

CELEBRATING A MILESTONE

On March 22, 2005, owner-operators Todd Tamplin and Dean Clayton purchased PSA Beverly Hills Pharmacy and renamed the icon, Blue Ridge Pharmacy, to represent the beautiful surrounding area. Prior to purchasing the pharmacy, they spent years learning the intricacies of the long-term care pharmacy industry before they began servicing facilities from the current location on Tunnel Road in Asheville. Their experience working with major national brands of long-term care providers helped them develop their own, client-based approach. Starting BRP as a neighborhood pharmacy with long-term care services attached, they have grown the coverage area statewide in less than 10 years and recently opened a second long-term care pharmacy in Cary, NC to better serve clients.

BRP is dedicated to all areas of pharmacy care in skilled nursing, assisted living, family care, retirement communities, foster care, and private schools, with dependable, accurate and swift fulfillment of needs. BRP helps to create a tailored service plan for all of its clients and facilities. Due to steady and controlled growth, Blue Ridge Pharmacy now has four distinct ways to serve clients; (1) a retail store east of downtown Asheville offering prescription delivery free of charge within Buncombe and Henderson counties; (2) a satellite pharmacy located in Hendersonville, focused on door-to-door prescription delivery; (3) the close-door pharmacy serving extended-care facilities throughout North Carolina; and (4) their newest innovation, Blue Ridge Access.

Blue Ridge Access is a collaborative pharmacy program with a focus on patients that have complex medication regimens who are at increased risk for compliance concerns and medication related hospitalizations. The Access team works directly with physicians and other healthcare professionals to identify and refer high-risk populations. The goal is to be a resource to medical professionals in order to improve patient outcomes. As a benefit, patients enjoy better health.

Owners Todd and Dean expect growth to continue with the additional pharmacy location in Cary and further expansion within Western North Carolina. They have carefully cultivated this growth not to strain services to existing clients. "Our model is simple, and has served us best. Always stick to the basics in customer care; clean medical records, accurate billing, and on-time delivery. If we miss the mark in those areas, nothing else matters."

In the next 12-18 months, Blue Ridge Pharmacy will move its community pharmacy from the current location on Tunnel Road, nearby to the Oakley Plaza at 805 Fairview Road. Upon completion, a newly designed and innovative community pharmacy concept will emerge offering a more clinical type atmosphere than that found in "big box" chain pharmacies. "As our footprint has enlarged, we have found it necessary to develop a space that can accommodate the growth we have been fortunate to experience. We are very excited about what the future holds for our company."



DEVELOPING A VALUE-BASED HEALTHCARE SYSTEM: WHERE ARE WE GOING AND HOW DO WE GET THERE?

Andria Eker, PharmD, BCACP, CDE

In response to increasing healthcare costs that were estimated to be near \$2.6 trillion in 2010, the Affordable Care Act (ACA) was signed into law by President Obama in March of 2010.¹ The primary objective of the law is to improve the quality and affordability of healthcare in the United States. The trillion dollar question is how to reform our current healthcare system from a fee-for-service to a pay-for-performance based model. The Centers for Medicare and Medicaid Services (CMS) leads the healthcare system in innovation and payment models. CMS' Value-Based Purchasing (VBP) Programs have been developed in alignment with the National Quality Strategy's three broad aims: better care, healthy people and communities, and affordable care.² The intent of this article is to provide a broad overview of current CMS initiatives to improve quality through Value-Based Purchasing (VBP) Programs and the Hospital Readmissions Reduction Program.

The Hospital Value-Based Purchasing (HVBP) Program was implemented in FY2013 and applies to acute care hospitals. It is designed to compensate hospitals based on adherence to evidence based care and patient experiences. Hospital payment is determined based on weighted scores in four domains, clinical process of care (20%), patient experience (30%), outcome (30%), and efficiency (20%).^{3,4} The initial phase of payment reform involved percentage reductions in the base operating diagnosis-related group (DRG) payment amounts, beginning at 1% in FY2013 and increasing by 0.25% until 2% is reached in FY2017 (FY2015 1.5%). Next, "value-based incentive payments" are calculated by multiplying the "value-based payment adjustment factor", which is the total performance score on HVBP measures, by the base operating DRG payment.⁵

CMS is also reducing healthcare costs through the Hospital Readmissions Reduction Program, which was implemented in October 2012. Hospital payments may be reduced by as much as 3% in FY2015 based on 30 day readmission rates for the following conditions: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), and total knee/hip arthroplasty (TKA/THA). Readmission payment adjustment amounts are determined based on the readmission adjustment factor and the diagnosis-related group (DRG).⁵ A similar initiative, The Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program is in the early stages of development and aims to incorporate incentive payments to further reduce hospital readmissions from SNFs. The Secretary of Health and Human Services (HHS) is tasked with determining the all-condition readmission measure by October 2015, risk-adjusted avoidable hospital readmission rate by October 2016, and performance measures and assessment levels by 2017. Incentive payments will be funded by withholding 2% of SNF Medicare payments beginning in October 2018.⁶

References:

1. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Care Expenditures Data, January 2012.
2. Agency for Healthcare Research and Quality. National Quality Strategy. About the National Quality Strategy (NQS). Available at: <http://www.ahrq.gov/workingforquality/about.htm>.
3. Centers for Medicare and Medicaid Services. Frequently Asked Questions Hospital Value-Based Purchasing Program Last Updated March 9, 2012. Available at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/FY-2013-Program-Frequently-Asked-Questions-about-Hospital-VBP-3-9-12.pdf>.
4. Centers for Medicare and Medicaid Services. Hospital Value Based Purchasing Program: Hospital Compare. Available at: <http://www.medicare.gov/hospitalcompare/data/hospital-vbp.html>.
5. Centers for Medicare and Medicaid Services: Readmissions Reduction Program. Available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>.
6. American Health Care Association. Issue Brief. 4/10/14. Skilled Nursing Facility Value-Based Purchasing Program. A Hospital Readmissions Reduction. Available at: <http://www.ahcancal.org/advocacy/solutions/Documents/Value%20Based%20Purchasing%20-%20IB.PDF>.

Hospital Value-Based Purchasing (HVBP) Program Quality Measures FY2015

<p>Clinical Process of Care – 12 Measures</p>	<ul style="list-style-type: none"> • Acute Myocardial Infarction (AMI) – 2 Measures: AMI-7a, AMI-8a • Heart Failure (HF) – 1 Measure: HF-1 • Pneumonia (PN) – 2 Measures: PN-3b, PN-6 • Surgical Care Improvement Project (SCIP) – 2 Measures: SCIP-Card-2, SCIP-VTE-2 • Healthcare Associated Infections (HAI) – 5 Measures: SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-9
<p>Patient Experience of Care - Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)</p>	<ul style="list-style-type: none"> • Communications with nurses • Communication with doctors • Responsiveness of hospital staff • Pain management • Cleanliness and quietness of hospital environment • Communication about medicines • Discharge information • Overall rating of hospital
<p>Outcomes</p>	<ul style="list-style-type: none"> • Mort-30-AMI: Acute myocardial infarction (AMI) 30-day mortality rate • Mort-30-HF: Heart failure (HF) 30-day mortality rate • Mort-30-PN: Pneumonia (PN) 30-day mortality rate • AHRQ PSI-90: Patient safety for selected indicators (composite) • CLABSI: Central line-associated bloodstream infection
<p>Efficiency Domain</p>	<ul style="list-style-type: none"> • Medicare Spending per Beneficiary (MSPB-1) Measure

Hospital Readmission Reduction Program FY2015

<p>Adopted Readmission Measures</p>	<ul style="list-style-type: none"> • Acute myocardial infarction (AMI) • Heart failure (HF) • Pneumonia (PN) • Chronic obstructive pulmonary disease (COPD) acute exacerbation • Elective total hip (THA) and total knee (TKA) arthroplasty
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Skilled Nursing Facility Value-Based Purchasing Program

<p>Timeline</p>	<ul style="list-style-type: none"> • FY2014-2016: All-cause, all-condition readmission measure • FY2017: All-condition, risk-adjusted potentially preventable readmission rate measure • FY2018: Public reporting on readmission on Nursing Home Compare • FY2019: SNF VBP begins and incentives and penalties are applied
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CLINICAL PRIMER: THE “NEW” ORAL ANTICOAGULANTS

Tasha Michaels, PharmD, BCACP

Before 2010, the only oral anticoagulant on the market was warfarin. In the last five years, there have been four new oral agents to enter the market and those medications are Pradaxa, Xarelto, Eliquis, and Savaysa. More and more patients are now taking these new agents, which have some advantages and disadvantages when compared to warfarin.

The new oral anticoagulants are divided into two primary therapeutic classes: direct thrombin inhibitors and direct factor Xa inhibitors. While warfarin is a vitamin K antagonist, which is why foods that contain vitamin K is a very important counseling point. The differences in these agents are outlined in the table I.

Even though the new oral anticoagulants do not require laboratory monitoring, all of these agents including warfarin can cause an increased risk of bleeding. One major concern with the new oral anticoagulants is the cost. If the patient cannot afford the medication and thus is not taking the medication in addition to no laboratory monitoring, patients could potentially be untreated and be at a higher risk of developing a blood clot.

TABLE I	Pradaxa	Xarelto	Eliquis	Savaysa	Coumadin
Therapeutic Class	Direct thrombin inhibitor	Direct factor Xa inhibitor	Direct factor Xa inhibitor	Direct factor Xa inhibitor	Vitamin K antagonist
Uses	Deep vein thrombosis (DVT) and pulmonary embolism (PE) Nonvalvular atrial fibrillation (A fib)	Deep vein thrombosis (DVT) and pulmonary embolism (PE) Nonvalvular atrial fibrillation (A fib)	Deep vein thrombosis (DVT) and pulmonary embolism (PE) Nonvalvular atrial fibrillation (A fib)	Deep vein thrombosis (DVT) and pulmonary embolism (PE) Nonvalvular atrial fibrillation (A fib)	Deep vein thrombosis (DVT) and pulmonary embolism (PE) Nonvalvular atrial fibrillation (A fib) or atrial flutter Transient ischemic attack (TIA) Post-myocardial infarction Mechanical valve Hypercoagulable disorder
Special Storage Instructions	Must remain in original bottle or blister package until administered	None	None	None	None

TABLE I cont.	Pradaxa	Xarelto	Eliquis	Savaysa	Coumadin
Administration	Given twice daily with a full glass of water and without food Do not crush, break, or open capsules	Given once daily 15mg or higher give with food May be crushed and mixed in applesauce	Given once daily with or without food May crush and suspend in 60 mL of D ₅ W followed by immediate delivery through a nasogastric tube but NOT oral route	Given once daily with or without food	Given once daily with or without food Must be at the same time each day usually in the evening so dose can be adjusted easily based on lab values
Dose adjustment	Dose adjusted based on renal function	Dose adjusted based on renal function Avoid use in moderate to severe hepatic impairment	Dose adjusted based on renal function Avoid use in severe hepatic impairment	Dose adjusted based on renal function Avoid use in moderate to severe hepatic impairment	None – monitor PT/INR and adjust accordingly
Laboratory Monitoring	None	None	None	None	PT/INR
Reversal agent for bleeding	None	None	None	None	Vitamin K

PHARMACY FACTS!

ORDERING REFILLS

- Fax refill requests 3-7 days prior to the last dose of the medication being administered.
- In most cases, during normal business hours, the medication will be filled and delivered the same day.
- If a medication cannot be refilled, a return fax will be sent which will include the date that the medication can be filled (see example below), or a representative from the pharmacy will call.

Blue Ridge
PHARMACY X

REFILL ORDER FORM
PLEASE NO NEW ORDERS-REFILLS ONLY

INSTRUCTIONS: To reorder peel label off medication and place in the next available box.
Fax the entire form to pharmacy and retain for verification of delivery.
PLEASE FAX FORM ONLY ONCE.

Page ____ of ____

Center Name: _____ Station/Wing: _____ Date: _____

DOE JANE
123 TAG 3456
DR. D. OTC
N 8488117

NO REFILLS
30 TAG 3456

WILL FILL 4/15

DOE JANE
SHUTTLES ORIGINAL
DR. D. OTC
N 8488117

DOE JANE
SHUTTLES ORIGINAL
DR. D. OTC
N 8488117

MAY REFILL UNTIL 08/25/15
90 SHUTTLES ORIGINAL

****Please note: if you are completely out of a medication and need it that day, please call the pharmacy directly.**

ANTIPSYCHOTICS IN DEMENTIA

David Phillips, PharmD, BCPS

In February, the North Carolina Department of Health and Human Services (DHHS) sent an email to nursing home administrators regarding the increasing number of tag F 329 citations being issued for the use of antipsychotic medications (email communication, February 2015). Examples of why the citations were issued included inadequate indications, unnecessary use, and use without other interventions being attempted.

There are numerous resources and tools to assist facilities in reducing the use of antipsychotics and to ensure appropriate use when indicated. A couple specifically mentioned in the email included the *Hand in Hand Tool* and the CMS QAPI site, which contains programs and tools that the facility can utilize.

When considering the use of an antipsychotic medication in a patient with dementia, remember the following:

1. Rule out reversible causes for the behavior.
2. Attempt non-drug behavior management first.
3. Document behaviors before and after treatments are tried.
4. Justify the use of an antipsychotic. In order to rationalize the use of an antipsychotic in this population, one of the following must be applicable and documented:
 - a. Behavior presents a danger to the resident or others
 - b. Behavior causes patient to experience one or more of the following:
 - i. Inconsolable or persistent distress (e.g., fear, continuously yelling, screaming, distress associated with end-of-life, or crying)
 - ii. A significant decline in function
 - iii. Substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear and not bathing leading to skin breakdown or infection).
5. Choose an appropriate medication based on the patient's comorbidities, and start with a low dose.
6. Monitor for side effects and adverse drug events.
7. Stop the medication, using appropriate tapering, if it does not help or causes side effects, or attempt gradual dose reductions (GDR) in order to find the lowest effective dose.

References:

1. Centers for Medicare & Medicaid Services. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf. Accessed March 19, 2015.
2. The University of Iowa: Iowa Geriatric Education Center. Improving Antipsychotic Appropriateness in Dementia Patients (IA-ADAPT) website. <https://www.healthcare.uiowa.edu/igec/iaadapt/>. Accessed March 19, 2015.

GET TO KNOW...

TASHA MICHAELS, PHARM.D, BCACP



Natasha (Tasha) Michaels, PharmD, BCACP is originally from Forest City, NC and completed her BS in Chemistry and Biology at Meredith College before attending pharmacy school at UNC Chapel Hill. Upon receiving her PharmD, Tasha completed a PGY1 Community Pharmacy Residency program with UNC Eshelman School of Pharmacy and Kerr Drug in Raleigh, NC. Tasha has been practicing community pharmacy in the Raleigh, Durham, and Chapel Hill area for the last 7 years. During this time, Tasha has been providing fulfillment of medication, medication therapy management, vaccinations, point of care testing, precepting pharmacy students and community pharmacy residents, and helping move community pharmacy forward through practice-based research and involvement in the North Carolina Association of Pharmacists (NCAP). She has been a board certified ambulatory care pharmacist (BCACP) since 2012 and is passionate about vaccinations. Tasha joined the Blue Ridge Pharmacy team in January and loves being back in Western NC! She lives in Arden with her husband, Ray, and two children, Carly (4 years old), and Eric (1 year old) along with their cat, Bela.

NENA CHANSERI, CPHT



Nena Chanseri became a member of the Blue Ridge Pharmacy team in February. She recently moved to Asheville from Johnson City, Tennessee, and absolutely loves the area. Nena was born in Cornelia, Georgia, and grew up in Greeneville, Tennessee. She has been a certified pharmacy technician for over three years and enjoys how the profession enables her to assist others. On a sunny day she spends most of her time outdoors with her two dogs, Kudo and Luna. Some of her favorite pastime activities include hiking and swimming. She cannot wait to explore all the trails in the area. Nena looks forward to her future with Blue Ridge Pharmacy and calling Asheville her new home.

"We rise by lifting others."

-Robert Ingersoll

Contact Us!



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Online: www.blueridgerx.com



Seasonal Allergies: A “Budding” Problem

What are seasonal allergies?

Seasonal allergies (aka hay fever, allergic rhinitis): a disorder characterized by a group of symptoms (see Figure 1) caused by exposure to airborne particles that emerge during a particular season (see Table 1).

What causes seasonal allergies?

Peak allergy seasons and how long they last vary based on geographical location. Allergy season typically starts in the spring when certain trees pollinate and ends in the fall with the pollination of some weeds. However, certain environmental allergies such as mold and dust can occur year-round.

Table 1.

Common Allergens and Seasonal Peaks				
Allergen:	Spring	Summer	Fall	Winter
Tree Pollen	Green			
Grass Pollen		Green		
Weed Pollen		Green		
Outdoor mold	Green			
Indoor mold	Yellow			
Dust mites	Yellow			
Pet dander	Yellow			
Cockroaches	Yellow			

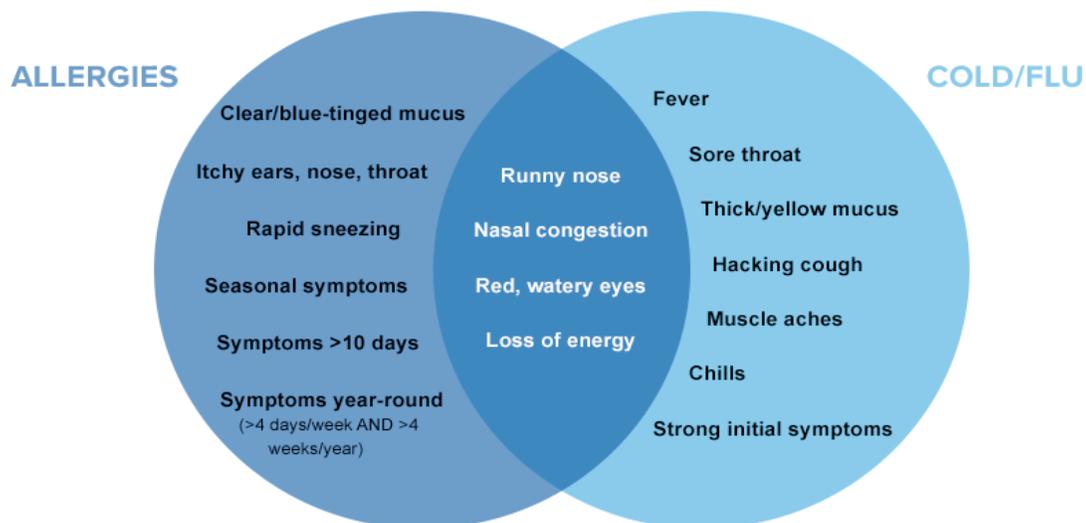
Adapted from: http://www.nasonex.com/nasx/jsp/nasal_allergies_resource_center/outdoor_vs_indoor.jsp

What are the symptoms of seasonal allergies?

The symptoms of seasonal allergies can be nonspecific and similar to other disorders such as the cold or flu (see Figure 1).

Figure 1.

Common allergy, cold, and flu symptoms



<https://nasacort.com/hcp/allergic-rhinitis.aspx>

For more information, or if you have specific questions regarding seasonal allergies, speak to one of our friendly pharmacists!

Seasonal Allergies: A “Budding” Problem

How are seasonal allergies diagnosed?

Seasonal allergies are diagnosed based on symptoms and whether they occur only during certain seasons. Usually, no testing is necessary, but skin tests can help confirm the diagnosis and identify the allergen.

How are seasonal allergies avoided and treated?

- Avoid allergens:
 - Watch the news and pay attention to pollen counts during peak seasons.
 - Keep windows and doors shut at home and in the car during allergy season and stay inside during peak allergen hours.
 - Wear a filter mask when working outdoors and remove clothes and shower after the work is complete.
 - Do not hang dry laundry.
- Treat symptoms with over-the-counter medications:

Sneezing,
itching, runny
nose

- Antihistamines - Claritin, Zyrtec, Allegra, Benadryl, Chlor-Trimeton
- Intranasal steroids - Nasacort, Flonase
- Cromolyn sodium nasal spray - Nasalcrom

Nasal
congestion

- Decongestants - Sudafed, Afrin[†], Neo-synephrine[†]
- Intranasal steroids - Nasacort, Flonase
- Sinus rinses - Nasaflo Neti Pot, Sinus Rinse
- Cromolyn sodium nasal spray - Nasalcrom

Speak to your pharmacist to determine which medications are best for you

Follow the package directions or speak with your pharmacist if you have questions

****Allergists recommend starting medications to alleviate symptoms two weeks before they are expected to begin****

[†]Only use nasal decongestants for short-term relief (72 hours max). Long-term use of decongestant nasal sprays can actually worsen symptoms.

- Consider immunotherapy (aka allergy shots)
- If the above over-the-counter treatments are not enough, or your symptoms are severe, speak with a doctor.

For more information, or if you have specific questions regarding seasonal allergies, speak to one of our friendly pharmacists!