LA HEALTH-SYSTEM PHARMACIST

Newsletter of the Louisiana Society of Health-System Pharmacists

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FROM THE DESK OF THE PRESIDENT

I would like to start off by saying it is an honor to serve as your LSHP president for the upcoming year. I would like to thank my predecessors Teresa Nash and Keturah Robinson for leaving the organization in such good shape.

A number of our board members and staff have recently been or will be blessed with new additions to their families. This constitutes many changes in our lives. At our recent LSHP annual meeting, Mr. Stan Kent gave us a preview of the new ASHP practice model initiative. This will mean changes in most of our practices. Our board will meet in August to discuss some of these changes and find ways to make our organization better.

Our annual meeting was once again a big success. Attendance reached 196 and 53 vendors participated on Friday afternoon. A special thanks goes out to Jay Schwab and Helen Calmes for chairing the committee. They also filled in on the REMS talk when our speaker cancelled at the last minute. In addition, congratulations to our award winners that were announced at the Awards Luncheon!

This is a great year to be a member of LSHP. For the first time since Katrina, New Orleans will be hosting the ASHP mid year meeting. We are in the process of planning a social event with ULM and Xavier Pharmacy schools. We hope that our membership will take advantage of this opportunity to support our national organization.

I was able to speak to quite a few members who were interested in becoming committee members or chairs. I encourage anyone who wants to get involved to contact me. We can always use your input and ideas. I hope everyone has a great summer.

Sincerely,
Scott Dantonio, R.Ph.
LSHP President

Special Thank You to All the LSHP Exhibitors for AM 2011

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2011 MIDYEAR MEETING

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FOR PROGRAM DETAILS

LSHP Bimonthly Newsletter LA HEALTH-SYSTEM PHARMACIST Publisher Information

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Please send article submissions to the newsletter editor, Dana Jamero, via email at djamero@xula.edu.

LSHP 2011 Annual Meeting Highlights

Thank you to all who attended the 2011 Annual Meeting! We had great attendance this year by attendees and exhibitors alike! The meeting kicked off with a welcome reception at the Rock-n-Bowl. Attendees ate, drank and socialized and a few even bowled.

LSHP was fortunate to welcome several national speakers who presented on a variety of topics including: Pain Management, Palliative Care and 797 Compliance We were also privileged to hear from several LSHP members who shared their knowledge of specialties ranging from designer illegal drugs to public policy. Thanks to all of our speakers!

The Awards Luncheon on Saturday featured an address by newly-installed ASHP President Stan Kent. The results from Friday's Poster Session were announced at the luncheon and are listed below. Also, the following LSHP award winners were honored at the luncheon. Congratulations to all winners!

Award Winners

President's Award
Theresa Nash

Industry Award
Corey Chimento

Outstanding Committee Chair
Lisa Ross

Outstanding Service Award
Tommy Mannino

Tommy Himel Award
Charlie Jastram

Pharmacy Technician of the Year
Shelly Dillon

Pfizer Health-System Pharmacist of the Year
Theresa Nash

Outstanding Chapter President
Brice Mohundro

Albert P Lauve
Ifeanyi Onor
Monica Morgan

Poster Winners

Clinical Poster

Prevalence of New Onset Diabetes After Transplant in Kidney Recipients Who Received Alemtuzumab Induction Versus Long-Term Steroids
Megan McSweeney, Stephanie Anders, Cody Allison, Ari Cohen
Ochsner Health Systems

Administrative Poster

Effectiveness of a Pharmacist-Based Education Program for Floor Nursing Staff on Proper Inpatient Hypoglycemia Management
Charles C. Snyder, Pharm.D., Jolene K. Johnson, M.D., Brice L. Mohundro, Pharm.D., Ann M. Wicker, Pharm.D., Paul S. Knecht, Pharm.D. LSUHSC Earl K. Long Medical Center / University of Louisiana at Monroe College of Pharmacy

Student Poster

Improving Patient and Medication Safety in the Blind Population Through Pharmacist Driven Blind-Friendly Health/Wellness Fair
Ibekweh, QO; Williams, LG; Bradley-Stephens, A; and Sarac, MS; Xavier University of Louisiana, College of Pharmacy, New Orleans, LA

A View from the 2011 LSHP Annual Meeting

Public Policy Update

By: William R. Kirchain, PharmD & Jeffery Evans, PharmD

June 1st brought the announcement of the final rule from CMS on preventable iatrogenic disease in patients with Medicaid. Beginning July 2012, Medicaid programs must withhold or recoup payments for illnesses and injuries that are preventable and iatrogenic. Included in the list of preventable illness is hospital acquired infections and serious medical errors.[1,2]

Around the country demonstration projects are beginning to document best practices and possible savings to the government associated with Accountable Care Organizations (ACO). The Affordable Care Act of 2010 defines ACO as integrated multi-disciplinary confederations of providers that agree to take responsibility for and shared savings (a form of value-based purchasing) over the care of at least 5,000 Medicare recipients. The ACO must include primary care providers that are linked with all other providers in a formal legal association. The ACO must have an administrative and clinical leadership structure driven by physicians that can manage and publish data on costs, processes and outcomes.[3] The organization must be tied together via a robust health information technology backbone with common access to the patient's electronic health record.[4] There must be evidence of patient engagement and the use of evidence-based medicine.[3,4] Hospitals excluded from participation include those that are not paid under the inpatient prospective payment system such as psychiatric, rehabilitation, long term care, children's, and cancer hospitals.[4]

The central theme to the ACO concept is to attempt to better align Medicare payments with provider costs in order to strengthen program integrity within Medicare and put Medicare on a firmer financial footing.[4] An ACO is expected to draw on best practice models that include telemedicine, electronic health records and innovative uses of existing professional staff to achieve better quality for patients.[4]

Hospitals remain as the center point of all ACO and are expected to provide the lion's share of administrative and clinical leadership.[5] Another important grouping within the structure is expected to be Community Health Teams (CTM). The CTM must be interdisciplinary and inter-professionally staffed. CTM are to support primary care providers who are accounted directly for a large majority of the Medicare beneficiary's personal health care needs. A CTM must establish contractual agreements with primary care providers to provide support services. The CTM may provide any or all of the following: (1) disease prevention; (2) chronic disease management; (3) transitioning between health care providers and settings; or (4) case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions. A CTM must utilize as a primary approach an interdisciplinary, interprofessional care plans that integrate clinical and community services for patients, including children.[4]

The management of unscheduled care and specialty services are expected to be important and ongoing cost and quality issues for all ACO no matter the approach to organization.[5] Adjusting the ACO model to accommodate physician-owned services already in place, pre-existing and independent provider groups or alternatively large corporations that transcend local communities will in evidently expand the ACO model currently proposed.[6]

Because pharmacists are already in place in the community and able to provide a large share of these services, successful implementation of an ACO will require our profession or be doomed to fail. Of particular value will be pharmacist involvement with medication reconciliation on the inpatient side and, as recently published from Connecticut, a network of pharmacist providers on the community side.[7] The Connecticut model involved a 9 pharmacist network who provided advanced medication therapy management to 88 Medicaid patients over the course of 1 year. The network was credited with cost savings of $1,123.00 per patient medication claims and a $472 reduction per patient in emergency room claims.[7] A systematic review of 298 studies was used by the research team to convince the Connecticut Medicaid Program to participate. This review provides evidence of pharmacist's ability to reduce drug expenditures, hospital admissions and length of stay in a hospital, along with a reduction in non-drug related medical costs as well.[8]

In Maryland, as part of the Ten City Challenge, large numbers of patients were assisted in taking control of their diabetes. Participants as a group achieved statistically significant reductions in control of blood glucose, blood pressure and LDL-cholesterol while saving the participating health insurance providers an average of $1,079.00 per patient.[9] Pharmacists are trained to work collaboratively but not submissively and this allows for more aggressive management of medications. The overall accessibility and trusted status in the community add to the value of the professions work.[10]

In Louisiana we already have in place the ability to participate in vaccination thus providing an important preventative care service to potential ACO. There are collaborative drug therapy management processes available and although these will need to be expanded and simplified, as a profession we are not starting from zero. Most importantly, since the single most important waste or cost to overall patient outcomes tends to occur at the transitions of care (ICU to Acute Care, Acute Care to Long Term Care and Acute Care to Outpatient) and pharmacists are already positioned at these transition points we can have a huge impact that an ACO will need to be successful.

References available upon request

Antibiotics for Irritable Bowel Syndrome

By Phi-Ha Ho, PharmD Candidate and Camtu Ho, PharmD

Introduction

Irritable bowel syndrome (IBS) is a motility disorder involving the entire GI tract causing recurring upper and lower GI symptoms. Symptoms include abdominal pain, constipation and/or diarrhea, and abdominal bloating. IBS is defined as chronic or recurrent abdominal pain with altered bowel habits (either constipation or diarrhea) and bloating with the absence of structural or biochemical abnormalities to explain these symptoms. Therefore, IBS is a "functional" gastrointestinal disorder as its cause is unknown. IBS is one of the most common chronic disorders causing patients to seek medical treatment. Although not life-threatening, it can have a serious impact on a patient's daily activities and quality of life. It is a major cause of absenteeism at the workplace and at school. As such, it exerts a significant economic burden in Western countries and is responsible for considerable morbidity. The economic costs associated with IBS are estimated to be $33 billion in direct and indirect costs in the United States annually. IBS is more prevalent in Caucasian and lower in Hispanic and Asian populations. It predominantly affects more women than men with a ratio of 3:1.

Although there is no definitive testing for IBS, it can be diagnosed based on the Rome II Criteria. Rome II Criteria base diagnosis on at least 12 weeks (which need not be consecutive) during the preceding 12 months of abdominal discomfort or pain that has two of the three following features: (1) relief with defecation; (2) onset associated with a change in frequency of stool; (3) onset associated with a change in form (appearance) of stool. Symptoms that cumulatively support the diagnosis of IBS include: (1) abnormal stool frequency (may be defined as greater than three bowel movements per day and less than three bowel movements per week); (2) abnormal stool form (lumpy/hard or loose/watery stool); (3) abnormal stool passage (straining, urgency, or feeling of incomplete evacuation); (4) passage of mucus; (5) bloating or feeling of abdominal distension.

Current IBS treatments include dietary restrictions (avoidance of artificial sweeteners, fructose, carbonated beverages, fatty foods and sometimes lactose), dietary fiber supplementation, pharmacotherapy (antidiarrheals, smooth muscle relaxants, bulking agents, prokinetic agents, serotonin receptor agonists and antagonists), and psychological therapy (relaxation, stress management). Such therapies are directed for symptom relief rather than treating the underlying cause of IBS. Recent findings have supported the use of antibiotics in the treatment of IBS due to evidence of intestinal bacterial overgrowth. Research trials have demonstrated the greatest efficacy with the antibiotic, rifaximin (Xifaxan®).

Research Findings

Rifaximin is an antibiotic with minimal systemic absorption and a broad spectrum of activity against gram-positive and gram negative aerobes and anaerobes. It is FDA approved for the treatment of travelers' diarrhea caused by noninvasive strains of E. coli. The effects of rifaximin on IBS have also been demonstrated in clinical trials. "The Effect of a Nonabsorbed Oral Antibiotic (Rifaximin) on the Symptoms of the Irritable Bowel Syndrome" was published in the Annals of Internal Medicine in October 2006. In this study, researchers tried to determine whether rifaximin, an antibiotic that works only in the gut, can improve symptoms in people with IBS. Patients between 18-65 years of age who met Rome I criteria were eligible. IBS is diagnosed by Rome I criteria if the following are present: (1) At least three months of continuous or recurrent abdominal pain that is relieved with defecation and/or is associated with a change in stool consistency (2) Plus, at least two of the following on at least 25 percent of days: altered stool frequency, altered stool form or passage, passage of mucus, bloating or feeling of abdominal distension. Exclusion criteria included the presence of underlying conditions that are known to predispose to bacterial growth (e.g. diabetes, cirrhosis, or any known chronic gastroenterological disease). Patients were also excluded if they were taking tegaserod and antidepressants (unless discontinued prior to the study) or had taken oral antibiotics within the previous 3 months. A total of 87 people were enrolled in the study. Patients were randomly assigned in a double-blind fashion to either 400mg of rifaximin 3 times daily for 10 days or a placebo. After completing the 10 day course of study medication, patients recorded their symptoms weekly for 10 weeks. Patients were also asked to complete a daily stool diary and symptom questionnaire at the end of follow-up period. Rifaximin patients experienced an average improvement in symptoms of 36.4% compared with 21% for placebo. Bloating and overall symptoms improved in participants who took the antibiotic, however, the researchers could not detect differences in symptoms of diarrhea or constipation. Rifaximin did not cause any clinically significant side effects. Limitations to the study included a relatively small number of patients and short study duration.

Another study looked at the efficacy of rifaximin in both the treatment and retreatment of IBS. "Rifaximin versus Other Antibiotics in the Primary Treatment and Retreatment of Bacterial Overgrowth in IBS" was published in the Digestive Disease Science in May 2007. A retrospective chart review was conducted based on Rome I criteria IBS patients. Charts were reviewed to evaluate all antibiotic treatments (rifaximin, neomycin, doxycycline, Augmentin, and ciprofloxacin), predating July 1, 2004. It has been noted that the symptoms of IBS are similar to small intestinal bacterial overgrowth (SIBO), a condition caused by colonization of the small bowel with bacteria that normally reside in the colon. Current standard of treatment for SIBO is empiric therapy with broad spectrum antibiotics. Conventional antibiotics often suffer from poor efficacy, with only 30-40% of SIBO eradication. Side effects limit the use of neomycin and low efficacy was shown in other antibiotics (e.g. doxycycline and Augmentin). High rates of SIBO recurrence are another problem (e.g. diarrhea quickly recurred after withdrawal of the antibiotic). Multiple antibiotic retreatment courses are concerning because they increase the likelihood of bacterial resistance and future treatment failure. Rifaximin has no systemic absorption which minimizes adverse side effects while maintaining good antibacterial activity with little resistance; therefore, it has become an antibiotic of interest in the treatment of IBS and SIBO. The data collection included symptoms, breath test results (pre- and post-treatment), antibiotics used, and clinical response to individual antibiotic treatments before and after rifaximin availability in the United States.

Continued on page 7

POSTER WINNER

Improving Patient and Medication Safety in the Blind Population through Pharmacist Driven Blind-friendly Health / Wellness Fair

Queenet O. Ibekweh, PharmD Candidate; LaKeisha G. Williams, PharmD; Miroslav S. Sarac, PhD

People with severe visual loss experience significant health disparities and barriers to health care and pharmacy service, as compared with people who do not have this type of disability. Absence of professional training on disability competency issues for health care professionals including pharmacists is one of the most significant barriers preventing people with vision loss from receiving appropriate and effective health care and pharmacy service. Cultural competence has been recognized as an important issue relevant to pharmacy practice as the pharmacy profession shifts its practice to more patient-focused services where continual communication is necessary for ensuring patient and medication safety outcomes. The lack of cultural competence by pharmacists is one of the most important barriers preventing people with disabilities from receiving appropriate and effective health care. Also, the Americans with Disabilities Act (ADA) has had limited impact on how health care is delivered for disabled people. There is an urgent need for professional training on disability competency issues for health care professionals. The purpose of this study is to explore facts and factors in a unique culture of blind people and to design a culturally competent health / wellness fair driven by pharmacists with a goal to improve patient and medication safety.

The Institutional Review Board of Xavier University of Louisiana approved the study protocol. This is a non-experimental, quantitative research study utilizing descriptive research design. Our human subjects are blind people (n=25) in the New Orleans metropolitan area. Initial health and wellness fair for the population of the blind people was organized and driven by Xavier University of Louisiana College of Pharmacy clinical pharmacy faculty members (n = 3) and students (n = 12). A total of twenty-five blind and severely visually impaired people attended the health and wellness fair that provided osteoporosis bone density, diabetes mellitus, hypertension, and obesity screenings, in addition to “medication brown bag” consultations. The health fair also utilized “various displays” and practical tools necessary and convenient for health and wellness.

Although the health and wellness fair specifically organized for blind and visually impaired people has gotten very positive feedback from participants, we realized that there is a lack of cultural competence in the pharmacy profession related to the unique culture of blind people. Our results from this study show that diabetes and glaucoma are the leading causes of acquired blindness in the greater New Orleans area and that the African American population is greatly affected relative to other races. Also, there seems to be a rift between the blind population and pharmacists where the participants in our health fair repeatedly accounted for poor services being provided to them by their pharmacists. There were even cases where some participants had admitted to not visiting their pharmacy due to lack of proper service.

This issue can lead to serious patient safety and medication safety issues already reported in the literature, and addressed by the American Foundation for the Blind (AFB) and the American Society of Consultant Pharmacists (ASCP). Furthermore, there is an unawareness of the needs of patients belonging to the blind population and an urgent need for educational programs related to cultural competence and health disparities for pharmacy students as well as health care professionals, especially pharmacists.

References available upon request

ASHP 2011 MIDYEAR MEETING

Continued from page 6

Of participants given rifaximin, 69% had a clinical response compared with only 33% with neomycin and 44% with all non-rifaximin antibiotics. Rifaximin was used as retreatment on 16 occasions and all patients improved. Despite the limitations that this was not a prospective study and there was a small percentage of patient follow-up, rifaximin was determined to be more effective than other antibiotics in the treatment and retreatment of IBS.

Conclusion

Antibiotics are an emerging therapeutic option for IBS involved in the role of enteric bacteria. However, there is no definitive cause-and-effect relationship between the two as of yet. The studies have shown that the benefit of rifaximin continued even after it was stopped, which provides evidence that irritable bowel syndrome may be due to an excessive amount of bacteria in the gut flora. Rifaximin may have superiority over other antibiotics in regards to success rates in symptoms and fewer cases of retreatment in recurrence of irritable bowel syndrome. Rifaximin has potential in antibiotic therapy for IBS in that it has minimal systemic absorption which has a low risk of systemic toxicity, minimal drug interactions, and antibiotic resistance compared to other antibiotics tested.

Studies show rifaximin does have clinical improvement of IBS, but further research trials are needed to support such claim. In both clinical trials, there were many limitations such as single center trials, small patient populations, lack of prospective studies, and lack of knowledge of patient’s adherence. In order to prove efficacy of rifaximin in irritable bowel syndrome, a comparison trial needs to be tested versus current therapy

References available upon request

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