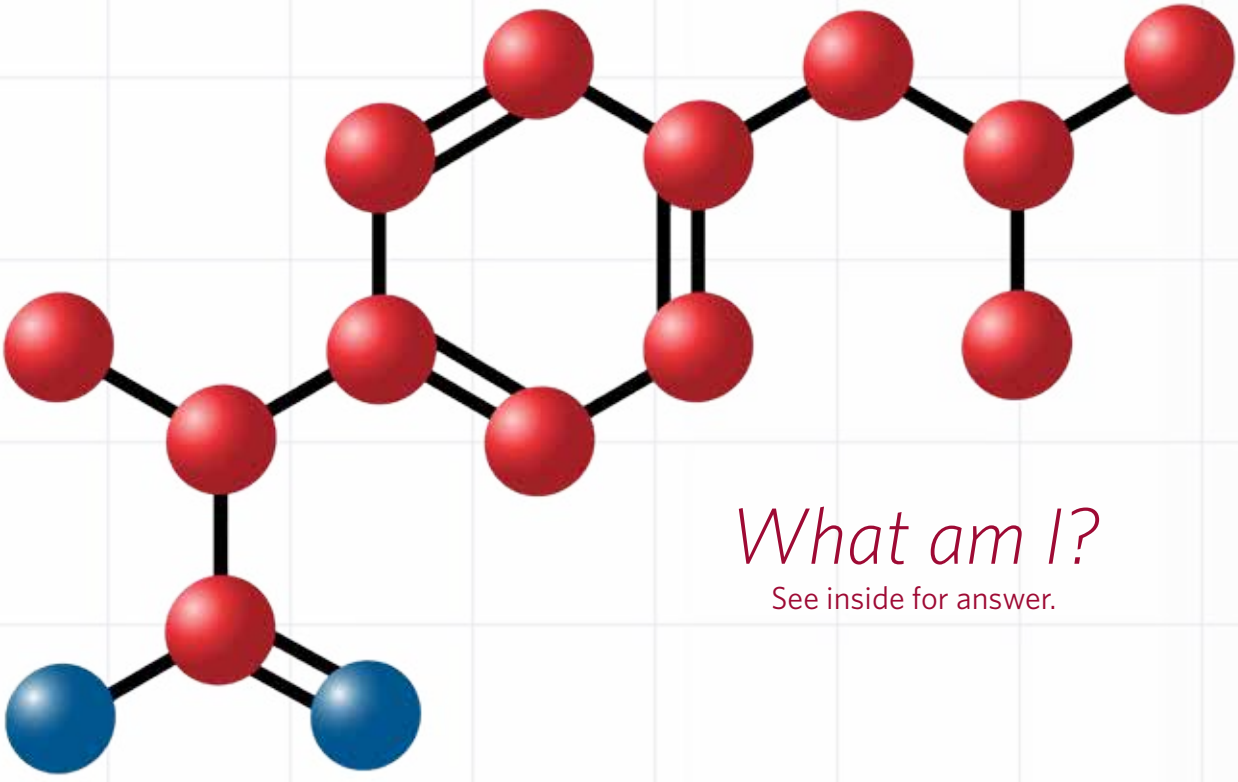
The Journal of the Georgia Pharmacy Association

Georgia Pharmacy®

October/November 2021



What am I?

See inside for answer.

Pain Management

FIRST, ONLY, DIFFERENT: HOSPITAL PHARMACY-LED ACUTE PAIN MANAGEMENT AND OPIOID STEWARDSHIP SERVICE

BEYOND OPIOIDS: OPTIMIZING NON-OPIOID PHARMACOTHERAPY FOR PAIN MANAGEMENT

NASIDS: THE GOOD, BAD, AND THE UGLY

HOSPICE: PAIN MANAGEMENT

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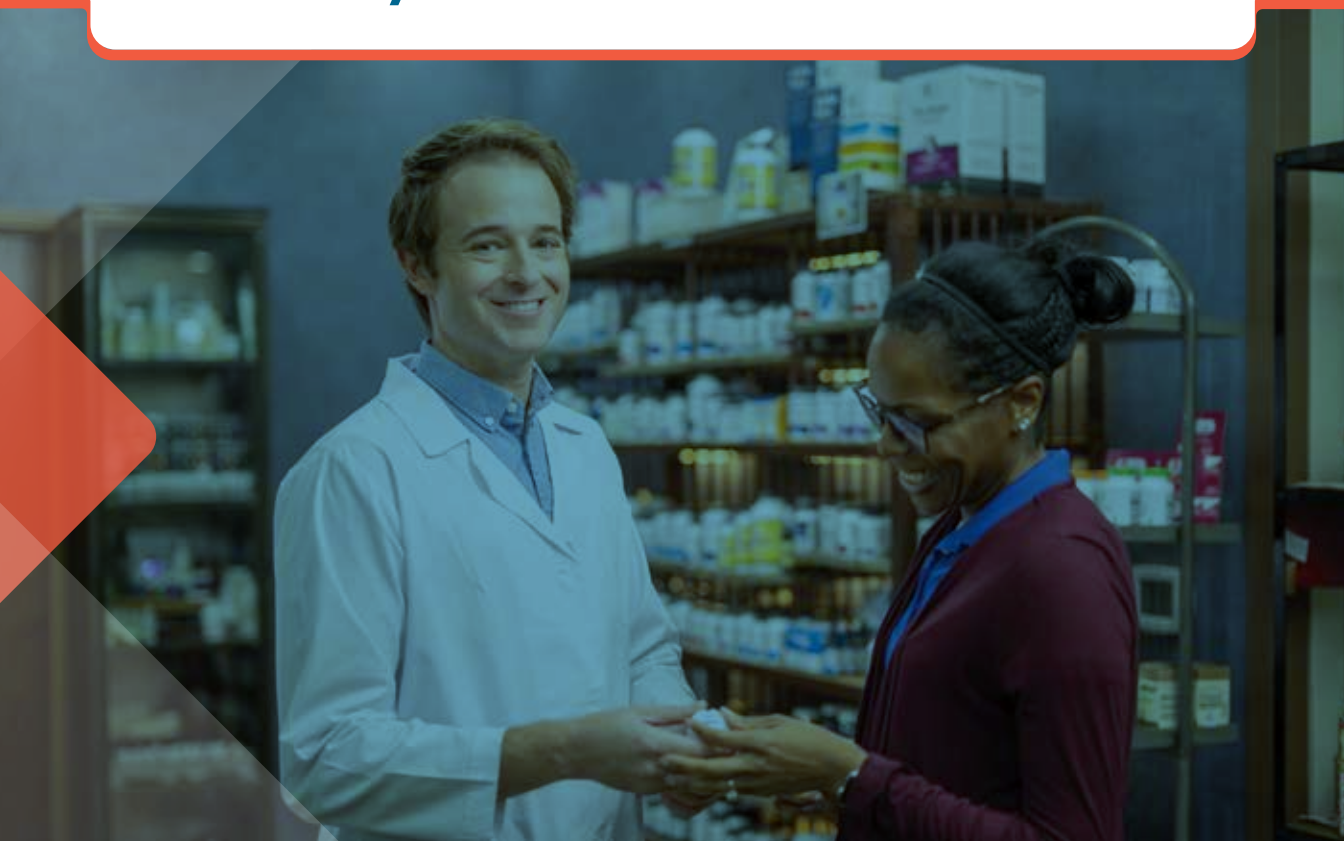

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The Journal of the Georgia Pharmacy Association

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From the CEO

Stop the Insanity!

BOB COLEMAN

One of the dangers of writing the Prescript is by the time you read it, facts, situations, and events may have changed. In fact, you'll be reading this approximately six weeks after it was written, so bear with me as I report the situation as it was in early August.

- In Florida, Governor DeSantis said that the state board of education could move to withhold the salaries of superintendents and school board members who disregard the governor's executive order that effectively prohibits mask mandates in school districts. This said, as 94,000 new cases, a 15% increase over the previous week of children with Covid-19, were being reported nationwide. DeSantis cited one of his priorities was to protect parent rights.
- 18,764 Georgians have perished due to Covid-19. Twelve of them were children. Nationwide, the seven-day average of daily Covid-19 cases has risen to 108,624 or an increase of 106% over the previous seven-day average.
- The New York Times reported that only 18% of eligible public-school students in Atlanta were vaccinated.
- Only 39% of Georgians were vaccinated as new cases of Covid-19 averaged over 4,000 a day in the state.
- According to the AJC, Nationwide, one in four hospital workers that have direct contact with patients, are not vaccinated and that number falls to one in three, if the nation's largest health care providers are considered.
- According to Neal Pruitt, CEO of Georgia based Pruitt Healthcare, as quoted in the AJC, "Low vaccination rates are fueling the current wave of Covid-19 our country is experiencing and we must trust in the science that was developed to protect us."

"IT'S TIME TO QUIT ARGUING OVER THE MERITS OF BEING VACCINATED OR NOT. **THOSE DAYS HAVE PASSED."**

Well, said Neal. It's time to quit arguing over the merits of being vaccinated or not. Those days have passed. Or, sticking magnets on arms to prove that the vaccine somehow makes a person magnetic. To use my grandchildren's terms, "it's silly."

And while we're at it, let's start using the correct grammar when referring to masks. It's not "the" mask, but "a" mask. "The" mask is a term the media and the politicians use to divide and scare us. "The mask" carries lots of political baggage, both left and right. "A mask" helps us protect ourselves and others from spreading a deadly disease. It's a piece of cloth, nothing more.

As healthcare providers, I don't have to tell you that you are on the forefront of fighting this virus. You've been there, done that, and will continue to do so in the future. Thank you!

But, if you haven't done so, reach out to your community. Vaccine hesitancy is not going to be overcome by pronouncements from the CDC, FDA or POTUS. People are going to listen to people they trust. That's you.

Our best chance to beat this virus is to overcome fear and misperception with education. Something, pharmacists do best. At the beginning of August, Scott Gottlieb, former head of the FDA predicted the wave we experienced in August might be the final wave. As you read this sometime in October, I hope and pray he was right.

Bob Coleman is Chief Executive Officer of the Georgia Pharmacy Association.

WELCOME NEW MEMBERS

By Mary Ritchie, GPhA Director of Membership

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Naghmeh Heshmat, Marietta
Rachel Hite, Baconton
Amber Smith, Kennesaw

AIP-Academy of Independent Pharmacists
Shana Sullivan, Leesburg

PRESIDENT'S CIRCLE 2020-2021

These are the newest members of GPhA's President's Circle — people who recruit their fellow pharmacists, technicians, academics, and others to become part of the association. Recruit a member and join!

Amand Daniels, Ellenwood
Ken DeLay, Millen
Christina Green, Atlanta
Thomas Sherrer, Marietta
Andrew Wilson, Alpharetta

YOUR WORD IS POWERFUL.

TELL A FRIEND ABOUT GPHA.

CALENDAR

OCTOBER

October 3
Pharmacy-based Point-of-Care Testing Certificate Program

October 3
Georgia Pharmacy Day at the Braves

October 15-17
Leadership GPhA

October 16
GPhA's Immunization Training for Pharmacy Techs

October 24
AIP Fall Meeting

October 28
Fall Virtual Medicaid Fair

FALL REGION MEETINGS

Region 5
Thursday, October 21

Regions 2 & 7
Tuesday, October 26

Regions 8 & 9
Wednesday, October 27

Regions 10 & 12
Thursday, October 28

Regions 1 & 3
Tuesday, November 9

Region 11
Wednesday, November 10

Regions 4 & 6
Thursday, November 11

DECEMBER

December 5
APhA's Pharmacy-Based Immunization Delivery: A Certificate Program for Pharmacists

SAVE THE DATE

FALL VIRTUAL MEDICAID FAIR

The Department of Community Health (DCH) and Gainwell Technologies encourage you to save the date for our Fall Virtual Medicaid Fair!

THURSDAY, OCTOBER 28, 2021

The Virtual Medicaid Fair will offer important updates on emergent issues by DCH leadership and several break-out sessions covering a variety of topics.

PHARMPAC 2021

INVESTING IN PHARMPAC IS INVESTING IN YOUR PRACTICE.

The following pharmacists, pharmacy technicians, students,and others have joined GPhA's PharmPAC for the 2021 calendar year.

The contribution levels are based on investment through July 31, 2021.

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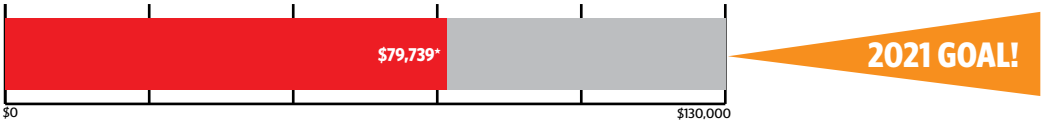
Help us reach our goal for 2021. Visit GPhA.org/PharmPAC to find out more.



*As of July 31, 2021

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Georgia Pharmacy Association

OPIOID STEWARDSHIP

FIRST, ONLY, DIFFERENT: Hospital Pharmacy-led Acute Pain Management and Opioid Stewardship Service

BY JASMINE JONES, PharmD, BCGP, Clinical Pharmacist - Pain Specialist, Wellstar Kennestone Hospital, Marietta, Georgia

Jasmine Jones, PharmD, BCGP, graduated from Florida A&M University in Tallahassee, Florida in 2002 and started her career in a non-traditional managed care and ambulatory care pharmacy residency at Henry Ford Health System in Detroit, Michigan. She had a passion to improve access to and increase compliance with medication therapy for elderly and vulnerable populations. After residency she managed a hospital retail pharmacy and then became one of the first hybrid clinical/staff pharmacists at the University of Michigan Hospital (UMH) in Ann Arbor. Her zest for patient-centered care led to her co-developing U of M's first transitional care pharmacy service which included discharge patient counseling and post-discharge follow-up phone calls. After moving from Michigan to Georgia in 2008, she decided to forgo a position offered to her at an acute care hospital for the opportunity to practice pharmacy with a deep purpose and compassion as a palliative care consultant pharmacist, with HospiScript Services, now known as Optum Pharmacy Services. As a consultant pharmacist, she expanded her skills and knowledge related to the management of end-of-life symptoms and pain. In 2014, she embarked on an adventure to be the FIRST, ONLY and purposefully DIFFERENT clinical pharmacy specialist dedicated to acute pain management and opioid stewardship in the Wellstar Health System. Her practice continues to be based at Wellstar's largest acute care hospital, Kennestone Regional Medical Center (KRMC) located in Marietta, GA, a northern suburb of Atlanta. KRMC is a 633-bed facility, including more than 85 critical care beds. The Level II Trauma Center features a new, state-of-the-art emergency department, comprehensive stroke center, and certified comprehensive cardiac center.

DARE TO MAKE A DIFFERENCE

The journey to building a purposefully different clinical pharmacy service began with the goal to support medical teams in providing safe and effective pain management by improving patient experiences, reducing discomfort, and increasing inpatient safety by mitigating and avoiding analgesic medication adverse events, particularly opioid-related events. Over the last four years, a new purpose has emerged to reduce harm and risk for opioid overuse in patients discharged from the hospital, who were exposed to unnecessary opioid treatment during hospitalization. A tall order for one person to fill.

Initially, I focused on post-operative pain management for spine and joint surgery patients. My objectives were quickly recognized, and my consultation was requested for additional patients. The Clinical Pharmacy Pain Specialist (CPPS) team was expanded and now includes two additional pharmacy specialists. The second full-time pharmacist, Danny Basri, PharmD, BCPS, completed PGY1 pharmacy practice and PGY2 pain and palliative care pharmacy residencies. The third pharmacist, Arielle Spurley, PharmD, BCPS, is part time. She completed a PGY1 pharmacy practice residency with an acute pain management rotation and additional study through the American Society of Health-System Pharmacists (ASHP) Pain Management Traineeship Program. Together this team has over 15 years of specialized pain, palliative care, and opioid stewardship experience. The CPPS services are available Monday

THE CLINICAL PHARMACY PAIN SPECIALIST (CPPS) TEAM

Danny Basri, PharmD, BCPS, Clinical Pharmacy Pain Specialist, Wellstar Kennestone Hospital

Amy W Behimer, PharmD, BCPS, Clinical Pharmacy Manager, Wellstar Kennestone Hospital

Kendra Ford, PharmD, PGY1 Pharmacy Resident, Wellstar Kennestone Hospital

Jasmine Jones, PharmD, BCGP, Clinical Pharmacy Pain Specialist, Wellstar Kennestone Hospital

Arielle Spurley, PharmD, BCPS, Clinical Pharmacy Pain Specialist, Wellstar Kennestone Hospital

through Friday, 8:00am – 4:00pm. Complex pain management consults may be requested by the provider or nurse and are sometimes suggested by the staff pharmacist verifying orders or by the clinical pharmacist rounding on the unit. Prospective high-risk opioid therapy review occurs based on the criteria developed by the CPPS team.

ENHANCE PATIENT SATISFACTION AND COMFORT

The CPPS team co-manages patients with complex pain due to persistent pain syndromes, advanced illness, and/or substance abuse. An example of a persistent pain syndrome is sickle cell vaso-occlusive crisis (VOC). VOC may be triggered by many factors including hypoxia, dehydration, and extreme temperatures both cold and hot. Once the vaso-occlusive process begins rapid hemolysis and deformation of the red blood cells occurs. The deformed red blood cells become stuck in the blood vessels leading to ischemic pain that is generalized throughout the body. We partnered with a hospital physician and a clinical nurse specialist to develop a clinical pathway to standardize management for patients who present to the emergency department with VOC.

The pathway includes an order set with suggested medications, non-pharmacologic therapies, and a default consult for the CPPS. The order set has a link embedded that directs the provider to a supplemental guidance document with detailed evidence-based recommendations for ordering and managing opioids for this patient population. The recommendations are aligned with National Heart Lung and Blood Institute and American Society of Hematology guidelines and emphasize ordering scheduled parenteral opioid therapy upon admission. A recent evaluation of the sickle cell pathway, completed by Kendra Ford, PharmD, Kennestone PGY1 pharmacy resident, demonstrated when the pharmacy pain specialist was consulted, patients were more likely to receive scheduled parenteral opioid therapy within the first 24 hours of admission.

INCREASE PATIENT SAFETY

The CPPS split their time to perform daily prospective review of high-risk opioid therapies for adult, hospitalized patients, and retrospective review of all naloxone administration events in non-procedural areas outside the emergency department. The CPPS generate daily trigger lists in the electronic health record platform (Epic) to quickly screen high-risk opioid orders and medication profiles for patients with risk factors for opioid related adverse events. These are referred to as "trigger reports." The trigger reports include parenteral and oral morphine ordered for patients with impaired renal function, parenteral hydromorphone, parenteral and oral methadone, fentanyl transdermal patches, and opioid intravenous patient-controlled analgesia (IV PCA). A sixth report is run to identify patients with unique risk factors who are also prescribed opioids. Those patient risk factors include ob-

"The CPPS team's objectives are being achieved and having an impact. Between June 15, 2020, and June 14, 2021, accepted CPPS interventions were associated with an estimated indirect cost-avoidance of $3,570,865."

—Jasmine Jones, PharmD, BCGP

structive sleep apnea, acute or chronic respiratory failure, chronic obstructive lung disease, or severe kidney disease. The CPPS developed the trigger lists by identifying high risk opioid regimens and patient risk factors in opioid safety literature and retrospective naloxone administration event case reviews. CPPS identify opportunities to modify analgesic regimens including the addition of non-opioid analgesics, renally dosing analgesics and recommending alternative therapeutics.

REDUCE OPIOID-RELATED HARM

On the opioid harm reduction front, I lead several clinical initiatives. One is the participation in Johns Hopkins' national collaborative, www.solvethecrisis.org, which aims to reduce unnecessary exposure to opioids after surgery. I collaborated with Wellstar IT analysts to revise discharge prescription order panels to include non-opioid analgesics and reduce the default quantity of opioid tablets prescribed. I also lead a workgroup to deploy an opioid risk predictive model and naloxone co-prescribing best practice advisory in Epic. The model will predict which patients are at high risk for experiencing an opioid-related adverse event or for developing opioid use disorder. The provider on discharge will be alerted and given a suggestion to co-prescribe a naloxone emergency kit.

MEASURE IMPACT

The CPPS team's objectives are being achieved and having an impact. Between June 15, 2020, and June 14, 2021, accepted CPPS interventions were associated with an estimated indirect cost-avoidance of $3,570,865. This figure is based on 2,544 interventions for which there is an associated cost-avoidance and excludes 3,318 interventions for which a cost-avoidance value was not found in the literature. The most frequent intervention types were dose or frequency adjustment for uncontrolled pain (372/2544; 14.6%), medication adjustment for renal or hepatic impairment (369/2544; 14.5%) and recommendation for non-opioid medication adjunctive to current regimen (361/2544; 14.2%). The impact of the opioid harm reduction project will be evaluated in 2022.

IMPROVE AND INNOVATE

The CPPS team continues to seek opportunities for leveraging technology to improve opioid prescribing and monitoring. I am the chairperson for KRMC's pain management and opioid stewardship quality improvement (QI) committee and a member of Wellstar's system-wide opioid safety steering committee. These interdisciplinary committees develop and support QI projects that drive practice changes and make prescribing and administering opioids easier and safer in the hospital. The QI committees facilitated the implementation of an opioid risk assessment tool and opioid sedation assessment scale. The integration of these tools has empowered nurses and improved interdisciplinary communication relating to patient risk and opioid tolerance. Future endeavors include expanding CPPS support to the inpatient and outpatient palliative care medical teams and establishing a PGY2 pain and palliative care pharmacy residency.

The CPPS team is a clinical pharmacy consult service under the purview of the Pharmacy Department. KRMC's inpatient clinical pharmacy service line is managed by Amy Behimer, PharmD, BCPS, Clinical Pharmacy Manager, and includes 30 pharmacists who participate in specialized clinical pharmacy services including infectious diseases, cardiology, critical care, emergency department, pediatrics, nutrition support and internal medicine. For more information on this service please contact Jasmine Jones, PharmD, BCGP, jasmine.jones@wellstar.org or Amy Behimer, PharmD, BCPS, amy.behimer@wellstar.org.

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BEYOND OPIOIDS: Optimizing Non-Opioid Pharmacotherapy for Pain Management

BY DANNY BASRI, PharmD, BCPS, Clinical Pharmacist - Pain Specialist, Wellstar Kennestone Hospital, Marietta, Georgia

The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—has resulted in over a half million deaths since 1990. The opioid epidemic is a serious national crisis that affects public health as well as social and economic welfare. Data released by the National Center for Health Statistics on July 14, 2021, show a steep rise in overdose deaths.[1] Between December 2019 and December 2020—a peak of the pandemic in the USA—more than 93,000 Americans died from drug overdoses (approximately one overdose death every six minutes), up 29.4% over the previous 12 months. These staggering numbers highlight a need to re-examine the opioid crisis response.

A wide range of medications are used to manage pain resulting from inflammation in response to tissue damage, toxins, and pathogens (nociceptive pain) and nerve damage or dysfunction (neuropathic pain). In recent years, several pain management guidelines recommend use of non-pharmacologic and non-opioids as first line treatments and to reserve opioids as second- and third line treatments.[2-4] The risks associated with opioid use, including the potential for dependence and overdose, have led providers to consider non-opioid analgesics, as well as non-pharmacologic alternatives such as cognitive behavioral and exercise therapy. It is particularly important for a pharmacist to understand the pharmacology of analgesics, be able to recognize analgesic-related side effects, recommend appropriate doses, and identify inappropriate use of analgesics based upon a patient's co-morbidities.

Non-opioid analgesics include a variety of agents with varying mechanism of actions that are indicated for a number of pain conditions. These include non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, various adjunctive neuropathic agents including tricyclic antidepressants (TCAs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and gabapentinoids, skeletal muscle relaxants, and topical analgesics.[4] A summary of non-opioid analgesics, label and off-label clinical indications and relevant side effects and risks is described in Table 1 and their mechanisms of action are described below.

Acetaminophen has anti-pyretic and analgesic properties. Acetaminophen is thought to reduce the levels of prostaglandins in the hypothalamus by acting to inhibit the cyclo-oxygenase (COX) 3 enzyme, which is present in the brain and spinal cord.[5] It does not interfere with COX 2 enzymes and therefore does not affect other components of inflammation (redness and swelling).

Drug Name	Pain-Related Indication(s)	Comments
Acetaminophen	Acute post-op pain, OA, and other painful musculoskeletal conditions	• Avoid in severe liver disease or heavy alcohol use • Weigh risk versus benefit in mild to moderate liver disease • No significant differences between oral versus intravenous (i.v.) administration of acetaminophen, however onset of action is faster with i.v. administration • Confirm all sources of acetaminophen are included when monitoring total daily dose
Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) Ibuprofen Naproxen Ketorolac Celecoxib	Inflammatory conditions (OA, RA, gout), acute migraine	• Prior to recommending, assess renal, cardiovascular, gastrointestinal (GI), and bleeding risks • Avoid in severe renal insufficiency, history of cardiovascular disease, recent active ulcer or GI bleed, cerebrovascular bleeding or other bleeding disorder, decompensated heart failure, concurrent use of anticoagulants • Ketorolac: Limit to 5 days, avoid prolonged use • Celecoxib (selective COX-2 inhibitor): Lower risk for gastrointestinal ulceration or bleeding than non-selective NSAIDs
Skeletal Muscle Relaxants Methocarbamol Cyclobenzaprine	Muscle spasms	• Relatively less sedating than other muscle relaxants at therapeutic doses • Monitor for anticholinergic effects (structurally similar to amitriptyline)
Tizanidine Baclofen	Muscle spasms and spasticity	• Monitor for orthostatic hypotension (structurally similar to clonidine) • Avoid abrupt withdrawal to reduce the potential for adverse effects (rebound spasticity, muscle rigidity, fever, seizures)
Tricyclic Antidepressants (TCAs) Nortriptyline Desipramine Amitriptyline	DPN, fibromyalgia, PHN, CLBP	• Associated with anticholinergic side effects & QTc prolongation • Nortriptyline & desipramine have relatively less anticholinergic effect than other TCAs • Avoid in patients over 65 years of age, history of previous myocardial infarction, stroke, cardiac conduction abnormalities, seizures, narrow angle glaucoma, or urinary retention
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) Duloxetine Venlafaxine	DPN, chronic musculoskeletal pain including CLBP, CIPN, fibromyalgia	• Use caution in patients with hypertension, renal impairment (dose reduction may be required), chronic liver disease or cirrhosis • Duloxetine: Likely no additional analgesic benefit with doses > 60mg per day •Venlafaxine: Likely no additional analgesic benefit with doses > 225mg per day
Gabapentinoids Gabapentin Pregabalin	Chronic neuropathic pain (general)	• Requires reduced dose in renal impairment • May decrease post-op opioid requirements and nausea given pre-operatively • Maximum daily dose for pregabalin varies by indication
Topical Analgesics Methyl salicylate	Minor muscle and joint pain	• Generally well-tolerated but limited by short duration of effect
Diclofenac	OA, acute musculoskeletal pain	• Less likely than systemic NSAIDs to cause adverse effects due to limited systemic absorption
Lidocaine	DPN, PHN	• May use of up three patches per day. Patches may be cut to size. • Patch is applied for 12 hours per day and removed for 12 hours to prevent development of tachyphylaxis • Cream or ointment may be applied and covered with dressing as alternative to patch

KEY

NSAIDs - Non-steroidal anti-inflammatory drugs
SMR = skeletal muscle relaxant
TCA = tricyclic antidepressant
SNRI = serotonin-norepinephrine reuptake inhibitor
OA = osteoarthritis
CLBP = chronic low back pain
PHN = post-herpetic neuralgia
RA = rheumatoid arthritis
DPN = diabetic peripheral neuropathy
CIPN = chemotherapy-induced peripheral neuropathy

NSAIDs such as ibuprofen, naproxen, and ketorolac reduce levels of chemical mediators (prostaglandins) produced during inflammation, relieving symptoms of pain, redness, and swelling.[6] NSAIDs inhibit the COX 2 enzyme which is integral in the synthesis of prostaglandins. NSAIDs, acetaminophen, and opioids decrease pain via different mechanisms and used together have been shown to additively, if not synergistically, decrease nociceptive pain.

Skeletal muscle relaxants have various mechanisms of action. Methocarbamol's exact mechanism is unknown but is believed to alleviate discomfort through its general sedative effect.[7] Cyclobenzaprine primarily works on the brain stem to reduce somatic motor neuronal activity leading to a reduction in muscle spasms. Tizanidine acts centrally as an alpha-2-receptor agonist resulting in inhibition of interneuronal activity, resulting in decreased spasm frequency.[8] Baclofen works at the spinal cord level and brain to reduce the release of excitatory neurotransmitters in the pre-synaptic neurons and stimulates inhibitory neuronal signals in the post-synaptic neurons resulting in relief of spasticity.[9]

Antidepressants including TCAs and SNRIs act by blocking the reuptake of the neurotransmitters norepinephrine and serotonin in the central nervous system potentiating their effect.[10]

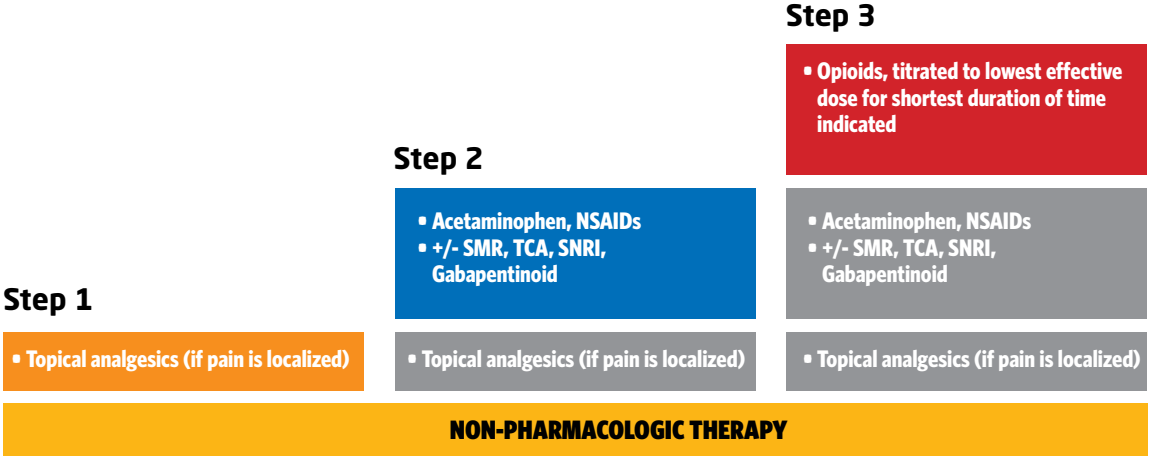
"It is important to understand the limitations of pharmacological management, particularly for chronic pain, and the importance of combining pharmacological approaches with non-pharmacological management."

Changing the chemical balance within these pathways affects the perception of pain and may also have a positive effect on an individual's mood.

Gabapentinoids are thought to work by binding to calcium channels in nerve cell membranes within the CNS.[10] This reduces the calcium ions flowing into the nerve terminals and inhibits the release of the excitatory neurotransmitter glutamate, resulting in reduction in neuropathic pain and improvement in associated problems such as sleep and anxiety.

FIGURE 1

Stepwise Approach to Pain Management. Non-pharmacologic therapies should be considered regardless of pain severity. Topical analgesics should always be considered when pain is localized. As pain intensity increases, more potent pain medications may be added in a stepwise manner. Opioids are reserved for pain that is not expected or does not respond to Steps 1 and 2.



Topical analgesics include rubefacients, topical NSAIDs and local anesthetics. Rubefacients (menthol, camphor, trolamine salicylate) provide a counterirritant effect by stimulating the sensory nerve endings and altering the pain in muscle and joints innervated by the same nerve. Prolonged use of topical capsaicin is thought to deplete substance P, a chemical involved in the pain signaling pathway, which results in pain relief for extended periods.[11] Topical NSAIDs such as diclofenac gel are used in acute and chronic musculoskeletal pain conditions and work by decreasing inflammation locally at the site of application.[12] Topical local anesthetics, such as lidocaine work by inhibition of sodium channels in peripheral neuronal conduction pathways resulting in localized numbness and decreased pain signaling.

STEPWISE APPROACH TO PAIN MANAGEMENT

Figure 1 shows a stepwise approach to pain management that reserves medications including opioids for pain that is not expected or does not respond to more conservative treatments. Non-pharmacologic modalities and topicals should be considered first for pain as these modalities usually have lower risks for adverse effects than systemic pain meds and provide benefit in reducing pain and improving function. When systemic pain medications are required for acute nociceptive pain, acetaminophen and NSAIDs should be considered as first-line pharmacologic options. For most neuropathic pain conditions, which tend to be chronic in nature, gabapentinoids, SNRIs, TCAs should be considered as preferred pharmacologic options. As healthcare providers are focusing on more judicious opioid prescribing and reducing the misuse of opioids, they should carefully evaluate all available alternatives to opioids including non-opioid analgesics and non-pharmacological options.

Individuals with persistent or chronic pain benefit from a biopsychosocial approach which addresses not only physical symptoms but also their feelings and perception about their condition combined with a treatment plan to increase levels of activity and promote self-management. It is important to understand the limitations of pharmacological management, particularly for chronic pain, and the importance of combining pharmacological approaches with non-pharmacological management. The use of such strategies alongside appropriate evidence-based active self-management strategies leads to better patient outcomes.[4]

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340B

Unlocking the Mystery Behind 340b Contract Pharmacy

BY AMANDA GADDY, RPh, Director of Clinical Services, GPhA

What is a 340B Contract Pharmacy?

The 340B Drug Discount Program was established in 1992 by Congress as part of the Veterans Health Care Act. It requires manufacturers to provide discounts on outpatient drugs purchased by qualifying health systems known as "Covered Entities" serving vulnerable patient populations. The savings this program produces allow the healthcare facilities to extend their reach to the communities they serve, provide additional services, and improve access to medication.

Community pharmacies can partner with Covered Entities, or CEs, to act as their agent with 340B eligible patients. Pharmacies and CEs negotiate a dispensing fee for each eligible claim. Revenue received from these claims by the pharmacy is then passed to the CE minus the negotiated fee. In return, the CE replenishes the pharmacy's inventory at the 340B price.

How will 340B impact my pharmacy financially?

The pharmacy receives a 'fee' for each 340B eligible claim. The fee should be, on average, greater than the pharmacy would have made without 340B. This could result in increased profit margins on existing prescriptions and future prescriptions that qualify for 340B.

In addition, once a full package has been dispensed, the CE purchases the item and ships it to the pharmacy to replace 340B inventory dispensed.

What are the potential pitfalls or challenges?

Inventory is only replenished after a full package/bottle has been dispensed. This could result in 'floating cash' to the CE without inventory replenishment. For example, if 25 tablets of a 100 count bottle are dispensed to a 340B eligible patient, in some arrangements, the pharmacy must pass the revenue for those 25 tablets to the CE without the CE being able to replenish the drug. As a result, pharmacies must monitor outstanding inventory due and ensure reconciliation is occurring on a regular basis.

> "The savings this program produces allow the healthcare facilities to extend their reach to the communities they serve, provide additional services and improve access to medication."

340B shipments could result in a pharmacy experiencing excessive inventory, also called inventory swell. This can occur due to the 340B testing process being performed retrospectively. When prescriptions qualify days later, the replenishment inventory is also delayed. This can result in the pharmacy potentially ordering the dispensed item from their wholesaler and subsequently receiving the 340B shipment of the same medication.

Dispensing fees must be higher than margins without 340B for the program to be beneficial. Thus, when calculating margins without 340B, wholesaler rebates and DIR fees must be considered as these directly affect Net margins. Comparing the 340B dispensing fee to the margin based on invoice cost alone, omits valuable information leading to an inaccurate analysis.

Are there any limitations?

Yes. There are manufactures who have stopped offering 340B discounts to covered entities on medications dispensed at some contract pharmacies. This action is in direct opposition to the law requiring manufacturers to do so. HRSA sent letters to six of the manufacturers in May stating the drug manufacturers must restore discounts

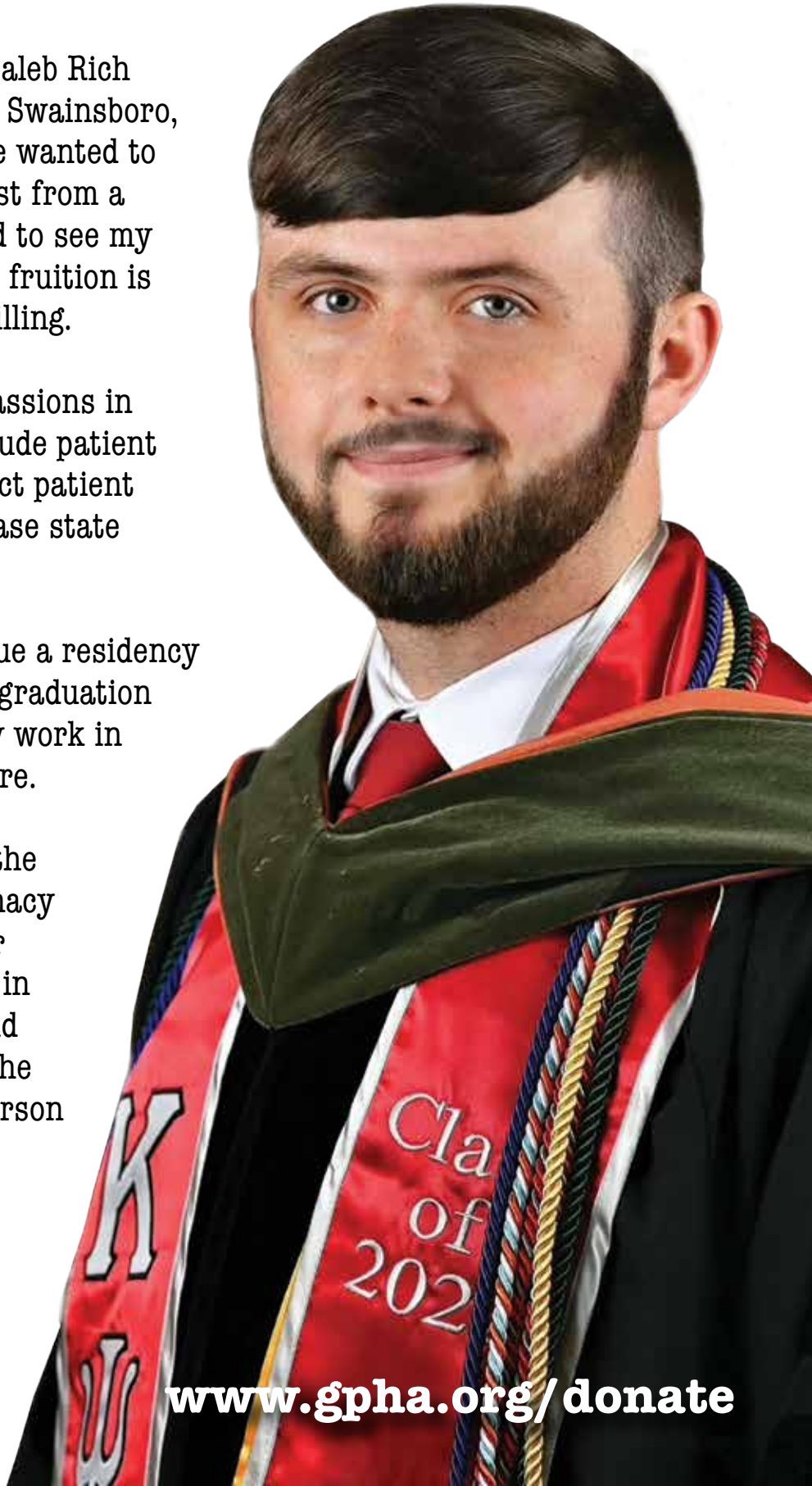
Be part of something good.

"My name is Caleb Rich and I am from Swainsboro, Georgia. I have wanted to be a pharmacist from a young age, and to see my goal coming to fruition is extremely fulfilling.

A few of my passions in pharmacy include patient advocacy, direct patient care, and disease state management.

I hope to pursue a residency position after graduation and eventually work in ambulatory care.

Thank you to the Georgia Pharmacy Foundation for playing a part in my journey and awarding me the Carlton Henderson Scholarship."



Georgia Pharmacy FOUNDATION

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and repay lost savings or be subject to fines of $5000 per instance of overcharge. Thus far, the manufacturers are still not abiding by the statute and are in litigation with HRSA.
https://www.hrsa.gov/opa/

What are best practices for 340B contract pharmacies?

340B programs have great potential to benefit communities. However, due to the complexity of the program, the program can be challenging if not structured correctly and monitored closely.

BEST PRACTICES

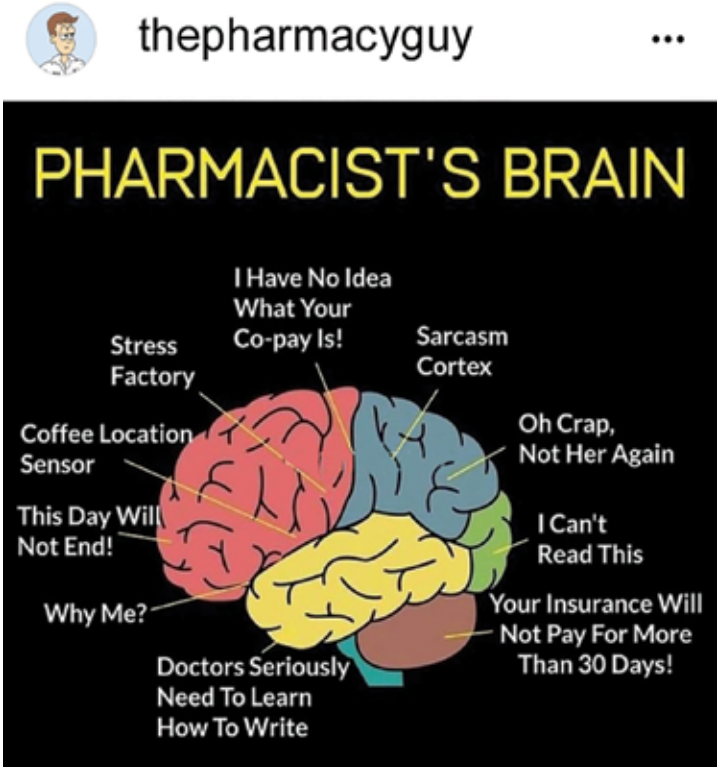
- Develop a partnership with the 340B CE. In addition to filling prescriptions for CE patients, identify other services and collaborate with the CE to improve outcomes and decrease overall costs.
- Determine if the dispensing fee is appropriate. There is not a 'one fee fits all' solution. The dispensing fee should be based on the program type, all claims or specific claims, DIR impact and the mix of claims. On average, the dispensing fee should be greater than the pharmacy's current margin (without 340B).
- If not already accounted for in the dispensing fee, identify claims with DIR fees adjusted after payment has been made to the covered entity and reconcile.
- Track un-replenished inventory. 340B administrators have true-up processes but often inventory remains due for partial packages.
- Monitor inventory levels to ensure inventory isn't increasing more than needed. Return excess 340B inventory on the pharmacy's retail account for a credit.
- Know what inventory is being shipped on the 340B account and reduce the retail order to prevent inventory swell.
- Review terms of agreement. Terms for payment from pharmacy to covered entity should allow sufficient time for pharmacies to receive payment from third party payers.

As a result of the above challenges, crafting the agreement with a CE should be done carefully to minimize risks to your pharmacy. Ensure you understand its implications before signing.

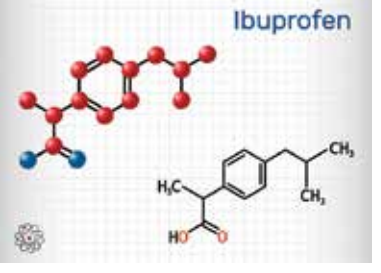
How can I find out more about 340B and potential opportunities in my community?

The program is administered by the Office of Pharmacy Affairs (OPA) located within the Health Resources and Services Administration (HRSA).
http://www.hrsa.gov/opa/

To find 340B CEs in your area, search the HRSA/Office of Pharmacy Affairs website.
https://340bopais.hrsa.gov/home



What am I?



Meet Hutton Madden, Chartered Financial Consultant (ChFC)

WHEN YOU MEET HUTTON MADDEN, you'll be drawn to his boyish Southern charm. Hutton grew up in Elberton, Georgia. Hutton's father, former State Senator Eddie Madden, owned two independent pharmacies. Hutton worked at his father's pharmacy as a pharmacy technician in high school and college. When he graduated from The University of Georgia, Hutton started a career in the insurance industry with State Farm. In 2002, he was in State Farm's Agency Program when he first learned about Pharmacists Mutual Insurance Company. "It was a perfect match," shared Hutton. "My pharmacy background and insurance experience lined up well for the opportunity and I will celebrate my 19th year with the company in December."

Founded in 1909, Pharmacists Mutual Insurance Company is a national insurer. Pharmacists Mutual has a great reputation and is an A rated insurer by AM Best Rating Services. Recently, Pharmacists Mutual became a GPhA exclusive provider of workers' compensation insurance member services. "We offer commercial liability, workers' compensation, commercial auto, bonds, as well as life and disability insurance," Hutton said.

Colton, Hutton, Marian, and Kate Madden

Eddie and Hutton Madden

We asked Hutton why workman's compensation insurance is important for pharmacists. He told us, "Workers' compensation insurance is important for pharmacies to protect the business from the costs associated with an injured employee. The state of Georgia requires employers with three or more employees to carry workers' compensation insurance. Those with fewer than three employees are still responsible for the injured employee's medical costs and wages but are basically self-insuring the risk."

Hutton and his wife, Marian, celebrated their 18th wedding anniversary in May. They have two children—Kate, who is 13, and Colton, who is 11. His father, Eddie, sold his business several years ago to another independent pharmacist. He is retired and now enjoys golfing, boating with his family and friends, and anything Georgia Bulldogs.

Hutton Madden, CHFC, is available for pharmacy-related insurance advice. You can reach him at Hutton.Madden@phmic.com or 800.247.5930 ext. 7149. For more information, the Pharmacists Mutual Insurance Company website is https://phmic.com.

Management of Physical Pain in Hospice

BY JOE ED HOLT, RPH

IN 1971, HOSPICE, INC. was founded in the United States. Piggybacking off the work of Dame Cicely Mary Strode Saunders, whose work in England provided the modern foundations of what proper hospice care looked like, they sought to make the end-of-life process a more dignified and holistic process. It was a paradigm shift from always trying to treat disease and extend life no matter what the cost to helping terminal patients face end-of-life pain free, anxiety free, and with dignity.

One of the main goals of hospice care is pain management. Treating pain in the hospice resident is more complex than it sounds. At the end-of-life there are many different components of pain that need to be addressed. Physical pain is the kind that always comes to mind when dealing with pain management, but there is also emotional and spiritual pain that complicates the issue as the individual faces what could be the end of their Earthly life. Proper pain management must address all areas of pain in helping address the quality of life for the patient.

Physical pain can be one of the easiest components to treat and one of the most difficult. Despite advances in understanding pain physiology and available pharmacotherapies, many patients with terminal illnesses, such as cancer, report untreated or undertreated pain.[1] Proper assessment of pain and the ability to swiftly initiate and taper proper pain medication is a cornerstone of treatment when dealing with end-of-life.

Proper pain assessment should include location of the pain, intensity, quality, onset, duration, and factors that exacerbate or alleviate it. It is prudent to determine the patient's best, worst, and average pain intensities during the previous 24 hours and track that data. Physical signs of pain, such as facial grimace, tachycardia, tachypnea, or restlessness, can provide a wealth of information, although that information can be highly subjective and open for interpretation. Patient or caregiver logs of analgesic use and pain intensity can provide essential information about the effectiveness of current interventions.

There are several pain scales and inventories to improve accurate assessment of pain. Although some have advantages in certain cases. No one scale or inventory has been determined to better than the other one.[2] A Likert-type scale (e.g., rating pain from 0 to 10, with 0 representing no pain and 10 representing the worst imaginable pain), the Wong-Baker FACES Pain Rating Scale, and a visual analog scale are commonly used. Consistent use of a chosen scale allows easier assessment of the patient's pain and the effectiveness of therapies.

Of course, proper pain assessment in the patient with a cognitive impairment or dementia can be a challenge in the proper treatment of pain. The first modality to use is direct communication with the individual. In some cases, they may be able to communicate with surprising detail the levels of their pain. When the patient cannot communicate well or is uncommunicative altogether, an interview with the caregiver is the next thing to attempt. Caregivers may be a spouse or child if the resident is in the home or could be a nurse or CNA if the person is located in a skilled nursing center. There are some pain scales that can be used, such as Pain Assessment in Advanced Dementia, which use objective measures to assess pain intensity and response to intervention.[3]

When it comes time to initiate therapy, a stair step approach is usually instituted, although clinician judgement should be used since strict adherence to the multi-step approach could delay

"Proper assessment of pain and the ability to swiftly initiate and taper proper pain medication is a cornerstone of treatment when dealing with end-of-life."

proper pain control. [4] Starting with non-opioid choices, such as acetaminophen or an NSAID, is usually the first step. Acetaminophen is useful as a primary analgesic, or in combination with other drugs, for treating mild to moderate pain. NSAIDs can relieve mild to moderate pain, particularly of somatic origin (e.g., bone, muscle, skin) as long there is no contraindications such as gastrointestinal, cardiovascular, or renal disease. In certain situations, such as with pain from bony cancer metastases, NSAIDs can be a helpful adjuvant for opioid therapies.

In order to really get a grip on pain in end-of-life, the jump to opioid therapy is almost a necessity. In hospice, the most common agent that is utilized, unless there is an allergy, is morphine. The World Health Organization has endorsed it as the gold standard of opioids, and it's considered the first-line treatment for moderate-to-severe pain.[5] Morphine is relatively cheap and readily available. It can be titrated quickly, due to a short half -life, based on patient response.[3] With virtually no ceiling to its analgesic effect, morphine is limited only by adverse reactions, which usually go away with further use and the development of tolerance. It also is available in an extended-release version which can help control pain around the clock.

Morphine is often used with adjuvant therapies to augment pain control. Corticosteroids, such as dexamethasone, prednisone, and prednisolone, are particularly useful as adjuvant therapy for metastatic bone pain, neuropathic pain, and visceral pain.[6] Antidepressants, such as tricyclic antidepressants and serotonin and norepinephrine reuptake inhibitors (SNRIs) can be used particularly for nerve pain but are also useful in treating depression and anxiety which can lead to emotional pain. Antiepileptic medications can also be used to treat neuropathic pain. Different topical meds can be used to treat different types of pain such as local anesthetics, certain topical NSAIDS, or certain counter irritants, such as menthol, eucalyptus, or oil of wintergreen.[7]

Unfortunately, with all the different ways to treat pain, there are still challenges when it comes to meeting the needs of the individual. To the family members, sometimes hospice has the connotation of speeding up the death process and when morphine is introduced, it leads to cases where families either don't give the medication or will underdose the morphine in the belief that the morphine will kill their loved one in a quicker manner There are also some family members who worry that by giving morphine they will cause their loved one to become addicted. Caregivers are sometimes hesitant to administer morphine, especially large doses of morphine due to fear of administering an overdose, being unaware of the appropriate dosing of the drug. Caregivers often aren't reliable to give a PRN dose for breakthrough pain because they do not want to administer too much morphine, or they erroneously assess the individual's pain as not needing the morphine.

Pharmacists are sometimes at fault. After being burned by dispensing narcotics throughout the opioid epidemic, they are sometimes hesitant to either stock the drugs needed to adequately treat pain in the end-of-life patient or are weary of dispensing the quantities needed

for the patient. Sometimes a lack of knowledge of current law as it pertains to filling medications for hospice residents makes the pharmacist reluctant to fill medication that they have on the shelf. For example, according to DEA regulations and Georgia law, a pharmacist may take a faxed copy of a schedule two prescription as a legal hard copy of the script as long as it is faxed by the physician or an agent of the physician and it is noted on the faxed prescription that it is for a hospice patient.[8] Also, it is perfectly legal to partial fill a scheduled two substance, if the order has "terminally ill" or "hospice patient" denoted on the face of the prescription. Such C-II prescription drug orders may be partially filled for a period not to exceed 60 days from the dispensing date or sooner if the medication is discontinued.[9]

The role of hospice in the healthcare equation is an important and a noble one. The person may not be able to control what they die of, but through hospice services, they can have a control over how they die. Through the nurses, chaplains, social workers, and volunteers working through hospice, the hospice patient can face the end-of-life process relatively anxiety free and pain free, as hospice tends to their needs, whatever they may be. They have become the experts on treating the physical pain, emotional pain, and spiritual pain that comes when we get to that place where curative medicine has reached its endpoint and that knowledge has led to better quality of life at the end of life as well as dying with dignity.

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NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS):

The Good, The Bad, and The Ugly

JANN JOHNSON, PharmD, RPh, J³ Consulting President and Scientific Content Expert

In exploring the advantages and disadvantages of the use of nonsteroidal anti-inflammatory drugs (NSAIDs), it is important to include an overview of prevalence, indications, mechanism of action (MOA), morbidity and mortality, nephrotoxicity including acute kidney injury (AKI), how dose plays a role, and recommendations for the pharmacist as well as the patient.

NSAIDs are a drug class FDA-approved for use as antipyretic, anti-inflammatory, and analgesic agents. These effects make NSAIDs useful for treating muscle pain, dysmenorrhea, arthritic conditions, pyrexia, gout, and migraines. They are at times used as opioid-sparing agents in certain acute trauma cases.

NSAIDs and cyclooxygenase-2 (COX-2) inhibitors are perhaps some of the most extensively used medications in the world. More than 20 drugs fall under the category of NSAID. More than 70 million prescriptions for NSAIDs are written each year in the U.S. Including over the counter (OTC) medications, more than 30 billion doses of NSAIDs are consumed annually in the U.S. alone.

MORBIDITY AND MORTALITY

Most of the commonly ingested NSAIDs have few toxic effects even when taken in significant quantities; however, with the numbers of both prescriptions and OTC NSAIDs increasing every year, so do the numbers of overdoses and NSAID-related complications reported to poison control centers around the country. Additionally, adverse events related to drug interactions or exposure to vulnerable patients with disease states that predispose patients to NSAID toxicity are common and may result in significant morbidity and mortality.

"The Arthritis, Rheumatism, and Aging Medical Information System (ARAMIS) has estimated that each year in the US more than 100,000 hospitalizations, more than 16,000 deaths, and costs greater than $2 billion are due to NSAID-related complications."

The American Association of Poison Control Centers National Poison Data System (AAPCC NPDS) recorded 105,259 case mentions of NSAID ingestion and 74,507 single exposures in 2018. Both acute and chronic poisonings with NSAIDs result in significant morbidity and mortality. The Arthritis, Rheumatism, and Aging Medical Information System (ARAMIS) has estimated that each year in the US more than 100,000 hospitalizations, more than 16,000 deaths, and costs greater than $2 billion are due to NSAID-related complications, e.g., gastrointestinal (GI), renal, central nervous system (CNS), hematologic, and dermatologic.

THE BAD AND THE UGLY: NEPHROTOXICITY

Renal side effects are significant affecting 1% to 5% of patients taking NSAIDs. NSAIDs have been associated with acute kidney injury (AKI) and with progression of disease in those with chronic kidney disease (CKD). NSAIDs are capable of inducing a variety of renal function abnormalities especially when used chronically.

Researchers found that 5% of people with moderate-to-severe kidney disease regularly used OTC NSAIDs. Two-thirds of them had used NSAIDs for more than a year. Many also had prescriptions for NSAIDs, including 11% of those with moderate-to-severe kidney disease and 8% of those with mild or no kidney disease.

Characteristics that may put individuals at increased risk for NSAID-associated nephrotoxicity include being elderly; higher drug doses; longer durations; concurrent use of angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), and loop diuretics; preexisting CKD and other conditions such as diabetes, heart failure, and cirrhosis; dehydration; and blood or fluid loss.

NEPHROTOXICITY: MECHANISM OF ACTION (MOA)

Most of the NSAIDs are nonselective and inhibit both cyclooxygenase-1 (COX-1) and cyclooxygenase-2 (COX-2). However, COX-2 selective NSAIDs, e.g., celecoxib, only target COX-2, thereby having a different side effect profile. More specifically, NSAIDs exert their analgesic and anti-inflammatory effects by inhibiting COX-1 and COX-2 that convert arachidonic acid to prostaglandin, prostacyclin, and thromboxane. COX-2 is induced during the inflammatory response and produces prostaglandins that mediate pain and inflammation. COX-2 is also expressed in kidneys and vascular endothelium.

NSAID agents, selective and non-selective, directly interfere with renal function due to prostaglandin inhibition and can cause acute and chronic toxicity, mild and transient disorders, all the way to CKD. The reason relates to the fact that prostaglandins are involved in regulating renal blood flow. In order to adequately perform filtration function, regulatory mechanisms such as prostaglandin synthesis will maintain glomerular filtration rate (GFR) and renal homeostasis.

In addition, NSAID toxicity can manifest as GI bleeding, hepatotoxicity, hypertension, convulsions, coma, and neurologic toxicity, e.g., drowsiness, confusion, nystagmus, blurred vision, diplopia, headache, and tinnitus.

ACUTE KIDNEY INJURY (AKI)

NSAIDs are linked to acute kidney injury (AKI), chronic kidney disease (CKD), and cardiovascular disease (CVD). Virtually all NSAIDs can be associated with AKI which is sometimes called acute kidney failure or acute renal failure. AKI is one of the fastest growing conditions affecting the kidney and a risk factor for accelerated loss of kidney function and CVD.

NSAIDs can bring about two different forms of renal failure. The main form is hemodynamically mediated failure due to a reduction in prostaglandin synthesis induced by the NSAID. The second type is acute interstitial nephritis from a direct toxicity of the drug on the renal parenchyma.

Unfortunately, survivors of AKI are at increased risk for future kidney dysfunction, cardiovascular complications, and death. One study demonstrated that nearly one in five AKI survivors were using NSAIDs regularly and that the prevalence remained consistently high regardless of time since the most recent AKI episode.

THE DOSE FACTOR

NSAIDs do not present great harm to patients at younger ages, and without renal diseases and comorbidities. Because of its dose-dependent effect, however, great caution should be exercised in chronic use of these agents. Chronicity increases the chances of developing some toxicity and morbidity.

Even therapeutic doses of NSAIDs in susceptible patients can cause acute renal injury. Furthermore, a recent study in the elderly population showed that regardless of the class of this medication, whether selective or not, both high doses and longer half-lives significantly increase the risk of CKD development. There are few studies showing the long-term effects of NSAIDs on the development CKD. It has been shown, though, that daily use for more than one year increases the risk of developing CKD.

RECOMMENDATIONS

The general public widely uses NSAIDs because of their wide range of commonly encountered indications. In light of this, it is crucial that healthcare professionals and patients continue to play a role in their safe use.

1. Collaborative Interprofessional Teamwork

The healthcare team can communicate and work together to ensure that each patient receives the proper dose for their specific condition and comorbidities, high enough for efficacy but as low as possible to reduce the incidence of adverse effects. Through this collaboration of clinicians, pharmacists, nurses, and other healthcare professionals, NSAID therapy can confer maximum benefit with minimal downside.

2. The Pharmacist Role

One of the most significant contributions is patient counseling on how to best use an NSAID and minimize adverse events. This is particularly important when the patient uses OTC NSAIDs. Other important responsibilities include verification of dosing and administration, checking for potential drug-drug interactions, recognizing the signs and symptoms of NSAID toxicity or adverse effects, and making recommendations as needed to the clinician to make changes to the patient's regimen.

3. Risk-Benefit Focus

The ultimate decision amounts to an individualized risk-benefit approach to determine if NSAID use is prudent. The individual approach encompasses weighing improvement of quality of life with NSAID use against the potential risk for kidney disease progression and further kidney damage. Key considerations include indication for therapy, expected dose and duration, individual risk profile, comorbidities, suitability of alternative options, medication profile, and goals of care.

"The ultimate decision amounts to an individualized risk-benefit approach to determine if NSAID use is prudent."

4. Patient Education

Research has demonstrated that patient awareness of CKD is low, and awareness among AKI survivors of the potential nephrotoxicity of NSAIDs may be similarly low. These findings support a critical role for improving education and awareness of the potential hazards of NSAID use. It is beneficial to discuss the risks of NSAID use not only with patients who already have kidney disease but also with those who take NSAIDs regularly but do not have CKD.

Healthcare professionals can make sure their patients know that OTC NSAIDs can damage kidneys, and potentially interact with medications such as angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), and loop diuretics.

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Meet the Student Leadership Board

BY SAVANNAH CUNNINGHAM and the Student Leadership Board

HELLO! My name is Savannah Cunningham, and I am a final year student pharmacist at Mercer University College of Pharmacy. I have served as the President of the GPhA Student Leadership Board for the past three years. During my P1 year, I attended Day at the Dome and was exposed to the advocacy efforts that GPhA is involved in for the first time. Before the end of the day, I had cornered GPhA CEO Bob Coleman and convinced him to meet with me about how to get students more involved in the association—and the Student Leadership Board (SLB) was born.

Since then, I have assembled a group of leaders from all four colleges of pharmacy in Georgia, comprised of students with diverse backgrounds, experiences, and interests in different practice areas. The SLB crafted "Student Central," an experience at the annual convention that includes many sessions specifically for student pharmacists, as well as a fun area to hang out and network, increasing student attendance tremendously over the past three years of conventions.

"If you are a student reading this and feeling inspired to get involved, contact your school's SLB representatives (or me!) and ask what upcoming events you can join in."

Contact: savannah.cunningham@live.mercer.edu, (615) 410-0254

We also help to coordinate the two annual Day at the Dome events, encourage students to attend the regional briefings, and sponsor GPhA events at each pharmacy school campus.

I am so proud of what the Student Leadership Board has accomplished so far and what I hope they will continue to do long after I graduate! If you are a student reading this and feeling inspired to get involved, contact your school's SLB representatives (or me!) and ask what upcoming events you can join in. Be sure to mark your calendar for Day at the Dome and the Summer Convention as well.

If you are a P1, applications to join the SLB are available every spring, and I encourage you to apply! If you are a pharmacist reading this, we ask for your support and encouragement as the future of the profession. All student pharmacists look up to you all and relish all opportunities to interact and make connections with the currently practicing experts in the field. If you have the opportunity to attend an event that students are also at, introduce yourself and encourage those students to continue being involved.

As the President this year, I would be happy to answer any questions, or direct you to the person who can. Thank you to all the awesome leaders who have served on the SLB for the past three years and to all the pharmacists and GPhA staff who have supported us along the way, we can't wait to see what the future brings.

President: Savannah Cunningham
School: Mercer University College of Pharmacy
Grad year: 2022
Quote: Creating and leading the Student Leadership Board over the past 3 years has been one of the best parts of pharmacy school for me. I am passionate about the work GPhA does to advocate for pharmacists and the patients we care for as well as helping connect student pharmacists to opportunities to get involved within GPhA. I look forward to continuing my involvement in my state pharmacy association following graduation in May.

President-Elect: Andrew Wilson
School: Philadelphia College of Osteopathic Medicine (PCOM)
Grad year: 2024
Quote: GPhA empowers members through their critical role of providing networking opportunities, education, and information related to current events and legislation relevant to the pharmacy community. I joined the Student Leadership Board to provide a voice for PCOM in this great organization, foster connections with other pharmacy programs in Georgia, and create networks between PCOM students and GPhA members.

Senior Member: Marlee Clements
School: Mercer University College of Pharmacy
Grad Year: 2023
Quote: Being a member of GPhA is important to me because the opportunities that come along with being involved in this organization are vital to my success as a future pharmacist. I am so grateful to be a part of an organization that continues to fight to ensure that our profession receives the admiration and recognition that is rightfully deserved.

Senior Member: Grayson Layton
School: Mercer University College of Pharmacy
Grad Year: 2023
Quote: As a Georgia resident, it is important, to me, that I stay involved with and up to date with all things regarding the regulation of pharmacy practice in the state in which I'll be practicing. Being a part of the GPhA Student Leadership Board has allowed me to do just that while, simultaneously, providing the opportunity to network with many Georgia Pharmacists and other Pharmacy students!

Junior Member: Laine Frazier
School: Mercer University College of Pharmacy
Grad year: 2024
Quote: GPhA is important to all things Georgia Pharmacy, but specifically, pharmacists, patients, and policy- all of which are very important to independent pharmacy. I have been a member of GPhA before pharmacy school and understand and support its purpose to better all things Georgia Pharmacy. I intend to learn more about what GPhA does currently and want to help make an impact on future pharmacy for my peers and myself.

Junior Member: Taylor Justice
School: Mercer University College of Pharmacy
Grad year: 2024
Quote: GPhA has accomplished so much to better the pharmacy community with their advocacy efforts within the recent days and years. It is an honor to serveon the board and to have a role in that continued progress. GPhA is the key to networking and leadership for all student pharmacists and pharmacists within Georgia, therefore, I believe the experience and knowledge that can be taken from GPhA is invaluable.

Senior Member: Dion Blocker
School: Philadelphia College of Osteopathic Medicine (PCOM)
Grad Year: 2023
Quote: GPhA has taught me how expansive the profession of pharmacy is here in Georgia and how much of an impact student pharmacists can really make here.

Senior Member: Krishna Patel
School: Philadelphia College of Osteopathic Medicine (PCOM)
Grad Year: 2023
Quote: The profession of pharmacy is constantly changing, and I've always been very intrigued by the different niches in this career field. My goal is to be able to advocate for pharmacy and be involved in the changes that are soon to come through GPhA!

Junior Member: Anslee Smith
School: Philadelphia College of Osteopathic Medicine (PCOM)
Grad Year: 2024
Quote: I recognize GPhA as a strong voice for legislative reform in Georgia and value the members role in advocating for pharmacy at the Day at the Dome. I understand the importance of networking and would like to help develop a positive experience for students at GPhA events.

Junior Member: Sophia Jenkins
School: Philadelphia College of Osteopathic Medicine (PCOM)
Grad year: 2024
Quote: I enjoy serving on the Student Leadership Board because it grants me the opportunity to network and use my student leadership platform to educate others on the vast opportunities GPhA has to offer to advance the pharmacy profession.

Senior Member: Megha Patel
School: South College of Pharmacy
Grad Year: 2023
Quote: I am continually exploring avenues that will enhance my educational experience, skill set and professional contribution to the community. As a member of the GPhA Student Leadership Board, it will help me expand my horizon as a pharmacist and provide opportunity to serve as a proficient leader while serving fellow pharmacy students and the community.

Senior Member: Shannon Barbour
School: South College of Pharmacy
Grad Year: 2023
Quote: I am eager to get involved with an organization that will provide me with leadership opportunities, chances to network with other students and pharmacists across the state, and to be an active advocate for the pharmacy profession. I view GPhA's student leadership board as a team that works together to advocate for the pharmacy profession and develop fellowship among their peers.

Senior Member: Annie Bridges
School: University of Georgia College of Pharmacy
Grad Year: 2023
Quote: GPhA has helped me develop my professional character tremendously! Being able to advocate for my profession and network with pharmacists and future pharmacists is one of my favorite things about GPhA.

Senior Member: Kristin DiSalle
School: University of Georgia College of Pharmacy
Grad Year: 2023
Quote: I am interested in being involved with GPhA because I want to help bridge the gap between pharmacists, technicians, and patients across the state. I think that it is important to communicate and work together to provide the best healthcare to the residents in Georgia.

Junior Member: Valery Cepeda
School: University of Georgia College of Pharmacy
Grad Year: 2024
Quote: The mission of GPhA is to promote the profession of pharmacy and the value of pharmacy services. I believe these are important statements that every pharmacy student and pharmacist should promote in their activities. I love being a part of a group whose purpose is to promote and advocate for the importance of the pharmacy profession in Georgia.

Junior Member: Alana Holliman
School: University of Georgia College of Pharmacy
Grad year: 2024
Quote: I learned how the Georgia Pharmacy Association is involved in advocating for legislation which made me interested in ways that I can be an active member of this organization. Being a junior member of the GPhA Student Leadership Board will give me the great opportunity to become a part of the legislative process and connect with other student pharmacists and pharmacists who have similar interests throughout the state.

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POSTSCRIPT

From the GPhA President/Board Chair

Think Bigger

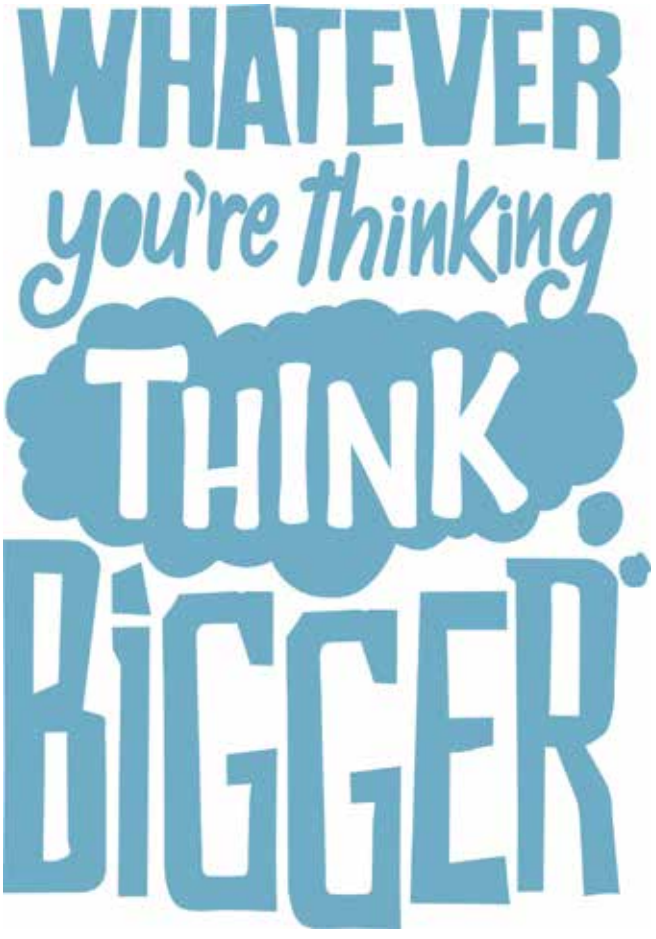
MAHLON DAVIDSON

As I begin my term, I think it is a good idea to set forth our priorities. As they say, if you don't know where you are going, any road will take you there. Let's move forward with commitment to our mission.

Over the past three years, we have passed the most aggressive legislation in the nation regarding pricing, patient choice, steering, and scope of practice. But just passing these laws is not enough. It is imperative we work with the Board of Pharmacy and the Insurance Commissioner to ensure enforcement of these laws. We will be calling upon members to help us identify and document abuses and violations of these laws, to bring unfair practices to an end. Fair reimbursement and patient freedom of choice are now required by law in Georgia.

With the focus on Georgia pharmacists' successes during the pandemic, I feel no better time will come to achieve provider status. It is a priority to assist the national effort to win provider status for pharmacists during the next year.

We will continue to work legislatively to achieve equitable pharmacy reimbursement in the Georgia Medicaid program.



GPhA presence in our schools of pharmacy, engaging with our future pharmacists, must improve in order to grow our membership. I challenge our board to provide ideas and tools to our staff so that GPhA membership is an obvious choice for every student.

I want to continue to supply the GPhA staff with the support necessary to reach employers to acquire group memberships, as part of our efforts to expand GPhA's footprint as the organization for all facets of pharmacy.

We must help find solutions for pharmacists who find themselves underwater with respect to workload. As the organization for Georgia pharmacists, we cannot ignore our brothers and sisters who find themselves in working conditions unfavorable to patient safety, nor conducive to job satisfaction and well-being.

I want to close my remarks with the reminder that we represent one of the most dynamic pharmacy associations in the country. Whatever you are thinking, think bigger.

Mahlon Davidson is the Georgia Pharmacy Association President/ Board Chair.

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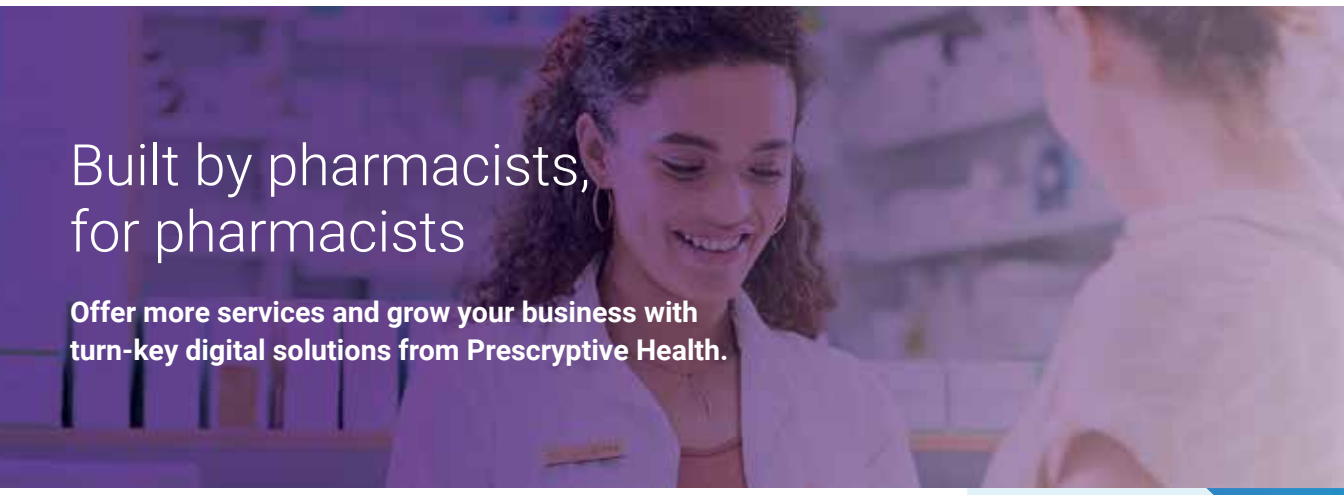

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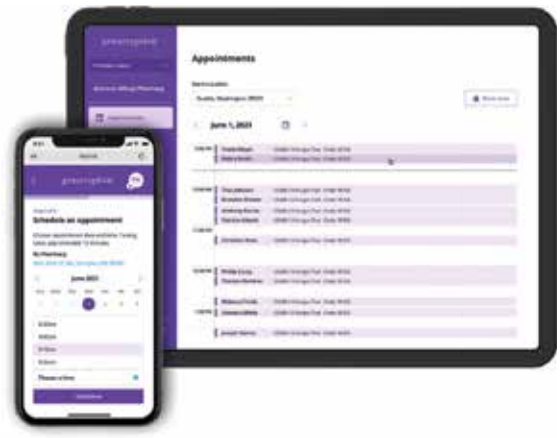

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- ✔ Audit relief (AIP efforts saved members more than $320,000)
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For more information, visit GPhA.org or call
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