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In This Issue

Quarterly Newsletter from the Florida Society of Health-System Pharmacists (FSHP)

Message from the President

Madeline Camejo
PharmD, BCACP

As I prepare to write my final Message as your President, I find myself reflecting on what we accomplished this year, but more so on what we built together and on the people who made it possible.

Our Diamond Anniversary reminds us that organizations are not defined by a single moment. Like a diamond, they are shaped through sustained commitment, resilience, and people willing to invest in something greater than themselves.

This year's legislative wins were earned. Meaningful pharmacy benefit manager reform strengthened protections for patients and pharmacies across Florida. HB 697 restored more than $30 million to Florida's AIDS Drug Assistance Program, reversing cuts that threatened lifesaving HIV medications for thousands of Floridians. HB 1425, expanding consultant pharmacist services, passed the House, which is proof the value we demonstrate is being heard. These victories matter not only because of what became law, but because of the relationships built along the way. Every conversation with a policymaker, every member who answered the call, is how progress is made. Advocacy is cumulative. Every relationship we build today creates opportunities for tomorrow.

Message from the President

Our organization grew in equal measure. The inaugural Leadership Conference delivered peer-to-peer learning no webinar can replicate. Our councils delivered, from ambulatory care wellness education to a professional development book exchange celebrating tomorrow's leaders. Our Communications Council connected councils, clinical forums, regional societies, and committees into a more unified voice, creating communication pathways, improving outreach and building on efforts laid out before. Those connections expanded how we share ideas, amplify member voices, and learn from one another. We have become a more unified Society; communicating more, collaborating more, and recognizing that our greatest work happens when we move forward together.

If there is one lesson this year reinforced, it is that lasting progress is built through relationships, with our peers, legislators, between councils, and among members committed to the same mission.

Pharmacy is evolving. As patients increasingly turn to artificial intelligence and digital tools to better understand their health, the pharmacist's role becomes even more important. Technology can generate information, but it cannot replace the clinical judgment, context, and trust that pharmacists provide. As patients navigate increasingly complex information, they need trusted professionals who bring clinical judgment, context, and compassion to every decision. We must continue crafting the policies, strengthening relationships, and leading the conversations that keep pharmacists where they belong; at the center of patient care.

I could not be prouder of how we are finishing this year; stronger than we started. As we celebrate our Diamond Anniversary Annual Meeting, let's continue refining what makes this Society exceptional and ensure our brightest days are still ahead. Know your council leaders, regional representatives, and Board members. Introduce yourself to new members, be curious and ask questions, and find time to serve your profession.

Every member, every volunteer, every student, every resident, every technician and every pharmacist adds another facet to this Society. Together we reflect something none of us could produce alone because when FSHP grows stronger, so does the care we provide to the patients and communities who depend on us.

The future of FSHP has never been brighter, and I look forward to watching all that comes next as a proud member of this Society.

CLINICAL PEARL

2026 ACC/AHA Guidelines Update on the Management of Dyslipidemia

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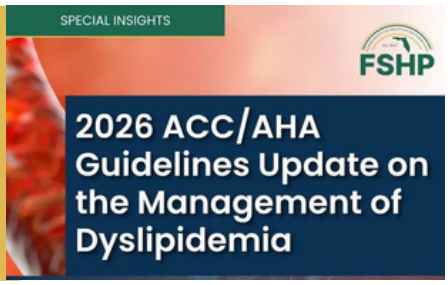

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The release of the 2026 ACC/AHA/Multisociety Guideline on the Management of Dyslipidemia marks an important evolution in cardiovascular risk reduction. This update introduces an updated approach to risk assessment with a novel scoring system called PREVENT, recommends more aggressive targets for low-density lipoprotein cholesterol (LDL-C), and advises at least one measurement of lipoprotein(a) [Lp(a)] to help identify patients at elevated cardiovascular risk.

A New Approach to Hyperlipidemia Screening – *The Earlier the Better*

The 2026 guidelines place increased emphasis on earlier identification of lipid disorders across the lifespan, recognizing that cumulative exposure to atherogenic lipoproteins is a major driver of ASCVD risk. Universal screening is recommended at ages 9-11 years old to identify familial hypercholesterolemia and other lipid disorders. Screening should be completed as young as 2 years of age if there is a family history of premature ASCVD, severe hypercholesterolemia, or familial hypercholesterolemia. Lipids should continue to be checked regularly, with lipid screening again at 19 years of age and at least every 5 years thereafter.

From PCE Scoring to the PREVENT Risk Assessment Model

The guideline introduces the Predicting Risk of cardiovascular disease EVENTs (PREVENT™) risk assessment model, which expands upon the prior Pooled Cohort Equation (PCE) by incorporating both 10-year and 30-year CVD, ASCVD, and HF risk estimates. The PREVENT-ASCVD risk equation should be used for adults 30-79 years of age who present with fasting or non-fasting LDL-C levels of 130 to 320mg/dL to estimate both 10-year and 30-year risk of ASCVD events. This allows clinicians to better identify younger patients who may benefit from earlier preventive strategies, even when short-term risk appears low. This model supports earlier statin initiation with the goal to protect the heart earlier when lipid load is lower and before plaque burden is high.

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Additionally, the guidelines emphasize the "CPR" framework for primary prevention in adults:

- **C**alculate 10-year ASCVD risk
- **P**ersonalize the estimated risk to patient based on other specific factors not included in the PREVENT-ASCVD equation
- **R**eclassify with selective use of coronary artery calcium (CAC) scored and reassess therapy regimen

	PREVENT-ASCVD Risk
Low Risk	<3%
Borderline Risk	3% - <5%
Intermediate Risk	5% - <10%
High Risk	≥ 10%

Advancements in LDL-C Goals – *Lower is Better*

One of the most notable changes is the reintroduction of specific LDL-C treatment goals, with more aggressive targets for high-risk populations. Previous guidelines recommended percent reductions in LDL for different patient populations, including patients with diabetes and/or ASCVD. However, there were some gaps in primary prevention for certain adult patients, and these new guidelines address the need for earlier screening and intervention through lifestyle modifications and pharmacotherapy.

Very high-risk atherosclerotic cardiovascular disease (ASCVD)	Major ASCVD events	High risk conditions
≥ 2 major ASCVD events or 1 major ASCVD event and ≥ 2 high-risk conditions	Acute coronary syndrome within the past 12 months, history of myocardial infarction, history of ischemic stroke, and symptomatic peripheral artery disease	Age ≥ 65, coronary bypass or percutaneous intervention, current smoker, diabetes, history of congestive heart failure, hypertension, and LDL-C ≥ 100 mg/dL despite maximally tolerated statin + ezetimibe

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These patients are now recommended to achieve an LDL-C of <55 mg/dL and a non-HDL-C < 85 mg/dL. Those with ASCVD and not very high risk are defined as those with clinical ASCVD and do not meet the very-high risk criteria as described above. Both patients with ASCVD and not very high risk and those who are high-risk without established ASCVD, defined as a PREVENT-ASCVD score of > 10%, should target an LDL-C of <70 mg/dL and non-HDL-C < 100 mg/dL. These updated LDL-C and Non-HDL-C goals reinforces the concept that "lower is better, and earlier is better," with cumulative LDL exposure over time playing a critical role in long-term cardiovascular outcomes. Please see below a brief summary of updated LDL goals:

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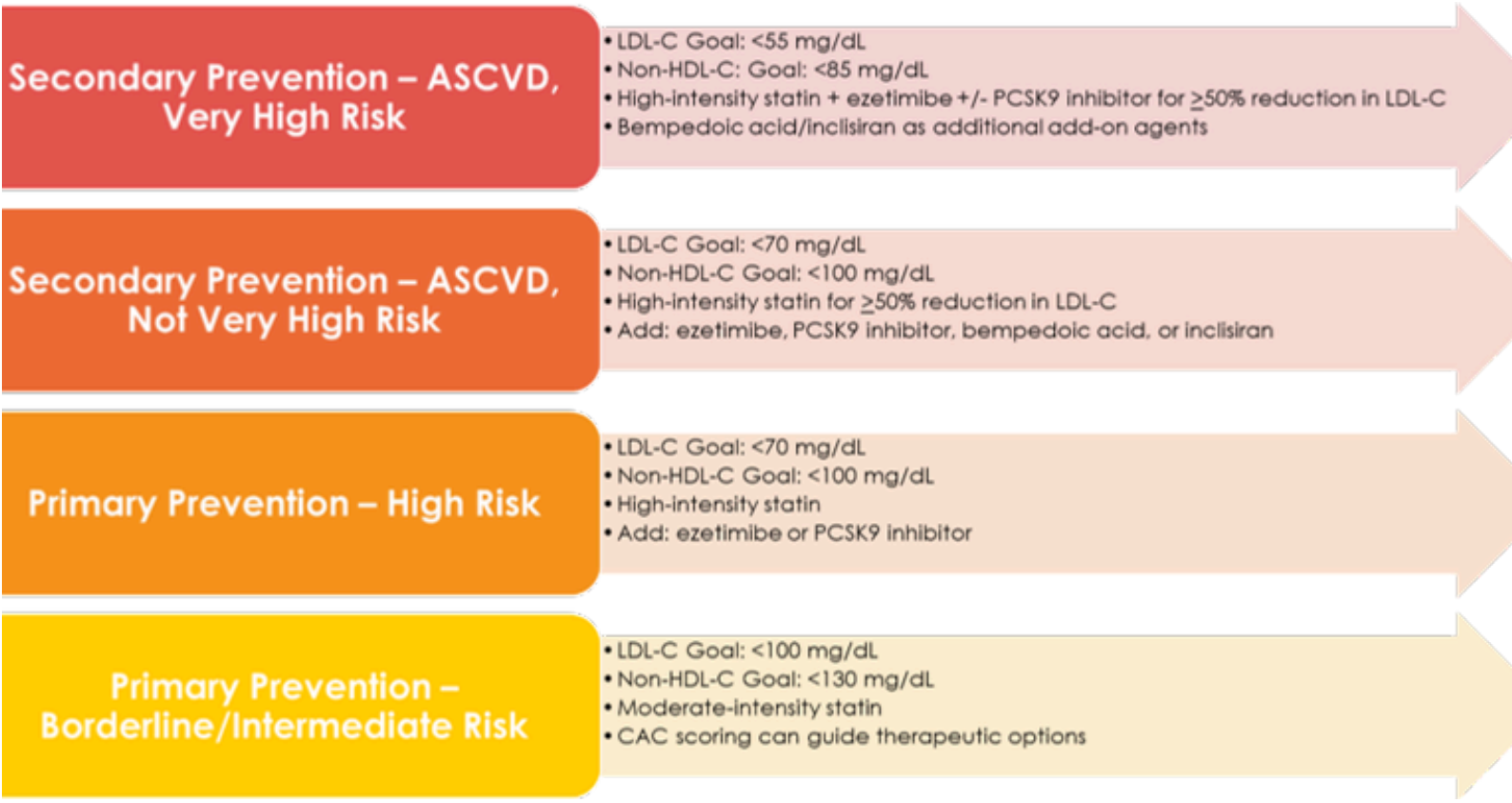

Re-emphasis on CAC Scoring as a Therapeutic Decision-Making Tool

The 2026 guidelines re-emphasize the utilization of coronary artery calcium (CAC) scoring as a valuable tool for guiding therapeutic decision-making. CAC scoring provides a more individualized measure of atherosclerotic disease by directly quantifying calcified plaque burden in the coronary arteries. Importantly, CAC scoring can help resolve clinical uncertainty in intermediate-risk patients, support shared decision-making, and improve adherence by offering a visual and objective marker of disease.

CAC Score (AU)	LDL-C Goal (mg/dL)	HDL-C Goal (mg/dL)
1-99 and < 75th percentile	<100 mg/dL (≥30-49% LDL reduction)	<130 mg/dL
≥100 to 299 or ≥75th percentile	<70 mg/dL	<100 mg/dL
≥300 to 999	<70 mg/dL with optional intensification to <55	<100 mg/dL with optional intensification to <85
≥1000	<55 mg/dL (≥50% LDL reduction)	<85 mg/dL

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Advanced Biomarkers – Understanding Residual Risk

Additional lipoprotein goals include apolipoprotein B (ApoB) and lipoprotein (a) (Lp(a)). While LDL remains one of the major lipid markers for assessment of ASCVD risk and therapeutic goals, ApoB and Lp(a) provide deeper insights for ASCVD risk assessment.

ApoB testing is now noted as a useful tool in assessing patient risk and guiding treatment selection once LDL-C and non-HDL-C goals are met. This testing can be particularly useful for patients with elevated triglycerides (>200 mg/dL), diabetes, or low achieved LDL-C (<70 mg/dL), as it can be used to identify hidden cardiovascular risk and guide therapy beyond traditional lipid panels. ApoB is present on all major lipoproteins that can promote atherosclerosis, including LDL-C, VLDL-C, IDL, and lipoprotein(a), and its level reflects the total number of atherogenic particles. The number of atherogenic particles is more directly linked to arterial wall penetration and plaque formation than cholesterol content alone. ApoB levels elevated beyond the normal range are a more accurate reflection of true ASCVD risk. Currently, there are no FDA approved treatments that target ApoB specifically, highlighting an unmet need for more targeted treatment options. The 2026 guidelines recommend the following ApoB goals for ASCVD risk reduction:

Patient Population	ApoB Goal (mg/dL)
Primary Prevention	PREVENT-ASCVD < 10% and TG 150-499: <90 PREVENT-ASCVD ≥ 10% and TG 150-499: <70
Diabetes	Without ASCVD risk factors: <90 With ASCVD risk factors: <70
Subclinical atherosclerosis	CAC 300-999 AU: consider <55
Hypertriglyceridemia	With clinical ASCVD, not at very high risk OR age 40-75y with ≥1 ASCVD risk factor: <70 With clinical ASCVD, at very high risk: <55
Clinical ASCVD	Not at very high risk: consider <55 mg/dL At very high risk: <55

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Furthermore, lipoprotein(a) [Lp(a)] should be measured at least once in all adults to identify individuals at higher risk of ASCVD. Lp(a) has proatherogenic and proinflammatory effects that may play a role in elevated ASCVD risk. The guideline states that Lp(a) concentrations of 50 mg/dL (125 nmol/L) or greater is associated with an estimated 40% relative risk increase in ASCVD compared with those of lower Lp(a) concentrations. Statin therapy has no clinically meaningful effect on Lp(a) concentrations, which represents a current limitation in dyslipidemia management. There is growing emphasis on adjunctive and targeted therapies for Lp(a) reduction, as there are currently five agents in the pipeline that target the reduction of Lp(a). Olpasiran, zerlasiran, and lepodisiran are small interfering RNA molecules, pelacarsen is an antisense oligonucleotide, and muvalaplin is a small molecule inhibitor. All these agents inhibit the hepatic production of Lp(a), and of these agents, pelacarsen, olpasiran, and lepodisiran are currently in phase 3 cardiovascular outcomes trials to determine whether lowering Lp(a) translates into reduced ASCVD events.

Established Pillars and Expansion of Therapy Options

Lipid lowering therapy (LLT) plays a vital role in the optimal management of patients with hypercholesterolemia and/or elevated ASCVD risk. Statins remain the cornerstone of LLT for reduction of LDL and ASCVD risk. They are effective, with a variety of LDL-lowering potential ranging from 30% to >50% LDL reduction. The benefits of statin therapy, including ASCVD event rate reduction, greatly outweighs the risks. However, it is important that clinicians remain vigilant to potential side effects that may require lower doses or alternative therapies.

Non-statin LLT have been underutilized due to several factors, including therapeutic inertia, barriers to medication access, and misconceptions that only statins reduce ASCVD risk. Non-statin LLT include medications like ezetimibe, bempedoic acid, proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors, inclisiran, and fibrates. Non-statin LLT that have been shown to reduce ASCVD events include bempedoic acid in primary prevention and PCSK9 inhibitors for secondary prevention.

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While the 2018 guidelines recommended the addition of ezetimibe prior to trial of PCSK9 inhibitors, this update provides recommendation that either ezetimibe, PSCK9 inhibitors, or bempedoic acid may be added as a second-line agent for LLT. Inclisiran may be reasonable for management of hypercholesterolemia in patients not at goal despite maximally tolerated statin, with or without ezetimibe, or intolerance to PCSK9 inhibitors. Thus, the guidelines emphasize the need for LLT intensification through combination therapy.

Moving Beyond LDL-C Control – Targeting Underlying Risk of Elevated Triglycerides

For adults with persistently elevated triglyceride levels > 150 mg/dL, first-line therapy remains aggressive lifestyle modification, including weight loss of 5% to 10% of body weight if overweight or obese, reduced intake of added sugars, alcohol and saturated, increased physical activity, which can significantly lower triglyceride levels when adhered to consistently. In ASCVD patients with persistently elevated triglycerides (150-999 mg/dL) and above LDL-C and non-LDL-C goals, intensification of statin therapy is recommended to achieve a triglyceride goal of <135 mg/dL. In patients with persistent elevations in triglyceride levels despite maximally tolerated statin therapy, particularly those with ASCVD or diabetes, additional therapies such as icosapent ethyl may be considered for further risk reduction. The REDUCE-IT trial showed that high-dose icosapent ethyl reduced major adverse cardiovascular outcomes in patients with elevated triglyceride levels despite statin therapy by approximately 25%, with an absolute risk reduction of about 4.8% over a median follow-up of 4.9 years. Furthermore, olezarsen is an apoC3 inhibitor recommended for patients with familial chylomicronemia syndrome and fasting triglyceride level > 1000 mg/dL. Overall, hypertriglyceridemia management in 2026 is no longer one-size-fits-all but instead a tiered strategy aligning triglyceride levels and ASCVD risk with progressively intensified therapy.

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	Icosapent Ethyl Use for ASCVD Risk Reduction (must be on maximally tolerated statin & TG 135-499 mg/dL)
Eligible Patient Populations	≥ 45 years of age with ASCVD
	≥ 50 years of age with diabetes and ≥ 1 additional risk factor
Risk Factors for Patients with Diabetes	Men > 55 years of age or women > 65 years of age Smoker or recently quit 3 months prior Hypertension (>140/90 mmHg) CRP >3.0 mg/L CrCl >30 to <60 mL/min Retinopathy or nephropathy ABI <0.9 without symptoms of intermittent claudication

Top Take-Home Messages

- Treatment of dyslipidemia should start earlier in young adulthood with an LDL-C of > 160 mg/dL or a strong family history of premature ASCVD
- PREVENT-ASCVD equation for primary prevention to help assess risk
  - LLT can be considered if 10-year risk is borderline (3-<5%)
  - LLT should be considered if 10-year risk is intermediate (5-<10%)
- ApoB is useful when LDL-C and non-HDL-C goals are met, especially in patients with:
  - TG > 200 mg/dL
  - Diabetes
  - Low achieved LDL-C (<70 mg/dL)
- Lp(a) should be measured in each adult at least once
  - Considered a risk enhancing factor when levels are >50 mg/dL (125 nmol/L)
- CAC score to improve risk assessment and guide LDL-C and non-HDL-C goals
  - Men >40 years of age
  - Women >45 years of age
- LLT is recommended for primary prevention in adults ages 40-75 years old with diabetes, CKD stage 3 or 4, or HIV, regardless of LDL-C level

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- Secondary prevention goals:
  - Very high risk: LDL-C <55 mg/dL, non-HDL-C <85 mg/dL
  - Not very high risk: LDL-C <70 mg/dL, non-HDL-C <100 mg/dL
- If triglycerides are persistently elevated:
  - Statin and lifestyle modifications are the foundation of therapy to reduce ASCVD risk
  - Consider TG lowering therapies, especially in patients with TG > 1000 mg/dL to prevent pancreatitis

In summary, the 2026 guideline moves beyond a one-size-fits-all approach and toward a more personalized, risk-based strategy. By incorporating tools such as advanced biomarker testing with ApoB and [Lp (a)] and the PREVENT risk assessment model, clinicians are better equipped to identify high-risk patients earlier and tailor therapy accordingly. Treatment is now focused on more aggressive LDL-C lowering, combination therapy, and earlier prevention strategies.

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TXA in Trauma: An Overview and Applications

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Reviewed by Cheryl Wood, PharmD, BCCCP

Trauma is a leading cause of preventable mortality worldwide, and hemorrhage is responsible for many early deaths.[1] Tranexamic acid (TXA), an antifibrinolytic agent that inhibits the conversion of plasminogen to plasmin, has gained widespread attention as a mortality-reducing intervention in traumatic hemorrhage.[2] Its use remains controversial due to variable trial results and concerns regarding timing, safety, and appropriate patient selection, yet it has been incorporated into many trauma protocols. This article aims to summarize the most influential modern clinical trials supporting TXA use in trauma.

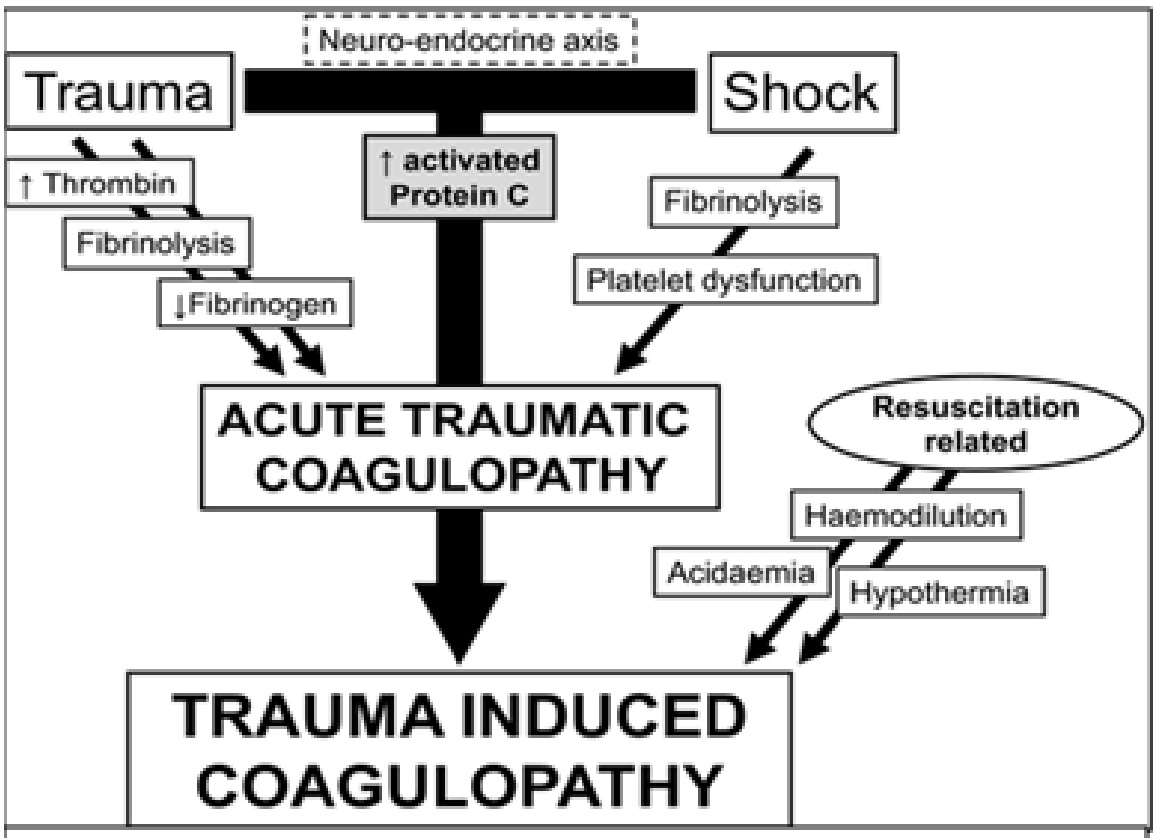

Figure 1. Trauma-induced Coagulopathy Pathophysiology
Curry NS & Davenport r. *Br J Haematol*. 2019;184:508-523.

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Trauma-induced coagulopathy (TIC) encompasses a spectrum of coagulation abnormalities that occur following traumatic injury. Coagulopathy, hypothermia, and acidosis form a "lethal triad" often accentuated by mechanisms including tissue injury and shock provoking endothelial, immune system, platelet, and clotting activation. Early TIC generally occurs within 6 hours of injury and is characterized by hypocoagulopathy, an inability to achieve hemostasis that can lead to shock and uncontrolled hemorrhaging. Early TIC is often driven by excessive fibrinolysis mediated by tissue plasminogen activator (tPA), accelerating clot breakdown and worsening hemorrhage. TXA directly targets this mechanism, stabilizing clot formation during the critical early phase. Late TIC usually occurs more than 24 hours after injury and is represented by hypercoagulopathy, where excessive macro-clotting and micro-clotting may result in thromboembolic events and multi-organ failure. However, early and late TIC are not mutually exclusive, and the transition between the two may occur within minutes or hours or be delayed for days. [1,3,4]

Historically, TXA has been supported in literature to prevent fibrinolysis and reduce surgical blood loss in major surgeries including cardiac, orthopedic, liver, and vascular surgery. Trials in these settings showed that TXA reduced the need for blood transfusion and that mortality was relatively rare in elective cases, without evidence of increased thromboembolic risk. After reviewing literature supporting TXA use in surgical patients, researchers were motivated to conduct the CRASH-2 trial, which examined TXA in trauma patients.[1]

Data from the CRASH-2 and CRASH-3 trials have guided indications, administration timing, and cost-effectiveness of TXA. CRASH-2 aimed to investigate the effects of early TXA administration on death, vascular occlusive events, and transfusion requirements in trauma patients. The trial found that all-cause mortality and death due to bleeding were both decreased with TXA, with no increase in vascular occlusive events such as myocardial infarction, stroke, pulmonary embolism, or deep vein thrombosis. The benefit of TXA was greatest when given early, especially within 3 hours of injury, although transfusion requirements and surgical intervention rates were similar between groups.[5] The Military Application of Tranexamic Acid in Trauma Emergency Resuscitation Study (MATTERS) also showed a survival benefit of a 1-gram bolus of TXA, especially in patients with severe injuries, penetrating trauma, or those requiring massive transfusion protocol.[6]

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CRASH-3 evaluated the effects of TXA in traumatic brain injury (TBI), as intracranial bleeding is common after TBI and can lead to rising intracranial pressure, brain herniation, and preventable early death. The primary outcome was head injury-related death in hospital within 28 days of injury in patients treated with TXA within 3 hours, with the time limitation derived from CRASH-2. CRASH-3 found that early TXA modestly reduced head injury-related death in patients with mild to moderate TBI (GCS 9–15), with no increase in thrombotic complications, but showed no clear benefit in severe TBI (GCS 3–8).[7] Together, CRASH-2 and CRASH-3 demonstrated that TXA can safely reduce preventable deaths from traumatic bleeding, including systemic hemorrhage and intracranial bleeding, when administered within 3 hours of injury.

Recently, the alternative methods of TXA administration before and within the trauma bay have been studied. The traditional dosing of TXA is 1-gram bolus over 10 minutes, followed by a 1-gram continuous infusion over 8 hours. Because of this dosing strategy, trauma patients occasionally do not receive the second dose of TXA. There have been recent trials examining pre-hospital TXA administration, which has been associated with reduced mortality compared to inhospital administration especially in patients with TBI.[8,9] Additionally, recent studies have examined the administration of 2-gram boluses of TXA instead of the traditional dosing strategy, with at least one trial showing clinical outcomes and 24-hour fibrinolysis state equivalence across these dosing strategies.[10] Further study will be needed in this area to determine the efficacy and utility of these strategies, though pre-hospital administration of TXA has gained wider acceptance to ensure administration of TXA within the 3-hour window established by the CRASH trials.[11]

While TXA use is common in the trauma bay and is often administered by EMS in the field to trauma patients at risk of hemorrhage, there are some unique uses of TXA that may also benefit the trauma patient. Topical TXA has shown promise in reducing localized bleeding, including improved control of epistaxis compared with anterior nasal packing in patients on antiplatelet therapy, and broader evidence suggests topical application can decrease bleeding across various minor procedures. [12,13] Nebulized TXA has also been explored as a noninvasive option for hemoptysis, with a small trial demonstrating reduced bleeding and faster symptom resolution compared with placebo.[14] Together, these alternative approaches highlight potential adjunctive uses of TXA in trauma care, though larger studies are needed to define their role.

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Questions remain about TXA usage in trauma including concerns about pro-thrombotic risk, uncertainty about patient population, debate about administration timing, and variability in prehospital versus in-hospital protocols.[2] Additionally, the risk of TXA-associated seizures has not been addressed thoroughly in the trauma population.[1] So while the use of TXA is prevalent within the trauma population, some future studies should be completed to fully elucidate TXA's potential and risks in the trauma population.

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SPECIAL INSIGHTS

Medications Slated to Become Generic Within the Next Four Years

Beatriz Jimenez Cadilla, PharmD, BCACP, CDCES, CPh

Though significant progress has been made toward improving chronic disease state management in recent years, questions about medication accessibility for patients who may not have the means to acquire newer drug therapies remain.

The table lists medications that will likely have a generic version available in the next several years. The timeframes listed are speculative based on ongoing litigation.

Some medications may become available as generic sooner than what is listed in the table as the dates recorded were based on the latest estimated resolution of litigation for each drug.

Year	Brand (generic)
2026	Brilinta® (ticagrelor) Entresto® (sacubitril/valsartan) Tradjenta® (linagliptin) Qsymia® (phentermine/topiramate extended-release) Jentadueto® (linagliptin/metformin) Jentadueto XR® (linagliptin/metformin extended-release) Januvia® (sitagliptin) Janumet® (sitagliptin/metformin) Janumet XR® (sitagliptin/metformin extended-release) Edarbi® (azilsartan medoxomil) Saxenda® (liraglutide)
2027	Xarelto® (rivaroxaban) Bydureon® (exenatide extended-release) Vitekta ® (elvitegravir) Edurant Ped ® (rilpivirine)
2028	Eliquis® (apixaban) Invokana® (canagliflozin) Invokamet® (canagliflozin/metformin) Invokamet XR® (canagliflozin/metformin extended-release) Edarbyclor® (azilsartan medoxomil/chlorthalidone) Triumeq® (abacavir/dolutegravir/lamivudine) Tivicay ® (dolutegravir)
2029	Juluca ® (dolutegravir/rilpivirine) Dovato ® (dolutegravir/lamivudine) Linzess ® (linaclotide) Belsomra ® (suvorexant) Duaklir Pressair ® (aclidinium/formoterol) Rukobia ® (fostemsavir) Prezcobix ® (cobicistat/darunavir) Dutrebis ® (lamivudine/raltegravir) Isentress ® (raltegravir) Evotaz ® (atazanavir/cobicistat) Stribild ® (cobicistat/elvitegravir/emtricitabine) Sovaldi ® (sofosbuvir)

COMMENTARY

The Power of Good Catches: Strengthening Patient Safety through Event Reporting

Jaimi Luke, PharmD, BCPS; Tim Carbone, PharmD, MBA, BCGP; Michelle Lamarque, PharmD, BCPS; Robyn Yarsley, PharmD, BCPS; Shivana Syne, PharmD, MHA, BCPS
Sponsored by the FSHP Medication Safety Clinical Forum

Healthcare systems utilize event reporting systems to identify both preventable and non-preventable gaps in processes and behaviors that could negatively impact patient safety. These issues are traditionally categorized as either active failures, associated with human error and individual mistakes, or latent failures, which result from system-based faults and error-producing conditions that passively create risks to patient safety.1 Reducing latent factors is a major focus in event reporting as human presence will always have the potential of influencing poor outcomes, as addressed in the Institute of Medicine landmark report 'To Err is Human'.2 However, identifying and reporting both types of failures is crucial in enhancing safety and outcomes, regardless of whether they result in direct patient harm. By recognizing and reporting "good catches" or near misses, these events are able to be discovered and intercepted before they reach the patient.3 These represent critical opportunities in identifying vulnerabilities within the system and in promoting a proactive approach to safety, organizations can address risks early on and ideally prevent recurrence of errors.

The difference between a near miss and a serious patient safety event is often a matter of timing and whether the environment present has the potential to generate gaps in care. Common contributors to systemic latent failures within health systems can include workflow inefficiencies, inadequate staffing, and time pressure, which can lead to fatigue and rushed clinical decision-making.4,5 Having non-standardized processes and poorly designed workflows may encourage temporary workaround measures, while unclear communication such as telephone and verbal orders remains at high risk for transcribing and ordering errors.6 Technology challenges such as alert fatigue or incompatibility between electronic health records and medication use technologies can also increase the likelihood of medication-related errors.7 When these conditions align, even highly skilled clinicians may miss potential errors that end up reaching the patient, as often illustrated in the "Swiss Cheese" model by James Reason.

COMMENTARY

Despite these risks, many medication safety events can be prevented through good catches and reporting the near miss incident. Examples of good catches surrounding medication safety include identifying an incorrect medication through barcode scanning with BCMA, immediate clarification of ambiguous or confusing orders and prescriptions, and intercepting dosing errors at pharmacist verification before it reaches a patient.8,9 Although these events may not always result in harm, their impact is still significant and when reported, good catches expose system gaps and drive meaningful process improvements with the overall goal to reduce the chance of recurrence. Frequent reporting is preferred over temporary workaround measures as these are not true solutions and do not eliminate the underlying vulnerability, potentially introducing new risks through these alternate pathways.

Psychological safety is essential for encouraging disclosure of these events and is achieved by creating an environment where good catches are consistently reported and rewarded. A 'Just Culture' supports open communication by focusing on objective learning and system improvement rather than placing blame.10 When staff feel safe raising concerns and trust that their reports will be taken seriously, organizations see increased reporting, collaboration, and overall safer patient care. By valuing good catches and supporting open reporting, healthcare systems transform vigilance into patient safety improvements.

As previously published in the FLORxIDA Times 18 th Issue last summer, the Medication Safety survey conducted by the FSHP Medication Safety Clinical Forum KPI Workgroup identified key performance indicators (KPIs) used for improving medication safety, with pharmacy leaders across nearly twenty different organizations answering questions surrounding medication safety issues, including good catch reporting. Of the 23 respondents, 18 of them (78%) report tracking good catches with 11 reporters provided details by both total number of events reported (8/11) and specific good catch reporting (3/11).

COMMENTARY

Tracking of these events was often manually tracked via Microsoft Excel or Word and overall noted to be inconsistent across institutions. Due to the small sample size and variability in medication safety practices across Florida institutions, there is further opportunity to standardize KPIs surrounding good catch reporting. Pharmacists may encounter a wide range of medication errors and risky behaviors in daily practice and are uniquely positioned to promote a supportive environment that encourages reporting of good catches. Reporting our good catches as recommended by ISMP Best Practices 2026-2027 increases awareness of the potential path to patient harm, with each report serving as a data point that can drive meaningful changes to the system, prevent future errors, and ultimately enhance patient safety. 11

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COMMENTARY

Medication Error	*Any preventable event creating inappropriate medication use or patient harm <u>while the medication is in control of the healthcare professional, patient, or consumer</u>* Medication Error Result Categories: • No Error • Near Miss ("Good Catch") • Error with No Harm • Error with Harm • Error resulting in Death
Adverse Drug Event (ADE)	*Any harm experienced by a patient <u>as a result of exposure to a medication</u>, possibly due to a medication error* ADE Categories: • Preventable • Potential • Ameliorable • Non-preventable (Adverse Drug Reaction)
Adverse Drug Reaction (ADR)	*Type of adverse drug event due to a harmful and unintended response to a drug that <u>is often unavoidable and occurs at normal dosing ranges for prophylaxis or therapeutic dosing</u>*
Good Catch	*A medication error or unsafe condition that occurred but is identified and corrected <u>prior to reaching the patient</u>*

Contemporary View of Medication–Related Harm. A New Paradigm. NCC MERP and Medication Errors. www.nccmerp.org

COMMENTARY

Medication Safety During EHR Transition: Anticipating the Inevitable Risk Shift

Lisaine Borges, PharmD, BCPS, BCCCP

The implementation of digital systems such as electronic health records (EHRs) has standardized documentation across healthcare systems, providers, and patients. EHRs enable the electronic storage of patient information, including medical history, medications, test results, and treatments (Centers for Medicare & Medicaid Services [CMS], 2024). Although no national benchmark exists for EHR replacement, transitions between systems are increasingly common as organizations pursue interoperability, consolidation, and enhanced functionality. Systematic reviews highlight that EHR-to-EHR transitions have become a significant phase in the health information technology lifecycle (Miake-Lye et al., 2023; Rinne et al., 2023; Saleem & Herout, 2018).

While transition planning often emphasizes financial, interoperability, workflow, and resource considerations, the immediate impact on medication safety is less well defined. Although EHR adoption is associated with improved medication safety, benefits are typically achieved only after systems mature and users gain experience. A meta-analysis reported a 26% reduction in medication errors, primarily in organizations with at least three years of EHR use (Mwogosi et al.,2025). In contrast, transitions to new EHRs are associated with temporary increases in medication safety events. For example, one academic health system observed a fivefold increase in reported events after implementation, returning to baseline within three months (Whalen et al., 2018). Transitions are also associated with shifts in error types, including increases in near-miss events and changes in reconciliation, ordering, and prescribing errors (Lindén-Lahti et al., 2022; Whalen et al., 2018).

A key factor influencing medication safety during transitions is disruption to workflow and system usability. The introduction of new technology alters navigation patterns, task sequencing, and cognitive workload. During early implementation phases, unfamiliar interfaces and redesigned workflows can increase cognitive burden and reduce efficiency, creating opportunities for error that can propagate across prescribing, dispensing, and administration processes.

COMMENTARY

Within prescribing and computerized provider order entry (CPOE), transitions often result in changes to how orders are displayed and accessed. Order sets may be incomplete or absent due to prioritization during system build, forcing reliance on non-standardized workflows. Errors may also arise from misconfigured orders, including incorrect defaults or dosing fields. Mitigation strategies include optimizing order sets before go-live, incorporating frontline clinician input, minimizing unnecessary dropdown selections, and validating names, synonyms, and visual presentation to support safe and intuitive prescribing practices.

Medication reconciliation is particularly vulnerable during EHR transitions due to fragmented data sources and workflow redesign. Incomplete medication histories, reconciliation gaps, and data migration issues can result in duplications, omissions, or unintended continuation of medications across levels of care. Mitigation requires pharmacy-led medication history verification, standardized reconciliation workflows, and clearly defined ownership supported by system-level processes beyond pharmacy alone prior to implementation.

Order verification, medication preparation, and dispensing are also impacted. Increased cognitive load among pharmacy staff may contribute to missed clinical decision support alerts or overlooked discrepancies. Interoperability challenges with automated dispensing cabinets (ADCs), medication database inconsistencies, and issues with National Drug Code (NDC) mapping further increase risk. Intravenous (IV) and infusion workflows are especially complex due to their reliance on integrated systems. Mitigation includes enhanced staffing during go-live, targeted training, validation of medication databases, and end-to-end workflow testing.

COMMENTARY

Clinical decision support systems may contribute to alert fatigue if over-alerting occurs or if alerts are poorly aligned with organizational needs. Conversely, ineffective or irrelevant alerts can reduce clinician trust. Mitigation requires careful customization, prioritization of high-value alerts, and ongoing monitoring of alert performance.

Medication administration processes are similarly affected, particularly in barcode medication administration (BCMA). System gaps may lead to workarounds that bypass safety checks, increasing the risk of administration errors. Addressing these issues requires real-time communication mechanisms, rapid-response teams, and prioritization of frontline feedback to resolve system gaps promptly.

In summary, while EHR transitions temporarily increase medication safety risks, particularly due to workflow disruption and system usability challenges, a proactive, standardized, and multidisciplinary approach is essential to identify vulnerabilities, implement targeted mitigations, and ensure a safe and effective transition.

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MEMBER SPOTLIGHT

Pam Lewis, RPh

Pam Lewis began her career at SMH as a Clinical Pharmacist on February 23, 1987. Soon after, she completed the Supervisor Management Course and was promoted to Evening Pharmacy Supervisor, where she quickly distinguished herself as a capable and trusted leader.

In 1993, Pam transitioned into the role of IRB Coordinator despite having no prior experience in the area. Her success in this position led to formal recognition in 1999 by Drs. J. Gallagher and M. Magenheim and the IRB members for five years of dedicated service. She later transitioned to Investigational Study Coordinator, a role she continues to serve in today, developing policies and procedures that ensure the safe and compliant participation of patients in clinical trials.

In 2000, Pam assumed the additional role of Medication Safety Specialist, expanding her impact across the organization. She led initiatives that measurably strengthened medication safety systems and improved patient outcomes. In 2016, she was instrumental in achieving hospital compliance with USP <800>, federally enforceable standards governing the safe handling of hazardous drugs in healthcare settings. This project was published and is cited on the CDC's website under hazardous drug resources as providing helpful "how-to" information for healthcare workers.

MEMBER SPOTLIGHT

Pam has also played a pivotal role in education and mentorship. Since the pharmacy residency program's inception in 2000, she has served as the primary preceptor for the core Medication Safety rotation. Nearly 100 pharmacy residents have benefited from her expertise, guidance, and unwavering commitment to excellence, carrying forward the patient safety principles she instilled in them.

Her contributions have been formally recognized through numerous honors, including the Patient Safety Culture Collaboration Participation Award (2013), the Excel Award of the Month (2018), and the Distinguished Pharmacy Research and Innovation Award (2023) for her leadership in the safe, accurate, and timely delivery of investigational medications. Throughout nearly four decades at SMH, Pam has not simply fulfilled her roles—she has elevated them. Her leadership has strengthened systems, protected countless patients and healthcare professionals, advanced research integrity, and shaped the next generation of pharmacists. Her impact is woven into the culture of safety and excellence that defines the organization today. Her leadership significantly enhanced protections for patients and staff.

As we celebrate Pam's extraordinary career, we also celebrate the beginning of a well-earned retirement. We wish her relaxation, adventure, and countless joyful moments in this next chapter. Enjoy your retirement, Pam — you have truly earned it.

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COMMITTEE HIGHLIGHTS

FSHP Sterile Compounding

★ Statewide Leadership

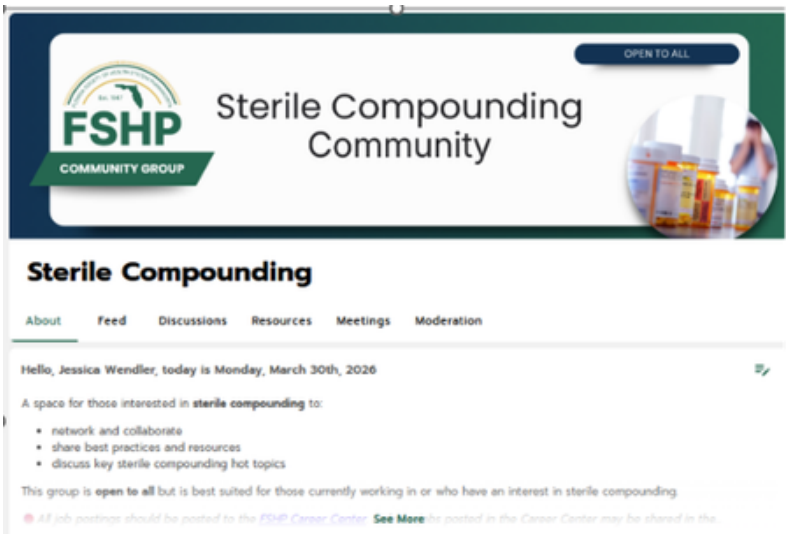
Representing the committee, Mala Cullipher delivered a presentation on non-sterile compounding at the FSHP Leadership Conference, contributing to statewide education and professional development.

2027 LEADERSHIP CONFERENCE

Event Info & Registration (fshp.org/events)

★ New Sterile Compounding Community

Launched our new webpage where members and non-members can share resources, ask questions, network, and access educational materials. Moderators are Jessica Wendler, Mala Cullipher, and Yuan Lian. Click here to join.



COMMITTEE HIGHLIGHTS

FSHP Sterile Compounding

★ Published in Florida Rx Times

Our first FSHP newsletter article highlighted the critical role of the Designated Person in maintaining sterile compounding quality and regulatory compliance.


April 2026, Issue 21 | FLORxIDA Times

COMMENTARY

The Role of the Designated Person in charge of sterile compounding integrity and regulations

Jack Iskander MBA, MHA, BCSCP
Jeff Cunningham, BS Pharm, Pharm.D., CPh, BCSCP
Vicki McConnell BSPharm, PharmD, CPh, BCSCP
Andrea Ledford, PharmD, CPH, MBA, BCOP, BCSCP, FASHP, FHOPA

★ Community Open Forum

Hosted an interactive April 2025 Open Forum featuring Suzanne Kluge, Mala Cullipher, and Carla Evans. Topics included certification report reviews, investigations & CAPAs, and quality systems.

★ Coming Soon

New committee resources in development:

- Designated Person qualifications
- Compounding resources
- BOP inspection pearls
- Immediate Use competency checklist

Thank you to our committee members, presenters, authors, and the entire FSHP community for supporting excellence in sterile compounding.

COMMITTEE HIGHLIGHTS

FSHP Technician Affairs Council Update

The FSHP Technician Affairs Council continues to make significant progress in advancing pharmacy technician engagement, professional development, and representation within the Society. Under the leadership of Chair Darren Davis and Vice Chair Crystal Lipko, the Council has completed many of its annual charges while laying the foundation for continued growth and inclusion across FSHP.

One of the Council's primary accomplishments this year has been increasing technician involvement in FSHP governance and leadership activities. Two technician-focused resolutions have been submitted to the House of Delegates, and technician representation has been expanded through the addition of a technician member to the Committee of Resolutions. The Council is also actively pursuing a bylaw change that would add a pharmacy technician representative to the Nominations Committee, creating additional opportunities for technician voices to be included in organizational decision-making.

The Council has also continued to strengthen professional development offerings for pharmacy technicians. A dedicated technician education track has been developed for the 2026 FSHP Annual Meeting, with all speakers confirmed and educational programming aligned with technician needs. In addition, a technician-specific webinar topic has been identified, and work is underway to secure a presenter. To ensure future programming remains relevant and impactful, a technician needs assessment survey will be distributed during the Annual Meeting through QR code access, helping guide educational offerings for the coming year.

Membership growth and mentorship remain key priorities. The Council has collaborated with the Membership Affairs Council to incorporate pharmacy technicians into FSHP's mentorship program and has developed updated outreach materials aimed at recruiting and re-engaging technician members. Discussions continue regarding mentorship opportunities within regional societies, helping create pathways for technicians to connect, develop leadership skills, and become more involved in FSHP activities.

COMMITTEE HIGHLIGHTS

FSHP Technician Affairs Council Update

Networking and member engagement initiatives have also gained momentum. The Council successfully met its charge of exploring alternative networking opportunities and is evaluating options for future in-person and virtual events. Preliminary discussions with vendor representatives have generated interest in sponsoring technician networking opportunities at future Annual Meetings. Additionally, the Council plans to host open forum sessions designed to introduce prospective technician members to FSHP, providing a welcoming environment to learn about the Society and opportunities for involvement.

Communication efforts have expanded through technician spotlights and regular council updates in FSHP publications. The Council recently featured Immediate Past Chair Elizabeth Lewallen in a Technician Spotlight and is developing additional opportunities to recognize the contributions of pharmacy technicians through newsletters and social media.

Looking ahead, the Council is developing standardized operating procedures to support succession planning, technician recruitment, council operations, award nominations, and leadership development. Preparations are also underway for the upcoming House of Delegates meeting, where an anticipated 9 technician delegates will help represent the interests of pharmacy technicians across Florida.

The Technician Affairs Council extends its appreciation to all members who have contributed their time and expertise throughout the year. Together, we continue to strengthen the role of pharmacy technicians within FSHP and advance opportunities for professional growth, leadership, and advocacy across the profession.

COMMITTEE HIGHLIGHTS

Professional Affairs Council Update

The Professional Affairs Council has been busy this year with preparing for the annual meeting and reviewing FSHP policies and procedures. Some key initiatives that are tackled each year are updating the rubrics and reviewing fellowship, awards and poster applicant submissions for the annual meeting. A key update to our usual procedure this year was the change to an online submission for posters. This was a successful initiative that seemed to ease the submission process. Another big addition to this year is that we initiated a FREE professional development book exchange at the annual meeting.

Sparkle Through Sharing- Share a Book. Inspire a Leader. Celebrate Growth.

Just as a spark can ignite a flame, one book can spark a new perspective, inspire confidence, or influence a future leader's career journey. This initiative encourages attendees to leave a lasting impact by sharing resources that helped them grow professionally.

As part of the Florida Society of Health-System Pharmacists Annual Meeting theme, "Sparkle, Shine & Celebrate," this professional development book-sharing initiative invites pharmacy professionals to donate and share impactful leadership, career development, wellness, innovation, and professional growth books with students, residents, peers, and colleagues.

The event celebrates the idea that leadership knowledge shines brightest when it is shared. By passing along books that have inspired personal and professional growth, attendees can help cultivate the next generation of pharmacy leaders while strengthening connections across all career stages.

Conference attendees were invited to bring one or more professional development books to donate or exchange. **It was a great turn out and we are excited to bring this back again for the 2027 Annual Meeting!**

REGIONAL SOCIETY UPDATE

Southern Gulf Society of Health-System Pharmacists

Regional Officers

Jack Iskander
President

Ashley Nebbia
Immediate Past President

Rebecca Orr
Secretary

Shelly Kearns
Treasurer

Rakhi Patel
CE Coordinator

The Southern Gulf Society of Health-system Pharmacists (SGSHP) has been enjoying an active year, and we look forward to continuing this in the second half of 2026.

SGSHP is now 72 members strong. We highly appreciate the support and involvement of our members and community. On April 9th, 2026, we held our first networking event in several years, at Top Golf in Fort Meyers.

Thirteen members showed up for great food, drinks, networking and fun! We are planning another SGSHP networking event in October. Paratek Pharmaceuticals will be sponsoring a dinner for SGSHP members on Tuesday October 6th at Diveito Restaurant in Bonita Springs. Information will be mailed out to membership once the event is finalized. We have an Oncology online CE event coming up for members on July 25th. SGSHP will have 9 delegates in the Florida House of delegates representing the organization at this years FSHP annual Seminar in Orlando.

REGIONAL SOCIETY UPDATE

SGSHP currently does not have a president-elect officer named. If you are interested, please visit https://fshp.org/affiliates/southern-gulf-society/, and click on the “contact regional officers” hyperlink. I want to thank our current officer volunteers for all their behind-the-scenes hard work to keep our organization going strong! We look forward to your continued support and partnership to help advance pharmacy services and continue to strengthen our organization to be one that connects pharmacy professionals in SW Florida!

Jack Iskander, Pharm.D, MBA, MHA, BCSCP
President, Gulf South Society of Health-system Pharmacists
Naples Comprehensive Health
System Director of Pharmacy Services

REGIONAL SOCIETY UPDATE

The Palm Beach Society of Health-System Pharmacists (PBSHP) has had an exciting and productive first half of 2026, with a continued focus on professional development, community engagement, networking, and supporting the next generation of pharmacy professionals.

In January, PBSHP members and student pharmacists participated in the 2026 Susan G. Komen More Than Pink Walk in downtown West Palm Beach as part of the "Pharmacy Pharmily" team. The event provided an opportunity for pharmacists and student pharmacists to come together in support of breast cancer patients, survivors, and ongoing cancer research while representing the pharmacy profession within our local community.

In February, PBSHP hosted a Networking Happy Hour that welcomed more than 30 pharmacists, pharmacy technicians, residents, and student pharmacists from across Palm Beach County. The evening fostered professional connections across a variety of practice settings while also raising funds to support student involvement in FSHP. Members raised $250 through a raffle, which PBSHP matched to provide a $500 travel scholarship for a student pharmacist to attend the 2026 FSHP Annual Meeting.

REGIONAL SOCIETY UPDATE

In April, PBSHP partnered with Palm Beach Atlantic University Gregory School of Pharmacy to host our annual Residency & Clinical Excellence Forum. Pharmacists, residents, and student pharmacists from across South Florida earned 7 hours of ACPE-accredited continuing education while learning from local experts on clinical and professional topics. The forum also provided valuable opportunities for networking, residency mentorship, and collaboration across multiple practice settings.

PBSHP is excited to continue this momentum throughout the remainder of 2026. In September, we will host our inaugural Mentor-Mentee Mixer, connecting pharmacy students with pharmacists from a wide range of practice areas to foster mentorship and career exploration. We also look forward to another Networking Happy Hour later this year. In October, PBSHP will present a virtual oncology consultant continuing education program featuring oncology specialists discussing challenging patient cases and emerging advances in cancer care. PBSHP will also be participating in several community service projects around Palm Beach County, including feeding the homeless with the Burrito Project in Lake Worth, Florida, volunteering at a soup kitchen on Thanksgiving, and collecting toys for a Christmas toy drive in December.

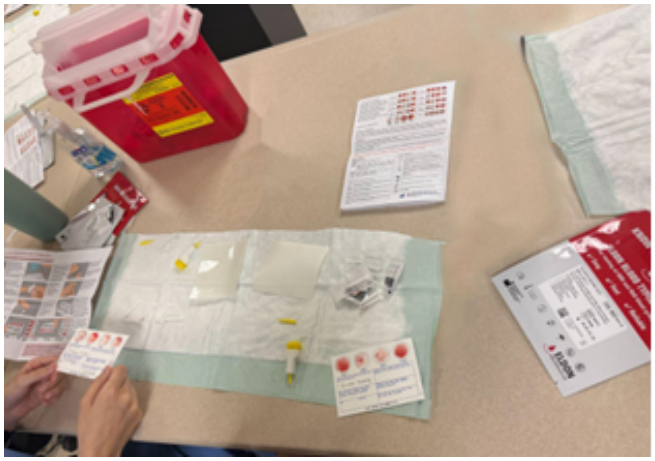
PBSHP thanks our members, volunteers, speakers, sponsors, and community partners for their continued support as we advance pharmacy practice and serve our community.

STUDENT SOCIETY UPDATE

UF SSHP's 2025–2026 Update

The University of Florida Student Society of Health-System Pharmacists (UF SSHP) experienced an exciting year filled with opportunities for service, professional development, leadership, and advocacy. Throughout the 2025–2026 academic year, members worked to strengthen their understanding of health-system pharmacy while giving back to the community and fostering meaningful connections with pharmacy professionals across Florida.

One event that truly reflected our chapter's mission was our Know Your Blood Type educational event. Students had the opportunity to determine their own blood type using blood typing kits while learning why blood type compatibility is essential during emergencies and lifesaving transfusions. Members also discussed which blood types can donate to or receive blood from one another, emphasizing the critical role blood donors play in maintaining an adequate blood supply. By combining hands-on learning with patient education, the event highlighted the pharmacist's role in promoting public health while encouraging future participation in local blood donation initiatives.



STUDENT SOCIETY UPDATE

Beyond this event, our chapter remained committed to helping students explore the many opportunities available within health-system pharmacy. Throughout the year, students connected with pharmacists representing a variety of specialties, including infectious diseases, oncology, pediatrics, critical care, psychiatry, pharmaceutical outcomes, and industry. These discussions provided valuable insight into diverse career paths while allowing students to ask questions about rotations, residency training, leadership, and professional growth.

Preparing students for postgraduate training also remained a major focus. Our annual Residency Showcase connected students with residency programs from across the country, giving members the opportunity to speak directly with residents and program directors while learning more about the residency application process. Events such as Mentor Night further strengthened these connections by allowing students to participate in small-group conversations with pharmacists from multiple specialties, creating an approachable environment for mentorship and career guidance.

Community engagement remained at the heart of our organization. Throughout the year, members volunteered with organizations including the Gainesville Giving Garden, Ronald McDonald House Charities, St. Francis House, and LifeSouth Community Blood Centers. Whether harvesting fresh produce, providing health screenings, supporting families experiencing medical hardship, or encouraging blood donation, students demonstrated the important role pharmacists play in improving the health and well-being of their communities.

In addition to service, UF SSHP emphasized advocacy and innovation within the profession. Members participated in pharmacy law discussions, learned about current legislative issues affecting pharmacy practice, and hosted educational programming focused on naloxone administration and harm reduction strategies. During our annual PAI Week, students explored topics including medication safety, pharmacy informatics, and emerging technologies that continue to shape the future of patient care.

STUDENT SOCIETY UPDATE

The accomplishments of this year would not have been possible without the dedication of our members, executive board, faculty advisors, alumni, and pharmacist mentors who continually invest in the next generation of health-system pharmacists. Together, they have created an environment that encourages leadership, collaboration, lifelong learning, and service.

As UF SSHP looks toward another exciting year, we remain committed to providing meaningful opportunities that prepare student pharmacists to become compassionate clinicians, effective leaders, and advocates for the profession. We are grateful for the continued support of the Florida Society of Health-System Pharmacists and look forward to continuing our partnership in advancing health-system pharmacy throughout Florida.

Follow UF SSHP
Instagram: @ufsshp

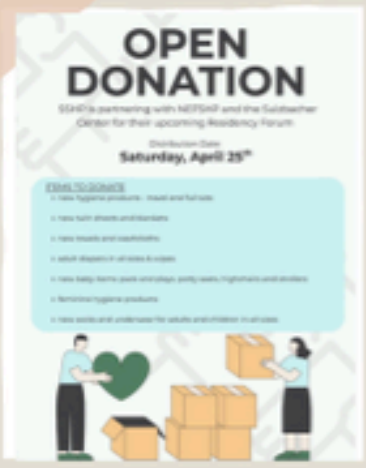
Student Society of Health System Pharmacists (SSHP)

UF College of Pharmacy, Jacksonville Campus

spring highlights!

Mini-CEs

Throughout the semester, SSHP hosted "Mini-CEs"" which gives first, second, and third-year students the opportunity to present on a topic of their choosing in front of their peers in preparation for their Advanced Pharmacy Practice Experience rotations. This semester, we had three different groups of students present to the organization on drugs with recent or upcoming FDA approval. These students even had the opportunity to speak at the Duval County Pharmacist's Association monthly meeting (pictured right) in which they gave their presentations in a formal setting and answered questions from practicing pharmacists.



NEFSHP Donation Drive and Residency Forum

SSHP partnered with NEFSHP at their Residency Forum to provide volunteers and donations for the event. Students who volunteered were also allowed to attend the seminars at the forum and network with residency programs in attendance.

RxREWIRED Inside What's Next

A podcast by FSHP

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Contact us to get your content in our next newsletter: fshp@fshp.org