IN THIS ISSUE
App for That! .................. 1
New Monitoring Tool – PDMP.. 1
2016 New Drugs ................. 2
Opiates and Overdose ........... 2
Consultant Corner ............... 3

APP FOR THAT!

This app is a picture sharing app similar to Instagram. However, these pictures are shared with other physicians to:

- Discover medical cases from every specialty;
- View rare conditions, innovative treatments, and teaching cases from around the world;
- Page more than 1 million healthcare professionals for instant feedback; and
- Communicate with colleagues using HIPAA-compliant direct messaging.

Think of sharing a picture of a patient’s skin rash and getting multiple second opinions!

NEW MONITORING TOOL - PDMP

The New Year kicked off with an enhanced Prescription Drug Monitoring Program (PDMP) for the State of Wisconsin. For a few years, Wisconsin has had a program where all controlled substances, when dispensed, are reported to a central database within seven days. This database allowed physicians and pharmacists to review a patient’s history of controlled substances to help them determine whether controlled substance prescriptions would be given in the future. This system basically generates a list.

Beginning this year, a newly developed PDMP has been rolled out. This system has built-in analytics and visual cues to support the physicians and pharmacists in their decision making. For example, the new system will calculate morphine milligram equivalents and alert providers to patients who are receiving more than the typical amount of controlled substances. In some cases, the amount may be justified. In other cases providers may not have known and, going forward, the provider can work to reduce the amount of controlled substances being prescribed.

Another analytic being utilized in the new PDMP is graphical representations of benzodiazepines and opioids prescribed and dispensed with overlapping use. As you may recall, last summer the Food and Drug Administration (FDA), after an extensive review of the latest scientific evidence, announced that it was requiring class-wide changes to drug labeling, including patient information.
This is being done to help inform health care providers and patients of the serious risks associated with the combined use of certain opioid medications and a class of central nervous system (CNS) depressant drugs called benzodiazepines. Among the changes, the FDA is requiring boxed warnings and patient-focused medication guides for prescription opioid analgesics, opioid-containing cough products, and benzodiazepines, including information about the serious risks associated with using these medications at the same time. Risks include extreme sleepiness, respiratory depression, coma, and death. The PDMP will significantly help providers review those patients that may have overlapping use and work to reduce the risk for these patients.

Due to legislation taking effect in April 2017, prescribers will be required to review the PDMP prior to issuing a prescription in most cases. As a surveyor you should be aware of this requirement. In some cases, providers have raised concerns that this will delay needed medications in nursing homes, assisted living, home health, and hospices. Surveyors should be aware that in emergency cases, for a supply of less than three days, the prescriber is exempt from checking the PDMP. Therefore, there should not be delays in individuals obtaining medications to treat pain.

### 2016 NEW DRUGS

In 2016 there were 22 novel drugs approved. These medications offer treatments for a wide range of diseases. Below are some of them that, as surveyors, you may see more routinely in the facilities you survey.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briviact / brivaracetam</td>
<td>To treat partial onset seizures in patients ages 16 years and older with epilepsy</td>
</tr>
<tr>
<td>Cinqair / reslizumab</td>
<td>To treat severe asthma</td>
</tr>
<tr>
<td>Nuplazid / pimavanserin</td>
<td>To treat hallucinations and delusions associated with psychosis experienced by some people with Parkinson’s disease</td>
</tr>
<tr>
<td>Zinbryta / daclizumab</td>
<td>To treat multiple sclerosis</td>
</tr>
<tr>
<td>Adlyxin / lixisenatide</td>
<td>To improve glycemic control (blood sugar levels)</td>
</tr>
<tr>
<td>Xiidra / lifitegrast</td>
<td>Ophthalmic solution to treat the signs and symptoms of dry eye disease</td>
</tr>
<tr>
<td>Zinplava / bezlotoxumab</td>
<td>To reduce the recurrence of Clostridium difficile infection in patients ages 18 years or older</td>
</tr>
</tbody>
</table>

### OPIATES AND OVERDOSE

The typical treatment for an overdose is naloxone. Over the past two years, legislation and provision of statewide standing orders has allowed naloxone to be available in many more settings. Emergency personnel, police officers, clinics, substance abuse treatment facilities, community-based residential facilities, nursing homes, and residents in their own homes who may be receiving home health care may now have ready access to naloxone as an injection or as a nasal spray to revive someone from an opiate overdose. (continued)
Entities that have naloxone and intend to respond should know the risk factors for an overdose. Risk factors include:

- **Tolerance.** Tolerance can decrease rapidly when someone takes a break from using an opioid. Restarting at the same dose puts individuals at risk for an overdose.

- **Physical Health.** Opioids can impair breathing. Individuals with asthma or other breathing problems are at a high risk for overdose. Individuals with liver and/or kidney problems or are positive for HIV are also at increased risk.

- **Previous Overdose.** An individual who has had a nonfatal overdose in the past has an increased risk of fatal overdose in the future.

- **Mixing Drugs.** Many overdoses occur when opioids are mixed with alcohol, sedatives/antianxiety medicines, or other substances.

In addition, facilities should have a plan for responding to an opioid overdose:

1. Identify an overdose.
2. Call 911.
3. Open airway and give rescue breaths.
4. Give naloxone.
5. Place individual in recovery position.

A great resource for giving naloxone is available at: https://www.dhs.wisconsin.gov/publications/p01576.pdf

**Note:** Facilities should adopt policies and train staff based on the types of naloxone they have available.

---

**CONSULTANT CORNER**  by Doug Englebert, R.Ph.

A hospice has ordered intravenous (IV) haloperidol, can we use that in a nursing home?

Haloperidol is not approved for intravenous administration. Although injectable haloperidol is approved by the FDA only for intramuscular injection, there is considerable evidence from medical literature that intravenous administration of haloperidol is a relatively common “off-label” clinical practice, primarily for treatment of severe agitation in intensive care units. Due to a number of case reports of sudden death, Torsades de pointes (TdP), and QT prolongation (heart rhythm) in patients treated with haloperidol (especially when the drug is given intravenously or at doses higher than recommended), the sponsor has updated the labeling for haloperidol. The updated WARNING states:

“Higher doses and intravenous administration of haloperidol appear to be associated with a higher risk of QT prolongation and TdP. Although cases of sudden death, TdP, and QT prolongation have been reported even in the absence of predisposing factors, particular caution is advised in treating patients using any formulation of haloperidol who:

- Have other QT-prolonging conditions, including electrolyte imbalance (particularly hypokalemia and hypomagnesemia),
• Have underlying cardiac abnormalities, hypothyroidism, or familial long QT syndrome, or
• Are taking drugs known to prolong the QT interval.

Due to this risk of TdP and QT prolongation, electrocardiogram (ECG) monitoring is recommended if haloperidol is given intravenously.

Nursing home and hospice providers must ensure that residents given IV haloperidol are monitored appropriately.”

If a resident is capable of self-administering medication, has a doctor’s order to self-administer, has a family member set up a pill planner, and has been assessed by a facility nurse, can the CBRF give time reminders if the family or the resident request it and still consider the resident to be self-administering medications?

Per Wis. Admin. Code § DHS 83.02(29), "Medication administration" means the direct injection, ingestion, or other application of a prescription or over-the-counter drug or device to a resident by a practitioner, the practitioner's authorized agent, CBRF employees, or the resident, at the direction of the practitioner. Medication administration does not include reminders to take medication.

Based on this definition, reminders can be given and it will still be considered self-administration.

Can a community-based residential facility (CBRF) receive a citation for not having medication carts attached to the wall?

Wis. Admin. Code § DHS 83.37(3)(c) Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF.

Wis. Admin. Code § DHS 83.37(3)(g) Controlled substances. The CBRF shall provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs subject to 21 USC 812(c), and Wisconsin's uniform controlled substances act, Wis. Stat. ch. 961.

The above two requirements in ch. DHS 83 must be met when the facility is storing medications and administering. For schedule II medications, they must be in something with a separate lock and securely fastened within a locked area. This can be a locked medication cart with a separate lock for a controlled substances drawer and the cart is securely fastened or in a locked storage area. If CBRFs wish to use a new cart that looks like furniture or would like to avoid securely fastening a cart, the facility should seek a waiver.