QUALITY BASED PAYMENT FOR POST-ACUTE CARE: HOW WILL MEDICATION RECONCILIATION AND TRANSITIONS OF CARE IMPACT YOU?

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On October 4, 2016, CMS published the final rule of the Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities. This is the largest legislative update to the long-term care facility regulations since 1991, and with it comes major changes and additions. One of the new requirements is included in the new section §483.21 Comprehensive Person-Centered Care Planning. As part of this section, CMS is requiring facilities to develop and implement a discharge planning process that focuses on the resident’s discharge goals and prepares residents to be active partners in post-discharge care, in effective transitions, and in the reduction of factors leading to preventable re-admissions. This includes requiring medication reconciliation (MR) to be performed and included in the discharge summary. CMS is also implementing the discharge planning requirements mandated by The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) by revising, or adding where appropriate, discharge planning requirements for LTC facilities. The goals of these legislative changes are to standardize care, decrease errors, and reduce preventable hospital readmissions.

An estimated 60% of all medication errors occur during transitions of care. Medication errors play a large role in poor patient outcomes and almost 50% of medication errors are considered to be related to poorly performed MR during admission, transfer, and/or discharge of the patient. It is also believed that 20% of these errors result in harm to the patient. Failure to implement safeguards within care transitions can lead to adverse events and higher rates of re-hospitalization. Also, poor communication during transitions of care is responsible for roughly one-half of all hospital-related medication errors and one-fifth of all adverse drug events. MR is designed to reduce medication errors and should be done at every transition of care.

If properly implemented, MR would improve communications between medical personnel during transitions of care and significantly reduce medication errors and improve readmission rates. Medication reconciliation consists of a five-step process:

1. Develop a comprehensive list of all current medications
2. Develop a list of medications to be prescribed
3. Compare original and updated medication lists
4. Make clinical decisions pertaining to what medications should be continued
5. Communicate the new medication information to patient and patient’s care giver

In addition to the CMS revisions above, the IMPACT Act includes language addressing MR and improving transitions of care which will impact payment and reimbursement to the four domains of post-acute care including skilled nursing facilities.

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Two claims-based measures that will affect the fiscal year 2018 payment determination are the discharge to the community and potentially preventable 30-day post-discharge readmission measures. Many of the circumstances post-discharge can be difficult to control from the Post-Acute Care (PAC) setting. So, what can skilled nursing facilities do to minimize risk at discharge? They can form partnerships with organizations that will coordinate care for patients when they discharge back into the community. An emerging opportunity for PAC providers is to partner with Accountable Care Organizations (ACOs), which are providers working together across the continuum of care to meet quality standards and reduce health care expenditure.

Another opportunity would be to partner with community pharmacies that offer innovative and collaborative programs within the community to improve outcomes and reduce hospitalizations for residents transitioning back into the community. Sona Pharmacy + Clinic, formerly Blue Ridge Pharmacy, is a participating pharmacy within Community Care of North Carolina’s Community Pharmacy Enhanced Services Network (CPESN), which includes pharmacies throughout the state of North Carolina offering enhanced services to Medicare and Medicaid beneficiaries. The services provided include transitions of care support, medication therapy management (MTM), medication synchronization, and medication delivery. Through this program, we are learning how to improve outcomes for the highest utilizers within the Medicare and Medicaid system by offering enhanced services and coordinating care. The health care system’s shift from a fee-for-service to a pay-for-performance model is a challenge, and if we can be successful through effective collaboration.

Our Sona Access Program is specifically designed to keep our patients at home and independent for as long as possible. As you can see from our referral and patient care processes, we always keep our patients and partners at the center of everything we do. Please give us a call at 828-348-3000 if you would like to partner with us to improve transitions and continuity of care for your residents discharging back into the community.

**Discharge Process:**

Our Pharmacy Technician Care Coordinators work with Long Term Care partners to identify residents discharging home that could benefit from enhanced community pharmacy services. Once a patient is enrolled, a discharge plan is developed, and the patient’s medications are delivered to the facility on the day of discharge.
Home Visit:  
The home visit is an integral part of the program for patients transitioning between settings (health system and long-term care) and patients referred from community sources (physicians’ offices and community partners). It is an opportunity to develop a relationship with the patient, as well as identify any barriers to care or unmet needs. A thorough medication history is gathered at the home visit to determine what medications the patient is currently taking.

Medication Reconciliation:  
The medication reconciliation is the core of Sona Access. An up-to-date and clean medication list improves continuity of care, patient outcomes, patient satisfaction, and relationships with partners. The medication lists that are used depend on the referral source, and can include: the discharge summary, PCP medication list, home visit medication history, and lists from any specialists (i.e. endocrinology, cardiology, etc.).

Medication Synchronization and Compliance Packaging:  
Once the patient’s medication list has been reconciled, Access staff synchronizes medications to one fill date each month. The patient has an appointment date for the pharmacy to call and review all medications that need to be filled. Prescriptions are filled and delivered out to the patient at no additional cost. Some patients need more support with adherence and choose one of our compliance packaging options (i.e. TCGRX strip packaging or 7-day pill packs).

Coordinated Care and Continued Patient Follow-up:  
Sona Access staff will continue to coordinate care and follow-up with patients. Our program is different from other pharmacy provided transitions of care services because we are taking responsibility and ownership for our patients’ health moving forward. We will connect them with community resources and care management services through their current providers. Follow-up calls will usually be more frequently for the first 3 months, and then taper to once monthly at a minimum as determined by the patient’s risk for readmission and negative outcomes.

References  
5. IMPACT Act
I won’t spread flu to my patients or my family.

Even healthy people can get the flu, and it can be serious.

Everyone 6 months and older should get a flu vaccine. This means you.

This season, protect yourself—and those around you—by getting a flu vaccine.

For more information, visit: http://www.cdc.gov/flu

Are you interested in learning more about antimicrobial stewardship in the long-term and post-acute care setting?

We will be sending out monthly emails informing you about the CDC’s Core Elements of Antibiotic Stewardship for Nursing Homes, new regulations involving antimicrobial stewardship, and how to start implementing a program at your facility.

Email dphillips@blueridgerx.com to learn more!
Parkinson’s disease (PD) is a devastating neurodegenerative disease that typically occurs later in life and leads the afflicted body to mismanage dopamine in addition to other key neurotransmitters. Downstream, this dysfunction causes a constellation of troublesome problems with motor control and cognitive function.\(^1\) Perhaps the most disruptive consequence, however, of progressive neuronal degeneration occurs in the more than 50% of Parkinson’s patients who develop psychosis (PDP). PDP manifests as delusions, hallucinations, and severe mood disorders; these symptoms are often cited as the most common reason for admittance to nursing homes.\(^2\) Psychosis becomes increasingly disruptive and disturbing over time; negatively impacting the quality of life of patients and caregivers dramatically.

The pathogenesis of PDP involves a complex interplay of intrinsic and extrinsic factors that is not wholly understood, however, new light has been shed on effective treatment modalities of psychosis, with the recent introduction of Nuplazid to market in April 2016.\(^3,4\) Nuplazid (pimavanserin) is an atypical antipsychotic taken once daily by mouth, and is unlike any other drug in its class. Structurally unique, this molecule acts as an inverse agonist at serotonin (5-HT) 2A receptor sites and unlike other antipsychotics, does not act on dopamine receptors at all. This is a huge difference, and one that may prove to be game changing for those Parkinson’s patients suffering from psychosis. While the specific mechanism of action of Nuplazid is unique from other drugs in the second generation antipsychotic (SGA) class, it still carries the same black box warning as it’s classmates; increased mortality in elderly patients with dementia-related psychosis and will therefore require the requisite Abnormal Involuntary Movement Scale (AIMS) testing and gradual dose reduction (GDR) schedule mandated by the Centers for Medicare and Medicaid Services (CMS).\(^5\)

Until Nuplazid, there was no drug approved for the treatment of PDP. The 2006 American Academy of Neurology practice guidelines, which are currently undergoing revision, recommend treating PDP with clozapine (Level B) or possibly quetiapine (Level C) and specifically not with olanzapine (Level B).\(^6\) The issue with olanzapine and other antipsychotics is that the action at dopamine receptors typically leads to worsened motor symptoms, and often without any relief of non-motor symptoms. The side effect profiles of these antipsychotics are similarly undesirable and typically serious enough to warrant a risk versus benefit discussion that generally culminates in the decision not to treat. It is not recommended to take Nuplazid concurrently with other antipsychotics. This recommendation was generated from the analysis of an open-label extension study that showed increased mortality rates, rates of serious adverse events such as infection, and worsened Parkinsonism when an antipsychotic was added to Nuplazid. Note, however, that these occurrences were limited to a small subset of patients, and may reflect complications of the natural disease progression rather than drug interactions.\(^2\)

In randomized, controlled trials Nuplazid showed a clinically meaningful, 23% improvement on the modified scale for the assessment of positive symptoms (SAPS-PD) score over placebo \((p = 0.0006)\) without worsening of motor findings as measured on the unified Parkinson’s Disease rating scale for motor examination (UPDRS III). Nuplazid also showed improvement on the caregiver burden scale. While extension trials with an average follow-up period of 15 months (longest 8 years) showed a modest and variable duration of effect (improvement stabilizing at ~ 1 year), the development of Nuplazid is absolutely a step in the right direction for Parkinson’s sufferers, their family, and caregivers.\(^2\)
NUPLAZID (continued from page 5)

Other important information about Nuplazid:

- Nuplazid is available as a single strength tablet (17 mg); normal dosing is 34 mg taken once daily
- Nuplazid is a substrate of CYP3A4, and therefore should be used cautiously, and with monitoring when given concomitantly with CYP3A4 inducers/inhibitors. **Dose adjustment is required.**
  - Dose adjustment for concomitant therapy:
    - Strong CYP3A4 inhibitors: 17 mg once daily
    - Strong CYP3A4 inducers: 34 mg once daily; monitor for reduced efficacy and increase dose if necessary
- Nuplazid may cause QTc interval prolongation on echocardiogram (ECG), orthostatic hypotension, peripheral edema, and/or central nervous system (CNS) depression.
- Nuplazid has not been studied in patients with hepatic impairment, therefore use is not recommended in these patients. Similarly, use in patients with severe renal impairment (CrCl < 30 mL/minute) is not recommended.

References

PHARMACY FACTS!
BLUE RIDGE PHARMACY WEBCONNECT

What is WebConnect and how can it help you?

- WebConnect is an online portal that connects your facility directly to Blue Ridge Pharmacy’s operating system, QS/1. It can be accessed from any internet connected device – computers, tablets, and smartphones.
- WebConnect has a number of useful features that can save you time. First, WebConnect offers a way to scan drugs you are returning to the pharmacy – no more handwritten forms! Simply scan the prescription, type in the quantity you are returning, select the date and the reason for the return. At the end of the process, multiple copies of the Return Form can be printed for Blue Ridge Pharmacy and the Facility’s records.
- WebConnect also gives you real-time access to see which medications are coming on your next delivery, what medications were sent on a past delivery, and the last time a prescription was refilled by the pharmacy.
- Finally, WebConnect allows you to print a drug monograph directly from a resident’s medication profile. If a resident or family member wants more information on a new drug, you can quickly access a patient information leaflet and print it out for their reference.

If WebConnect sounds like something that could be beneficial, we are happy to schedule a demonstration tutorial for facility staff. Call 828-298-7600 ext. 1313, or email Wes McCall at wmccall@blueridgerx.com for more information.
NEW GUIDELINES FOR APPROPRIATE OPIOID USE

Charyne Tovar, PharmD Candidate; Andrea Leone, PharmD, BCACP

In March 2016, the CDC released new guidelines on the use of opioids to treat patients with chronic pain. Evidence supporting the use of long-term use opioids for chronic pain is limited and serious risk may outweigh benefit. These recommendations focus on treating chronic pain, which is defined as pain lasting longer than three months, or past the time of normal tissue healing. The review focused on the effectiveness of long-term opioid use and long-term outcomes. It does not apply to patients with active cancer, palliative care patients, or hospice patients. The guidelines focus on three major points of interest to guide recommendations and addresses five clinical questions: effectiveness of long-term use, risks, comparative effectiveness of dosing strategies, use of prediction instruments for abuse/misuse, and the effects of therapy for acute pain on long-term use. Short-term opioid use for acute pain was not a primary focus of this CDC recommendation, but other guidelines addressing acute pain are incorporated into this article for completeness.

Focus 1: When to initiate or continue opioids for chronic pain
Opioids should not be considered for first line treatment or routine treatment in patients with chronic pain. Non-opioid therapies should be tried first, whether it is pharmacological or non-pharmacological. Exercise, cognitive behavioral therapy, NSAIDs, acetaminophen, SNRIs, TCAs, and anticonvulsants are recommended first line, depending on the origin of pain. Opioids are not recommended in patients with migraines, fibromyalgia, or neuropathic pain and should only be considered when the benefits for the patient’s pain and function outweigh the risk, such as in a patient with a serious illness and poor prognosis to regain function. The CDC recommends that if an opioid regimen is started or continued, that it be paired with a non-opioid therapy. Make sure there is meaningful improvement, defined as greater than 30% improvement in both pain and functional goals before continuation of opioid therapy. It is important to establish realistic goals, including emotional, social, and physical function goals. Patients should be aware that complete pain relief with an opioid is unlikely. It is also important to optimize treatment for other psychological comorbidities such as depression and anxiety. Discuss the benefits versus risk for opioid use at the initiation of therapy, and periodically throughout. It is important to educate patients on benefits and risks of treatment, including common adverse drug events, related harms, withdrawal symptoms and alternatives to opioid therapy.

Focus 2: Opioid selection, dosage, follow-up, and discontinuation of opioid therapy
The guideline recommends to start with the lowest possible effective dose, and to use an immediate release formulation over an extended release or long-acting formulation when initiating an opioid for chronic pain. The use of any IR opioid is cautioned when combined with methadone, fentanyl, or with an ER or LA formulation. Serious risk of harm appears dose-dependent. Risk versus benefit must be carefully considered at doses exceeding 50 morphine milligram equivalents (MME) per day. If exceeding 90 MME/day, careful rationalization should be used if titrating to that dose, and other options for pain relief must be considered. When prescribing opioids for acute care, it is recommended to use the lowest effective dose and the duration should be 3 days or less.

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NEW GUIDELINES FOR APPROPRIATE OPIOID USE (continued from page 7)

Durations longer than seven days for acute care are not recommended in an effort to decrease the amount of patients that become dependent on unnecessary opioid therapy. Benefits and harms should be evaluated by the clinician within one to four weeks after initiation, tapering, dose escalation, and/or discontinuing drug. Regular follow-up is recommended to be done at minimum every three months. Other therapies should be optimized. Postsurgical pain was not addressed in the guidelines, but instead were referred to the Washington State Agency Medical Directors’ Group guidelines. Those guidelines essentially recommend to prescribe the briefest and lowest effective dose to provide pain relief. It is not recommended to send the patient home on more than a two-week supply, preferably less if possible. Evaluation for continuation of therapy should be done by the surgeon.

♦ Focus 3: Assessing risk and addressing harms of opioid use
The new guidelines want clinicians to focus on a risk mitigation and management plan, especially for high risk patients, when placing them on opioid therapy. Opioid treatment for patients with severe sleep breathing disorders is contraindicated and naloxone is suggested for patients with a history of abuse, overdose, with concurrent benzodiazepine, and when the therapy is ≥ 50 MME/day. It is recommended to avoid concomitant benzodiazepine use if possible. Baseline urine tests are advocated to check for other opioids or illicit drugs before initiating therapy, and then annually. It should also become standard practice to check Prescription Drug Monitoring Programs (PDMP) at the start of therapy, and around every three months to monitor the patient’s use. If a clinician suspects a patient of abusing opioids, the physician should be comfortable recommending an evidence based treatment, such as buprenorphine or methadone, along with behavior therapy.

References

WE JUST WANT TO SAY...
THANK YOU!

We would like to take this opportunity to thank you, our partners, for all that you do to provide a better quality of life for those you serve and for those who are unable to care for themselves. Thanks to your efforts, life is sustained or made more whole, and we are honored to support you.
GET TO KNOW...

Peggy McKeon, RPh
Pharmacist

Born in Michigan, I earned my pharmacy degree from Wayne State University in Detroit. Family matters brought me to Asheville in 2000. Over the next fifteen years, I worked in various retail settings in the Oteen area where I established good customer rapport and many became like family. This last spring, I found myself in need of change and was fortunate to run into Dean Clayton (owner). I expressed my desire to work for BRP and a week later found out I got the job. Once again, I’m in Oteen caring for many of my long-time customers who are now in nursing facilities. I’m grateful to be a part of the BRP team where customer service, along with teamwork, are their number one priorities.

Without love in the dream, it will never come true. - Jerry Garcia-

Amber Korn, PharmD
PGY1 Resident

Amber was born and raised in Swannanoa, NC. She is a 2012 graduate from Western Carolina University (Go Cats!), earning her B.S. in forensic anthropology. She is a 2016 graduate from Presbyterian College School of Pharmacy in Clinton, SC. She chose to pursue a community pharmacy residency because she loves the progression of the practice and the opportunity to form long-term relationships with her patients. While at WCU, she met her husband Caleb who is currently a paramedic for Greenville County EMS. In her free time, Amber enjoys reading, road trips, and spending time with her husband and dog Stella.
Contact Us!

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Fax: 828-785-1490
Hours: 8:30am–5pm Mon-Fri, Closed Saturday & Sunday
Online: http://ripleyrx.com/

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Service and care you can trust from people you know.
Myths vs. Facts - Flu Vaccines

Tasha Michaels, PharmD, BCACP

One of my passions as a pharmacist is educating patients about the importance of vaccinations and answering their questions to make sure they are well informed and can make the best decision for themselves and their family members. So, I wanted to help answer some of the most common questions about the flu vaccine for the 2016-2017 flu season.

**Myth: It’s too early to get the flu vaccine.**

Fact: Flu season is now here! While it feels like it’s too early to be talking about getting the flu vaccine, it’s NOT! There are a couple of reasons why: (1) the Centers for Disease Control (CDC) recommends getting the flu vaccine as soon as it becomes available (2) it takes your body two weeks to build up immunity to the vaccine to ensure you are fully protected. Sona Pharmacy has had the vaccine in stock since mid-August. We have the high dose and regular flu vaccine available 7 days a week. We promise it will be quick and easy! Visit our website for location and hours: [www.sonapharmacy.com](http://www.sonapharmacy.com)

**Myth: If I get the vaccine now, then I won’t be protected during the last part of the flu season.**

Fact: Based on previous published studies, most individuals’ immunity after receiving the flu vaccine lasts through the full flu season. However, everyone’s immune system is different. As we age, our immune system declines over time, and there is some evidence that shows immunity in older adults might decline more quickly. For older adults, there is a high dose flu vaccine that is specifically designed for patients 65 years of age and older. This vaccine has a higher dose of antigen, which is intended to create a stronger immune response. We have both kinds of flu vaccines and we’re here to answer any questions and help you make a good decision.

**Myth: If I get the flu vaccine, I will get the flu.**

Fact: We’ve all heard people say this, including my own mom! But the flu shot does not have any live strains, so the vaccine cannot cause the flu. In the example of my mom, she received her flu vaccine when she was young and remembered getting sick afterward and refused to get another one for years. She changed her mind when I became a pharmacist and educated her about the importance of receiving the vaccine and explained that most people simply have a sore arm. Some people have a low grade fever, headache, or muscle aches that can last a couple of days. My mom also remembered having a sore throat and nasal congestion, but was not at home for multiple days due to illness, so she probably just had a cold. The flu usually comes on quickly and often people describe it as being ‘hit by a Mack truck.’ Flu symptoms include fever (usually 100-102 °F), headache, chills, muscle aches, fatigue/weakness that can last 2-3 weeks, and extreme exhaustion in the beginning. In addition, there can be some symptoms that are similar to a cold such as stuffy nose, congestion, and cough.

**Myth: I’m afraid of needles because flu shots are painful**

Fact: I’ve never met someone that does like getting shots or likes needles! However, the flu shot is a quick and often painless experience. Many patients who don’t watch don’t even know they received their injection until I tell them they are all done! If you are afraid of needles, the best thing you can do is take deep breaths, relax your mind, and relax your muscles. Since the vaccine is injected into the muscle, if it’s relaxed, then it’s less likely to be painful. After you receive the vaccine, I encourage patients to move their arm around to work the soreness out quicker. Watch this video from [@WLOS_13](http://wlos.com/news/local/flu-vaccines-available-before-flu-season-begins) to see how quick, easy, and painless it can to receive the vaccine:**
Myths vs. Facts - Flu Vaccines

Tasha Michaels, PharmD, BCACP

Myth: I don’t have a doctor so I can’t get the vaccine or it’s too expensive

Fact: Now people can receive the flu vaccine at the pharmacy. You don’t have to have a primary care physician in order to receive the vaccine. You can simply walk into the pharmacy and ask for a flu vaccine. Pharmacies are setup to bill most insurances (including Medicare and Medicaid) for the flu vaccine, which means it’s a $0 copay for most patients. Missing work is expensive.

Myth: I can’t get the flu if I’ve had the vaccine.

Fact: Unfortunately, some might still get the flu even though they received the vaccine.
  1. One reason they might get the flu is because they were exposed to the flu virus shortly before receiving the vaccine or during the 2 weeks it takes the body to build up immunity to the vaccine.
  2. Each year the strains that are in the flu vaccine are based on the most prevalent strains during the previous flu season. As the new flu season emerges, a particular strain might develop that is not covered by the current vaccine. However, getting a flu shot is better than having no protection at all, as it can help protect against other strains and lessen the severity of the flu if you do get it.

Myth: The nasal vaccine is just as effective as the shot.

Fact: This year the CDC is recommending that everyone 6 months of age or older should receive a flu shot but NO one should receive the live-attenuated nasal vaccine. The nasal vaccine was shown to be less effective, and therefore, is not recommended this year. Otherwise, the CDC does not recommend one injectable product over another product, but they do recommend to get vaccinated.

Myth: I don’t need to get a flu shot every year.

Fact: Yes, you do! Every year the strains in the vaccine can change based on predictions and past evidence of the influenza strains in the community. For example, in 2008 when H1N1 cases started showing up everyone was encouraged to receive an additional H1N1 flu vaccine that year since the regular flu vaccine did not contain that strain. Every year since, H1N1 has been included in the flu vaccine. Also, your immunity protection decreases over time, so getting a yearly vaccination is the best protection against the flu!

Myth: Getting the flu isn’t really a big deal.

Fact: The flu is a serious illness, especially to young children, older adults, and people with certain health conditions such as asthma, heart disease, and diabetes. Children less than 6 months cannot receive the vaccine and it highly encouraged that all other family members or people that come into contact with the child become vaccinated to help protect the child. More than 200,000 people on average in the US are hospitalized for flu related complications each year.

Myth: If I get the flu, I will just take Tamiflu®

Fact: Tamiflu® can help reduce the severity of the flu if you are diagnosed and start treatment within 48 hours, but it cannot cure the flu! The treatment is costly (copay often exceed $100) and way more expensive than a flu shot. Also, depending on your family size (young children, people with weakened immune systems), if one person has the flu then everyone in the house will need to be treated with Tamiflu® and those costs add up quickly. This is why prevention is the key!

  Don’t delay! Come by Sona Pharmacy and get your flu shot today!