What CMS Really Wants of the Hospice Industry: Totally Competent Medication Therapy Management

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CMS Chaos 2014

What happened?

- Sequestration
- CR 8358
- Medicare Part D Hospice Reform

CMS Expectation of the Hospice Industry

- CoPs 2008 compliance
- Improved quality of life
- Improved patient and caregiver satisfaction
- Decreased cost
- Reduction in Medicare Part D utilization
- Increased utilization of hospice?

Hospice MTM

Medication Therapy Management

1. Primary Hospice Diagnosis
2. Secondary Diagnosis
3. Comorbidities

Goals of Hospice MTM

- Improve efficiency and safety of medication use !
  - Hospice Clinical Pharmacist Consultation
- Decrease medication costs
  - Patient & Family Education
    - Alignment of goals
  - "Portmanteau" Medications
  - Therapeutic Interchange
  - Renal Dosing of Medications
  - "You can't manage what you don't know!"
    - Medication Utilization Reporting Makes Cents!
  - PBM Purchasing Model Options
    - Traditional
    - Mail Order
    - Transparent + Pass Through

Pharmaco-Therapeutic Support System

3 Components:

- PDL
- Hospice Clinical Pharmacist
- Pharmacy and Therapeutics Committee

Comorbidity Management

The big three:

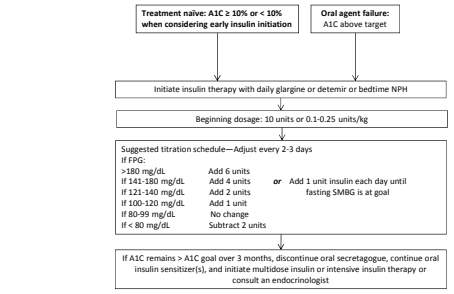
- DM
- COPD
- CHF

Diabetes

Remember: The HBA1C goal is no longer 7% !

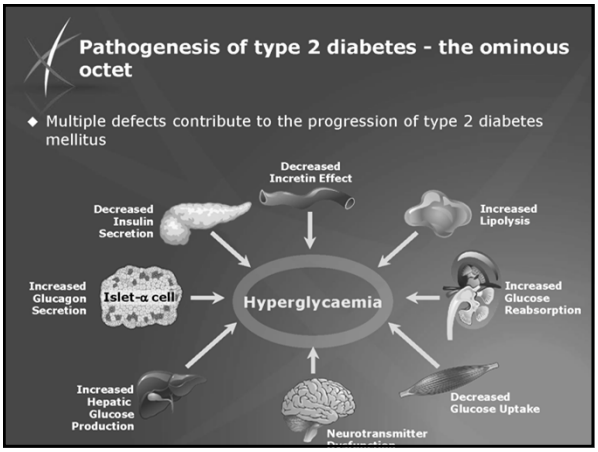
Autonomic dysfunction?
Neuropathic Pain?
Renal Function?
Vision?

Initiation of once-daily insulin therapy for type 2 diabetes mellitus in children and adults



FPG: Fasting plasma glucose
SMBG: self-monitored blood glucose

Adapted from: Triplitt CL, Repas T, Alvarez CA. Diabetes Mellitus. Figure 57-9, Insulin algorithm for type 2 DM in children and adults (reprinted with permission from Texas Diabetes Council). In: DiPiro JT, Talbert RL, Yee GC, et. al. *Pharmacotherapy: A Pathophysiologic Approach*. 9th ed. New York, NY: McGraw-Hill; 2014: 1178.



Oral Agents for the Treatment of Type 2 Diabetes Mellitus

Drug Class	Special Precautions
Sulfonylureas (1st and 2nd generations)	Severe hypoglycemia, weight gain; dose adjustment in renal impairment
Short-acting insulin secretagogues	CYP 2C8/9 and 3A4 metabolism
Biguanides	CHF(lactic acidosis), GI side effects; dose adjustment in renal and hepatic impairment
Thiazolidinediones	Caution in hepatic impairment, bladder cancer; contraindicated in CHF (causes edema)
α-Glucosidase inhibitors	Caution in renal impairment, elevated LFTs; contraindicated in chronic intestinal diseases
Dipeptidyl peptidase-4 (DPP-4) inhibitors	Pancreatitis; dose adjustment in renal impairment (except linagliptin)
Bile acid sequestrants	Constipation, drug-drug absorption interaction issues, increased in triglycerides
Dopamine agonists	Cardiac valvular fibrosis, hypotension, significant nausea, impulse control disorders

Injectable Agents for the Treatment of Type 2 Diabetes Mellitus

Drug Class	Special Precautions
Rapid acting insulin	Hypoglycemia, hypokalemia
Short acting insulin	Hypoglycemia, hypokalemia
Intermediate acting insulin	Hypoglycemia, hypokalemia
Long acting insulin	Hypoglycemia, hypokalemia
Glucagon-like peptide-1 (GLP-1) agonists	GI side effects, thyroid tumors (Bydureon), pancreatitis; avoid use in impaired gastric motility; use not recommended in severe renal impairment
Amylinomimetics	Avoid use in impaired gastric motility

COPD

Is the patient strong enough to continue to use MDI and Spinhaler devices?

How do we know?

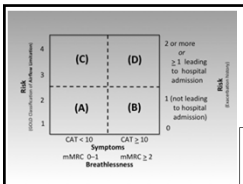
Grip strength? Spirometry?

Many new products:

Breo Ellipta®

Combivent Respimat®

Daliresp®



Global Strategy for Diagnosis, Management and Prevention of COPD

Combined Assessment of COPD

*When assessing risk, choose the **highest** risk according to GOLD grade or exacerbation history. One or more hospitalizations for COPD exacerbations should be considered high risk.)*

Patient	Characteristic	Spirometric Classification	Exacerbations per year	CAT	mMRC
A	Low Risk Less Symptoms	GOLD 1-2	≤ 1	< 10	0-1
B	Low Risk More Symptoms	GOLD 1-2	≤ 1	≥ 10	≥ 2
C	High Risk Less Symptoms	GOLD 3-4	≥ 2	< 10	0-1
D	High Risk More Symptoms	GOLD 3-4	≥ 2	≥ 10	≥ 2

Global Strategy for Diagnosis, Management and Prevention of COPD

Therapeutic Options: COPD Medications

Beta$_2$-agonists
Short-acting beta$_2$-agonists
Long-acting beta$_2$-agonists
Anticholinergics
Short-acting anticholinergics
Long-acting anticholinergics
Combination short-acting beta$_2$-agonists + anticholinergic in one inhaler
Combination long-acting beta$_2$-agonists + anticholinergic in one inhaler
Methylxanthines
Inhaled corticosteroids
Combination long-acting beta$_2$-agonists + corticosteroids in one inhaler
Systemic corticosteroids
Phosphodiesterase-4 inhibitors

Global Strategy for Diagnosis, Management and Prevention of COPD

Manage Stable COPD: Non-pharmacologic

Patient Group	Essential	Recommended	Depending on local guidelines
A	Smoking cessation (can include pharmacologic treatment)	Physical activity	Flu vaccination Pneumococcal vaccination
B, C, D	Smoking cessation (can include pharmacologic treatment) Pulmonary rehabilitation	Physical activity	Flu vaccination Pneumococcal vaccination

Global Strategy for Diagnosis, Management and Prevention of COPD

Manage Stable COPD: Pharmacologic Therapy

(Medications in each box are mentioned in alphabetical order, and therefore not necessarily in order of preference.)

Patient	RecommendedFirst choice	Alternative choice		Other Possible Treatments
A	SAMA prn *or* SABA prn	LAMA *or* LABA *or* SABA and SAMA		Theophylline
B	LAMA *or* LABA	LAMA and LABA		SABA *and/or* SAMA Theophylline
C	ICS + LABA *or* LAMA	LAMA and LABA *or* LAMA and PDE4-inh. *or* LABA and PDE4-inh.		SABA *and/or* SAMA Theophylline
D	ICS + LABA *and/or* LAMA	ICS + LABA and LAMA *or* ICS+LABA and PDE4-inh. *or* LAMA and LABA *or* LAMA and PDE4-inh.		Carbocysteine *SABA and/or* SAMA Theophylline

Global Strategy for Diagnosis, Management and Prevention of COPD

Manage Exacerbations: Treatment Options

Oxygen: titrate to improve the patient's hypoxemia with a target saturation of 88-92%.

Bronchodilators: Short-acting inhaled beta$_2$-agonists with or without short-acting anticholinergics are preferred.

Systemic Corticosteroids: Shorten recovery time, improve lung function (FEV_1) and arterial hypoxemia (PaO_2), and reduce the risk of early relapse, treatment failure, and length of hospital stay. A dose of 40 mg prednisone per day for 5 days is recommended .

Global Strategy for Diagnosis, Management and Prevention of COPD

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Global Strategy for Diagnosis, Management and Prevention of COPD

Manage Exacerbations: Treatment Options

Antibiotics should be given to patients with:

- Three cardinal symptoms: increased dyspnea, increased sputum volume, and increased sputum purulence.
- Who require mechanical ventilation.

Global Strategy for Diagnosis, Management and Prevention of COPD

Manage Exacerbations: Treatment Options

Noninvasive ventilation (NIV) for patients hospitalized for acute exacerbations of COPD:

- Improves respiratory acidosis, decreases respiratory rate, severity of dyspnea, complications and length of hospital stay.
- Decreases mortality and needs for intubation.

 GOLD Revision 2011

Global Strategy for Diagnosis, Management and Prevention of COPD

Therapeutic Options: Other Treatments

Palliative Care, End-of-life Care, Hospice Care:

- Communication with advanced COPD patients about end-of-life care and advance care planning gives patients and their families the opportunity to make informed decisions.

Heart Failure

Shortness of breath ?
Edema?
Hypoalbuminemia?
Renal function?
Hepatic function?
Spironolactone?

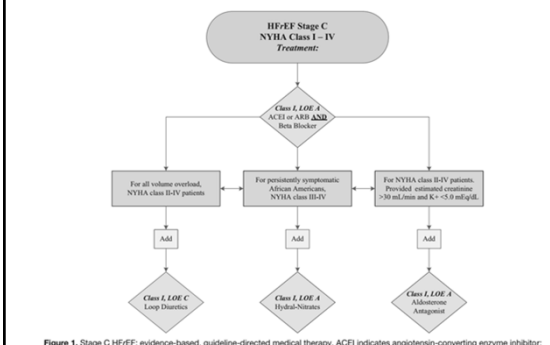

Figure 1. Stage C HFrEF: evidence-based, guideline-directed medical therapy. ACEI indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin-receptor blocker; HFrEF, heart failure with reduced ejection fraction; Hydral-Nitrates, hydralazine and isosorbide dinitrate; LOE, Level of Evidence; and NYHA, New York Heart Association.

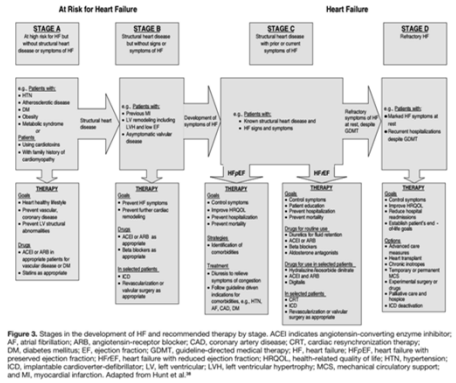

Figure 3. Stages in the development of HF and recommended therapy by stage. ACEI indicates angiotensin-converting enzyme inhibitor; AF, atrial fibrillation; ARB, angiotensin-receptor blocker; CAD, coronary artery disease; CRT, cardiac resynchronization therapy; DM, diabetes mellitus; EF, ejection fraction; GDMT, guideline-directed medical therapy; HF, heart failure; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HRQOL, health-related quality of life; HTN, hypertension; ICD, implantable cardioverter-defibrillator; LV, left ventricular; LVH, left ventricular hypertrophy; MCS, mechanical circulatory support; and MI, myocardial infarction. Adapted from Hunt et al.[34]

Remember

" It is neither immoral nor unethical to think about the cost of therapy!"

M.Mihalyo

Questions?

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