INSIDE:
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Photos from Convention, and more!
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MPhA Calendar at a Glance

September 13  Consultant Seminar  UMMC School of Pharmacy  Wells Auditorium  Jackson, MS  2500 North State Street  Registration: 7:45 a.m.  Seminar: 8 a.m. - 5 p.m.

September 15  District 3 Meeting  AC’s Steakhouse Pub  Hernando, MS  333 Losher Street  6:30 p.m.

September 22  Consultant Seminar  The Powerhouse  Community Arts Center  Oxford, MS  413 S 14th Street  Registration: 7:45 a.m.  Seminar: 8 a.m. - 5 p.m.

For more information about upcoming events, visit our website www.mspharm.org

Thank You to our 2016 Convention exhibitors and sponsors!

AbbVie  Freedom Pharmaceuticals  MS State Dept. of Health, OEPR
ACT for Tobacco Treatment, Education, & Research  Grifols  Mylan Inc.
American Pharmacy Cooperative Inc.  Hospira  Novo Nordisk Diabetes
AstraZeneca Diabetes  Janssen  Novo Nordisk, Inc.
Avanir Pharmaceuticals  Lilly USA, LLC  Pfizer Injectables
Cardinal Health  McKesson  Pfizer Vaccines
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Rite Aid Pharmacy  Sanofi  Southern Pharmacy Cooperative
Sunovian Pharmaceuticals, Inc.  Trividia Health  Walgreens
XenoPort
Welcome to all the pharmacists and technicians across the state from across all of our worksites!

We held our 145th Annual Convention and Trade Show in July, where the 2016-2017 Executive Committee was sworn in, and am I excited! But I have to start with the obvious – 145th convention? Since 1871, the pharmacists in this state have been meeting to move this profession forward to where it is today. The first law in Mississippi requiring a license for pharmacists wasn’t enacted until 21 years later in 1892 when the Board was also created. Ole Miss’s School of Pharmacy wasn’t even opened until 1908 – 16 years after the Board and 37 years after the association had been formed and operating. Quite an accomplishment for our association to assist and help form both entities!

I look back at the history of our association for one purpose – to help us draw inspiration for our future. At the beginning of our profession – the pharmacists were essential developers to the path that future generations would take. The law did not come first; the school did not come first – the practitioners were first. The law and the school followed as an extension of the practitioners to educate pharmacists, protect citizens, and grow our profession. Please do not misunderstand me – the law and the school are critical components of our careers and I do not minimize their impact. Both institutions are wonderfully open and inviting of the practitioner’s input and feedback and I generously thank them for their continued support of our profession.

I do believe that our future roles are to be guided by our current practitioners and we must embrace our destiny by once again working together across all practice sites to provide a future greater than our own for those coming behind us. It’s our turn to receive the baton and run our leg of the race. It’s a marathon to be sure but we are not charged with running the entire race by ourselves, rather just our portion and to run it well.

My personal objective this year is to continue to build upon the work set by our previous presidents – to unify our community of pharmacists in thought and action to effectively and efficiently move us to the next stage of our profession’s growth. A very long time ago, pharmacists were the chemists and compounders, then most of us became dispensers and retailers, and now the push is to become practitioners of our knowledge. It’s a very significant challenge that we’re embarking upon and I’m glad to say that the profession has taken a very healthy step across all sites to form a Workgroup Coalition to have pharmacists in our state recognized as bona fide health care practitioners. Representatives from all pharmacist groups have been invited to this Coalition and, for the most part, have been present and active.

This month we will once again hold our Board of Advisors meeting in order to help the association direct its steps this year and for the coming years. And we will be soliciting feedback during all of the District meetings throughout the year. I ask that you submit all of your ideas and suggestions through direct communication to our office or through our district leaders for discussion at the upcoming August meeting. We take seriously your views and opinions and want them addressed appropriately.

I’m a firm believer in the power of the individual to affect change. When individuals group together for a common goal the chance of success in achieving the goal is greatly increased. Our profession’s history in our state is testament to our practitioner’s ability to succeed. Once again, we are being asked to step forward and step up.

This year, I am asking for your help. Submit your ideas, volunteer for committees, attend district meetings, make your voice heard, support the PAC, sponsor students, interact with the school and board, become a preceptor, and/or any other activity with which you can get involved. There are many opportunities for you to help the group that will fit into your current life’s events and commitments. Join me this year! Your participation will make the difference.

Together,

Chris McLaurin
145th Annual Convention and Trade Show
Will You Avoid These Estate Planning Mistakes?

Too many wealthy households commit these common blunders.

Many people plan their estates diligently, with input from legal, tax, and financial professionals. Others plan earnestly, but make mistakes that can potentially affect both the transfer and destiny of family wealth. Here are some common and not-so-common errors to avoid.

**Doing it all yourself.** While you could write your own will or create a will or trust from a template, it can be risky to do so. Sometimes simplicity has a price. Look at the example of Warren Burger. The former Chief Justice of the United States wrote his own will, and it was just 176 words long. It proved flawed – after he died in 1995, his heirs wound up paying over $450,000 in estate taxes and other fees, costs that likely could have been avoided with a lengthier and less informal will containing appropriate language.¹

**Failing to update your will or trust after a life event.** Relatively few estate plans are reviewed over time. Any life event should prompt you to review your will, trust, or other estate planning documents. So should a life event affecting one of your beneficiaries.

**Appointing a co-trustee.** Trust administration is not for everyone. Some people lack the interest, the time, or the understanding it requires, and others balk at the responsibility and potential liability involved. A co-trustee also introduces the potential for conflict.

**Being too vague with your heirs about your estate plan.** While you may not want to explicitly reveal who will get what prior to your passing, your heirs should have an understanding of the purpose and intentions at the heart of your estate planning. If you want to distribute more of your wealth to one child than another, write a letter to be presented after your death that explains your reasoning. Make a list of which heirs will receive particular collectibles or heirlooms. If your family has some issues, this may go a long way toward reducing squabbles and the possibility of legal costs eating up some of this or that heir’s inheritance.

**Failing to consider what will happen if you & your partner are unmarried.** The “marriage penalty” affecting joint filers aside, married couples receive distinct federal tax breaks in this country – estate tax breaks among them. This year, the lifetime gift and estate tax exclusion amount is $5.45 million for an individual, but $10.9 million for a married couple.¹² If you live together and you are not married, it is worth considering how your unmarried status might affect your estate planning with regard to federal and state taxes. As Forbes mentioned last year, federal and state taxes claimed more than more than $15 million of the $35 million estate of
Oscar-winning actor Phillip Seymour Hoffman. He left 100% of his estate to his longtime partner, and since they had never married, she could not qualify for the marriage exemption on inherited assets. While the individual lifetime gift and estate tax exclusion protected a relatively small portion of Hoffman’s estate from death taxes, the much larger remainder was taxed at rates of up to 40% rather than being passed tax-free. Hoffman also lived in New York, a state which levies a 16% estate tax for non-spouses once estates exceed $1 million.1

Leaving a trust unfunded (or underfunded). Through a simple, one-sentence title change, a married couple can fund a revocable trust with their primary residence. As an example, if a couple retitles their home from “Heather and Michael Smith, Joint Tenants with Rights of Survivorship” to “Heather and Michael Smith, Trustees of the Smith Revocable Trust dated (month)(day), (year)”. They are free to retitle myriad other assets in the trust’s name.1

Ignoring a caregiver with ulterior motives. Very few people consider this possibility when creating a will or trust, but it does happen. A caregiver harboring a hidden agenda may exploit a loved one to the point where he or she revises estate planning documents for the caregiver’s financial benefit.

The best estate plans are clear in their language, clear in their intentions, and updated as life events demand. They are overseen through the years with care and scrutiny, reflecting the magnitude of the transfer of significant wealth.

CITATIONS.
1. raymondjames.com/pointofview/seven_estate_planning_mistakes_to_avoid [10/16/15]
2016 MPhA Awards

Distinguished Young Pharmacist, Ann Franklin

Spirit of Pharmacy, Andrew Mays

Pharmacy Technician, Traci Tarver

Hall of Fame, Jillian Foster

Student Pharmacist, Stephanie Sollis

Student Pharmacist, Kelsey Stephens

Excellence in Innovation, Kristi Phelps (accepted on her behalf by Bob Broadus)

J.D. Slater District Achievement, Emily Melton

MPhA Member of the Year, Tripp Dixon

Cardinal Health Generation Rx Champions Award Winner, Chris McLaurin

Bowl of Hygeia, Robert Salmon
2016 Ron “Ace” Borne/Neal Wyatt Golf Tournament
Meet Your Leadership
2016-2017 Executive Committee

The 2016-2017 Executive Committee was sworn in at MPhA’s 2016 Convention. In this issue, you’ll be able to learn a little bit more about them.

President: Chris McLaurin

Chris McLaurin is a native of Corinth, MS, and resides in Brandon, MS, with his wife of 22 years and four children. He has been with Walgreens since 2003, most recently as the healthcare supervisor. In this role, he serves as the clinical lead for professional pharmacy services offered to patients throughout the state through the retail locations. He is a graduate with honor of the University of Mississippi School of Pharmacy with a minor in business administration. Dr. McLaurin has spent a majority of his practice in the retail sector with experience in independent, grocer, and chain pharmacy practice. He is a preceptor with undergrad Ole Miss students as well as a residency preceptor with the school’s community residency program. In 2015, Dr. McLaurin served as the lead administrator and clinical preceptor for the Walgreens community residency program in Mississippi. He also serves on the Board of Trustees for the Leukemia & Lymphoma Society focused on fundraising for curing blood cancers.

President-Elect: Cliff Osbon

Cliff Osbon serves as President of Transcript Pharmacy, Inc. Transcript is an independent specialty pharmacy provider, based in the Jackson, MS area. Transcript holds board of pharmacy permits in all 50 states and currently serves patients in about half of those states. His background includes 9 years of community pharmacy practice, 5 years of nuclear pharmacy practice and management, 5 years of pharmacy benefits consulting and 13 years of management at Transcript. Cliff graduated from University of Louisiana – Monroe College of Pharmacy with honors in 1984 and completed Purdue University’s nuclear pharmacy program in 1993. He is a long-time advocate for “any willing provider” issues and seeks to ensure that patients and clinicians may select or recommend any willing and qualified pharmacy provider. Cliff has been a resident of Mississippi since 1995. He and his wife, Angela, have four children, Sarah, Hannah, Josh and Grant.

Vice President: Lauren Bloodworth

Lauren Bloodworth is originally from Batesville, Mississippi. Lauren is a 2000 graduate of the University of Mississippi School of Pharmacy. She then completed an ASHP-Accredited Pharmacy Practice Residency at the North Mississippi Medical Center in 2001. She was then employed as a Clinical Pharmacy Specialist at Saint Francis Hospital in Memphis, Tennessee for 2 years. Dr. Bloodworth moved to the Jackson Metro area in 2003 and was employed at the University of Mississippi Medical Center as a Medical Intensive Care Unit Pharmacist and then a Clinical Pharmacy Specialist in Ambulatory Care. She was Director of the Adult Asthma Pharmacy Clinic and worked in the Anticoagulation and Metabolic Clinics. She then transitioned to a position with the University of Mississippi School of Pharmacy where she was Assistant Dean for Student Services in Jackson, as well as, Administrator of the School’s Community-Based Research Program. She recently moved to Desoto County and is currently a Clinical Associate Professor at the University of Mississippi School of Pharmacy in Oxford. Lauren has previously served as MPhA’s Central District Chairman from 2003-2007 and currently serves on the Education and Award’s and Nominations Committees. Lauren and her husband, Ward, live in Hernando, MS with their three children, Max, Drake, and Rivers.
Treasurer: Lee Ann Griffin

Lee Ann Griffin is currently a Team Leader of Medical Outcomes Specialists for Pfizer, covering the Gulf Coast/Plains region. After graduating from Ole Miss with her PharmD, Lee Ann completed a Pediatric Specialty Residency at Texas Children's Hospital (TCH) in Houston, TX. Post-residency, Lee Ann was a Clinical Pharmacy Specialist at TCH, then joined Pfizer Medical Affairs as a Medical Outcome Specialist. Her career with Pfizer took her to Milwaukee and New York before bringing her back home to Mississippi in 2007. Lee Ann is a member of MPhA and AMCP, and is the co-sponsor of the student AMCP chapter for the School of Pharmacy Jackson campus. She currently serves as President of the University of MS Pharmacy Alumni Board, and is both a PBL facilitator for PY3 students. She is a member of the MPhA Education Committee, and enjoys working as a relief pharmacist for an independent pharmacy in the Jackson area. Lee Ann has served as the Executive Chair of the Diabetes Coalition of MS, and was a member of the MS Health Insurance Exchange Advisory Board under the direction of Insurance Commissioner Chaney. Lee Ann and her husband, Brad, live in Jackson with their two children, Harper and Cooper, and their two black labs, Miller and Duke.

At-Large Member: Ross Guastella

Ross Guastella has more than 25 years of pharmacy retail leadership experience. Ross is a Pharmacy Supervisor for CVS Health for Central Mississippi. Previously, Ross was a HealthCare Manager for Fred’s Pharmacy in Central Mississippi – Delta. He also has 19 years of experience with Walgreens in leadership positions including Store manager and District Manager, managing two districts. Ross began his pharmacy career working with his father in family owned pharmacies in the Chicago land area. Ross comes from a family of pharmacists to include his father, sister and wife. Ross has years of retail experience with both Independent and Chain pharmacy operations. Ross Guastella received his bachelor’s degree in pharmacy from Butler University in Indianapolis, Indiana. He has practiced pharmacy in several states including Illinois, Indiana, Ohio and Mississippi. Ross has severed as member of the Chamber of Commerce, Kiwanis Club and Relay for Life. Ross also serves on the Board for Belle Point Home Owners Association and Lake Caroline Home Owners Association. Ross is an avid deer hunter, enjoys fishing and is a member of the NRA.

At-Large Member: Peyton Herrington

Peyton Herrington graduated from The University of Mississippi in 2006 and worked at University Medical Center before realizing that community pharmacy was a better practice setting for him to work in as a pharmacist. He has worked for 2 different retail chains, 2 hospitals, has worked as a relief pharmacist at an independently owned pharmacy, and practiced pharmacy in another state for a period of time as well. Peyton has maintained membership in APhA since graduating and has served in various positions at MPhA since joining around 2009. He stays active in his community and those organizations that he feels positively impact his community, especially those organizations hoping to increase literacy. He also looks forward to finding opportunities that will introduce his children to ways to become active in their local community.

Past President: Phil Ayers

Phil Ayers, Pharm.D., BCNSP, FASHP, received his Bachelor of Science degree in pharmacy from the University of Mississippi. He also received his Doctor of Pharmacy degree from the University of Mississippi. Dr. Ayers is currently employed by Baptist Health Systems in Jackson, MS. He is a clinical specialist in nutrition support and serves the Department of Pharmacy as Chief of Clinical Pharmacy Services. Dr. Ayers is a Clinical Associate Professor, School of Pharmacy for the University of Mississippi. He was awarded the Clinical Science Teaching Award in 2007 and 2008 by the School of Pharmacy. Dr. Ayers was named the APPE Preceptor of the Year by the 2012 School of Pharmacy Graduating Class. Phil currently serves on the Mississippi Board of Pharmacy and is the Secretary-Treasurer for the American Society for Parenteral and Enteral Nutrition (ASPEN) Board of Directors. ASPEN awarded Dr. Ayers the Stanley Serlick Award in 2016 for his work in the area of Parenteral Nutrition Safety. Phil is a member of the United States Pharmacopoeia (USP) Healthcare Quality Committee and Chair of the USP Parenteral Nutrition Safety Expert Panel. The Mississippi Society of Health-System Pharmacists named Dr. Ayers the Health-System Pharmacist of the Year in 2002 and in 2009. He was named the Mississippi Pharmacists Association Member of the Year in 2013. Phil holds membership in American Society of Health System Pharmacists (ASHP), American Society for Parenteral and Enteral Nutrition (ASPEN), Mississippi Society of Health System Pharmacists (MSHP), Mississippi Society for Parenteral and Enteral Nutrition (MSPEN) and the Mississippi Pharmacists Association (MPhA). He has served as President of MPhA, MSHP, MCCP and MSPEN.
Dennis B. Worthen, PhD
Cincinnati, OH

1991
(25 years ago)
- Chicago College of Pharmacy—Midwestern University established at Downers Grove, IL

1966
(50 years ago)
- FDA contracted with the National Research Council to undertake the Drug Efficacy Study Implementation (DESI) Program to determine the efficacy of products marketed prior to 1962. One of the early effects of the DESI study was the development of the Abbreviated New Drug Application (ANDA).

1941
(75 years ago)
- Baxter introduces the Plasma-Vac container, providing the first means of separating plasma from whole blood and storing it for future use.

1916
(100 years ago)
- The U.S. Pharmacopoeia drops whiskey and brandy from its list of drugs.

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# What District Do You Live In?

**DISTRICT 1**

<table>
<thead>
<tr>
<th>Counties</th>
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<tr>
<td>Hinds</td>
<td>Clinton, Jackson, Raymond, Byram, Bolton, Edwards, Terry, Utica</td>
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<tr>
<td>Madison</td>
<td>Madison, Ridgeland, Canton, Gluckstadt</td>
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<td>Rankin</td>
<td>Brandon, Flowood, Pearl, Richland, Pelahatchie, Puckett, Florence</td>
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<td>Rolling Fork, Anguilla, Cary</td>
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<td>Simpson</td>
<td>Magee, Mendenhall, D’Lo</td>
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<td>Warren</td>
<td>Vicksburg</td>
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<td>Yazoo</td>
<td>Yazoo City, Benton</td>
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**DISTRICT 2**

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<td>Grenada</td>
<td>Durant, Lexington, Cruger, Goodman, Pickens, Thula, West</td>
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<td>Holmes</td>
<td>Belzoni, Isola, Louise, Silver City</td>
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<td>Humphreys</td>
<td>Greenwood, Itta Bena, Morgan City, Sidon, Schlater</td>
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<td>Leflore</td>
<td>Indianola, Drew, Moorhead, Ruleville, Doddsville, Inverness, Sunflower</td>
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<td>Senatobia, Coldwater</td>
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<td>Panola</td>
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<td>Desoto</td>
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<td>Tallahatchie</td>
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<td>Benton</td>
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<td>Itawamba</td>
<td>Fulton, Mantachie, Tremont</td>
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<tr>
<td>Lee</td>
<td>Tupelo, Baldwyn, Verona, Saltlilo, Shannon</td>
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<tr>
<td>Marshall</td>
<td>Holly Springs, Byhalia, Potts Camp</td>
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<tr>
<td>Pontotoc</td>
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<td>Prentiss</td>
<td>Booneville, Jumpertown, Marietta</td>
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<td>Tippah</td>
<td>Ripley, Blue Mountain, Dumas, Walnut, Falkner</td>
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<tr>
<td>Tishomingo</td>
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<td>Lowndes</td>
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<td>Monroe</td>
<td>Aberdeen, Amory, Nettleton</td>
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<td>Montgomery</td>
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<td>Stewart, Eupora, Mathiston, Maben</td>
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<td>Bay St. Louis, Waveland, Diamondhead, Kiln</td>
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<tr>
<td>Harrison</td>
<td>Biloxi, D’Iberville, Gulfport, Long Beach, Pass Christian, Lyman, Saucier</td>
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<tr>
<td>Jackson</td>
<td>Vancleave, Gautier, Moss Point, Ocean Springs, Pascagoula</td>
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<tr>
<td>Pearl River</td>
<td>Lumberton, Picayune, Poplarville</td>
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<tr>
<td>Stone</td>
<td>Wiggins, Perkinston</td>
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**DISTRICT 9**

<table>
<thead>
<tr>
<th>Counties</th>
<th>Cities</th>
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<tr>
<td>Adams</td>
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<td>Copiah</td>
<td>Crystal Springs, Georgetown, Hazlehurst, Wesson</td>
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<td>Bude, Meadville, Roxie</td>
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<td>Pike</td>
<td>Magnolia, McComb, Osysa, Summit</td>
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<td>Tyrlentown</td>
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<tr>
<td>Wilkinson</td>
<td>Centreville, Crosby, Woodville</td>
</tr>
</tbody>
</table>

[Image of district maps]
Joan is leasing a new building for her expanding pharmacy practice. As part of her lease, she must provide a certificate of insurance to her landlord. The landlord is insisting on a number of provisions that must be included on the certificate. However, her insurance company is unwilling to provide the certificate as required by the landlord. Joan is unhappy and stressed at being caught in the middle of this tug of war.

A certificate of insurance is a document issued by an insurance company that provides evidence of property and/or casualty insurance coverage. This certificate is evidence for Joan’s landlord that she has coverage on her property and on other items required under the lease. The trend has been that landlords, vendors, customers, and others who have a contractual relationship with the insured business want additional provisions included on the certificate. Examples of these provisions include longer notice periods for policy cancellation, statement that coverage can’t be voided by the insured’s actions, or statements that the policy coverage meets the requirements of the contract.

This is where the tug of war begins. The certificate is only evidence that insurance coverage exists. It is not an insurance policy. The certificate cannot...
change the policy or guarantee compliance with a contract. At least 16 states have specific laws that do not allow the insurance companies to add these sorts of provisions to the certificate. Numerous other states have implemented this prohibition through issuance of bulletins by the insurance commissioner. Here are two examples.

Indiana’s law\(^1\) became effective in 2013. The law specifically states that a certificate does not amend, extend or alter the coverage provided by the policy referenced. It also states that the certificate cannot grant rights to a person that are not contained in the policy, such as an extended notice period. Massachusetts has a very similar law\(^2\) that was passed in 2015. In addition to what Indiana’s law says, Massachusetts also says that the certificate shall not be construed as an insurance policy. Both states’ laws provide that it is a violation of the law to knowingly prepare, issue, request or require the issuance of a certificate contrary to the law. In both states, the insurance commissioner can enforce the law with a cease and desist order and the imposition of a fine (up to $500 in Massachusetts and up to $1,000 in Indiana).

In many states, the certificate of insurance is a filed form. This means that the insurance company must have the certificate form filed with and approved by the Department of Insurance prior to using it. In these states, the insurance company is not allowed to deviate from the state-approved certificate.

These laws and regulations are what put Joan in the middle of the tug of war. The landlord or other party is trying to modify the insurance policy issued to Joan through changes on the certificate. The policies themselves are state-approved forms and cannot be changed arbitrarily. That may be why they are attempting to make the changes via the certificate. That is why Joan’s insurance company is reluctant to change the policy or the certificate of insurance. In many jurisdictions, it is a violation of the law for the insurance company to do so. In the states with laws specifically addressing certificates, Joan or the landlord could also be in violation of the law and fined accordingly for asking or requiring that the changes be made. In these situations, the insurance company is not just trying to be difficult. They are trying to comply with the law. You should ask your insurance company for an explanation as to why the requested changes can’t be made. This can then be passed on to the landlord or other requesting party.

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1 Ind. Code Section 27-1-42.
2 Mass. Gen. L. Ch. 175L.
Kentucky pride: Advocating for change in the Bluegrass State

RACHEL BALICK

Chris Clifton, PharmD, LDE, president of the Kentucky Pharmacists Association (KPhA), is proud of what pharmacists have achieved in his state.

“As far as pharmacy goes, we think that Kentucky has done a lot of great things to advance the profession,” Clifton told Pharmacy Today.

“We have passed legislation to streamline collaborative care to facilitate patient care; have advocated and advanced pharmacists’ role in immunization provision via protocol; championed and helped consumer groups pass legislation to mandate parity for oral chemotherapy; facilitated efforts for legislative authority for pharmacists to become certified to initiate the dispensing of naloxone via protocol; added necessary audit protections for pharmacies; and worked with the state legislature to obtain emergency authority for pharmacists during a state of emergency as declared by the governor,” said Clifton.

Kentucky’s pharmacists and student pharmacists have been successful in building support among their elected officials in Washington, DC. All of Kentucky’s congressional delegation have signed on as cosponsors of the Pharmacy and Medically Underserved Areas Enhancement Act (H.R. 592), which was introduced by Rep. Brett Guthrie (R-KY), along with Reps. G.K. Butterfield (D-NC), Todd C. Young (R-IN), and Ron Kind (D-WI).

“We are continuing to work in getting our senators to support and cosponsor S. 314,” Clifton said. “We are striving and advocating to being 100% in both chambers by the end of the year.”

**PBM transparency**

The Bluegrass State is a pioneer. In 2013, Kentucky became the first state to pass a PBM transparency bill, and during a busy legislative session this year, pharmacy advocates were able to expand that bill even further.

“This bill provides additional transparency regarding PBMs, requiring them to be separately licensed and regulated by the state Department of Insurance. It also requires PBMs to update a comprehensive MAC list and individually notify every contracted pharmacy when there is an appeal granted on a drug,” said Clifton. “This puts much-needed teeth into our PBM bill, and we are happy to report that this bill was passed unanimously in both chambers and has been signed by the governor.”

**Access to care**

But the work is far from over.

Trish Rippetoe Freeman, BSPharm, PhD, FAPhA, director of the Center for the Advancement of Pharmacy Practice at the University of Kentucky and recipient of the 2012 APhA Good Government Pharmacist-of-the-Year Award, told Today that access to care and improved public health remain the key issues in the state.

“Eighty-five of Kentucky’s 120 counties are designated as medically underserved, so having provider status and increasing patient access to care through the over 5,000 registered pharmacists in Kentucky would have significant impact,” Freeman said.

“We recently amended our collaborative care agreement [CCA] statute to make it easier and more efficient for pharmacists and physicians to collaborate. The key to successful implementation of CCAs in Kentucky, however, will be the ability to bill and be reimbursed for care provision,” she continued.

**‘Start advocating’**

Freeman urges tenacity. “It’s never too late to start advocating. Never think that ‘someone else will do that’ when you are fully capable of doing it yourself,” she said. “The personal and professional satisfaction you gain from seeing key advocacy messages heard and implemented through statutory and regulatory changes is a powerful experience.”

Freeman, who is KPhA president-elect, plans to continue advocating for change that advances the ability of pharmacists to increase patient access to care and improve public health as KPhA president next year.

Rachel Balick, Assistant Editor
Patients break cycle of readmissions with help from Hawaii pharmacist
SONYA COLLINS

When Sheena Oakes, PharmD, stepped inside “John”’s home, it didn’t take long for the pharmacist to understand why her older patient struggled to adhere to his medication regimen and why he returned to the hospital so quickly after discharge.

“He came into the pharmacy almost every day for refills, and I could see that he was very disheveled and disorganized. But when I went to his house, he was just living in filth. It was total chaos. There were pills everywhere,” Oakes recalled.

The patient, Oakes added, lives with multiple chronic conditions, including type 2 diabetes, heart failure, and atrial fibrillation.

Oakes visited the patient’s home as part of Hawaii’s Pharm2Pharm program—a collaboration among the University of Hawaii at Hilo College of Pharmacy, Hawaii Health Systems Corporation, and Hawaii Pacific Health. The 3-year initiative aimed to reduce hospital readmissions through care coordination between pharmacists in the hospital and their colleagues in the community.

A $14.3 million CMS Innovation Grant allowed pharmacists to do what was necessary within their scope of practice—from medication reconciliation and pillbox setup to home visits—to help keep patients out of the hospital. Without special funding, community pharmacists typically can’t be paid for this type of patient care. CMS does not recognize pharmacists as health care providers. As a result, few health insurance plans reimburse for their services.

An hour a week
Preventable hospital readmissions cost billions of dollars each year, and the average cost of a single hospital readmission is more than $11,000. One hour per week of a pharmacist’s time could prevent a readmission. “That care transition period is a common time for medication errors,” Oakes said. “Having a pharmacist there to help patients during that time would be ideal.”

John was first admitted to the hospital for a stroke. Discharged on warfarin, he was soon back in the hospital with a gastrointestinal bleed. Oakes visited John in his home after the second discharge. There, among the medication bottles scattered about the house, Oakes found ibuprofen, naproxen, herbal supplements—all contraband for someone taking warfarin.

Oakes got rid of the medications that could have risky interactions with warfarin. She recommended to John’s physician that he be switched to apixaban (Eliquis—Bristol-Myers Squibb, Pfizer), which wouldn’t require as much monitoring. Then, in discussions with John’s family, case worker, and health care providers, Oakes advocated for him to move in with a family member.

“Now he is living with his son and to this day, I’m filling a pillbox for him every week,” she said. Oakes provides classic care coordination for a patient who lacks the resources and cognition to manage his multiple conditions and medications on his own. “All the doctors know I fill that box for him, so they call me directly and say, ’Hey, this week we’re going to bump up his diuretic, or he is going to start an antibiotic, switch out the iron,’ and so forth.”

Valuable services
Oakes spends about an hour each week talking with John’s doctors, filling the box, and arranging for John to come in.

“He knows he doesn’t have to worry about having all the bottles and keeping track of everything. He just takes whatever is in the pillbox,” Oakes said. Because the 3-year Pharm2Pharm grant has ended, Oakes isn’t paid for this service—which arguably keeps John out of the hospital from one week to the next.

“I’m in a small, very family-oriented pharmacy, so doing these extra things for one person is not a big deal,” she said. “I wish I could do it for so many other patients whom I know have these types of problems, but there just isn’t a billing mechanism. If we were recognized for this type of service and reimbursed appropriately, we could help more people.”

Sonya Collins, MA, MFA, contributing writer
State policy makers are increasingly recognizing that pharmacists are assets in the effort to increase access to important public health services. Pharmacist-administered vaccines showed that new services can be provided in community pharmacies and scaled in a way that makes an impact on public health goals. Now states are looking to pharmacists to ensure patient access to products such as naloxone, hormonal contraceptives, nicotine replacement therapy, and more.

Statewide protocols, issued by a state body, permit pharmacists who meet certain qualifying criteria to prescribe specific medications—typically ones for preventive care or for acute or self-limiting conditions that require no diagnosis or are easily diagnosed.1

**Advantages**
Statewide protocols have an advantage of expanding pharmacists’ contributions to patients’ and public health needs because of their broad application. Statewide protocols have appropriate referral mechanisms. Also, because any pharmacist in the state who meets the education requirements can opt into the statewide protocol, the services provided are predictable and consistent across the state.

For example, in Oregon and California, patients will be able to anticipate that no matter where they are in the state, they will likely be able to find a pharmacist who is able to provide them with their hormonal contraceptives. (Note that this authority is quite new still, and it will take some time for pharmacies to implement the new service into their workflow).

**Big picture**
Currently, at least 25 states have one or more statewide protocols for pharmacists.2 Most of the statewide protocols currently in place are for immunizations (most often influenza) or naloxone. California has the most statewide protocols—naloxone, hormonal contraceptives, nicotine replacement therapy, and travel medications. Oregon and Idaho recently authorized their respective health departments to issue statewide protocols, and Oregon has already implemented a protocol for hormonal contraceptives. (See Figure 1.)

**NASPA/NABP meeting**
To better understand the marketplace and determine what resources were needed for states considering this policy, the National Alliance of State Pharmacy Associations (NASPA) and the National Association of Boards of Pharmacy (NABP) convened a stakeholders meeting in March 2016.

During this meeting, participants heard from representatives from California, Idaho, and Oregon and made recommendations for the development of model policy elements, model language, and model statewide protocols to be used by state boards of pharmacy and state pharmacy associations considering statewide protocols.

The full report is available on the NASPA website.2

**Important opportunity**
Participants at the NASPA/NABP meeting felt that statewide protocols offer an important opportunity for pharmacists to assist in meeting public health goals and increasing patient access to care. Advocating for state authority to issue statewide protocols will give pharmacists and public health advocates the chance to collaborate to meet public health goals.

**References**

Krystalyn K. Weaver, PharmD, Vice President, Policy and Operations, National Alliance of State Pharmacy Associations
Dale Tinker just wanted to do the right thing for his health. After 50 years, he finally quit smoking. But in the process of freeing himself from one health problem, he developed another.

“I immediately started gaining weight. At my next doctor visit, my A1C [glycosylated hemoglobin] was increasing and working toward [diabetes],” Tinker said. “I was trying to get healthier by quitting smoking, but instead went crazy with the snacking.” At the following visit, Tinker’s doctor diagnosed him with type 2 diabetes.

Shortly after his diagnosis, Tinker was referred to see Kathleen Wade, PharmD, PhC, CDE, for care. For Tinker, it was no surprise when the doctor referred him not to another physician but to a Pharmacist Clinician for diabetes education and disease management. “Since I was a lobbyist who helped pass the [advanced pharmacy practice] bill in 1993, I always expected that eventually I would work with a Pharmacist Clinician myself. I’ve spent the last 25 years trying to convince health plans they ought to reimburse pharmacists for clinical services,” Tinker said.

Pharmacist Clinicians in New Mexico, upon referral from a Primary Care Provider, can manage a disease from A to Z, including writing prescriptions and ordering labs. Although CMS does not recognize pharmacists as providers, Presbyterian Health Services in Albuquerque, NM, recognizes Pharmacist Clinicians as Advanced Practice Clinicians with a unique skill set that can help keep their patients healthier and out of the hospital.

Advocate—and patient
Tinker, who is executive director of the New Mexico Pharmacists Association, has to advocate for health plans to reimburse pharmacists because pharmacists do not have provider status. CMS does out the qualification of “provider” to most providers of health services—but not to pharmacists.

CMS sets the standard for whom commercial health plans reimburse as well. As a result, health plans may only cover clinical pharmacy services for a small subset of patients under specific circumstances, or they may not cover the services at all.

With provider status, more pharmacists could help more patients like Tinker—people with a new diagnosis of diabetes who have a lot to learn in order to manage their condition.

“Most new [patients with diabetes] just don’t understand the disease, what they have to do. And the comorbidities are, what the complications are. So in the first visit, I talk to them and get a sense for how much they know about their condition and then decide how the visit needs to go,” said Wade, who is Tinker’s Pharmacist Clinician.

Pharmacist Clinicians recognize the unique skill set that pharmacists bring to patient care. They have valuable expertise in managing chronic conditions and providing disease management for multiple health problems—management that pharmacists lack with just a 10-minute walk each day, rather than assume he had to do 30 minutes or nothing. “It’s easier to find 10 minutes than it is to find the half-hour that all the guidelines recommend.”

Because diabetes requires everyday self-management that includes the coordination of medications, diet, and exercise, patients need comprehensive education. That level of orientation doesn’t align easily with the 15-minute doctor visit model. “There is such a provider shortage that everybody wants pharmacists involved in patient care,” Wade said. “The Pharmacist Clinicians at Presbyterian are an integral part of the patient-centered medical home, and our contribution to a patient’s medical care is becoming the norm.”

Road to health
With his smoking habit behind him and Wade’s help, Tinker is on his way to controlling his weight and diabetes. While he’s at it, Tinker will continue to advocate for other patients to get the kind of care he receives.

Sonya Collins, MA, MFA, contributing writer

Keeping diabetes under control
During their first visit, Wade taught Tinker about the condition and the first steps toward keeping it under control. “She explained the role of the pancreas, what eating habits don’t work the same way because of diabetes, what I should be eating, and how much I should be exercising,” Tinker recalled.

Wade has also helped Tinker devise an exercise strategy to fit his schedule. “My commute is about an hour,” Tinker said. “I don’t get home until 7:00 [pm] and eat dinner at 8:00 or 8:30 [pm], so finding time to exercise is very difficult.” Wade encouraged Tinker to start with just a 10-minute walk each day, rather than assume he had to do 30 minutes or nothing. “It’s easier to find 10 minutes than it is to find the half-hour that all the guidelines recommend.”

Because diabetes requires everyday self-management that includes the coordination of medications, diet, and exercise, patients need comprehensive education. That level of orientation doesn’t align easily with the 15-minute doctor visit model. “There is such a provider shortage that everybody wants pharmacists involved in patient care,” Wade said. “The Pharmacist Clinicians at Presbyterian are an integral part of the patient-centered medical home, and our contribution to a patient’s medical care is becoming the norm.”

Provider status stories
Pharmacists are health care providers. In a series of profiles appearing in Pharmacy Today and on pharmacist.com, pharmacists explain how their patients would benefit from provider status. And as part of our campaign for provider status, APhA has asked pharmacists to share their story of how they provide care to their patients and how provider status will improve health care. These stories are collected on the APhA YouTube channel at https://www.youtube.com/user/aphapharmacists/playlists. If you would like to share your story, please visit PharmacistsProvideCare.com.
Sand Dollar Painting and Pool Party
In 2012, 29.1 million people were estimated to have diabetes in the United States.\(^1\) Diabetes treatment is ever changing. In Mississippi alone, 11.3% of adults are diagnosed with diabetes.\(^2\) Diabetes treatment is ever changing, and as pharmacists, we are always looking for new medications and techniques to improve care and control the disease. In this article, we will review the American Diabetes Association’s 2016 updates to the Standards of Medical Care in Diabetes.\(^3\) We will discuss diagnosis, screening, treatment, and patient goals for diabetes, highlighting new recommendations included in the document.

**Diagnostic Updates:**

As described in previous updates, the diagnosis of diabetes is made if the patient fits any of the following four categories: a hemoglobin A1C (A1C) $\geq 6.5\%$, a Fasting Plasma Glucose (FPG) $\geq 126$ mg/dL, Oral Glucose Tolerance Test (OGTT) of two hour plasma glucose $\geq 200$ mg/dL, or random plasma glucose $\geq 200$ mg/dL for a patient with hyperglycemia symptoms.\(^1\) The 2016 update clarifies that no one test is preferred over the other, and continues with the suggestion to repeat testing in any case that does not involve unequivocal hyperglycemia with symptoms.\(^1\)

Screening recommendations were updated to include testing of all adults beginning at age 45, regardless of weight. This is a change from the previous standards of care when it was suggested to screen adults age 45 or greater who were overweight or obese (BMI $>25$ kg/m\(^2\)). This recommendation was changed based on a cost-effectiveness analysis finding that it was cost-effective to begin screening for all patients between 30 and 45 years of age.\(^4\) Currently, asymptomatic adults with a BMI $>25$ kg/m\(^2\) and have one or more additional risk factors for diabetes should be screened.\(^3\) Additional risk factors for diabetes include: physical inactivity, a family history of type 2 diabetes (T2D) in a first degree relative, certain races or ethnicities, signs of insulin resistance, history of cardiovascular disease, or maternal history of diabetes/ gestational diabetes during pregnancy. Race or ethnicities with higher incidence of diabetes include Native American, African American, Latino, Mexican American or Pacific Islander. A skin condition known as acanthosis nigricans, in which areas of dark, velvety, discoloration in body folds and creases is present, hypertension, dyslipidemia, polycystic ovary syndrome in women, or women delivering a baby larger than 9 pounds are considered signs of insulin resistance and are included as risk factors for T2D.\(^3\)

**Treatment Updates:**

Lifestyle modifications and diet recommendations remain consistent. Adults with diabetes should partake in aerobic exercise of moderate intensity, about 50-70% of maximum capacity, for 150 minutes per week. The 150 minutes is recommended to be broken up into at least 3 days of exercise per week, with no more than 2 days of rest in between exercise days. Pediatric patients with diabetes should be motivated to get 60 minutes of physical activity each day. Diet recommendations for all patients consists of replacing refined carbohydrates (e.g. processed foods) and added sugars with whole grains, fruits, and vegetables.\(^3\)

Glycemic medication treatment recommendations for 2016 did not differ from those indicated in 2015. The ADA has published a flow chart to utilize as a guide when evaluating the different treatment options for T2D. Treatment should be considered based on patient specific criteria, such as hypoglycemia risk, acceptable side effects, and cost. One unacceptable side effect of many of these oral diabetes medications is the effect of the medication on a patient’s weight. Metformin is the initial treatment of choice for all patients with T2D. If goals are not met using metformin alone, then the next step is to add an oral medication with a differing mechanism of action such as a sodium-glucose co-transporter-2 (SGLT-2) inhibitor or glucagon-like peptide-1 (GLP-1) agonist. If combination therapy with two oral agents is not sufficient, then a third oral medication can be administered from a different class than the already prescribed agents. Still, if a 3rd oral anti-diabetic drug is not enough for that patient to meet goals, then a patient will need to be started on metformin and basal insulin. Mealtime insulin may be added as deemed appropriate, for instance if the patient is not well controlled between meals, and continues to have spikes in blood glucose during the day.\(^3\)

**Treatment Goal Updates:**

Treatment goals for a patient with diabetes vary depending on certain populations. Non-pregnant adults should strive to achieve an A1C $\leq 7\%$, however this can be modified based on patient-specific factors, including high risk patients for hypoglycemia, time since initial diagnosis, life expectancy, comorbidities, and patient resources. Goals may be more or less stringent based on amount of vascular complications or the patient’s attitude towards treatment.\(^3\) For patients at high risk of hypoglycemia, A1C goals may be less stringent to avoid the patient becoming hypoglycemic and needing to be treated. It is recommended patients have more stringent goals when they are newly diagnosed or are predicted to have
a longer life expectancy. If a patient has numerous comorbidities, their target can be less strict until comorbidities are treated sufficiently. Finally, patient resources may cause goals to shift as well, as patients with access to many resources are more equipped to meet goals and should benefit from a more strict A1C target.3

Blood pressure (BP) goals have remained constant for patients with diabetes and hypertension. The systolic BP goal for a patient with HTN and diabetes is <140 mmHg and a diastolic BP goal would be <90 mmHg. In certain populations, these goals can be even more stringent, with a systolic goal of <130 mmHg and a diastolic goal of <80 mmHg. The more stringent goals are appropriate for patients including younger adults or patients with risk factors for cardiovascular disease. Specific treatments for patients with hypertension are published by the American Heart Association. It is important to remember patients with a BP >120/80 mmHg should be counseled on therapeutic lifestyle changes whereas patients with BP >140/90 mmHg should be treated with medications as well as lifestyle changes.3

Pediatric goals suggest an A1C < 7.5%, as well as family counseling on caring for a patient with diabetes and coping with the disease state. The main change to the guidelines regarding caring for children and adolescents with diabetes was in the age at which lipid profile testing should be conducted. The recommendation for requiring a lipid profile in children was modified from 2 years old to 10 years old. This recommendation stems from a scientific statement released by AHA and ADA on type 1 diabetes mellitus and cardiovascular disease (CVD) in 2014. (reference the scientific statement) Other goals for pediatric patients include a preprandial blood glucose range of 90-130 mg/dL and bedtime blood glucose range of 90-150 mg/dL.3

Pregnant patients with diabetes now have an A1C goal of 6-6.5%, which is less stringent than the previous goal of <6% in this population. The 2016 Standards clearly emphasizes the importance of family planning and effective contraception in women with preexisting diabetes. Regarding the treatment of gestational diabetes, glyburide was deemphasized as it was shown to be inferior to metformin and insulin, as well as increases the risk for hypoglycemia.3

If treatment goals are not being met initially, providers should focus on adding to the treatment regimen as well as focusing on increasing patient adherence. Patients may not be adherent due to a number of patient, medication, or system factors. Patient factors may include remembering to take multiple medications, obtaining transportation to the pharmacy to pick up medications on time, developing depression that affects their lifestyle or motivation to take their medications. Medication factors may include cost of medications, especially those that have been recently approved, multiple daily dosing of medications, or bothersome side effects. System factors could include missing appointments, providers not following up, and patients not being held accountable. As providers, all adherence issues should be addressed while modifying therapy to the best possible medication regimen.3

Prevention and Management of Cardiovascular Disease: The modifications made to CVD focused on the treatment of atherosclerotic cardiovascular disease (ASCVD). Recommendations for patients on statin use follow the recommendations by the 2013 ACC/AHA prevention guidelines for blood cholesterol. Table 1 shows the efficacy and prescribed doses of both high-intensity and moderate-intensity statins. The ACC/AHA guidelines address patients with diabetes ages 75 years and younger without ACSVD. The ADA addresses the older population by recommending a daily moderate-intensity statin and lifestyle therapy for patients over the age of 75 without additional ASCVD risk factors and either a daily moderate-intensity or high-intensity statin along with lifestyle therapy for those with ASCVD risk factors. High-intensity statin therapy is predicted to lower LDL cholesterol by ≥50%, and moderate-intensity statin therapy is predicted to lower LDL cholesterol by 30% to <50%. Routine evaluation of this population should be done to assess tolerability.

A new recommendation was made to add ezetimibe to a moderate-intensity statin to provide additional cardiovascular benefit. The Improved Reduction of Outcomes: Vytorin Efficacy International Trial (IMPROVE-IT)4 was a randomized controlled trial evaluating major cardiovascular events between ezetimibe and simvastatin versus simvastatin alone. Patients eligible were ≥50 years of age, experienced an acute coronary syndrome event within the preceding 10 days, and had an LDL-cholesterol ≥50 mg/dL. Patients enrolled with diabetes in the group taking simvastatin 40mg and ezetimibe 10 mg showed a reduction of major adverse cardiovascular events over patients with diabetes taking simvastatin 40mg alone. Absolute risk reduction was 5% (40% vs 45%), and relative risk reduction was 14% (RR 0.86, 95% CI 0.78-0.94).5 The ADA now recommends to consider adding ezetimibe to patients fitting the IMPROVE-IT criteria who are unable to tolerate a high-intensity statin.

This revision also addresses the role of proprotein convertase subtilisin-kevin type-9 (PCSK9) inhibitors in patients with diabetes. No recommendation is given as phase 4 studies are currently underway. The ADA does suggest using evolocumab or alirocumab in patients with diabetes at high risk for ASCVD and require further LDL-cholesterol lowering or are intolerant.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>- High-intensity and moderate-intensity statin therapy</th>
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<tr>
<td><strong>High-intensity statin</strong></td>
<td><strong>Moderate-intensity statin</strong></td>
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<td>Atorvastatin 40-80 mg</td>
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<td>Pitavastatin 2-4 mg</td>
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to high-intensity statins.\(^3\)

A major change in aspirin recommendations has been made with the 2016 diabetes update. In 2010, the ADA, AHA, and American College of Cardiology Foundation recommended low-dose aspirin for primary prevention in men over age 50 years and women over age 60 years with diabetes and one or more of the following risk factors: smoking, hypertension, dyslipidemia, family history of premature ASCVD, and albuminuria. Since that time, multiple meta-analyses\(^6-8\) have been published reporting the risks of heart disease and stroke are equivalent, if not higher, in women compared with men with diabetes. The ADA has now revised their recommendations for both men and women \(\geq 50\) years old with diabetes and one or more risk factors to be initiated on low dose (75mg-162mg) aspirin.\(^3\)

For patients at intermediate risk of ASCVD (patients age \(< 50\) years with one or more risk factors; patients age \(\geq 50\) years with no risks; 10-year ASCVD risk of 5-10%) the ADA recommends using clinical judgement on primary prevention with aspirin.\(^3\) This position may change once further research is available.

### Obesity Management:

A new section was created on obesity management for the treatment of T2D. Evidence continues to show that obesity management can delay progression from prediabetes to T2D and is beneficial in improving glycemic control due to obesity-associated insulin resistance. In the Action for Health in Diabetes (Look AHEAD) trial, participants assigned to the intensive lifestyle group achieved equivalent cardiovascular risk factor control than the standard care group, but required fewer glucose-, blood pressure-, and lipid-lowering medications. Patients in the intensive lifestyle group also reported improvements in health-related quality of life.

The section begins with recommendations on the comprehensive assessment of weight in diabetes. A patient’s BMI should be calculated and documented at each encounter. Providers should assess a patient’s readiness for weight loss and then decide together on goals and intervention strategies. Pharmacotherapy is recommended as an adjunct to diet, physical activity, and behavior modifications if the patient’s BMI is 27.0 kg/m\(^2\) or greater. Bariatric surgery is recommended for patients with a BMI of 35.0 kg/m\(^2\) or greater.

The ADA recommends achieving a weight loss goal of 5% initially in patients with T2D ready to achieve weight loss (A). A sustained weight loss of \(\geq 7\%\) is optimal, but benefits are seen with as little as 5% weight loss. Sustainable weight loss focuses on diet, physical activity (200-300 min/week), and behavior modifications. For most patients, a 500-750 kcal/day energy deficit is recommended (A). Patients should attend at least 16 sessions over six months that focus on altering diet, increasing physical activity, and providing behavioral strategies to achieve this goal. The ADA also gives recommendations on short term (3-month) high-intensity lifestyle interventions for select patients wanting to achieve a greater short-term weight loss (10-15%). Caution is given though, as weight regain is more likely to occur following cessation of high-intensity interventions, unless a long term comprehensive weight loss maintenance program is provided.\(^3\)

Before selecting a pharmacologic treatment for weight loss, providers are advised to consider glucose-lowering

<table>
<thead>
<tr>
<th>Generic drug name (Brand drug name)</th>
<th>Dosing frequency</th>
<th>Medication class</th>
<th>Average weight loss relative to placebo</th>
<th>Adverse effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orlistat (Ali, Xenical)</td>
<td>60 mg or 120 mg TID (during or up to 1 h after a low fat meal)</td>
<td>Lipase inhibitor</td>
<td>2.5 kg (60 mg), 3.4 kg (120 mg)</td>
<td>Abdominal pain/discomfort, oily spotting/stool, fecal urgency, mal-absorption of fat-soluble vitamins and medications, potentiation of warfarin, Liver failure, oxalate nephropathy</td>
</tr>
<tr>
<td>Lorcaserin (Belviq)</td>
<td>10 mg BID</td>
<td>Selective serotonin (5-HT(_2)) receptor agonist</td>
<td>3.2 kg</td>
<td>Hypoglycemia, headache, fatigue, serotonin syndrome or NMS-like reactions, heart valve disorder, bradycardia</td>
</tr>
<tr>
<td>Phentermine/topiramate ER (Qsymia)</td>
<td>3.75 mg/23 mg QDay for 14 days, then increase to 7.5 mg/46 mg QDay (maximum dose: 15 mg/46 mg QDay)</td>
<td>Sympathomimetic amine anorectic/antiepileptic combination</td>
<td>6.7 kg (7.5 mg/46 mg), 8.9 kg (15 mg/46 mg)</td>
<td>Paresthesia, xerostomia, constipation, headache</td>
</tr>
<tr>
<td>Naltrexone/bupropion (Contrave)</td>
<td>16 mg/ 360 mg BID</td>
<td>Opioid antagonist/ amnoketone antidepressant combination</td>
<td>2.0-4.1 kg</td>
<td>Nausea, vomiting, constipation, headache, depression, precipitation of mania</td>
</tr>
<tr>
<td>Liraglutide (Saxenda)</td>
<td>3 mg SC QDay</td>
<td>Acylated human glucagon-like peptide 1 (GLP-1) receptor agonist</td>
<td>5.8-5.9 kg</td>
<td>Hypoglycemia, nausea, vomiting, diarrhea, constipation, headache, pancreatitis, thyroid C-cell tumors in rodents, acute renal failure</td>
</tr>
</tbody>
</table>

\(^{†}\)Adapted from ADA Standards of Medical Care in Diabetes
medications as well as medications for other comorbid conditions, and consider their association with weight gain. Glucose-lowering medications associated with weight loss are metformin, α-glucosidase inhibitors, glucagon-like peptide 1 agonists, amylin mimetics, and SGLT-2 inhibitors. Atypical antipsychotics, antidepressants, glucocorticoids, oral contraceptives that contain progestins, anticonvulsants, antihistamines, and anticholinergics are other medications that promote weight gain. A summary table (Table 2) of the five currently FDA approved weight loss medications is provided. A more comprehensive table is given in the 2016 update. The ADA does not give preference of one weight loss medication over the other: Low adherence, modest efficacy, adverse effects and weight regain after medication cessation have been reported. The ADA therefore suggests using clinical judgement on the potential benefits versus the risks when prescribing these medications. Safety and efficacy should be assessed at least monthly for the first 3 months. Inadequate response or developments of safety or tolerability issues warrants discontinuation and alternative treatment (A). All approved medications are pregnancy category X. Female patients of childbearing years must be counseled on using a reliable method of contraception when taking these medications.

Guidelines must be continually updated in order to reflect the new evidence available in improving patient care. No patient is the same, nor are they often predictable; therefore, clinical judgement is an important aspect of treatment of patients with diabetes. Diabetes mellitus is a widespread condition that many people suffer from and rely on their practitioners for appropriate and up to date treatment choices.

References
3. Cefalu WT et al; American Diabetes Association Standards of Medical Care in Diabetes - 2016. Diabetes Care, Jan 2016;39

Overview of the American Diabetes Association (ADA) 2016 Update

INSTRUCTIONS: After reading the continuing education article, photocopy or detach this page. Take the quiz below. A grade of 70 percent or better is required to earn 2.0 hours of continuing education credit. This is a free service for MPhA members. Include a self-addressed and stamped envelope. Mail to: Mississippi Pharmacists Association, 341 Edgewood Terrace Drive, Jackson, MS 39206-6299 or fax to 601-981-0451.

Print name, address and phone number:

<table>
<thead>
<tr>
<th>Question</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Which diagnosis of diabetes is preferred over the others?</td>
<td>A. A1C &gt; 6.5%</td>
<td>B. FPG &gt; 126 mg/dL</td>
<td>C. 2 hour OGTT &gt; 200 mg/dL</td>
<td>D. They are all equally preferred</td>
</tr>
<tr>
<td>2: What is the recommended amount of exercise that a patient with diabetes should get per week?</td>
<td>A. 150 minutes at 100% capacity</td>
<td>B. 150 minutes at 50-70% capacity</td>
<td>C. 210 minutes at 100% capacity</td>
<td>D. 100 minutes at 50-70% capacity</td>
</tr>
<tr>
<td>3: What is the preferred oral antidiabetic medication for all patients?</td>
<td>A. Canglitin</td>
<td>B. Glimepiride</td>
<td>C. Metformin</td>
<td>D. Sitagliptin</td>
</tr>
<tr>
<td>4: At what age should a pediatric patient with diabetes have a lipid profile test?</td>
<td>A. 10 years old</td>
<td>B. 2 years old</td>
<td>C. 13 years old</td>
<td>D. Age does not matter: Whenever they are diagnosed.</td>
</tr>
<tr>
<td>5: Which of the following would be considered a high intensity statin?</td>
<td>A. Atorvastatin 20 mg</td>
<td>B. Rosuvastatin 20 mg</td>
<td>C. Pitavastatin 2 mg</td>
<td>D. Pravastatin 80 mg</td>
</tr>
</tbody>
</table>
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