BRANCHING OUT

ISSUE 17
Quarterly Newsletter

January 2025

Highlights

What we've been doing…

Green Tree Pharmacy has provided over 4200 flu vaccines to our facilities this flu season!

Rumor vs. Truth…

***Rumor…** A resident that is 55 years old with no known previous pneumococcal vaccination history must wait until age 65 to receive a pneumococcal vaccine*

***Truth…** CDC lowered the recommended age from 65 to 50 because many adults 50 to 65 already have risks for invasive pneumococcal disease.*

See CDC's PneumoRecs VaxAdvisor app or website for full guidance.

Updates:

*FDA approved **tirzepatide** (Zepbound – Eli Lilly) for the treatment of moderate-to-severe obstructive sleep apnea (OSA) in adults with obesity, in conjunction with a reduced-calorie diet and increased physical activity.*

Suggestions/Comments…

We'd love to hear how we are doing and are always open to your feedback to improve our services. Please call 1-800-913-8174 or visit our website greentreepharm.com and click "contact us" to submit the request / comment.

News from Our Pharmacy Operations Team

Immunization Compliance:

CMS historically requires LTC facilities participating in Medicare and Medicaid programs to offer all residents influenza and pneumococcal vaccines, and to document the results.

In October 2024, CDC lowered the recommended age for the pneumoccal vaccine from 65 to 50 years old.

Effective October 1, 2024, Section O of MDS 3.0 will include resident COVID-19 vaccination status. Residents (and staff) must be offered the COVID-19 vaccine.

While reviewing immunizations, residents 60+ should be offered RSV vaccination. CDC recommends a single dose of RSV vaccine for older adults (60+) to help prevent serious RSV infection and hospitalization.

Potential Tags for Investigation:

F658: professional standards of practice for provision of vaccines

F880: infection prevention and control

F883: Influenza and pneumococcal vaccinations

F887: COVID19 vaccination

Pharmacy Team Spotlight:

Ashley is a Certified Pharmacy Technician (CPhT) that joined our Green Tree Pharmacy team in October of 2015. She originally started with packaging medications to send to our facilities and soon grew to be an essential part of our workflow team in other areas such as the C-II room and IV room. Ashley continued her pharmacy growth by becoming APhA certified in administering immunizations and BLS certified. Ashley shows her "Happy to Oblige" through her exceptionally positive attitude. Her work ethic is exemplary as she regularly seeks out ways to help co-workers and better serve our facilities.

Operations Tips and Tricks

Be sure to communicate with pharmacy when medications from the convenience boxes have been used to ensure timely replenishment and eliminate the need for utilizing a back-up pharmacy due to stock-outs.

Health Awareness Months:

January: National Blood Donor Month
Thyroid Awareness Month
January 12th – National Pharmacist Day

February: American Heart Month

March: National Kidney Month

March 16-22: National Poison Prevention Week

Clinical Acorns and Guidelines

Regulatory Update/ Review

CMS Phase 3 guidance:

The definition of a psychotropic medication now includes "any drug that affects brain activities associated with mental processes and behavior." These drugs include antipsychotics, antidepressants, antianxiety, hypnotic, as well as medication classes that may affect brain activity.
*This expanded list of psychotropic medications includes CNS agents, anticonvulsants, muscle relaxants, anticholinergic medications, antihistamines & **OTC natural or herbal products.***

Please treat melatonin as a psychotropic due to this classification. PRN melatonin orders should be entered for 14 days as well as GDRs will be requested by your consultant pharmacist.

Anticoagulant Monitoring:

A survey focus currently is ensuring that any resident with an order for an anticoagulant (Warfarin, Eliquis, Xarelto, Pradaxa, etc.) has monitoring in place on orders.

Example includes:

Anticoagulant medication-monitor for discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, SOB, nose bleeds.

Clinical Focus: Hypertension treatment

Uncomplicated hypertension:

1st line: include ACEi (nonblack) or ARB, thiazide, or long acting CCB

2nd line: after optimizing doses, add another first-line agent. Don't use ACEi plus ARB.

3rd line: add spironolactone (preferred), amiloride, doxazosin, eplerenone, clonidine or BB

BP goals for elderly based on ACC/AHA guidelines: SBP < 130 mmHg.

JNC8 guidelines recommend a goal of < 150/90 mmHg for those 60 years of age and older. Patients with CKD or < 60 years of age: goal: < 140/90 mmHg.

AAFP guidelines: < 140/90 mmHg to reduce all cause and CV mortality.

Treatment of hypertension in patients with diabetes:

1st line: ACEI or ARB, dihydropyridine CCB, or thiazide.

BP goal: < 130 mmHg per ADA

Misc:

Although not indicated for hypertension, SGLT2 inhibitors (dapagliflozin, etc.) reduces BP and could be added at any time in appropriate patients with DM, CKD, or HF.

Lifestyle changes:

Maintain a healthy weight. A weight loss of 1 kg can reduce SBP by 1 mmHg.

Consume a heart healthy diet. The DASH diet can reduce SBP by 11 mmHg.

Cutting sodium by 25% or 1000 mg/day can reduce SBP by 5 mmHg.

Aerobic activity for 150 min/week can reduce SBP by 5 mmHg.

Hypertension Prescribing Cascade:

Pharmacotherapy is commonly prescribed to reduce risks of elevated blood pressure. When medication is either started or increased, there are risks of adverse effects, which often go unrecognized and led to new medications that treat those adverse effects, leading to a prescribing cascade.

Polypharmacy can increase the risk of drug interactions. Polypharmacy is the number one predictor of adverse drug events (falls, hospitalization, death). The concept of "deprescribing" unneeded or potentially harmful medications have been suggested. Here are top three medications that can lead to a prescribing cascade in hypertension medication:

ACE inhibitors: a side-effect is a persistent dry cough (5-20%). This side effect can develop within a few weeks after initiation, is not dose dependent and is more common in woman. This cough may be treated with antitussive agents, which constitutes irrational pharmacotherapy. Substitution with alternative agents, preferably ARBs, is recommended.

Calcium Channel Blockers (CCBs): a common adverse effect from the dihydropyridine CCBs (amlodipine, etc) is peripheral edema, which is due to vasodilation. This often leads a prescribing cascade with diuretics being prescribed. Risks of adding a diuretic can lead to unnecessary side effects like dehydration, electrolyte imbalances, and increased risk of falls in older adults.

Thiazide diuretics: urinary frequency from thiazide diuretics may be diagnosed as overactive bladder. Symptoms may be treated with urinary anticholinergics, which have numerous side effects (dry mouth, constipation, blurry vision, cognitive side effects, etc.) and can contribute to their own prescribing cascade.