pleasure serving as the chair of the student, resident and fellow committee this year. I will continue to participate with this committee and hope to see many of the committee members at events in the future. Thanks for a great year!

Secretary-Treasurer — Lisa Peters

I have enjoyed the opportunity to serve as DC-CCP's first secretary-treasurer. As our membership has grown so has our bank account: we currently have about $2500 in our account. These funds will help us to host more events and provide more benefits to our members. We welcome any creative ideas to help us build our financial strength as an organization. Thank you again for the opportunity to serve, and I encourage you to step up to a leadership position in DC-CCP. I promise that you will find it to be educational and rewarding in ways you never expected.

> **"I encourage you to step up to a leadership position in DC-CCP"**

Join DC-CCP's Social Media Groups!

Click to like us on Facebook!

Click to join us on LinkedIn!

Join a Committee!

Your engagement as an active DC-CCP member is essential for our committees to be successful. We hope that members will consider dedicating one or two hours a week to supporting DC-CCP. Most of the work can be done on your own time, and all of the meetings will be teleconferenced for your convenience. Our committees are: **Education/ Networking Committee** and **Communications Committee.**

Please consider joining one of these two committees! If you are interested, please e-mail Chai Wang with your committee preference at Chaifu.Wang@gmail.com.

All You Need to Know About DC-CCP

DC-CCP is a non-profit professional association and an independent chapter of the American College of Clinical Pharmacy (ACCP) dedicated to improvements in pharmacotherapy practice, education, and research in the Washington DC Capital Region, including the District of Columbia, State of Maryland, and Commonwealth of Virginia. Membership will be open to any licensed or registered health care professional or health care professional student in the Capital Region. Membership in the American College of Clinical Pharmacy is not required to become a member of our organization.

Purpose and Goals of DC-CCP

A. To promote the rational use of drugs in society
B. To advance the principles and practice of clinical pharmacy
C. To promote the full-time, advanced practice of clinical pharmacy
D. To provide an advanced level of continuing education programs in the area of clinical pharmacy and therapeutics
E. To provide a forum for the expression of opinion on pharmacy practice, education, and research from the perspective of clinical pharmacists
F. To support, promote, and advance the goals and objectives of ACCP as outlined in its constitution and bylaws
G. To provide a local recruiting base for ACCP

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