Pharmacy's Roadmap to the Future

Want to know where the VUH Department of Pharmaceutical Services is headed in the future? Take a look at our departmental Strategic Plan which can be found on the Departmental website at the following address: https://www.mc.vanderbilt.edu/pharmacy/web/documents/strategicplan09.pdf This plan outlines the direction for Pharmacy for the 2009 to 2013 time period and is intended to serve as a roadmap for the achievement of Pharmacy’s Mission and Vision which are as follows:

**Departmental Vision**: To establish a model of Pharmacy practice that is universally recognized as the leader in the delivery of innovative institutional Pharmacy practice and in the provision of contemporary Pharmaceutical Care.

**Departmental Mission**: To provide optimal medication use to facilitate exceptional patient centered care, education and research. We do this using the best people, the best business practices and state of the art technology and facilities.

Our Strategic Plan focuses on 6 strategies:

1. We will be recognized as a national leader in safe medication practices
2. We will implement practices which ensure the best use of medication
3. We will be nationally recognized as a Pharmacy employer of choice.
4. We will provide outstanding service to internal and external customers.
5. We will demonstrate stewardship and support the financial viability of VMC and its mission
6. We will support the growth of the VMC enterprise.

Each of these strategies is grouped under a VMC Pillar Goal and are associated with metrics to allow for monitoring progress. I would like to highlight a current initiative focused on improving and redesigning the medication use process to advance patient safety, health related outcomes, and prudent use of human resources and efficiency. This initiative modifies the role of our satellite pharmacy operation and centralizes some distributive services while moving more clinical services to a unit based model. We believe this initiative will enhance our ability to deliver safer and more efficient services. Thanks to all of you that will be participating in the rollout of this important initiative.

Please keep in mind that our Strategic Plan is a living document, subject to updates to stay in sync with VMC objectives. With changes in healthcare on the national level, there will most likely be changes at VMC. As always, we welcome your input, either by email, phone, or thru the Pharmacy website at www.vanderbiltpharmacy.com.
In February, ASHP convened a Practice Model Summit Advisory committee of expert practitioners to advance the Hospital Pharmacy practice model. Planning for this process started at an April 2008 meeting of the ASHP board. The following objectives were identified for development.

1. Create a pharmacy practice model that ensures safe, effective, efficient accountable and evidence-based care for all health system patients.

2. Determine patient care-related services that should consistently be provided by pharmacy and increase demand for pharmacy services by patients, healthcare professionals, healthcare executives and payers.

3. Identify the available technologies that should be leveraged to support implementation of the practice model and the emerging technologies that could impact the model.

4. Support the optimal utilization and deployment of health system pharmacy resources through development of a practice model that is operational, practical, and measurable.

5. Identify specific actions for pharmacy staff and leaders to take to implement practice model change, including identification of needed staff, skills development, and competencies.

In his April editorial, Bill Zelmer wrote of a need for “better ways” in hospital pharmacy. Tackling the practice model challenge to help health system pharmacists build the optimum model in their practice setting will be a top ASHP priority. Two urgent issues should be considered, achieving unfinished medication safety goals, and addressing the discontinuity of pharmaceutical care in a highly fragmented health care delivery system.

In his June editorial in AJHP, Paul Pierpaoli highlighted a need to creatively use our intellectual capital in hospital pharmacy. Pharmacy production supporting the core of the medication use process, must be balanced with planning for the best deployment of pharmacy’s intellectual capital. Mark Woods highlighted the challenge of Practice Model change in his July editorial on the topic in AJHP, stating “there is no topic of greater importance to our profession.” He defined the three primary models in practice; Drug distribution-centered, Clinical Pharmacist centered, and Patient-centered integrated model. “The current economic and political environments make meaningful health care reform more likely than any time in recent memory”, thus the need for pharmacy to be positioned to meet the first objective above is both critical and timely.

**Coping with Change**  
*By Mariah Coe, PhD, CPhT*

We love positive change in our lives — having a baby or getting a promotion; etc. And we adapt to negative changes — the current economic recession, illness of a family member, somebody scraping your car door and ruining the paint job. It’s all change . . . We usually prefer change when (1) it’s our idea, and (2) when we know what to expect. But even if change is externally imposed (someone else’s idea), we can still control how we think about things to better cope with fluid situations — even if we’re already doing a great job of adjusting to change!

**Feeling competent (“in control”) during change:** Most people want to feel in control — and we feel more competent when life and work are stable and predictable (when we know what, when, and how to do things in all realms of life — from making a morphine PCA, to remembering your anniversary every August. We feel better about ourselves when we move through life and work with some degree of certainty and habit. But change, any change, involves learning something new, however small . . . . Our brains/bodies need time to learn new habits. Modern psychology is increasingly "neuropsychology" — and research on how our brains adjust to new information shows that any new habit, including the brain’s message to "reach out and flip light switch on the wall in the dark", takes time (about 3 weeks, on average, for something to be well-encoded). So when something changes at work, for example, it can feel a little threatening to our confidence/competence to have to stop and think for a second about the new procedure — but, again, it’s normal to feel that way for awhile.

Remember this: How you feel (e.g. a little awkward or uncomfortable doing a new task) may not affect your competence at all — you’re probably doing a great job adjusting your behavior to the new system. It just takes a short while for it to feel automatic and easy — like learning the location of the light switch or how to comb that new haircut to best advantage!

**Next month—How to know what to expect during change.**

About the author: Dr. Coe is a health and child clinical psychologist (licensure in progress) who enjoys “translating” the latest in neuroscience and health psychology research into plain English so that people can use the concepts to improve their daily lives.
Staff News - Events - Transitions

Credo Corner – Shelia Martin—Central Pharmacy

A patient in S 7400 benefited from Shelia’s help this month. The patient had an acute metabolic magnesium disorder which required home infusion of magnesium, 9.9gm in 50ml of D5W. When the orders for “a pharmacy miscellaneous infusion of magnesium, use patient’s home supply”, came thru the central pharmacy, Shelia immediately recognized an opportunity for pharmacist involvement. She checked with her central colleagues to make sure the work flow was covered, then went to the Round Wing to see the patient.

After introductions had been made, the patient, who was also a healthcare professional, worked with Shelia to provide the needed information that would allow her to receive the appropriate treatment. Shelia contacted the home infusion pharmacy to confirm the preparation that the patient had been receiving as well as the resident and attending physician to update the orders that would allow the patient to be safely converted to medications provided by the central pharmacy sterile products area. Finally, she enlisted Matt Marshall, to assist with the order entry of this non standard regimen. The entire process added 2 hours to her day, but the patient and medical team were definitely appreciative of Shelia’s efforts.

Transitions

Mackenzie Brown, (on the right in the adjacent photo) with Beth Slusher, her trainer, joins us this month as a Pharmacy Technician. Mackenzie is a student at the Belmont School of Pharmacy. Morgan Walker, is a new central pharmacy technician and she recently relocated to Nashville from Iowa. Doug Perry is a new central pharmacy technician with previous experience in retail pharmacy. Cecilia Faggioi is a new Central pharmacy technician who

Nashville from Erie, PA. She has previous experience in hospital and manufacturing pharmacy practice.

Cecilia has worked with Public Health in the US, and manufacturing in El Salvador. Valliene Kirby, central pharmacy technician has previous experience in retail pharmacy practice. Sharon Adams will be returning to the Central Pharmacy night shift the first week in August. Amanda Burgess has been promoted to Pharmacy Technician Advanced in the Central Pharmacy.

We bid adieu to the VUH 2008 Residency Class this month. Zac Cox is taking a position at Lipscomb College of Pharmacy as a professor of Internal Medicine. Alyson Gibson is moving to Univ. of Maryland to take a Clinical Pharmacist position. Sherry Peryam is moving to Wyoming. Christine Tseng is moving back to Chicago to take a Transplant position at Northwestern University. Ashley Quintili will be remaining at VMC in the PGY2 Critical Care residency.

We appreciate their efforts and accomplishments during their time in Nashville and wish them well during this transition!

Geri Foster—Service Awards

June 18th was Geri’s 30th anniversary at VUMC. She participated in the transition to VUH from MCN, the implementation of the first pharmacy computer system at VUH, the transition from bulk dispensing of a 3 day supply of medications to the unit dose system, supported the early Peds pharmacy, was the manager of the first oncology pharmacy, as well as the IV program, and provided an excellent foundation for compounding services. She has served as a pharmacy representative on the IRB and currently serves as a pharmacist in the IDS pharmacy. Please join us in congratulating Geri on this milestone and thank her for her many contributions to the care of Vanderbilt patients.
Pharmacy Fast Facts -

By Christine Tseng, Pharm.D

The FDA has recently approved everolimus (Afinitor®); Novartis Pharmaceuticals) on March 30, 2009 for the treatment of advanced renal cell carcinoma (RCC) refractory to treatment with sunitinib (Sutent®) or sorafenib (Nexavar®). It works as a proliferation signal inhibitor.

It binds to a cytosolic immunophyllin (FKBP-12) to inhibit the mammalian target of rapamycin (mTOR) kinase activity, which becomes dysregulated in certain types of human cancers.

It reduces the activity of S6 ribosomal protein kinase and eukaryotic elongation factor 4E-binding protein, inhibits the expression of hypoxia-inducible factor, and reduces the expression vascular endothelial growth factor.

Dosage and administration:

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<td>Standard* 10 mg PO daily</td>
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<td>Moderate hepatic impairment (Child-Pugh class B)* 5 mg PO daily</td>
<td>With or without food</td>
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<td>Severe or intolerable adverse reactions 5 mg PO daily</td>
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^ Concomitant strong CYP 3A4 inducers, may increase by 5 mg increments up to 20 mg PO daily
* Everolimus has not been evaluated in patients with severe hepatic impairment (Child-Pugh Class C)

Warnings and precautions:
Non-infectious pneumonitis (14%) is a class effect of rapamycin derivatives. Fatalities have been observed.

Discontinue everolimus for moderate or severe symptoms; restart at 5 mg when clinically appropriate.

Immunosuppressive properties may predispose patients to opportunistic infections.

Discontinue everolimus if a diagnosis of invasive systemic fungal infection is made; start antifungal therapy.

Most common adverse reactions:
Stomatitis (44%), infections (37%), fatigue (31%), cough (30%), and diarrhea (30%).
Leading to treatment discontinuation: pneumonitis and dyspnea.

Monitoring parameters:
Baseline labs including serum creatinine, BUN, glucose, lipid panel, and complete blood count should be obtained and then periodically thereafter.

Formulary Status: This drug is not currently formulary at VMC