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From the Front Lines

AlixaRx Clinical Pharmacists Address Everyday Challenges in Long-Term Care

Influenza Vaccine 2016-2017
Get Vaccinated For Your Residents!

All persons age 6 months and older should receive the influenza vaccine annually. Less than half of all Americans received the influenza vaccine last year. Long-term care workers have the worst vaccination rates among all health care providers nationwide. We need to work as a team to improve our status within the healthcare setting.

Vaccination of all employees working in long-term care is critical because our residents have a decreased response to the vaccine and are at greater risk of complications, including death from the flu. The best tool to protect our residents is getting vaccinated ourselves. A study estimated that influenza was associated with 114,018–633,001 hospitalizations, 18,476–96,667 intensive care unit (ICU) admissions, and 4,866–27,810 deaths per year. Among these, an estimated 54%–70% of hospitalizations and 71%–85% of deaths occurred among adults aged 65 years and older. If you refuse to be vaccinated you are putting the lives of your residents at risk.

In this issue:

Vaccines Available 2016-2017:

Standard Dose Trivalent vaccine (Fluvirin™, Afluria™) is approved for ages 6 months and older. Trivalent vaccines protect against three different virus strains. One formulation is available via a jet injector for persons 18-64 years old.

High Dose Trivalent Vaccine (Fluzone High Dose™) – approved for people age 65 and older. Fluzone High Dose™ was 24.2% more effective in preventing influenza than a standard dose vaccine in adult's age 65 years and older per a recent study published in the New England Journal of Medicine.

Adjuvanted Inactivated Influenza Vaccine, trivalent (Fluad™) – newly approved for persons age 65 and older based upon immune response.

Vaccine that is egg free (Flublok™) is approved for ages 18-49 with an egg allergy.

Quadrivalent Vaccine (Fluarix™, FluLaval™, Fluzone™, Fluzone Intradermal™) protects against two influenza A and two influenza B viruses. Different vaccines are approved for different age groups – visit the CDC website or ask your healthcare professional for details.

Quadrivalent nasal spray vaccine should not be used during the 2016-2017 influenza season. This is an interim recommendation based on lack of effectiveness.

Which Vaccine is best?

The CDC doesn't favor any one vaccine over another but rather recommends that everyone ages 6 months and older get vaccinated. Protect yourself and your residents - http://www.cdc.gov/flu/nivw/pledge/index.html.

Storage and labeling of the Influenza Vaccines

- Storage in dormitory-style refrigerators is not recommended. The CDC strongly recommends using a compact refrigerator without a freezer compartment. Vaccines should never be stored in the door of the refrigerator. Daily temperature logs need to be within 35-46 degrees Fahrenheit.
- Label each vial with the date opened. Multi-dose vials should be discarded after 28 days unless specified otherwise by the manufacturer. CDC notes that multi-dose influenza vials stored properly without visual changes can be used until the expiration date on the label.
- Do not use last years (2015-2016) vaccine as it is now expired. Please destroy these if you have any remaining in storage.

References: 1. Reed C, Chaves SS, Daily Kirley P, et al. Estimating influenza disease burden from population-based surveillance data in the United States. PLoS One 2015;10:e0118369. 2. N Engl J Med 2014; 371:635-645 3. www.cdc.gov

Butrans (buprenorphine): 7-day Transdermal Opioid Analgesic

Butrans is indicated for the management of pain severe enough to require around the clock, long term opioid treatment. Butrans is addictive even at recommended doses and therefore should be reserved for patients for whom alternative treatment options are ineffective or are not tolerated.

Available doses: 5mcg/hour, 7.5mcg/hour, 10mcg/hour, 15mcg/hour, and 20mcg/hour

Dosing: Butrans dose for opioid naïve patients is 5mcg/hour every 7 days. Butrans doses greater than 7.5mcg/hour are for opioid experienced patients only. Dose adjustments may be made every 3 days in 5, 7.5, or 10mcg/hour increments by using no more than two patches to obtain the desired dose and the total dose from both patches should not exceed 20 mcg/hour. The medication should not be abruptly discontinued. Titrate Butrans slowly every 7 days to prevent withdrawal symptoms in physically-dependent patients.

Side Effects: Common adverse reactions of Butrans are headache, insomnia, constipation, application

site pruritis, profound sedation, and dry mouth. The medication may also cause hypotension (including orthostatic hypotension), which is a great concern in the elderly population due to the increased risk of falls. Patients may also experience respiratory depression as a result of Butrans therapy.

Contraindications: Butrans should not be administered in patients with significant respiratory depression. Patients with acute or severe bronchial asthma must be monitored closely otherwise Butrans is contraindicated. Additionally, do not use the medication in patients with paralytic ileus or hypersensitivity to buprenorphine.

Warnings/Precautions: Butrans should be used with caution in patients with a history (or family history) of Long QT Syndrome. Patients taking Class IA (Quinidine, Procainamide, Disopyramide) or Class III (Amiodarone, Sotalol, Ibutilide, Dofetilide) antiarrhythmic medications should also use Butrans with caution.

Disposal: Butrans should be sealed in the Patch-Disposal Unit provided with the medication and disposed of in the trash. Never place Butrans in the trash without sealing in the Patch-Disposal Unit. Alternatively, the patch can be removed, folded over onto itself, and flushed down the toilet.

Concerns in the elderly: When using Butrans, elderly patients should be closely monitored due to the risk of life threatening respiratory depression. Dosing should start low and titrate slowly due to altered pharmacokinetics and clearance in the elderly.

Reference: Butrans Full Prescribing Information. www.butrans.com

CMS Reform of Requirements for LTC Facilities

CMS published the so-called “Mega Rule” earlier this month to revise the requirements that long-term care facilities must meet to participate in the Medicare and Medicaid programs. This article highlights some of this rule, especially those changes that will affect medication use and pharmacy services. These changes are listed in Phase 2, which shall be implemented no later than November 30, 2017.

Comprehensive Person-Centered Care Planning

- Immediately after admission to a Skilled Nursing Facility (SNF) is a critical time when many adverse events can occur due to a lack of person-centered care, including review of all medications. It is recommended that a consultant pharmacist, having access to the full medical record, conduct a comprehensive medication regimen review (MRR) as soon as possible after admission to determine the clinical value of each medication (benefit vs. risk).

Medication Reconciliation upon Discharge

- A new requirement has been added that a medication reconciliation of a resident’s pre and post discharge medications be included in the discharge summary

Pharmacy services

- CMS is adding the requirement that a pharmacist review a resident's full medical chart, monthly as part of the MRR review.
- CMS believes that the pharmacist's monthly review of the medical record mentioned above can contribute to the proposed requirements for infection control and antibiotic stewardship.
- Any irregularities should be reported to the attending physician, director of nursing, and facility medical director.
- Psychotropic Drugs: "We are concerned that as the use of antipsychotic drugs has decreased, the use of other psychotropic medications has increased. These drugs include, but are not limited to, drugs in the following categories: (1) anti-psychotic, (2) anti-depressant, (3) anti- anxiety, and (4) hypnotic. CMS has revised existing requirements regarding "antipsychotic" drugs to refer to "psychotropic" drugs.
    - o Requires facilities ensure residents who have not used psychotropic drugs not be given these drugs unless medically necessary.
    - o Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue use of these psychotropic drugs.
    - o PRN orders for psychotropic drugs should be limited to 14 days: "For psychotropic drugs that the attending physician believes a PRN prescription for longer than 14 days is appropriate, the attending physician can extend the prescription beyond 14 days for the resident by documenting their rationale in the resident's medical record." However, they are requiring that a new order be written to continue PRN antipsychotic drugs beyond 14 days: "If the attending physician believes that the resident requires an anti-psychotic drug on a PRN basis for longer than 14 days, he or she will be required to write a new PRN prescription every 14 days after the resident has been evaluated."

Reference: https://www.gpo.gov/fdsys/pkg/FR-2016-10-04/pdf/2016-23503.pdf

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