ABSOLUTE
PHARMACY, INC.

Q3: August 2015 Newsletter | #3

KEEPING TABS

Absolute Pharmacy is the prescription for what ails you.

In each edition, you'll find news about the latest in pharmacy, new medications, technology and more – all through the lens of what is pertinent to the long-term care (LTC) industry.

Absolute Pharmacy has been serving the LTC industry since 1994. We're a part of a dynamic circle of care that consists of rehabilitation, home health care services, hospice care and much more. We have a rich perspective, and we're thrilled to share what we've been learning from other industry leaders, our employees and our customers – you!

We hope you find the information useful. If you have a suggestion for something you'd like to see, let us know at marjo.mcelyea@abshealth.com.

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Medicaid Redeterminations

by Emily Cherry, Absolute Pharmacy

Federal law requires state Medicaid programs to redetermine eligibility every 12 months, unless the agency receives information about a change that may affect eligibility in the interim. “Redetermination” means a review to verify whether an individual continues to meet all of the eligibility requirements of the medical assistance category.

In 2014, redeterminations were temporarily waived due to Ohio implementing a new system to determine eligibility for benefits. Annual Medicaid redeterminations have resumed, starting in December 2014, and were due back by January 31, 2015.

The local county Job & Family Services office will mail out redetermination packets one month before they are due. If the packets have not been returned, a reminder will be sent out. However, if the packets are not completed, a notice of termination will be sent for failing to update information.

To help streamline the process, Ohio Medicaid implemented passive renewals for consumers scheduled for redetermination in May. Passive renewals mean that the eligibility system will automatically review the information on file for the beneficiary, and if all criteria can be confirmed by the system, coverage is renewed automatically without requiring additional documentation from the individual.

Understanding A Common Blood Test: CMP (Comprehensive Metabolic Panel)

by Victor Silea, Consultant Pharmacist

COMPONENT	DEFINITION
Sodium	An electrolyte essential to carry electrical impulses for muscle contraction.
Potassium	An electrolyte necessary for the heart, kidneys and other organs to work normally.
Chloride	Needed for metabolism and regulating the body’s acid-base balance.
Calcium	A mineral needed to maintain strong bones.
Glucose	Sugar in the blood, a main source of energy.
Carbon Dioxide	Gaseous waste product from metabolism, indicates if there is an oxygen/carbon dioxide imbalance.
BUN	Blood urea nitrogen (a waste product formed in the liver); determines whether the liver and kidney work properly.
Creatinine	A waste product of muscle metabolism, determines how well kidneys function.
Protein	(Albumin & Globulin) Checks how well the liver and kidneys function and if diet contains enough protein.
Bilirubin	A pigment in the bile produced when the liver breaks down old red blood cells. An indicator of liver function and if something is blocking the bile ducts.
ALP/ALT/AST	Enzymes found in the liver and other tissues. Can determine whether there is a liver or bone problem and keep track of the effects of medicines that can damage the liver.

Psychopharmacological Meds: The Rules in LTC

by Tracy Penrose, Consultant Pharmacist

Why do consultant pharmacists keep asking to reduce psychotropic meds? What needs to be documented in the patient's record? How often do practitioners need to review these meds?

The answers can be found in the federal regulation F-Tags. A summary applicable to psychopharmacological meds follows*:

F-329 – FREE FROM UNNECESSARY DRUGS - 42 CFR 483.25-

- Residents who haven't used antipsychotics are not given them unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed/documented in the clinical record, and
- Residents who use antipsychotics receive gradual dose reductions, and behavioral interventions (unless clinically contraindicated), in an effort to discontinue these drugs.

The first purpose of F-329-related to antipsychotic drug use is to prevent nursing home staff from giving a resident an unnecessary antipsychotic drug. Despite the FDA's black box warning of the potentially fatal side effects of antipsychotics for people suffering from dementia, these powerful drugs are too often used as a means of sedating elderly nursing home residents with dementia as a substitute for appropriate care.

The second purpose is to ensure that facilities take steps to wean residents off antipsychotics. This goal is accomplished through either the implementation of behavioral interventions (unless diagnoses do not call for such interventions) or through recorded and monitored gradual dose reductions (GDR) or, most likely, a combination of the two.

F-309 – NECESSARY CARE FOR HIGHEST PRACTICABLE WELL BEING - 42 CFR 483.25

- Each resident must receive the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

It is important that use of medications be consistent with the goals for comfort, control of symptoms, and for the individual's desired level of alertness.

F-222 – RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS - 42 CFR 483.13

- The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat medical symptoms.

A facility may be in violation of F-222 if an antipsychotic is administered and not required to treat medical symptoms. A staff member could claim that the resident is exhibiting a "behavioral problem" and administer an antipsychotic drug to sedate the resident. This treatment may be easier for the staff member, but is not necessarily therapeutic for the resident. Masking behavioral symptoms of dementia is not an appropriate substitute for care that responds to a resident's needs.

*summary by Long Term Care Community Coalition

SOM (STATE OPERATIONS MANUAL), APPENDIX PP, GUIDANCE TO SURVEYORS READS:

- Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication;
- Clinically significant adverse consequences are minimized; and
- The potential contribution of the medication regimen to an unanticipated decline or symptom is recognized, and the regimen is modified when appropriate.

TAPERING OF A MEDICATION DOSE/GRADUAL DOSE REDUCTION (GDR):

The requirements underlying this guidance emphasize the importance of seeking an appropriate dose and duration for each medication and minimizing the risk of adverse consequences. The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms.

The time frames and duration of attempts to taper any medication depend on factors including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and pharmacologic characteristics of the medications. Some medications (e.g., antidepressants, sedative/hypnotics, opioids) require more gradual tapering so as to minimize or prevent withdrawal symptoms or other adverse consequences.

NOTE: If the resident's condition has not responded to treatment or has declined despite treatment, it is important to evaluate both the medication and the dose to determine whether the med should be discontinued or the dose altered, whether or not the facility has implemented GDR as required.

TAPERING OF ANTIPSYCHOTICS:

Within the first year a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

For a resident on an antipsychotic to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if:

- The resident's target symptoms returned or worsened after the most recent attempt at a GDR*

For a resident on an antipsychotic to treat a psychiatric disorder (ie; schizophrenia, bipolar mania,or depression with psychotic features), the GDR may be considered contraindicated if:

- The continued use is in accordance with current standards of practice* or
- The resident's target symptoms returned or worsened after the most recent attempt at a GDR*

TAPERING OF SEDATIVES/HYPNOTICS:

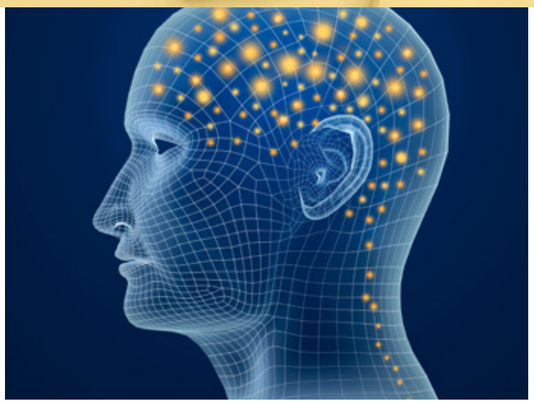
For as long as a resident remains on a sedative/hypnotic used routinely and beyond the manufacturer's recommendations for duration, the facility should attempt to taper the medication quarterly unless clinically contraindicated.

Clinically contraindicated means:

- The continued use is in accordance with relevant current standards of practice* or
- The resident's target symptoms returned or worsened after the most recent tapering*

TAPERING OTHER PSYCHOPHARMACOLOGICAL MEDICATIONS (ANXIOLYTICS, ANTICONVULSANTS, ANTIDEPRESSANTS):

During the first year a resident is admitted on a psychopharmacological medication or after the facility has initiated one, the facility should attempt to taper the medication during two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated.



The tapering may be considered clinically contraindicated if:

- The continued use is in accordance with relevant current standards of practice* or
- The resident's target symptoms returned or worsened after the most recent tapering *

*If any psychopharmacologic med is clinically contraindicated, the physician must document the clinical rationale why additional attempted dose reductions would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

OTHER NOTES:

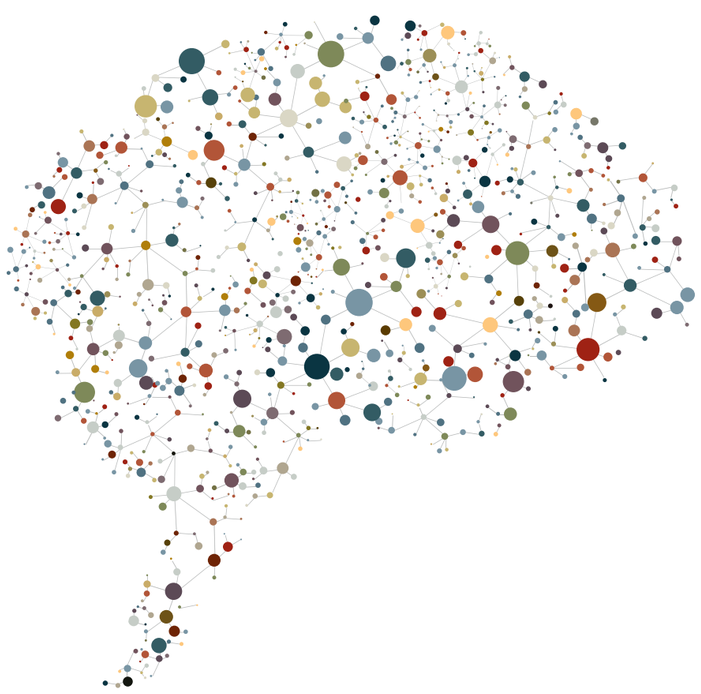
- Use of two or more antidepressants simultaneously may increase risk of side effects; there should be documentation of expected benefits that outweigh the associated risks and monitoring for increase in side effects.
- Duration should be in accordance with pertinent literature including clinical practice guidelines.
- Prior to discontinuation, many antidepressants may need a gradual dose reduction to avoid a withdrawal syndrome (e.g., SSRIs, TCAs, SNRIs).
- F329 states that Diphenhydramine (Benadryl) and Hydroxyzine (Vistaril) are not appropriate for use as anxiolytics.
- All residents being treated with an antidepressant should be monitored closely for worsening of depression and/or suicidal behavior or thinking, especially during initiation of therapy and during any change in dosage.
- SSRIs in combination with other medications affecting serotonin (e.g., tramadol, St. John's Wort, linezolid, other SSRIs) may increase the risk for serotonin syndrome and seizures.

Drug News

INDICATIONS

An antipsychotic medication should be used only for the following conditions/diagnoses:

Mood disorders (e.g. mania, bipolar disorder, depression with psychotic features, and treatment refractory major depression)	Medical illnesses or delirium with manic or psychotic symptoms and/ or treatment-related psychosis or mania (e.g., thyrotoxicosis, neoplasms, high dose steroids)	Dementing illnesses with associated behavioral symptoms
Schizophrenia	Schizophreniform disorder	Brief psychotic disorder
Schizo-affective disorder	Psychosis NOS	
Delusional disorder	Atypical psychosis	



ANTIPSYCHOTIC CONCERNS:

The use of an antipsychotic must meet the criteria and requirements listed below.

1. **Criteria**
   Since diagnoses alone do not warrant the use of antipsychotic medications, the clinical condition must also meet at least one of the following criteria:

   A. The symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions such as paranoia or grandiosity); OR

   B. The behavioral symptoms present a danger to the resident or to others; OR

   C. The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress (e.g., fear, continuously yelling, screaming, distress associated with end-of-life or crying); a significant decline in function; and/or substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear and not bathing leading to skin breakdown or infection).

2. **Acute Psychiatric Situations**
   When an antipsychotic medication is used to treat an acute psychiatric emergency (i.e., abrupt onset or exacerbation of symptoms), that use must meet one of the above criteria and all of the following additional requirements:

   A. The acute treatment period is limited to seven days or less; and

   B. A clinician, in conjunction with the interdisciplinary team, must evaluate and document the situation within seven days to identify and address any contributing and underlying causes of the acute psychiatric condition and verify the continuing need for antipsychotic medication; and

   C. Pertinent non-pharmacological interventions must be attempted and documented following the resolution of the acute psychiatric situation.

3. **Enduring Psychiatric Conditions**
   Antipsychotic medications may be used to treat an enduring (i.e., non-acute, chronic or prolonged) condition if the clinical condition/diagnosis meets the criteria in No. 1 above. The target behavior must be specifically identified and monitored objectively and qualitatively to ensure the behavioral symptoms are:

   A. Not due to a medical condition or problem (e.g., headache or joint pain, fluid or electrolyte imbalance, pneumonia, hypoxia, unrecognized hearing or visual impairment) that can be expected to improve as the underlying condition is treated; and
   B. Persistent or likely to reoccur without continued treatment; and

   C. Not sufficiently relieved by non-pharmacological interventions; and

   D. Not due to environmental stressors that can be addressed to improve the psychotic symptoms or maintain safety; and

   E. Not due to psychological stressors or anxiety stemming from misunderstanding related to his or her cognitive impairment.

   After initiating or increasing the dose of an antipsychotic medication, the behavioral symptoms must be reevaluated periodically to determine the effectiveness of the antipsychotic and the potential for reducing the dose. **Exception:** When antipsychotic medications are used for behavioral disturbances related to Tourette's disorder or for non-psychiatric indications such as movement disorders associated with Huntington's disease, hiccups, nausea and vomiting associated with cancer or cancer chemotherapy, or adjunctive therapy at end of life.

4. **Inadequate Indications**
   In many situations, antipsychotic medications are not indicated. They should not be used if the only indication is one or more of the following: 1) wandering; 2) poor self-care; 3) restlessness; 4) impaired memory; 5) mild anxiety; 6) insomnia; 7) unsociability; 8) inattention or indifference to surroundings; 9) fidgeting; 10) nervousness; 11) uncooperativeness; or 12) verbal expressions or behavior that are not due to the conditions listed under "Indications" and do not represent a danger to the resident or others.

MONITORING/ADVERSE CONSEQUENCES OF ANTIPSYCHOTICS:

The facility assures that residents are being adequately monitored for adverse consequences such as:

anticholinergic effects	blood sugar elevation	falls
excessive sedation	cardiac arrhythmias	tardive dyskinesia
akathisia	orthostatic hypotension	lethargy
cerebrovascular event (e.g.,stroke, transient-ischemic attack [TIA]) in older individuals with dementia	death secondary to heart-related events (e.g., heart failure, sudden death)	increase in total cholesterol and triglycerides
neuroleptic malignant syndrome (NMS)	parkinsonism	

Legalities of Controlled Substance Prescriptions

by Courtney Salvino, RPh, PharmD

Recently, Absolute Pharmacy received a number of calls regarding requirements for controlled substance prescriptions. When health care providers work in various settings, prescription laws can vary slightly, depending on the practice site. This is where confusion can arise. Hopefully, this brief overview will help clear up some of the confusion regarding controlled substance prescriptions in some of the practice settings Absolute Pharmacy encounters. This overview includes both Ohio and federal law. The following information applies to group homes, intermediate care facilities, assisted living facilities, skilled nursing facilities, nursing homes, and hospice patients. Exceptions to the rules will be noted where applicable. If you have questions, comments or concerns, do not hesitate to contact your pharmacist.

REQUIREMENTS FOR ALL FACILITIES

At minimum, the following must be on *all* controlled substance prescriptions for it to be legal:

Date Signed by Prescriber	Prescriber's Full Name	Medication Name
Patient's Full Name	Prescriber's Signature	Medication Strength
Facility Address	Prescriber's DEA Prescriber's Address Prescriber's Title	Directions Quantity (in Words and Numbers)

Additionally, here are a few other things to keep in mind:

- **For *all* controlled prescriptions:**
  -The first fill of a new prescription must be within six months of the date the prescription was written.

  -Prescriptions shall not be post-dated. If the prescriber does not want a particular order to be sent until a certain date, "Do not dispense until" date must be written on the prescription up to a 90 day supply.

  -Only one controlled substance per prescription.

  -No non-controlled substances on the same prescription as a controlled substance.

  -Controlled substances may not be on preprinted forms with several drugs listed. (See exception below.)

  -Prescribers cannot write prescriptions for controlled substances for immediate family members. This includes parents, spouses and children.

  -Physician's Assistants (PA) and Certified Nurse Practitioners (CNP) must include Certified to Prescribe (CTP) number on all controlled substance prescriptions.

- **For *CIII-CV* prescriptions:**
  -A quantity up to a 180 day supply or five refills may be written for CIII-CIV.

  -A quantity up to a 360 day supply may be written for CV (for example, guaifenesin with codeine).

  -Prescriptions may be written, given orally by the prescriber or an agent on file, faxed or electronically transmitted through an approved electronic prescribing transmission system. At this time, Absolute Pharmacy does not have electronic prescribing capability.

- **For *CII* prescriptions:**
  -No refills are allowed by law. (See partial filling exceptions below.)

  -A hard-copy prescription must be manually signed by the physician and mailed to the pharmacy, or it can be electronically sent by a DEA-approved electronic prescribing transmission system. At this time, Absolute pharmacy does not have the electronic prescribing capability. (See exceptions below.)

  -Prescriptions cannot be altered in anyway by the practitioner, even if there are initials beside the error.

SKILLED NURSING FACILITIES/ TERMINALLY ILL PATIENTS (HOSPICE)

It is important to remember that this is the "exception" group.

- **For *CIII-CV* prescriptions:**
  -Preprinted forms for a hospice resident may contain CIII-CV along with other non-controlled medications.

- **For *CII* prescriptions:**
  - On preprinted forms for a hospice patient, CII cannot be a preprinted option; however, it can be handwritten on the preprinted form along with other controlled and non-controlled medications.

  - Partial dispensing of a medication is legal as long as "hospice/terminally-ill patient" or "long-term care facility" is documented on the prescription.

  - Partial dispensing can only occur for 60 days from the date the prescription was originally written.

  - Faxing a prescription is valid as long as the resident is in a skilled nursing facility, nursing home, terminally ill/ hospice or for home infusion/IV pain therapy. This must be documented on the prescription and the hard copy prescription must be kept at the facility.

There is a distinction between partial dispensing and refills. Partial dispensing is the subtraction of the sent quantity from the written total quantity on the prescription. For example, Dr. Smith wrote a prescription for a ***hospice*** patient for Norco 5/325mg tablets with a written quantity of 120 tablets with zero refills. The pharmacy dispenses 30 tablets and there are 90 tablets on the remainder of the prescription. Since this is a hospice patient, the pharmacy is allowed to send part of the entire quantity written on the prescription. In contrast, Dr. Smith also writes a prescription for a patient in an ***assisted living*** facility for Norco 5/325mg tablets for 120 tablets with zero refills. The pharmacy dispenses the entire 120 tablets. Because this is an assisted living patient, partial dispensing of the total written quantity is not legal.

ASSISTED LIVING FACILITIES/GROUP HOMES/ INTERMEDIATE CARE FACILITIES

With this group of facilities, it is easiest to think of them as "retail" prescriptions.

- **For *CII* prescriptions:**
  - By law, we cannot accept faxed prescriptions as legal prescriptions. We can fill from a fax as long as the hard copy script is placed in the tote or mailed to Absolute Pharmacy and received within seven days of prescription issuance. This is in compliance with Federal and DEA regulations.

  - Refills and partial dispensing are not legal. A hard copy prescription, hand-signed by the prescriber, must be obtained each time a prescription runs out and placed in the tote or mailed to Absolute Pharmacy.

Resources:

1. Ohio Revised Code. Ohio State Board of Pharmacy Website: https://pharmacy.ohio.gov/LawsRules/ORC.aspx. Accessed: 23 May 2015.

2. Ohio Administrative Code. Ohio State Board of Pharmacy. Website: https://pharmacy.ohio.gov/LawsRules/OAC.aspx. Accessed: 23 May 2015.

3. 2014 Code of Federal Annual Regulations. US Government Publishing Office. Website. http://www.gpo.gov/fdsys/browse/collectionCfr.

Absolute Insights

Put a Face to a Name: Mary Jo McElyea

1. How long have you worked for Absolute Pharmacy?

A: Since April 2014.

2. What do you do for Absolute Pharmacy?

A: I am the business development manager, which includes, but is not limited to, establishing new customers, retaining and building relationships, and coordinating industry events.

3. What's your favorite quote or saying?

A: "Pain is temporary; quitting lasts forever."

4. What chore do you absolutely hate doing?

A: Putting laundry away.

5. What do you enjoy doing the most?

A: Spending time in the summer doing any activity at the Metro Parks – playing with my girls, running, walking, biking with my husband.

6. If you could be any fictional character, who would you choose?

A: Katniss Everdeen from "The Hunger Games." She is tough, caring, and smart.

7. If you could choose anyone, who would you pick as your mentor?

A: My sister, Ellen. She has guided me on many decisions throughout my life.

8. What did you want to be when you grew up?

A: A nurse.

Continuous Improvement

Absolute Pharmacy is focused on continuously improving and acclimating to the changing long term care market needs. In the month of May 2015 we have made two changes.

1. PUNCH CARDS

We installed new punch-card automation that has the ability to produce the card in a slightly different format. We are introducing this card throughout the summer and will be adjusting its format as we determine the best use. The new card has each drug cavity (blister) labeled on the reverse side and the Absolute Pharmacy logo printed on the front of the card. This provides advantages of redundant labeling and bar codes that can assist with patient safety and, in addition, will help with the return process for unused medication. The patient-specific label (front side) has been modified in order to allow use of the new card. The cards should cause no change to how nurses use, store, administer and return. Please let us know if you encounter any difficulty.

2. TELECOMMUNICATION/PHONES

Electronic transmission, telephones and faxes are our primary methods of communication. Advancements in software and technology allow us to greatly improve this service.

- Fax. We have established a prescription-only fax (800-858-7394) and a business administration fax (855-552-1826). This delineation is aimed at expediting prescription needs.
- E Rx Software. We are enhancing management of electronic prescriptions to develop bidirectional messaging. Our goal is connect to each customer's unique operating system and electronic medication administration record (E-MAR).
- Telephones. We are routing the phones differently, but are maintaining the personal touch we're known for with trained technicians managing calls. They have access to all medical records and can manage or route drug order calls.

Our intention is continuous improvement that improves quality and service. Please provide feedback to your service representative, consultant pharmacist or any team member so we can provide the best service.

Absolute Insights

DOB is an Extra Safeguard

As you may be aware, Absolute Pharmacy adopted, following the recommendations of the Institute for Safe Medication Practices (ISMP) and other safety-conscious organizations, by mandating that the resident's date of birth be written on all new orders and given during verbal communication to the pharmacist birth as a secondary patient identifier. Absolute Pharmacy adopted this policy in 2011.

Patient verification using two identifiers (the resident's name and date of birth) has been shown to decrease quality-related events because it is a double-check during the order entry process. The resident's date of birth is a searchable value within our order entry system and will be used when completing orders to verify that the correct resident is selected.

Please assist Absolute Pharmacy with patient safety by writing the resident's date of birth on all written new orders or by giving the date of birth to the pharmacist during spoken communication.

Upcoming Events:

LEADINGAGE OHIO

Columbus, OH, **Sept. 9-11**, See us at booth 201

OHCA FALL CONFERENCE

Columbus, OH, **Sept. 17-18**, Visit our table

LEADINGAGE NATIONAL CONVENTION

Boston, MA, **Nov. 1**:

- Pennsylvania Reception, Westin Waterfront
- Ohio Night Out, Cheers

PA CULTURE CHANGE COALITION ACCORD

Mars, PA, **Nov. 10**