



PHARMACY HORIZONS

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The Expectation of Success...



*~Allen Sapp
VP for Correctional Administration
Maxor National Pharmacy Services Corp.*

As one of the newest members of the Maxor leadership team, I want to share my perspective about the changes underway through the CDCR pharmacy improvement project. Over the course of my 28 years in corrections, I have been deeply involved in many important change initiatives. Based on my experience,

I can identify several factors that were common to the success of these ventures. Each of these is present within the CDCR project and bode well for the long-term success of our joint endeavor. These factors include: (1) a clear need for change; (2) a driving force propelling the change forward; (3) endorsement of the change initiative by leadership; (4) a committed and persistent effort to implement the change; and, (5) a constant expectation of success.

Within the CDCR pharmacy program, the need for change has been clearly established. By any measure of quality, cost or service, most reasonable people would agree the program was not performing up to even minimum expectations. Enter the Receivership--clearly a driving force for change. With a clear goal of better patient safety and improved health outcomes, the Receivership has pushed the entire program forward. The *Roadmap to Excellence* clearly delineates the goals and directions for the changes now taking place. The CPR/CDCR leadership team has endorsed those goals and has worked diligently to ensure they are communicated, understood, and supported. The Maxor team, in conjunction with the CPR and CDCR has demonstrated an unparalleled commitment to implementing improved and more accountable processes and has maintained a laser-like focus on achieving results.

While each of the factors above is important to ensuring the ultimate success of our collective efforts, it is the expectation of success that I believe to be most critical. We can succeed if we believe that we will. Our expectations define how we respond to changing circumstances, to evolving technologies, to new challenges, to our coworkers and to our larger organizational allies. If we remove the concept of “can’t” from our vocabulary and replace it with an expectation that together we “can”--we

find ourselves empowered with new levels of creativity, desire and drive. No better example is found than illustrated in the movie, *Apollo 13*, which is based on actual events. When actor Ed Harris, playing NASA Flight Director Gene Kranz, faced with the eminent loss of three astronauts in space, uttered those now famous words: *"Failure is not an option,"* he changed the entire paradigm for the mission. Instead of focusing on what went wrong and who was to blame, the focus shifted to how to get those men home safely. In doing so, new creative solutions were developed, tested and implemented in unbelievably difficult circumstances. The Apollo 13 team had the desire and the drive to succeed.

By adopting a similar expectation of success, we too can achieve our mission of bringing about significant and meaningful change to the CDCR pharmacy program. I know we have a talented and motivated team in place, with a clear goal and a demonstrated commitment to achieving results. And, if we expect success, we can make it happen.



Mary Adams, RN has joined the Maxor/CPR Project team as Nurse Consultant. Mary has more than 35 years of extensive experience in various healthcare setting with 20 years of experience in corrections. She is a welcomed addition to our team and we are delighted to have her.

Jorge Gonzalez has joined the Maxor/CPR Project team as Pharmacy Technologist. Jorge brings in more than 10 years of experience in pharmacy. We are pleased to have him join our team.

New shipmates at the facility level include **Gregory Pryer** (Pharm I), **Jaime Sioson** (Pharm Tech) and **Simone McGee** (Pharm Tech) at DVI; **Min Trinh** (Pharm I) at LAC; **Christine Ayad** (Pharm I) at NKSP; **Steven Chu** (Pharm I); **Reed Mathis** (Pharm I), **Brandi Kirk** (Pharm Tech), **Janelle Abiog** (Pharm Tech), **Rosemary Espinoza** (Pharm Tech) and **Garciela Rodriguez** (Pharm Tech) at SATF; **Shelle Johannsen** (Pharm Tech) at CEN; **Bryan Peters** (Pharm I) at CCWF; **Anh Hoang** (Pharm I) and **Tuesdie Carloni** (PharmTech) at CMF; **Sean Mi** (Pharm I) and **Michael Bujanda** (Pharm Tech) at CIM; **Crystal Alaniz** (Pharm Tech) and **Roshanda Smith** (Pharm Tech) at COR; **Robby Sukhvir** (Pharm Tech) at PVSP; **Dawn Jurewitz**, Pharm I **Sharon Cates** (Pharm I), **Jessica Shepard** (Pharm Tech) and **Dao (Danny) Lee** (Pharm Tech) at CSP-SAC.

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

*Welcome
Aboard...*

Maxor/CPA Pharmacy Program News

CDCR Formulary is now Available on Epocrates...

The CDCR formulary is now available on Epocrates for PDA download free of charge. A desktop version is also available. Both versions may be accessed through the Epocrates website at www.epocrates.com

Guardian Go-live at COR and SATF...

Effective April 7th, 2008, the GuardianRx pharmacy management system has been implemented at COR and SATF. This is the first time 2 facilities went live on Guardian simultaneously. Simultaneous go-live approach will be utilized for adjoining CDCR facilities.



CSP-Corcoran GuardianRx® Implementation Team



SATF GuardianRx® Implementation Team

CDCR Pharmacy & Therapeutics

Committee...

The **CDCR System-wide Pharmacy & Therapeutics (P&T) Committee** met on April 15, 2008. The committee discussed the pharmacy dashboard and several revisions to Pharmacy Policies and Procedures. The Committee approved a new policy for Clozapine therapy, which will be distributed and implemented by Mental Health. In addition, the Committee approved new Disease Medication Management Guidelines for Chronic Obstructive Pulmonary Disease (COPD) and Guidelines addressing Black Box Warnings. Both guidelines have been distributed to CDCR facilities.

Policy & Procedure Update...

CDCR System-wide Pharmacy & Therapeutics (P&T) Committee approved revisions to the following system-wide Pharmacy Policies and Procedures in the April 2008 meeting:

Pharmacy Policy & Procedure Revisions

Chapter 3 – Pharmacy Scope of Service and Supervision

Chapter 6 – After-hours Medication Supply [formerly Drug Night Locker]

Chapter 17 – Ordering, Receiving and Stocking Medications

Chapter 20 – Floor Stock Orders

The revised policies have been distributed to CDCR facilities and should be fully implemented by no later than June 20, 2008.

Disease Medication Management Guidelines...

The P&T Committee has approved Disease Management Medication Guidelines for Chronic Obstructive Pulmonary Disease. The guidelines also include handy patient education material. The following flow diagrams summarize the approved guidelines:

COPD Disease Medication Management Guidelines

This pathway does not replace sound clinical judgment or apply to all patients

COPD (Chronic/NonAcute)

- Establish diagnosis of COPD
- Medical history
 - Exposure history – occupational, environmental and smoking (pack years)
 - Physical Exam
 - Spirometry
 - Chest X-ray

Assess Severity of Disease
(see table 2 on page 2)

MILD Step 1 → Albuterol 2 puffs Q4-6H PRN

MODERATE Step 2 → Continue Albuterol PRN
PLUS
Scheduled Atrovent (ipratropium) 2 puffs QID (Titrate as indicated. Max 4 puffs QID)
Consider scheduled albuterol (+ PRN) with ipratropium prior to next box

Options:
Switch to Serevent (salmeterol) 1 puff BID if no response with Atrovent (ipratropium)
OR
Add Serevent (salmeterol) 1 puff BID if suboptimal response with Atrovent (ipratropium)
[Albuterol should be continued PRN when used with Serevent]

SEVERE Step 3 → ADD*
Asmanex (mometasone) 1 puff QHS (avg dose 1-3 puffs/day)
[A trial of 6-8 weeks is sufficient to determine effects on breathlessness but it may take 6 months to see a reduction in exacerbations]
*May consider NF request for trial of Spiriva (tiotropium) before adding ICS. Tiotropium is not allowed KOP.

VERY SEVERE Step 4 → Consider referral to specialist, accesibility of long term oxygen & pulmonary rehabilitation.

COPD	
Goals of Therapy	
<ul style="list-style-type: none"> • Reduce risk factors (stop smoking) • Decrease symptoms • Decrease exacerbations • Decrease dyspnea that limits activity • Improve quality of life • Prevent COPD related complications • Control co-morbidities that may complicate COPD 	
Referral Criteria	
<ul style="list-style-type: none"> • Disease onset at age <40 yrs • Frequent exacerbations (two or more per year) despite adequate treatment • Rapidly progressive course of disease • Severe COPD (FEV1 <50% predicted) despite optimal treatment • Need for oxygen therapy • Onset of related comorbid illness (osteoporosis, heart failure, bronchiectasis, lung cancer) 	
Patient Education Component	
<ul style="list-style-type: none"> • Information about the nature of COPD • Instruction on how to use inhalers and other treatments • Recognition and treatment of exacerbations • Strategies for minimizing dyspnea 	
Vaccinations	
<ul style="list-style-type: none"> • Annual Influenza vaccine strongly recommended • Pneumococcal vaccine as indicated (patients ≥ 65 yo or < 65 with severe COPD) 	
Combining Inhalers	
<ul style="list-style-type: none"> • When to use combination therapy instead of monotherapy has not been clearly established. • Short acting and long acting anticholinergics should not be combined (Spiriva / Atrovent / Combivent) 	

Approved by the CDCR P&T Committee April 2008
Adapted from GOLD, ATS/ERS, ACP, Chest, and ICSI Guidelines

COPD

Table 1: Differentiating COPD from Asthma

	Asthma	COPD
Onset	Early in life (often childhood)	Mid-Life
Symptoms	Vary from day to day Symptoms at night/early morning are common	Slowly progressive Dyspnea during exercise progressing to persistent breathlessness Chronic cough Chronic sputum production
History	Family history of asthma Allergy, rhinitis and/or eczema	History of tobacco smoking
Airflow Limitation	Largely reversible	Largely irreversible

Table 2: Classification of COPD Severity Based on Post-Bronchodilator FEV₁ and Dyspnea

Severity	Post Bronchodilator FEV ₁ /FVC	FEV ₁ % Predicted	Degree of Breathlessness
Stage I Mild	< 0.7	≥ 80%	Troubled by shortness of breath when hurrying or walking up a slight hill
Stage II Moderate	< 0.7	50-79%	Walks slower than people of the same age due to breathlessness or has to stop for breath when walking at own pace on the level
Stage III Severe	< 0.7	30-49%	Stops for breath after walking approximately 100 meters or after a few minutes on the level
Stage IV Very Severe	< 0.7	< 30% or < 50% plus chronic respiratory failure	Too breathless to leave the house or breathless when dressing or undressing

FEV₁: forced expiratory volume in one second; FVC: forced vital capacity
Adapted from 2004 ATS/ERS and Modified Medical Research Council (MMRC) Dyspnea Scale (Bestall et al., 1999)

Table 3: Example Assessment of Pharmacologic Therapy

- What medications do you currently take, how much and how often?
- How much can you do before you get short of breath? (Use an everyday example, such as walking up flights of stairs, up a hill, or on flat ground.)
- Has your breathlessness worsened, improved, or stayed the same since your last visit?
- Have you had to reduce your activities because of your breathing or any other symptom?
- Can you do some things now that you couldn't do before or do some things faster than before?
- Do you get less breathless when doing things you did before?
- Have you experienced any new symptoms since your last visit?
- Has your sleep been disrupted by breathlessness or other chest symptoms?
- Since your last visit, have you had any unscheduled medical visits for your COPD?
- In your opinion, is your treatment ineffective, satisfactory, effective, or very effective?

COPD Indicators

Demographics

Age

Race

Gender

Weight

Renal / Hepatic Impairment

Co-Morbidities

Current medications

Previous Medication Regimens

Compliance

Adverse Drug Effects

Drug Interactions

Monitoring

Disease severity noted

Frequency of symptoms assessed

Response to therapy

ER visits in past 12 months

Nebulizer treatments in past 3 months

Unscheduled clinic visits in past 3 months

Oral steroid use in past 3 months

Patient education on risk factors and inhaler use noted

Annual Influenza vaccine given

Pneumococcal vaccine given

COPD REFERENCES

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