Newsletter Update

Get to know your MN ASCP Chapter. It is time for YOU to get involved.

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>Joe Litsey</td>
<td><a href="mailto:jlitsey@thriftywhite.com">jlitsey@thriftywhite.com</a></td>
</tr>
<tr>
<td>President Elect</td>
<td>Travis LaCore</td>
<td><a href="mailto:tlacore79@gmail.com">tlacore79@gmail.com</a></td>
</tr>
<tr>
<td>Vice President</td>
<td>Jordan Wolf</td>
<td><a href="mailto:jwolf@thriftywhite.com">jwolf@thriftywhite.com</a></td>
</tr>
<tr>
<td>Secretary/Treasurer</td>
<td>Melanie Kluck</td>
<td><a href="mailto:seniorrxllc@hotmail.com">seniorrxllc@hotmail.com</a></td>
</tr>
<tr>
<td>Board Members</td>
<td>Mark Dewey</td>
<td><a href="mailto:Mark.Dewey@ndsu.edu">Mark.Dewey@ndsu.edu</a></td>
</tr>
<tr>
<td></td>
<td>LeNeika Roehrich</td>
<td><a href="mailto:leneika.roehrich@gmail.com">leneika.roehrich@gmail.com</a></td>
</tr>
<tr>
<td></td>
<td>Rebecca Wright</td>
<td><a href="mailto:jimbecky12@hotmail.com">jimbecky12@hotmail.com</a></td>
</tr>
</tbody>
</table>

ASCP Minnesota Chapter – Annual Meeting

ASCP-MN chapter continues to work with the Minnesota Pharmacists Association to provide our members opportunities for professional development and networking. We are excited to announce there will be educational programing at the MPHA Annual Learning Networking Event directly pertaining to our practice setting. Also, we are working with MPHA to provide a discounted registration fee for this event for all of our ASCP-MN members. Be on the lookout over the next few months for further information on programing and discounted registration; in the meantime please mark your calendars for the event: September 9th and 10th 2016 at the St. Paul River Centre, Saint Paul, MN.

The 2016 MPHA Leadership Summit and House of Delegates Meeting will be held June 16th, 2016. This is another opportunity to get involved in policy discussion and professional development. All ASCP-MN members are welcome to join this event as well.

Further information on the Annual Learning Networking Event, Leadership Summit and other upcoming events can be found on the MPHA events page... please take a look for further information on what is going on in our state!

Also, please remember it is never too early to start planning for the 2016 ASCP Annual Meeting & Exhibition November 4th-6th in Dallas, Texas!

Thank you

Joe Litsey, Pharm.D. CGP
**Antimicrobial Stewardship in Long-Term Care**

(written by: Jill Spitzmueller, University of Minnesota Pharm.D. Candidate 2016 & Mark Dewey, Pharm.D., CGP, FASCP, Associate Professor of Practice NDSU School of Pharmacy)

In late 2014, the Obama Administration released the “National Action Plan for Combating Antibiotic-Resistant Bacteria” program with the goal of reducing inappropriate antibiotic use by 50% in the outpatient setting by 2020. The CDC estimates that antibiotic resistant bacteria are responsible for approximately 2 million illnesses and 23,000 deaths each year. Long-term care facilities (LTCF) can play a large role in reaching this goal. Approximately 40% of all prescribed medications in LTCF are antibiotics. Various studies have shown that 25-75% of the antibiotics in LTCF are inappropriately used. In a recent study published in JAMA Internal Medicine, researchers reported that one in eight nursing home residents experienced an adverse event related to antibiotic use, regardless if they used antibiotics during the study period. This study also found that suspected urinary tract infections account for 30-56% of the antibiotics that were inappropriately prescribed. In order to meet the Obama Administration’s goal to reduce inappropriate antibiotic use, every member of the health care team will have to play a role. Due to the high antibiotic use in LTCF, consultant pharmacists will have the opportunity to play a key role in the development and implementation of antibiotic stewardship programs in the facilities they serve.

To reduce antimicrobial resistance in LTCF, it is important for health care workers to take actions that prevent and control the spread of these bacteria. Steps can be taken throughout all levels of the health care system. It is important to administer vaccinations to patients, as well as encourage staff members to receive vaccinations. Throughout a patient’s stay at a LTCF, health care workers should assess if it is appropriate to remove devices, such as a catheter or IV lines, since they place a patient at a higher risk for developing an infection. Providers can also diagnosis and treat infections effectively by obtaining cultures and selecting the antibiotic that offers the best coverage. It is just as important for providers to recognize when it is not appropriate to prescribe antibiotics, to de-escalate antibiotics, and to minimize their use of broad-spectrum antibiotics. Health care workers can work together to prevent the transmission of bacteria within LTCF by isolating the pathogen. They can also reduce the spread of bacteria by educating themselves and others when to stay home if they are sick and on proper hand hygiene.

There is no consensus on the specific components of antimicrobial stewardship programs within LTCF. However, there are a few studies that have shown a variety of interventions that have been successful in reducing the amount of inappropriately prescribed antibiotics. As antibiotic stewardship is being addressed on a national level, it is important for every health care worker to understand how they can assist to make this goal a reality.

Consultant pharmacists have the opportunity to play a key role in integrating antibiotic stewardship programs into their LTCF practice sites. As the medication experts, consultant pharmacists can be a great resource for providers when they have questions about the necessity of antibiotic therapy, the selection of antibiotics, and the duration of therapy. They can also help LTCF monitor their antibiotic use through quantitative analysis and host educational sessions for providers and staff members about antibiotic stewardship.
References:

Updates on Cholesterol Management: Treatment in the Elderly Still Vague
(written by: Jordan Wolf PhamD, CGP)

In 2013, the American College of Cardiology and American Heart Association published new lipid management guidelines, which have changed the way in which practitioners should approach Cholesterol Management. The updated guidelines favor the use of statins as first-line treatment of hyperlipidemia, and shy away from the use of non-statin lipid-lowering medications as initial options due to a lack of evidence that they reduce cardiovascular risk. There may still be a role for non-statin lipid-lowering agents in patients who require additional LDL reduction beyond that which is achieved with a high-dose statin.

Statins have been shown effective in both the primary and secondary prevention of Atherosclerotic Cardiovascular Disease (ASCVD). Four “Benefit Groups” have been identified, in which the benefit of treatment with statins outweighs the potential risks. These groups are as follows:

1. Patients with Clinical CVD (Acute Coronary Syndromes, History of MI, Stable or Unstable Angina, Stroke, TIA, or Atherosclerotic Peripheral Arterial Disease)
2. Patients with LDL-C >190mg/dL (without the presence of secondary causes for cholesterol elevation)
3. Diabetics 40-75 years old with LDL between 70-189 mg/dL without clinical CVD
4. Patients without CVD or diabetes with LDL-C between 70-189 mg/dL with a 10-year CV risk >7.5%

The 10-year CV risk referenced above is based on the new “Pooled Cohort Equation.” Multiple online calculators and mobile apps are available to simplify this calculation. The American Heart Association has one such calculator, which can be accessed at http://my.americanheart.org or downloaded to a smartphone or tablet.

In initiating primary prevention with statin therapy, secondary causes of hyperlipidemia should be ruled out. Secondary causes of cholesterol elevation can include, but are not limited to, the use of various medications, some of which include: antipsychotics, thiazides, glucocorticoids, estrogens, etc. Once these factors have been ruled out, statin therapy can be initiated.

1. For patients with LDL > or equal to 190 mg/dL, a High dose statin can be initiated.
2. For patients with LDL between 70 and 189 and a 10-year CV risk of >7.5%, a High dose statin can be initiated, with the option to start a moderate-intensity statin if a high-dose agent cannot be tolerated
3. For diabetic patients with LDL between 70 and 189 and an estimated 10-year CV risk of <7.5%, a Moderate-intensity statin can be initiated.
4. Low-dose statins should be reserved for those patients who cannot tolerate moderate-intensity or high-dose therapy
Secondary Prevention for ASCVD should include High-dose statin therapy for all patients <75 years old, unless they cannot tolerate the doses due to side effects.

Despite these new guidelines, there is still some controversy as to how patients 75 years of age and older should be managed. This should be an individualized decision based on a proper risk-benefit discussion. Age >75 years old is a risk factor for statin-associated adverse effects, however it is not considered a contraindication. Expert consensus recommends that elderly patients who already on a statin should continue with their current therapy, as long as there are no current adverse effects. This notion is supported by the JUPITER trial, which showed strong evidence for the use of statins in patients >75 years old. Initiation of new high-dose statin therapy for secondary prevention in patients >75 years old, however, is not routinely recommended. Moreover, there is not sufficient data to recommend the primary prevention of ASCVD via statin use in patients >85 years old.

For all patients receiving statin therapy, baseline liver function tests are recommended, along with a fasting cholesterol panel 4-12 weeks after initiation of statin therapy. After initial monitoring, fasting lipid panels should be checked every 3-12 months. Routine ALT/AST monitoring is not recommended, as it has not been shown to be valuable in identifying or preventing serious liver damage. If signs and symptoms of liver failure arise, however, Liver function tests should be checked.

References:


Survey Results Update
(written by: Jordan Wolf, PharmD, CGP)

Each month, the Minnesota Department of Health posts the most recently completed survey results, with links to each facilities finalized report, including the FORM CMS-2567, which lists all deficiencies assessed at the given survey. This information is located at the MDH website, at the following address http://www.health.state.mn.us/divs/fpc/directory/surveyfindings.htm.

In an effort to stay up to date with what surveyors are citing, and to help focus the monthly Medication Regimen Review to the areas that are of specific concern, it is important that the consultant pharmacist stay apprised of this information. In particular, it is prudent to look at each 2567 report and assess for the following tags, which are pertinent to a consultant pharmacist’s practice: F329, F332, F333, F425, F428, and F431. Of these, F329, F428, and F431 seem to be the most commonly cited.

Thus far in 2016, and spanning back to late 2015, it appears that several trends exist among the various surveys. Not surprisingly, the majority of F329/F428 tags continue to revolve around facilities failing to ensure:
Side effect monitoring
Appropriate diagnoses
Non-pharmacological interventions,
Target behaviors monitoring,
Care plan development
Efficacy for use of psychotropic medications.

Multiple facilities have been tagged for failing to perform sleep assessments to justify the ongoing use of medications to treat insomnia, including Melatonin. A number of facilities have failed to monitor orthostatic blood pressures for residents taking antipsychotics. Finally, facilities continue failing to complete adequate Gradual Dose Reduction attempts or provide specific documentation as to why a dose reduction would be contraindicated for psychotropic medications, in some cases despite the consultant pharmacist having recommended a reduction.

Several F329/428 tags have focused on medications that are not psychotropic agents as well. Notably, multiple surveys over the past couple months have identified a lack of parameters for residents prescribed one or more prn pain medications, often times of different classes (i.e. Acetaminophen and an Opioid). Other F329/428 tags include: failing to identify a drug interaction between Simvastatin and Gemfibrozil, failing to monitor blood pressures despite resident taking multiple blood pressure-lowering medications, failing to monitor for potential side effects with warfarin use, etc.

In addition to the above F329/428 tags, there have been an abundance of F431 tags – related to medication storage and handling. A significant number of facilities have been cited for having expired medications in their medication carts or medication storage areas. Closely related to this, facilities continue to fail to date certain medications upon first use, despite their having a shortened expiration date once opened (i.e. Insulin, Advair, latanoprost eye drops, etc.). Several facilities have failed to ensure proper storage of refrigerated medications by either failing to refrigerate agents when required or by maintaining a medication refrigerator outside of the recommended range 36-46 degrees Fahrenheit. Finally, several facilities did not have set policies on Fentanyl destruction or failed to follow their policies on this matter.

**Lake Superior Quality Innovation Network**

As a part of federal health care reform efforts, the Centers for Medicare & Medicaid Services (CMS) has been restructuring the Quality Improvement Organization (QIO) Program with the purpose of creating a new approach to improve care for beneficiaries, families and caregivers. This restructuring process is being rolled out in multiple phases, and in August of 2014, the second phase of this restructuring awarded 14 organizations new contracts designed to work with providers and communities on data driven quality initiatives.

The Medicare quality improvement initiatives for 2014 to 2019 are:

- Improving Cardiac health and reducing cardiac health care disparities
- Reducing disparities in diabetes care
- Improving prevention coordination through meaningful use of health information technology
- Improving the coordination of care between health care settings
- Improving quality though value-based payment, quality reporting and physician feedback reporting program
- Reducing healthcare-associated infections in hospitals
• Reducing healthcare-acquired conditions in nursing homes

**Coordination of care**

Pharmacist are encouraged to become involved in programs which enhance coordination of care. As hospitals and Long Term Care facilities focus on reducing readmission rates we want to be sure pharmacy has a voice in the decision changes moving forward in this area. One initiative which has been focusing on this topic is a program with Stratis Health.

Lake Superior Quality Innovation Network/Stratis Health was awarded the contract for Minnesota, Michigan and Wisconsin areas and works in partnership with local providers, practitioners, hospitals, hospice programs, skilled nursing facilities, assisted living facilities, pharmacies and other health care organizations to achieve national quality goals.

Lake Superior Quality Innovation Network works to improve coordination of care by organizing meetings of community health professionals. Pharmacists should and are encouraged to participate in these meetings. Below is a map of Minnesota’s communities currently participating in collaborative meetings and the upcoming meeting dates.

**Cuyuna/Riverwood Area**
Next meeting in May. Check website for updates.

**Mora Area**
Tuesday, May 3, 1 – 3:00 p.m. at FirstLight Health System.

**North Central MN**
Wednesday, April 27, 12 – 1:30 p.m. at Essentia Health St. Joseph’s Medical Center.

**North East MN**
Tuesday, May 24, 2 – 3:30 p.m. at Essentia Health Third Street Clinic.

**North West MN**
Wednesday, May 4, 3 – 4:30 p.m. at Dakota Medical Foundation, Fargo, ND.

**Ridgeview Area**
Thursday, March 24, 9 – 10:30 a.m. at Ridgeview Medical Center.

**West Metro**
Wednesday, March 23, 2 – 4:00 p.m. at Fairview Southdale Hospital.

Register for the meetings on their website [www.lsqin.org/initiatives/coordination-of-care/join/mn-collaborative/](http://www.lsqin.org/initiatives/coordination-of-care/join/mn-collaborative/). The website also provides a variety of webinars related to Medicare’s initiatives.

For more information on The Coordination of Care Programs contact:

Janelle Shearer
952-853-8553
jshearer@stratishealth.org
ASCP-MN Annual Meeting

Please join us **September 9th, 2016**

**Time:** TBD  
**Location:** TBD (somewhere near the St Paul River Center, St Paul MN)