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From the Maxor/CPR Project Manager...



During the past several months, I have been extremely impressed with the professionalism and the desire to improve by all the pharmacy employees that I have met. The challenges and resultant opportunities for becoming a leader in the delivery of pharmaceutical care are tremendous, and I personally appreciate each of your efforts in this group endeavor.

Our role in the constitutional delivery of health care to offender patients is huge. In the 1976 U.S. Supreme Court case of *Estelle v. Gamble*, it was established that our offender patients have a right (in a timely manner) to being seen by a clinician, being given a professional clinical opinion, and receiving the care that is ordered. Therefore, our efforts in delivering pharmaceutical care are a critical link in the totality of offender care.

Not only is our responsibility to ensure provision of ordered care in a timely manner, but also, it is to ensure that pharmaceutical care is continuous throughout the daily life of our offender patients—at the institution, between institutions, and as our patients transition to life in the world outside of the prison system. There are multiple points of opportunity, and, yes, challenges to seamless provision of pharmaceutical care each step of the way.

So, our role at Maxor National Pharmacy Services is to assist in the standardization of patient care and to develop a system that reflects current standards of practice of pharmacy—product delivery, clinical services, and patient education—in a safe and cost effective manner that is distinctly “Californian” in approach and challenge resolution. Truly, the practice of ship-shipmate-self is our opportunity to reach this goal, and with the collaboration of each of you, we shall reach it.

I look forward to working with you all.

*~ Glenn Johnson, MD
Maxor/CPR Project Manager
Maxor National Pharmacy Services Corp*

Morgan Allred has joined the Maxor/CPR Project team as Office Assistant. Morgan completed her AA degree in business administration and is currently pursuing her BA degree. She has worked in several settings in the past performing office and customer services functions. We are glad to have her join our team.

Welcome Aboard...

New shipmates at the facility level include **Roger Toevs** (Pharm I) at ASP; **Dana Swanson** (Pharm Tech) at CAL; **John Barclay** (Pharm I), **Tina Goldberg** (Pharm I) and **Nguyen Thanh Tri** (Pharm Tech) at CMF; **Gladys Boateng** (Pharm Tech) at CRC; **Shaun Lee** (PIC) and **Harrison Liu** (Pharm I) at LAC; **Rachel Rideout** (Pharm Tech) at PVSP; **Monica Flores** (Pharm Tech) and **Malia Flauio** (Pharm Tech) at RJD; **Raina Elkib** (Pharm I) at SQ; **Sue Varughese** (Pharm I) at SVSP; **Sherry Hartline** (Pharm Tech) at KVSP, **Ed Maurino** (Pharm I) at CCC, and **Gerald Beck**, (PIC) HDSP.

Let us know if there are other new shipmates at your facility.



Out on the Horizon!!

We would like to recognize our nursing, pharmacy, medical and security teammates at Folsom for their dedication and hard work in the recent roll out of the new pharmacy operating system. In addition to changing the operating system in pharmacy, the team has made numerous changes to the medication management process, from prescribing to administration, in an effort to improve care. Thank you everyone at Folsom for your hard work and dedication.

Matt Keith, Pharmacy Administrator

Maxor/CDR Pharmacy Program News

Destruction and Reclamation Contract: Maxor has negotiated a destruction and reclamation contract with Guaranteed Returns for CDCR, which went into effect June 10th, 2007. Detailed instructions on how to utilize Guaranteed Returns services to dispose of expired and unusable pharmaceuticals in the pharmacy was sent out to all Pharmacists-In-Charge.

Clinical Pharmacy Services are now being offered at 3 CDCR facilities. Mike Namba, Pharm D, Clinical Pharmacy Specialist divides his week among CMF, SQ, and Folsom offering clinical consultative and educational services. Mike is the first of 8 full time regionally-based Clinical Pharmacy Specialists to be hired by Maxor to provide Clinical Pharmacy Services in CDCR facilities Statewide. Recruiting is underway to fill the remaining positions with opportunities for both full and part-time available.

The New CDCR Formulary is Now Available: Copies of the newly approved CDCR formulary have been disseminated electronically to CDCR facilities for immediate implementation. Plans are underway to make a downloadable PDA version available as well. There is a 90 day (July 1st – September 30) transition period after which the formulary will be strictly enforced.

TCAs Remain Non-Formulary for Mental Health: All tricyclic antidepressants (TCA), including the drugs listed on the new CDCR formulary [Pamelor (Nortriptyline), Elavil (amitriptyline), Sinequan (doxepin) and Tofranil (imipramine)], are considered to be nonformulary for all mental health indications. A non-formulary request is required and must be pre-approved by the supervising psychiatrist before a TCA prescription can be processed by the pharmacy.

All tricyclic medications for medical indications (non-mental health) must have a clear indication written on the prescription by the prescriber before it can be processed by pharmacy.

Pharmacy & Therapeutics Committee

The **System-wide Pharmacy & Therapeutics (P&T)** Committee had another highly productive meeting on June 12, 2007. The Committee approved Hyperlipidemia Disease Medication Management Guidelines. The Committee also approved policies and procedures including a policy and procedure for inspecting medication storage areas.

The policies and guidelines have been disseminated to CDCR institutions for immediate implementation.

Tricyclic Antidepressants (TCAs) Not Keep On Person. Due to the dangerous nature of this class of medications, the P&T Committee decided that prescriptions for tricyclic antidepressants will be dispensed as nurse administered medications unless the prescriber indicates otherwise. TCAs are non-formulary for psychiatric indications; however, they are available for medical indications.

Policy & Procedure Update

The P&T Committee approved a revised policy for inspecting medication storage areas inside and outside the pharmacy.

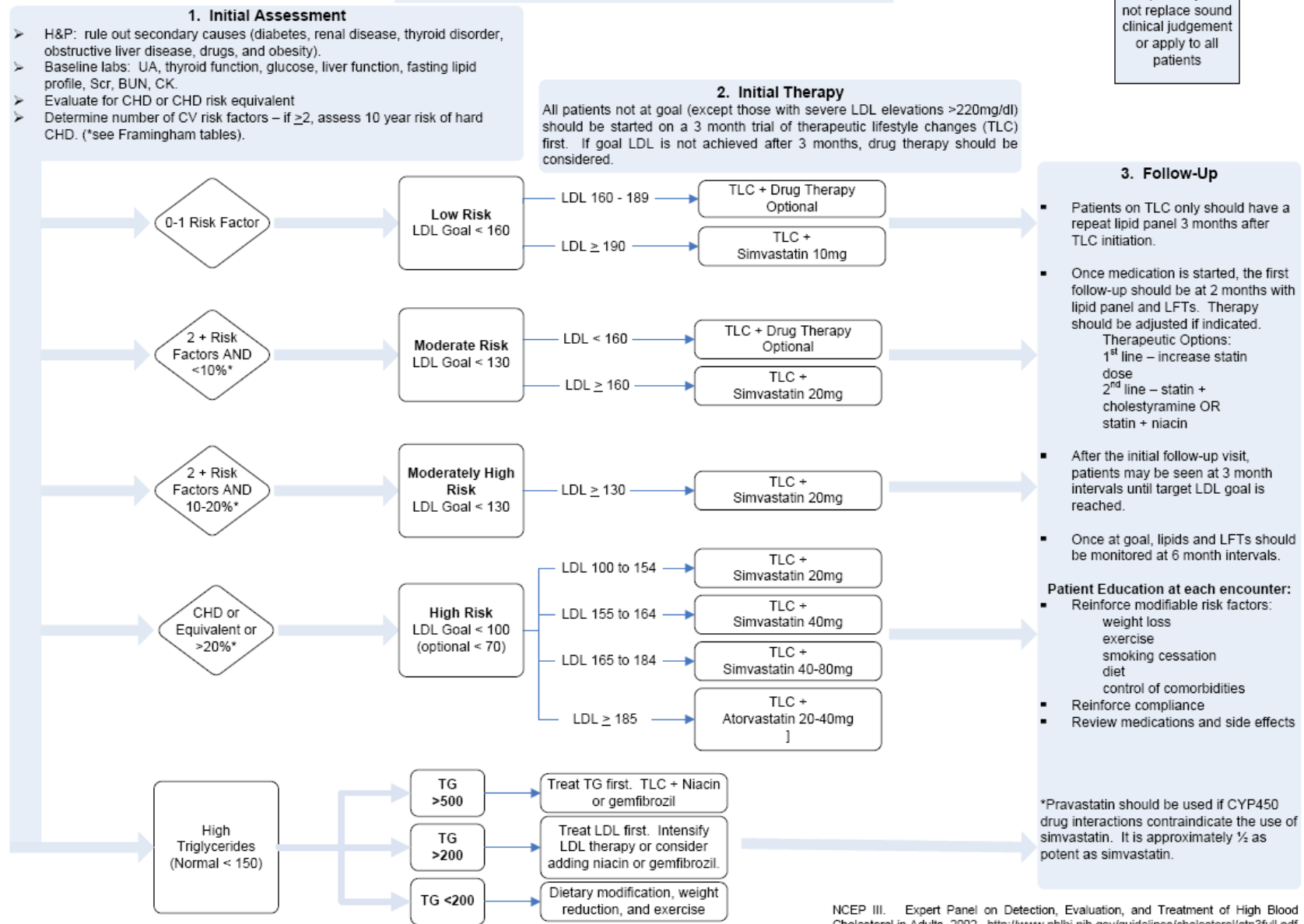
Chapter 25. Inspecting Medication Storage Areas: outlines the policy and process for inspecting all Pharmacy and non-Pharmacy medication storage areas and insuring compliance with regulatory and best practice requirements.

Disease Management Guidelines....

The P&T Committee has approved Disease Management Medication Guidelines for Hyperlipidemia. The following flow diagrams summarize the approved guidelines:

Hyperlipidemia Disease Management Guidelines

HYPERLIPIDEMIA



HYPERLIPIDEMIA QUICK REFERENCE

Achieving Goal LDL Levels

Baseline LDL	130	160	190	220
(Percent Reduction Required to Achieve Goal)				
Goal LDL < 100	23%	38%	47%	55%
Goal LDL < 130		19%	32%	41%
Goal LDL < 160			16%	27%

Adapted from ATP III

Equivalent Statin Dosing

Atrovastatin	Fluvastatin	Lovastatin	Pravastatin	Rosuvastatin	Simvastatin	Vytorin	% LDL ↓
--	40mg	20mg	20mg	--	10mg	--	25-30%
10mg	80mg	40 or 80mg	40mg	--	20mg	--	30-40%
20mg	--	80mg	80mg	5 or 10mg	40mg	--	40-45%
40mg	--	--	--	--	80mg	10/20	45-50%
80mg	--	--	--	20mg	--	10/40	50-55%
--	--	--	--	40mg	--	10/80	> 55%

*Adapted from OSHU HMG-CoA Reductase Inhibitor Class Review

Formulary Lipid Lowering Agents

Drug Class	Dosage Range	Lipid Effects			Side Effects	Contraindications
1. <u>Statins</u>		<u>LDL</u> ↓	<u>HDL</u> ↑	<u>TG</u> ↓	myopathy elevated LFT's	<u>absolute</u> : liver disease <u>relative</u> : certain drugs
pravastatin	10-80mg	20-37%	5%	5-15%		
simvastatin	10-80mg	30-48%	5-10%	10-25%		
atorvastatin	10-80mg	40-55%	5%	15-35%		
2. <u>BAS</u> cholestyramine	4-8gm twice daily	15-30%	3-5%	May ↑	GI upset constipation ↓ drug absorption	<u>absolute</u> : TG >400, biliary obstruction, and dysbetalipoproteinemia <u>relative</u> : TG >200
3. <u>Fibric Acids</u> gemfibrozil	600mg twice daily	5-20%	10-20%	20-50%	GI upset gallstones myopathy	<u>absolute</u> : severe renal, hepatic, or gallbladder disease
4. <u>Niacinic Acids</u> Niacin	500mg-3gm in 2-3 divided doses	5-25%	15-35%	20-50%	flushing hyperglycemia hyperuricemia GI upset hepatotoxicity	<u>absolute</u> : chronic liver disease, severe gout <u>relative</u> : PUD, diabetes, hyperuricemia

Therapeutic Lifestyle Changes (TLC) Major Features

1. Weight Reduction
2. Increased Physical Activity
3. TLC Diet
 - a. Reduced intake of cholesterol-raising nutrients
 - saturated fats <7% total calories
 - dietary cholesterol <200mg per day
 - b. LDL-lowering therapeutic options
 - plant stanols/sterols 2gm per day
 - viscous(soluble) fiber 10-25gm per day

Cardiovascular Risk Factors

1. Cigarette smoking
2. Hypertension
3. HDL < 40 mg/dl
4. Family history of premature CHD in first degree relative
 - Male < 55 yo
 - Female < 65 yo
5. Age (men ≥ 45, women ≥ 55)

*HDL > 60 counts as a negative risk factor

CHD & CHD Risk Equivalents

Coronary Heart Disease (CHD):

- myocardial infarction
- unstable angina
- stable angina
- angioplasty
- bypass surgery
- evidence of myocardial ischemia

CHD Risk Equivalent:

- peripheral arterial disease
- abdominal aortic aneurysm
- carotid artery disease
- diabetes mellitus
- multiple risk factors that incur a 10 year risk of hard CHD > 20%

Framingham Scoring System for Estimating 10-Year Risk of Hard CHD (MI /Death)

Estimate of 10 Year Risk for Men		
<u>Age</u>	<u>Points</u>	
20-34	-9	
35-39	-4	
40-44	0	
45-49	3	
50-54	6	
55-59	8	
60-64	10	
65-69	11	
70-74	12	
75-79	13	
Total Cholesterol		
	<u>Points</u>	
	<u>age 20-39</u>	<u>40-49</u>
	<u>50-59</u>	<u>60-69</u>
	<u>70-79</u>	
<160	0	0
160-199	4	3
200-239	7	5
240-279	9	6
≥280	11	8
HDL (mg/dl)		
	<u>Points</u>	
≥60	-1	
50-59	0	
40-49	1	
<40	2	
Systolic BP (mmHg)		
	<u>If Untreated</u>	<u>If Treated</u>
<120	0	0
120-129	0	1
130-139	1	2
140-159	1	2
≥160	2	3
Point Total	10 Year Risk %	
<0	<1	
0	1	
1	1	
2	1	
3	1	
4	1	
5	2	
6	2	
7	3	
8	4	
9	5	
10	6	
11	8	
12	10	
13	12	
14	16	
15	20	
16	25	
≥17	≥30	
10 Year Risk	____%	

Estimate of 10 Year Risk for Women		
<u>Age</u>	<u>Points</u>	
20-34	-7	
35-39	-3	
40-44	0	
45-49	3	
50-54	6	
55-59	8	
60-64	10	
65-69	12	
70-74	14	
75-79	16	
Total Cholesterol		
	<u>Points</u>	
	<u>age 20-39</u>	<u>40-49</u>
	<u>50-59</u>	<u>60-69</u>
	<u>70-79</u>	
<160	0	0
160-199	4	3
200-239	8	6
240-279	11	8
≥280	13	10
HDL (mg/dl)		
	<u>Points</u>	
≥60	-1	
50-59	0	
40-49	1	
<40	2	
Systolic BP (mmHg)		
	<u>If Untreated</u>	<u>If Treated</u>
<120	0	0
120-129	1	3
130-139	2	4
140-159	3	5
≥160	4	6
Point Total	10 Year Risk %	
<9	<1	
9	1	
10	1	
11	1	
12	1	
13	2	
14	2	
15	3	
16	4	
17	5	
18	6	
19	8	
20	11	
21	14	
22	17	
23	22	
24	27	
≥25	≥30	
10 Year Risk	____%	

Hyperlipidemia Indicators

Patient demographics
Current and previous lipid measures
Blood pressure
Blood sugar
Liver function tests
Comorbidities
Cardiac Risk & History
Current medications and dosing
On low fat/cholesterol diet
Evidence of counseling on lifestyle modifications