Newsletter Update

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

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<tr>
<th>Position</th>
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<th>Email</th>
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<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>
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ASCP Minnesota Chapter – Annual Meeting

We are excited to announce our annual meeting will be held September 11th, in conjunction with MPHA’s Annual Learning and Networking Event - September 11 & 12 2015 at the St. Paul River Centre.

To learn more about and to register for MPHA’s Annual Learning and Networking Event please visit the MPhA website.

Specifics for our meetings:

ASCP Minnesota Chapter Annual Meeting

**September 11th, 2015 at 6 P.M.**

The St. Paul Hotel
350 Market Street
Saint Paul, MN 55102
(a short 5 minute walk from the Saint Paul River Centre)

You may RSVP by emailing or texting Joe Litsey, ASCP-MN President: JLitsey@thriftywhite.com; 612-965-4883

All ASCP-MN chapter members and MPhA members are welcome to attend at no cost, however:

**Space is limited – so please RSVP soon to guarantee availability**

The last page of this newsletter will contain the official invite, which will also be emailed out to all members and posted on the ASCP-MN Chapter Website.
ASCP-MN Chapter Survey
Thank you for participating in our ASCP=MN educational survey. The outcomes of the survey helped us plan the our Annual Meeting and provided much appreciated insight into what are members are looking for from the chapter. Here is a recap of the survey questions and top answers:

- Preferred method of education
  1. Live-Seminar
  2. Webinar
- Which day of the week is most convenient
  1. Monday
  2. Friday
- Preferred time for education
  1. Lunch
  2. After business hours
- Specific topics that interest you
  1. Specific disease state information
  2. CMS/Governmental regulation
- Factors influencing participation
  1. Convenience
  2. Program content

Thank you again for participating…. We look forward to seeing you at MPhA and ASCP-MN Chapter events in September!

Legislative update 2015
(written by: Jeff Lindoo, RPh.)

A couple of bills passed by the Minnesota Legislature in 2015 will have, or may have, an impact on long term care practice. Both of these bills were rolled into the Health & Human Services Omnibus bill that was passed in the last days of the session. Changes for pharmacy in this legislation are effective July 1, 2015, and include the following.

**Pharmacist immunization authority:** The age limit for influenza immunizations was lowered from age 10 to age six. The age limit for all other immunizations was lowered from age 18 to age 13. Pharmacists are now required to report all immunizations to MIIC, the Minnesota Immunization Information Connection. Pharmacists are also now required to check a patient’s immunization status on MIIC prior to giving any immunization other than influenza for patients age nine and above.

**Technician ratios:** The basic technician ratio for pharmacies was increased from 2:1 plus 1 to 3:1 plus 1. The “plus one” means that, if at least one technician is certified, there may be one additional technician in the pharmacy. It does not mean there may be one additional technician for each pharmacist in the pharmacy. This does not make any changes to the current ratio of 3:1 plus 1 that is allowed in rule for unit dose dispensing, compounding, prepackaging or IV admixture.

**Epinephrine auto-injectors:** For several years, schools have been allowed to possess epinephrine auto-injectors for use in anaphylactic emergencies. New legislation allows recreation camps, colleges and universities, preschools and daycares to also possess these auto-injectors. These “authorized entities” must
complete an anaphylaxis training program every two years and must present a certificate of that training to
a pharmacy that is licensed by the Board as a wholesaler to purchase the auto-injectors. The pharmacy will
not dispense the auto-injector as a prescription, but rather sell it as a wholesale sale. The commissioner of
Health may designate additional authorized entities in the future.

Remote dispensing technology may now be used in licensed boarding care homes. Previously, all cassettes
or canisters used in remote dispensing technology had to be filled at the managing pharmacy and checked
by a pharmacist employed there. New language allows the purchase of filled canisters from a repackager
that is licensed by the Board as a manufacturer.

A few years ago, language that required OTC medications to be dispensed in the manufacturer’s original
packaging was repealed, but the requirement to bill in shelf package quantities remained. This year, the law
was changed to allow billing of OTC medications in less than the shelf package quantities, but only when
using a dispensing system that dispenses medications in less than one-month quantities and uses
retrospective billing procedures that bill only for medications actually used by the long term care resident.
This change is effective January 1, 2016.

**Federal Legislation**

Proposed federal legislation that is of particular interest to long term care pharmacy is [S.314/H.R.592, the
Pharmacy & Medically Underserved Areas Enhancement Act](https://www.congress.gov/bill/114th-congress/senate-bill/314), more commonly referred to as **Pharmacist Provider status**. This legislation would recognize pharmacists as a provider of clinical services under Medicare in medically underserved areas and would allow pharmacists to be reimbursed for clinical services under Medicare Part B in those areas. The legislation does not create any new practice authority for pharmacists, that responsibility continues to reside with State Boards of Pharmacy, but it would allow for billing of clinical services that are allowed under individual state pharmacy practice acts. In Minnesota, authority for those services would come primarily under collaborative practice agreements with prescribers, either physicians or nurse practitioners. You are probably already thinking of services that you could provide and would be valuable to the patients you serve, if only there was a way to be paid for it.

Several efforts have been made in past years to pass similar legislation, but this legislation seems to be
gaining greater traction than any time in the past. As this is being written, there are 149 co-sponsors in the
House and 20 co-sponsors in the Senate. Representatives Nolan, Paulsen, Peterson and Walz have all signed
as co-sponsors of this legislation. Representatives Ellison, Emmer, Kline and McCollum and both Senators
Franken and Klobuchar have yet to sign as co-sponsors. Most national pharmacy associations, including
ASCP, APhA, NCPA and NACDS, have mounted a joint effort to lobby for this legislation in Washington, but
letters from constituents are the most effective means to encourage legislators to support legislation. That
means YOU can make a difference in seeing pharmacists finally recognized as health care providers. If you
have not already done so, you can go to [www.CommunityRxAction.com](http://www.CommunityRxAction.com), click on “Take Action” and send a
letter to your Representative and both Senators in support of this legislation. If your Representative is
already a co-sponsor, your letter will thank them for their support, which is just as important as encouraging
their support if they are not. If they are not a supporter, your letter will urge their support. We encourage
you to personalize your letter, or erase the letter that comes up and write your own letter. However you do
it, you can be part of passing this important legislation for pharmacists. Then pass the message on to your
colleagues!
Medical Marijuana: How Will Cannabis Impact LTC?
(written by: Joe Litsey, Pharm.D. CGP and Katie Stein, APPE Pharmacy Rotation Student)

Recent Legislation - The CARERS ACT
The “Compassionate Access, Research Expansion, and Respect States” (CARERS) Act: Was introduced in March 2015. This act aims to amend the Controlled Substances Act of 1970. The proposed amendment would allow an exemption to prosecution for people who grow, distribute, or use marijuana for medical purposes in compliance with their state law.

I. The CARERS Act has multiple provisions:
   • Changes marijuana enforcement under the CSA such that the federal law no longer takes priority if it differs from state law. This could allow protection for those who are involved in manufacturing, processing, possessing, and distributing medical marijuana.
   • Re-scheduling marijuana as a Schedule II controlled substance. By doing so, more scientific research can legally be done on marijuana’s components.
   • Would allow VA physicians to prescribe/recommend medical marijuana to patients that live in states where it is legal. Currently, this practice is illegal as the VA is federally run.
   • Makes banking services more accessible to businesses involved in medical marijuana. As of now, banks may shut down their accounts or decline to advance loans out of fear of being prosecuted by the federal government.
   • Suggests removing marijuana with less than 0.3% THC (low-THC strains, also known as cannabidiol) from the CSA entirely, allowing it to cross state lines legally

II. Where is the CARERS Act now?
   • Its current status is still “Introduced”, meaning it has to pass the Senate and House before being sent to the President. There are many hurdles, and likely many more modifications.

Eligibility and Considerations in Minnesota

I. The Minnesota Department of Health details our new Medical Cannabis Law: http://www.health.state.mn.us/topics/cannabis/

II. In Minnesota, there are nine conditions that medical marijuana can be prescribed for: Cancer associated with chronic pain/severe wasting, Glaucoma, HIV/AIDS, Tourette’s Syndrome, ALS/Lou Gehrig’s disease, Seizure disorders, severe/persistent muscle spasms, Crohn’s disease, and terminal illnesses with a life expectancy of less than 1 year that produce severe pain, nausea, vomiting, or wasting.

III. According to 2008 CMS data, 8.6% of enrollees 65 years or older had been diagnosed with glaucoma, one of the qualifying conditions for medical cannabis. This number gradually increased with the length of stay in a long-term care facility. Thus, there could be a significant amount of residents that may qualify, whether for glaucoma or another condition.

IV. A few states in the U.S. include “agitation of Alzheimer’s” – (Michigan, Oregon, and Rhode Island at this time, Minnesota is not one of those states.

Unique Considerations in Long-Term Care

I. Storage: If residents are permitted to use medical marijuana in a nursing home, issues surrounding the storage and access to the drug must be discussed. For instance, would medical cannabis be stored in a lockbox or patient room? Who would have access?
Washington state LTC facilities have skirted this issue by requiring patient “providers” to bring in the cannabis to the facility for consumption, and then promptly removing once the client has consumed. This requires ‘visitor’ to bring in a new dose each time it is given.

II. **Administration:** The administration of medical marijuana depends largely on the dose form that is manufactured/legalized. Some states have legalized the plant (smoking) form, whereas others (like Minnesota) only have allowed marijuana in oil, pill, and liquid forms. Since its legalization in individual states, proper dosing and documentation must also be addressed.

- New Mexico, which legalized medical cannabis in 2007, has cited lack of dosing direction of the marijuana as a major concern in their LTC facilities - it’s near impossible to determine whether one pinch or two has been given.

III. **Caregivers:** For residents of long term care facilities, the issue of having a caregiver licensed to handle/transport medical cannabis brings up a new concern. Minnesota law details how personal caregivers (spouse/representative) can apply for access to a patient’s account after passing a background check and how parents/legal guardians can do so without a background check, but the law neglects to address caregivers in other settings, such as a care facility. Caregivers (nurses, aids) could fluctuate based on staffing/schedule, and not all caregivers may be comfortable assisting a resident with cannabis use.

- In Maine’s law, nursing homes and inpatient hospice organizations are explicitly allowed to act as registered medical marijuana primary caregivers, provided the cannabis is obtained from an approved dispensary.
- In California, the owner/operator of a healthcare facility can be a primary caregiver or designate up to 3 employees to do so.

III. **Multi-State Facilities:** Concerns have also been voiced regarding Long Term Care/Senior Living corporations that operate facilities in multiple states, some which have legalized medical marijuana and some that have not.

i. One valid concern is that with multi-state involvement, the federal government and law enforcement may be more likely to get involved.

ii. If a long term care corporation was to develop policies and procedures regarding marijuana use in their facilities spanning multiple states, an ‘umbrella policy’ for all locations may be harder to reconcile with differing state laws.

**Resources:**


IV. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3875249/


VII. Cannabis use in Alzheimer’s disease - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3942876/
Reform of Requirements for LTC Facilities: CMS Proposed Rule Changes
(written by: Joe Litsey, Pharm.D. CGP)

The Highlights:

I. Medication Regimen Review
   - A pharmacist must review a resident’s entire medical record when the patient is new to the facility, returns to or is transferred from a hospital or other facility, and at least every six months.
   - A pharmacist must review the medical chart when the resident has been prescribed a psychotropic drug, an antibiotic, or any drug the Quality Assessment and Assurance (QAA) committee has requested be included in the pharmacist’s monthly drug regimen review.
   - Attending physician must document in the medical record that they have reviewed the irregularities identified and what they have done to address it with rationale provided if no action is taken.

II. Psychotropic drug use
   - Revising the current requirements that apply to antipsychotic drugs to also apply to any psychotropic drug – defined as any drug that affects brain activities associated with mental processes and behavior.
   - Ensure residents prescribed psychotropic drugs receive gradual dose reductions and behavioral interventions
   - PRN (as needed) orders for psychotropics be limited to 48 hours unless primary care provider has reassessed and documented the continued need for the psychotropic medication.

III. Healthcare Associated Infections (HAIs)
   - Will include provisions to establish an antibiotic stewardship program

IV. Discharge Planning
   - Facilities would be required to reconcile all pre-discharge medications with resident’s discharge medications. This medication reconciliation would be part of the discharge summary.

Thank you!

Joe Litsey, Pharm.D. CGP
Chapter President
jlitsey@thriftywhite.com

cell: 612-965-4883 | voice mail: 763-513-4364 | fax: 763-463-4464
Annual Meeting

Please join us September 11th, 2015

Location: The St. Paul Hotel
350 Market Street
Saint Paul, MN 55102
(a short 5 minute walk from the Saint Paul River Centre)

Agenda:

6:00-6:30 P.M. Sign in/cocktails and conversation
6:30-7:15 P.M. Chapter Meeting
7:15-8:30 P.M. Dinner/Education
Diabetes Management and New Insulin Alternatives
Sponsored by Sanofi
8:30-9:00 P.M. Closing remarks and follow up

You may RSVP by emailing or texting Joe Litsey, ASCP-MN President:
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