Feb-March 2018

Volume 5, Issue 2

NYSCHP | New York State Council of Health-system Pharmacists

President's Message

It's Not Too Late….

If the persistent winter weather and unusual number of Nor'easters have thrown off your early spring schedule, it's not too late to register for our 57th Annual Assembly in Saratoga Springs!

The Board of Directors met in Albany on March 16th for its last meeting before the event. While the Annual Assembly Committee already has this year's fantastic program planned out, the Board was looking to ensure that all the details are in place. It promises to be an exciting event with a new format. The House of Delegates will convene on one day rather than being split into two days. For the first time, there is a clinical competition for our students and future pharmacists. However, you will still be seeing all the valuable programming and events that the Council delivers each year, including the residency forum, updates in therapeutics, exhibit hall and numerous networking opportunities. We also look forward to introducing you to our new officers and board members, award winners and pharmacy vendors who support health-system practice.

New York State Pharmacy Lobby Day is scheduled for Tuesday, April 17th. NYSCHP will be represented among the numerous organizations and pharmacy schools advocating for our profession and the patients we serve pharmacy throughout the state. The Council leadership will also be scheduling additional focused visits to meet our legislators in the state capital after the Assembly. You can assist us in our lobbying efforts by contributing to the NYSCHP Political Action Committee (PAC). Our Vice President of Public Policy, Andrew Kaplan, is spearheading our efforts to have legislative bills passed affecting our profession with regard to CDTM, Pharmacy Technicians, Pharmacy Interns and immunizations.

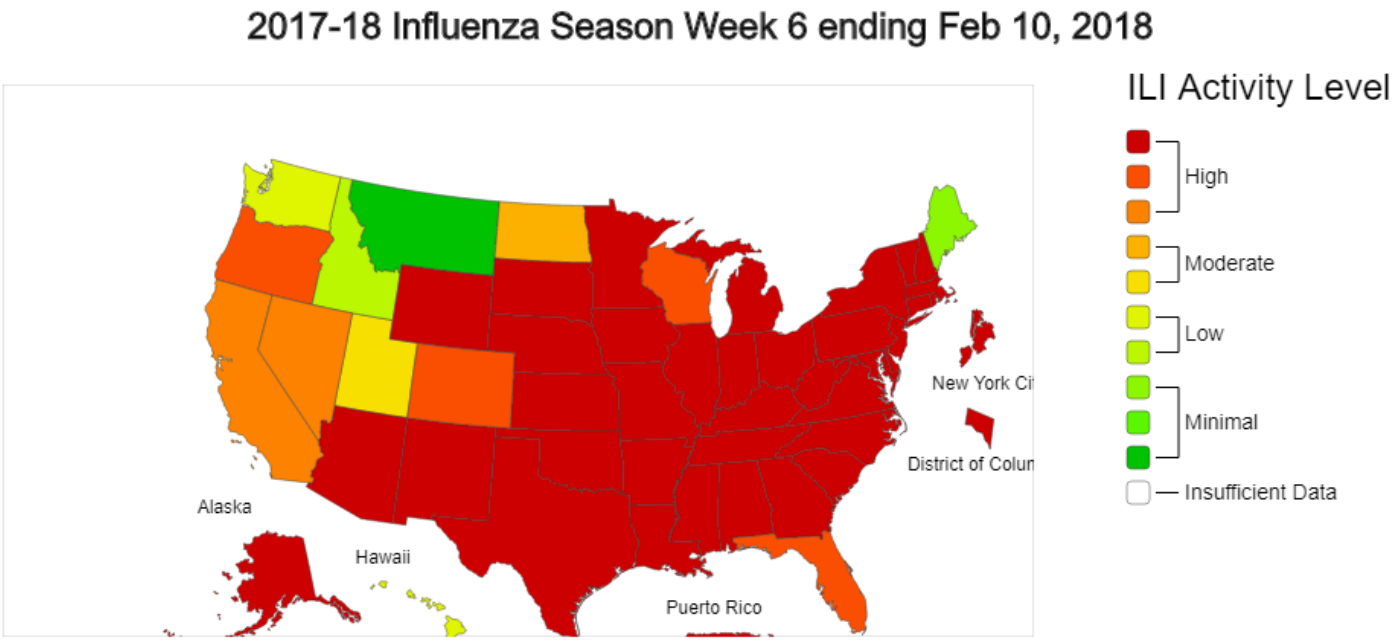
I very much look forward to seeing you in Saratoga!

Regards,
Christopher Jadoch
President

2017-2018 Influenza Season

The Centers for Disease Control and Prevention (CDC) reported that the 2017-2018 influenza season has been the most severe in recent years. This year's vaccine is composed of H1N1, H3N2, and B/Victoria lineage virus, and B/Yamagata lineage virus, with the most commonly identified subtype being H3N2.[1] Potential factors which contribute to vaccine inefficacy and the severity of this year's flu season include vaccine mismatch or other factors, such as prior influenza exposure, vaccine history, age, co-existing conditions, and the growth of vaccine in eggs.[2]

Nationwide, between October 1, 2017 and February 3, 2018, 17,101 influenza-associated hospitalizations have been reported. During week 5 of this year's influenza season (January 27, 2018 to February 3, 2018), 48 states reported widespread influenza activity. New York was among the 43 states reporting high influenza-like illnesses (ILI) activity, while three states reported moderate ILI activity, two states reported low ILI activity, and two states reported minimal ILI activity. Activity levels are determined by comparing the percent of ILI outpatient visits in each state to the average percent of ILI visits during non-influenza weeks. Low, moderate, and high activity levels correspond to below, average, and above average ILI visits, respectively. Currently, 7.7% of health care provider visits reported through the Outpatient Influenza-like Illness Surveillance were for ILI, the highest recorded since the 2009 pandemic and significantly higher than the national baseline of 2.2%. The baseline is calculated by the mean percentage of patient visits for ILI during non-influenza weeks for the past three seasons and the addition of two standard deviations.[1]



* Figure 1: A Weekly Influenza Surveillance Report Prepared by the Influenza Division Influenza-Like Illness (ILI) Activity Level Indicator Determined by Data Reported to ILINet

This season, there has been a reported 63 influenza-associated pediatric deaths, 10 of which occurred during week 5.[1] In efforts to reduce the rate of pediatric influenza diagnoses and deaths, on January 25, 2018, Governor Cuomo announced Executive Order No. 176 to temporarily permit pharmacists to administer influenza vaccines to children ages two to eighteen. On January 27, 2018, Commissioner Howard A Zucker MD, JD signed the statewide non-patient specific order. The non-patient specific order states the procedure, conditions, administration techniques, as well as required documentation pharmacists must abide by and have in order to vaccinate children. This executive order expires on February 23, 2018. However, Governor Cuomo announced on February 12, 2018 that he wants to make this executive order permanent.[3] To increase the convenience for children to acquire immunizations, he proposed a 30-day budget amendment to encourage pharmacies to enroll in the New York State Vaccines for Children Program, which allows children to be vaccinated for free. Contrary to adult vaccines, the first and second time the influenza vaccine is administered to any child six months through eight years of age, it must be administered as a two-dose regimen separated by 28 days during the same influenza season.[1] Pharmacists are required to have pediatric epinephrine on hand, be certified in pediatric CPR, and report all vaccinations to the New York State Immunization Information System (NYSIIS) or Citywide Immunization Registry (CIR), and check for appropriate dosing.[3] Influenza vaccines available for children such as, Fluarix, FluLaval, Fluzone, Flucelvax, Aflura, and Fluvirin, must be administered in specific doses depending on the child's age.[1] These requirements are difficult to implement, thus the benefits of this standing order remains in question.

In efforts to create an effective influenza vaccine, researchers at the University of Nebraska recently developed an adenoviral vectored multivalent centralized influenza vaccine that protects against more strains, and therefore may protect people for years instead of a single season. Virologist Eric Weaver and his team partially reconstructed ancestral influenza viruses into an artificial virus by tracing back the genes of modern influenza strains and finding similarities. Weaver reported 18 subtypes of influenza strains, but worked with four that are most likely to cause influenza outbreaks. The team altered the artificial virus gene so that it would not potentially cause influenza and then inserted it into a vector of the adenovirus. The immune response occurs to the ancestral virus when the adenoviral vector is used to deliver the vaccine into cells. The team tested the vaccine on mice, by immunizing them with the new vaccine in high or low doses and compared it to mice immunized with 2010-2011 FluZone (25 ng of each hemagglutinin protein/mouse) and FluMist (2µl/nare). The mice were then exposed to nine different influenza viruses. FluZone and FluMist protected mice from only four of the nine influenza viruses, therefore the viruses killed most of the mice. The multivalent centralized vaccine successfully protected 100% of mice from eight of the nine influenza viruses at a high dose and seven of the nine influenza viruses at a low dose. The future of this vaccine would turn the course of influenza seasons and eliminate the struggle of predicting the strains for the vaccines annually. It may be years until a long-term vaccine will be ready for use as research for this vaccine is ongoing. Although this year's vaccine may have been less than ideal and possibly less effective, it is imperative for pharmacists to continue encouraging patients to get the influenza vaccine to provide some protection against influenza.[4]

Shireen Farzadeh
Pharm.D. Candidate 2019
St. John's University

1. Centers for Disease Control and Prevention. Influenza. CDC. https://www.cdc.gov/flu/index.htm. Published 02/02/2018.
2. Paules CI, Sullivan SG, Subbarao K, et al. Chasing Seasonal Influenza — The Need for a Universal Influenza Vaccine. *N Engl J Med.* 2018;378(1):7-9.
3. New York State Department of Health. Non-Patient Specific Order for the Administration of Influenza Vaccine (2017-2018 Season). January 27, 2018. http://files.constantcontact.com/599cc597301/26bdc669-c068-48c7-ae8b-1d22ff79708c.pdf. Accessed February 6, 2018.
4. Lingel A, Bullard BL, Weaver EA. Efficacy of an Adenoviral Vectored Multivalent Centralized Influenza Vaccine. *Sci Rep.* 2017;7(1):14912. doi: 10.1038/s41598-017-14891-y.

* Figure 1: Centers for Disease Control and Prevention . Weekly U.S. Influenza Surveillance Report. CDC. https://www.cdc.gov/flu/weekly/index.htm#ILIMap. Published 02/16/2018.

Update in the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults

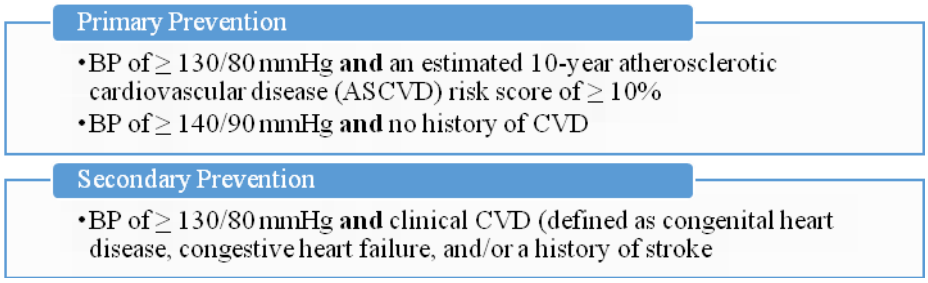
The American College of Cardiology (ACC) and the American Heart Association (AHA), in collaboration with nine other organizations, released new guidelines for the prevention, detection, evaluation, and management of high blood pressure in adults on November 13, 2017. Prior guidelines on hypertension were released by the Joint National Committee (JNC) in 2014 (JNC 8 Report) and in 2003 (JNC 7 Report).

One of the major changes from the preceding JNC 8 and JNC 7 guidelines is the classification of blood pressures. "**Normal**" BP is defined as a systolic blood pressure (SBP) of < 120 mmHg and a diastolic blood pressure (DBP) of < 80 mmHg. "**Elevated**" BP is defined as a SBP of 120-129 mmHg and a DBP of < 80 mmHg. Clinical hypertension now begins at a BP of ≥ 130/80 mmHg and is separated into two distinct categories. "**Stage 1 hypertension**" is now classified as a SBP of 130-139 mmHg or a DBP of 80-89 mmHg. "**Stage 2 hypertension**" is now described as a SBP of ≥ 140 mmHg or a DBP of ≥ 90 mmHg. If a patient has a SBP and DBP in two separate categories, the patient should be designated to the higher blood pressure category. Overall, these changes have essentially lowered the threshold of where clinical hypertension begins. Below is a chart summarizing the major changes:

2014 JNC 8 / 2003 JNC 7	2017 ACC/AHA
• **Normal**: <120/80 mmHg • **Prehypertension**: SBP: 120-139 mmHg DBP: 80-89 mmHg • **Stage 1 Hypertension**: SBP: 140-159 mmHg DBP: 90-99 mmHg • **Stage 2 Hypertension**: ≥160/100 mmHg	• **Normal**: SBP: <120 mmHg **and** DBP: < 80 mmHg • **Elevated**: SBP: 120-129 **and** DBP: <80 mmHg • **Stage 1 Hypertension**: SBP: 130-139 **or** DBP: 80-89 mmHg • **Stage 2 Hypertension**: SBP: ≥ 140 **or** DBP: ≥ 90 mmHg

Weight loss, physical activity, and a healthy diet (i.e. sodium reduction, potassium supplementation, and limiting alcohol consumption) are still the cornerstones of nonpharmacological therapy.

Another main change is the recommendation of when pharmacological treatment should begin. It is recommended that pharmacological treatment should be initiated in patients for both primary and secondary prevention of cardiovascular disease (CVD) events.



Target blood pressure goals have also been lowered from 140/90 mmHg to **130/80 mmHg**. Studies have shown that targeting a BP to 130/80 mmHg or less has led to a reduction of stroke, coronary events, major CVD events, and CVD mortality. The guidelines have also eliminated age-related targeted BP goals. In patients with confirmed hypertension and no known markers of increased CVD risk, the target BP goal is set at < 130/80 mmHg. It is recommended that any adult with confirmed hypertension and known CVD or a 10-year ASCVD risk score of ≥ 10%, the target BP goal is also at < 130/80 mmHg. In patients with comorbidities such as ischemic heart disease, congestive heart failure, type 2 diabetes mellitus, and chronic kidney disease, the recommended target BP goal is 130/80 mmHg.

First-line pharmacological treatment include angiotensin-converting enzyme inhibitors (ACEIs), angiotensin-receptor blockers (ARBs), calcium channel blockers (CCBs), and thiazide diuretics. These four classes of antihypertensive medications are the mainstay of hypertension treatment and are consistent from previous JNC guidelines.

For the treatment of hypertension and ischemic heart disease, first-line antihypertensive medications include guideline-directed medication therapy (GDMT), such as beta-blockers (BBs) and ACEIs or ARBs. BBs have been shown to prevent angina pectoris and coronary events. In the setting of post-myocardial infarction, BBs reduce all-cause mortality. ACEIs and ARBs reduce the incidence of myocardial infarction, stroke, and CVD.

For the treatment of hypertension and reduced ejection fraction heart failure (HFrEF), first-line treatment is also with GDMT. Medications include ACEIs or ARBs, angiotensin receptor-neprilysin inhibitors, BBs, diuretics, and aldosterone antagonists. With the exception of diuretics, all other agents are shown to reduce mortality in the setting of HFrEF. Recommended BBs include carvedilol, metoprolol succinate, and bisoprolol. Non-dihydropyridine CCBs, such as diltiazem and verapamil, are not recommended in the setting of HFrEF due to their myocardial depressing activity. If a CCB is necessary, it is recommended to use amlodipine or felodipine.

For the treatment of hypertension and chronic kidney disease (CKD), first-line treatment depends on the stage of CKD and the presence or absence of albuminuria. In patients with CKD stage 3 or higher or in patients with CKD stage 1 or 2 with albuminuria > 300 mg/dL, ACEIs or ARBs are recommended. If the patient has CKD stage 1 or 2 with no albuminuria, ACEIs, ARBs, CCBs, or thiazide diuretics can be utilized.

For the treatment of hypertension and type 2 diabetes mellitus (DM2), first-line treatment depends on the presence of albuminuria. If albuminuria is present, ACEIs or ARBs are recommended. If albuminuria is not present in patients with DM2, ACEIs, ARBs, CCBs, or thiazide diuretics are recommended.

African-Americans have a higher prevalence of hypertension in contrast to all other racial classes. The first-line recommended agents include thiazide diuretics and CCBs. In patients with hypertension and concurrent CKD and DM2, ACEIs and ARBs are recommended agents in the treatment plan.

In summary, the major changes are as followed:

1. Clinical Stage 1 hypertension is now defined a SBP of 130-139 mmHg or a DBP of 80-89 mmHg, which is a lowering from prior guidelines.
2. Pharmacological treatment should begin in primary prevention and secondary prevention of CVD events, depending on the presence of CVD history, the calculated ASCVD risk score, and measured BPs.

Target blood pressure goals have also been lowered and is now < 130/80 mmHg.

Stephanie Lim, Pharm.D.
PGY-1 Pharmacy Practice Resident
St. Francis Hospital

A Hero Among Us

Nearly three years after swabbing her cheek at an educational dinner sponsored by the Long Island Society of Health-system Pharmacists to sign up for the National Marrow Donor Program (NMDP) registry, Stony Brook Medicine's own Claudia Alfiero was informed that she was a perfect match for a patient in England who was in desperate need of life-saving stem cells.

After undergoing testing to confirm that she was a healthy donor, Claudia was led through the stem cell donation process by coordinators from the Blood and Marrow Transplant program at Stony Brook. She received daily injections of filgrastim, a mobilization agent which prepared her body for donation, causing stem cells from her marrow to proliferate and enter her circulating bloodstream. Five days after starting her injections, she then proceeded to Stony Brook's Blood Bank for a day of collection via apheresis. For six hours, she was hooked up to a machine that took her blood, pulled the desired stem cells from it, and then reinfused the blood back into her. While this is typically a single day procedure, Claudia unexpectedly required a second day of apheresis to garner a sufficient amount of stem cells to donate. Fortunately, the Blood Bank staff was incredibly kind and helpful during this process.

Claudia's stem cells were then processed in the BMT laboratory and shipped off to England where the patient was already prepped and awaiting transplant. While Claudia does not know any details about the recipient other than where he/she lives, she has the option of reaching out to her recipient in one year.

For more information about signing up for the bone marrow registry, visit https://bethematch.org. You too could be called to save a life!

Caesar Alaienia, Pharm.D., BCPS, BCCCP
Clinical Assistant Professor of Pharmacy Practice and Clinical Sciences
Critical Care Pharmacy Specialist
Stony Brook School of Pharmacy and Pharmaceutical Sciences
Stony Brook University Hospital

To Pick or Not to Pick: A Case of Mushroom Poisoning

Case Presentation

A 61 year-old female presented with nausea, vomiting, and upper abdominal pain 18 hours after ingesting local wild mushrooms. Initially, her physical exam was benign including a normal abdominal exam. Her laboratory values were unremarkable and vital signs were stable; however, she was unable to tolerate oral intake, and was thus admitted for observation and symptom control. During her hospital course, she received supportive care, in addition to intravenous n-acetylcysteine (NAC), and penicillin G for empiric treatment of mushroom poisoning, likely from *Amanita verna*. Her liver function tests (LFTs) trended upward with a peak of AST 15,102 U/L, ALT 9,005 U/L, and INR 2.42 on day 3. Given the rising LFTs, there was a concern for the development of fulminant hepatic failure secondary to mushroom poisoning. As a precaution, she was transferred to an outside hospital with an active liver transplant program. At this second institution, NAC was continued and her LFTs began to normalize, thereby eliminating her need for transplant. The patient continued to stabilize and was discharged home five days after the transfer.

Discussion

The majority of fatal mushroom poisonings occur following ingestion of *Amanita* species, which contain amatoxins. The toxic effects of amatoxins manifest primarily in the liver resulting in hepatic necrosis. The mechanism of toxicity is unclear and likely multifactorial. Possible mechanisms include production of free radicals, induction of TNF-alpha-mediated apoptosis, and inhibition of RNA polymerase. Initial presentation of mushroom poisoning occurs 6-24 hours post-ingestion and is characterized by severe gastrointestinal symptoms, such as abdominal pain, vomiting, and diarrhea. Elevations in liver enzymes become apparent 18-36 hours post-ingestion and can eventually lead to fulminant hepatic failure and death within 2-6 days.

Currently, there is no antidote for amatoxin poisoning. Management generally involves supportive care and administration of NAC, penicillin G, and/or silibinin. NAC acts as a free radical scavenger and restores glutathione which is associated with reduced mortality. Penicillin G, which has been used historically, inhibits the uptake of amatoxins into the liver. Silibinin, an extract of milk thistle, is available in Europe and is currently under investigation in the United States. It may be hepatoprotective by inhibiting uptake of amatoxins into the liver and reducing hepatic TNF-alpha. The highly variable regimens and outcomes published to date provide unclear recommendations as to which treatment modalities are most beneficial.

Conclusion

Clinicians should be aware of mushroom toxicity as it is a rare but fatal condition. This case highlights the importance of rapid recognition and initiation of treatment in order to achieve favorable patient outcomes.

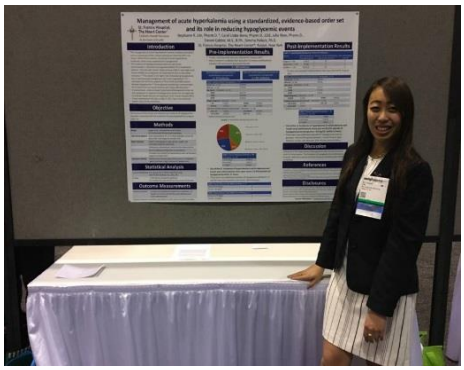
Bhumi Pandhi, PharmD, BCPS, Clinical Pharmacy Coordinator, Emergency Department, Huntington Hospital
Nicholas Fausto, PharmD, Pharmacy Resident, Huntington Hospital

New Residency Program Opens on Long Island

St. Francis Hospital (SFH), The Heart Center®, is a member of Catholic Health Services of Long Island (CHSLI). Located on the north shore of Long Island in Nassau County, the hospital is in close proximity to New York City and is the only specialty designated cardiac center in New York State. St. Francis Hospital is nationally recognized as a leader in cardiac care with specialties in heart surgery, cardiac catheterization angioplasty, and the diagnosis and treatment of cardiac arrhythmias. Additional outstanding clinical programs include urology, orthopedics, gastroenterology & gastrointestinal surgery, neurology & neurosurgery, pulmonology, geriatrics, and oncology. The Cancer Institute is an accredited comprehensive community-based cancer program that provides compassionate care involving a multidisciplinary team led by distinguished Oncologists with a focus on excellence.

A PGY-1 Pharmacy Residency program was initiated in 2017. It is a twelve-month structured training program that focuses on inpatient medication therapy management. Residents work collaboratively with the multidisciplinary team to provide optimal pharmaceutical patient care. The program is designed to enhance the residents' clinical skills and competence. Rotations can be tailored to each resident's field of interest. The program is led by Program Director, Carol Liotta-Bono, Pharm.D., CDE and Director of Pharmacy, Steven Cabble, M.S., R.Ph.

St. Francis Hospital



Stephanie Lim, Pharm.D.
PGY1 Resident

The Unit-Based Pharmacy Program at the hospital supports the active clinical role of pharmacists as a vital member of the healthcare team. Unit-Based Pharmacists are involved in multidisciplinary rounds, provide drug information to the healthcare team and patients, and assist in medication reconciliation. The off-site Infusion Center Pharmacy provides medication management services for the Cancer Institute and other specialties requiring parenteral therapy. The department has

affiliations with several Schools of Pharmacy offering rotations in Cardiology and Acute Care/Institutional for Advanced Pharmacy Practice students.

Core Rotations of the PGY-1 Residency include Pharmacy Practice, Internal Medicine, Antimicrobial Stewardship/Infectious Diseases, Emergency Medicine and Cardiac Critical Care. Elective rotations include Oncology and Administration/Leadership. Longitudinal rotations allow the Resident to gain experience in developing clinical pharmacy skills, interprofessional education, research opportunities, leadership/administrative responsibilities, and student preceptorship.

One Resident began in 2017 and there are two positions available for 2018. The requirements for accreditation by the American Society of Health-System Pharmacists (ASHP) are being pursued at this time. The PGY-1 Residency Program at St. Francis Hospital offers a variety of clinical, leadership and teaching experiences in a caring environment with a commitment to excellence in patient care.

Carol Liotta-Bono, Pharm.D., CDE, Assistant Director, Clinical Pharmacy Services, Pharmacy Department, St. Francis Hospital

The NYSCHP New Practitioner Committee

NYSCHP is pleased to introduce a new committee for our new practitioner members. Mirrored from the American Society of Health-System Pharmacists (ASHP) New Practitioner's Forum, this committee is meant to support new practitioners' transition into real world practice and kindle lifelong involvement in professional organizations.

Scope
The committee primarily targets pharmacists in their first 1-5 years after formal education or residency training.

Mission
Increase engagement within NYSCHP by providing a community and collective voice for new practitioners as they transition into pharmacy practice.

Vision
Advance the future of the profession through the growth of pharmacy practice leaders and ensure NYSCHP and ASHP are their preferred professional organizations.

The purpose of the NPC is to provide a network of educational and professional support to our newest pharmacists and inspire NYSCHP involvement early on in their careers. Our goal is to provide opportunities for professional collaboration and development, as well as mentorship and support from seasoned pharmacy practitioners. The committee intends to serve the educational and informational needs of new practitioner members through programs that promote leadership and engagement opportunities. We hope to engage our newest members on topics such as clinical updates, grassroots advocacy and leadership.

We welcome new practitioner members and hope to give them the most value possible as a NYSCHP member. This initiative will encourage lifelong NYSCHP involvement from the new generation of pharmacists and create an impact on NYSCHP members in years to come.

Keep a look out for more information regarding the NPC on the NYSCHP website!

References:

1. New Practitioner Forum. ASHP. https://www.ashp.org/new-practitioner/new-practitioners-forum

If you have any questions, feel free to contact:

Amy Wojciechowski, PharmD, BCPS-AQ ID, BCCCP (amy.wojciechowski@nfmmc.org)
Harshal Shukla, PharmD, BCPS (hshukla@montefiore.org)
Stephanie Lombardi, PharmD Candidate 2018 (stephanie.lombardi@acphs.edu)

Event Highlights: Quad Meeting

The Long Island Society of Health-system Pharmacists

This has been an exciting year for the Long Island Society of Health System Pharmacists.
Our enthusiastic Board members have been working hard to plan monthly continuing education dinners, networking events and community events that promote our profession.

Community service is important to us. In January, our overwhelmingly generous members donated warm winter clothing for those in need living on Long Island. We also helped a group of Girl Scouts earn their Best Bones badge by educating them about Osteoporosis. The event went so well, we were invited back to educate another group in May!

Another benefit of membership is networking opportunities. This year, we held a Residency Networking event in the Fall which brought together residents and preceptors from the nine programs on Long Island. We are also planning a Paint Night in April for our members.

We had the opportunity to host the Quad in February, and it was truly a rewarding experience. It was great to see members from different Chapters sitting together throughout the room. Our speaker, Leigh Briscoe-Dwyer, gave an inspiring talk on Advocacy, Leadership and the Future of Health-system Pharmacy.

It has been gratifying being President of LISHP this year. The contributions of our loyal members remind me of the following quote by Helen Keller: “Alone we can do so little; together we can do so much.”

Thank you to all of our members for your dedication to our profession and your contributions to our Community.

Allison Raich, Pharm.D., BCPS
President, LISHP

LISHP 2017-2018 Board Members

Event Highlights

In January, LISHP held an event at Forest Lake Elementary School in Wantagh for the Girl Scouts. LISHP helped a group of 9 year old girls earn their Best Bones Badge by teaching them all about Osteoporosis. They discussed how to take care of bones and then asked the girls to make posters at the end describing what “strong bones” mean to them.

LISHP presentation was well received and they have been invited back to educate an additional group of Girl Scouts.

NYSCHP
New York State Council of Health-system Pharmacists
60 YEARS

2018

New York State Council of Health-system Pharmacists

57th Annual Assembly

PHARMACISTS AS PROVIDERS:
COMPLETING THE CIRCLE OF PATIENT-CENTERED CARE.

April 19 - April 22

The Saratoga Hilton

Saratoga Springs, NY

NYSCHP | New York State Council of Health-system Pharmacists

230 Washington Avenue Ext., Suite 101
Albany, NY 12203
Phone: 518-456-8819

2018 ANNUAL ASSEMBLY SOCIAL EVENT

A NIGHT IN VENICE

BRING YOUR MASKS AND CAPES.
MASKS WILL ALSO BE PROVIDED.

Friday, April 20, 2018

SARATOGA HILTON | SARATOGA SPRINGS, NY

8:00-11:00 PM

Join with your colleagues from across New York State as we celebrate the Council's 60th anniversary at the 2018 Annual Assembly.

New York State Council of Health-system Pharmacists

Annual Assembly 2018: Save the Date Student Flyer

PHARMACISTS AS PROVIDERS:
COMPLETING THE CIRCLE OF PATIENT-CENTERED CARE

The Saratoga Hilton
Saratoga Springs, NY

- **Registration Cost: $100 (Decreased from $175 last year!)**
- **Student Clinical Competition**
  - One pair of students from each college of pharmacy will compete in this Inaugural Competition
  - Each college of pharmacy will determine which pair of students will represent their school
  - The competition will take place on Saturday, April 21st, 2018 from 3-6pm
  - Please contact your school NYSCHP liaison or office@nyschp.org with any questions
- **Poster Session**
  - Submit an abstract to present a poster at the AA
    - Results are required for all submissions
  - Deadline for abstract submission: February 19, 2018
  - Scheduled for Saturday, April 21st, 2018
- **Highlighted programs**
  - Opioid crisis and epidemic
  - New guideline overviews
  - Practice changing papers and recent landmark publications
- **House of Delegates**
  - Come observe the House of Delegates in action as we discuss important resolutions for NY state!

NYSCHP New York State Council of Health-system Pharmacists

230 Washington Avenue Ext., Suite 101 Albany, NY 12203
Phone: 518-456-8819
Fax: 518-456-9319
www.nyschp.org

For more information go to www.nyschp.org

Forget Bitcoin and Virtual Cryptocurrencies…….
How about a REAL one-of-a-kind "CouncilCoin"?

For a minimum donation of $60 to the NYSCHP PAC Fund, you can receive a

Limited-edition challenge coin commemorating our 60th anniversary!

Only 250 coins were commissioned, so don't wait to support the Council's advocacy initiatives. Coins will be reserved on a first-come basis until 4/13/18 and any remaining will be available at the Annual Assembly

Your coin can be picked up at the Annual Assembly in Saratoga Springs (or shipped thereafter if you cannot attend)

For any questions, contact NYSCHP President Christopher Jadoch at (716) 829-8340 or jadochc@dyc.edu

Make checks payable to "NYSCHP PAC" and mail to:

Christopher Jadoch, Assistant Dean
D'Youville School of Pharmacy
320 Porter Avenue
Buffalo, NY 14201

Important HOD and Resolutions Dates

March 2018

- March 30th: Opening Hearing Conference call (noon – 1 pm)

April 2018

- April 9th: Resolution Committee call (noon – 2 pm)
- April 19th: HOD Open Hearing (on site) 6 – 7 pm
- April 20th: HOD (8 am – noon)

NYSCHP and Local Chapter Upcoming Events

March 2018

- March 27th: NYCSHP Clinical and Director Roundtable
- March 29th: Northeastern Chapter Resident Webinar Series - Review of Neuropathic Pain Management
- March 29th: Northeastern Chapter Resident Webinar Series - Direct Oral Anticoagulants in Patients with Venous Thromboembolism and Obesity

April 2018

- April 3rd: Northeastern Chapter Non-CE Program - Cancer Immunotherapy: An Interprofessional Approach to the Management of Immune-Mediated Adverse Events
- April 12th: NYCSHP Student Roundtable
- April 12th: Northeastern Chapter Non-CE Program
- April 19 – 22nd: NYSCHP Annual Assembly, Saratoga Springs, NY
- April 28th: NYCSHP Adopt-a-Highway

May 2018

- May 5th: NYCSHP Brown Bag Event (St. Charles Borromeo on 141st)
- May 12th: NYCSHP Football Scrimmage (Central Park)
- May 16th: WNYSHP, Free Resident Lunchtime CE

June 2018

- June 21st: NYCSHP Installation Dinner (Sheraton Marriott Time Square)

Follow NYSCHP on Facebook!

Click here to Like or page!

Connect with us through LinkedIn

Journal of Pharmacy Practice

The Journal of Pharmacy Practice (JPP) is the official journal for NYSCHP.

For the latest issue, please follow the link below.

http://journals.sagepub.com/home/jpp.