HOSPICE PHARMACY INSIGHTS

AUGUST 11TH, 2020

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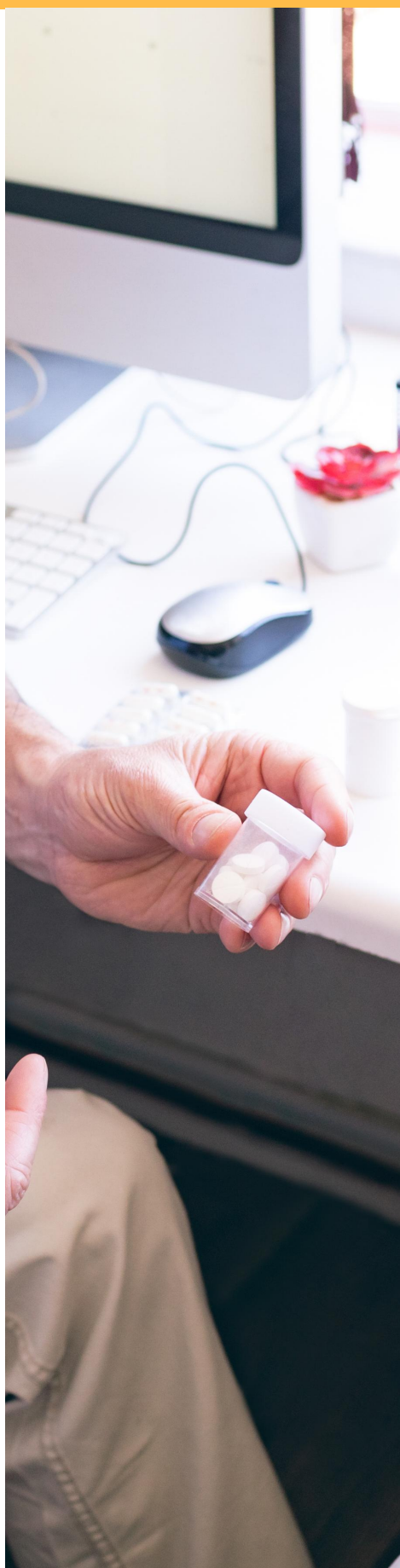
FOR YOUR CONSIDERATION

DEPRESCRIBING: SHARED DECISION MAKING



In a JAMA Neurology article in April 2020 they recognized that "The emerging field of deprescribing—the systematic process of discontinuing drugs where harms outweigh benefits in the context of an individual patient's values—seeks to rescue patients and clinicians alike." In a query of prescribing and deprescribing the ratio of hits was 120 to 1. As you can see good clinical information on deprescribing is scarce at best.

As hospice professionals we have been deprescribing for years because many of our patients come to hospice on 10-20+ medications per day. Many of those patients are not only elderly but are often frail and debilitated as well. These factors significantly increase the risk for drug/drug interactions, adverse events, etc. This makes one of our first tasks to review medications to determine which are either doing nothing or are causing harm. Then to devise a plan to appropriately deprescribe those medications.

With this in mind, we have been keeping a close watch on the clinical research for anything that supports and enhances our clinical practice of deprescribing. Recently I came across a research article, "A concept analysis of deprescribing medications in older people" (see below for full citation). As a nurse I appreciate algorithms and stepwise processes that assist me in being a better clinician and provide better care to my patients. In this research article I found a couple of multi-step processes that I hope you will find useful as you consider deprescribing for your patients.

"Deprescribing is a variation from the status quo and is thus perceived as an active intervention. This perception of deprescribing as an active intervention differentiates it from simply omitting a medication without careful consideration. Structured and iterative processes involving multiple steps underpin deprescribing interventions. The steps are often presented in a linear fashion, but it is an iterative process. In 'Deprescribing: a guide for medication reviews', we recently described the multi-step, co-operative process to deprescribing (Steps One to Five below). The BMJ recently published a review on the need for health professionals and consumers to discuss deprescribing as a shared decision-making process. In this review, they outlined the steps A, B and C below, which are needed to discuss deprescribing with consumers to facilitate a shared decision. The combined steps from these papers detail the process."

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STEP 1.

IIdentify people suitable for deprescribing

STEP 2.

Take a medicine-focused history.

STEP 3.

Write a medicine withdrawal plan:

- Step A: Creating awareness that options exist.
- Step B: Discussing the options and their benefits and harms.
- Step C: Exploring patient preferences for the different options.

STEP 4.

Stop the medicines according to the plan.

STEP 5.

Monitoring and follow-up.

The CEASE acronym is a mnemonic for the steps involved in the deprescribing process.

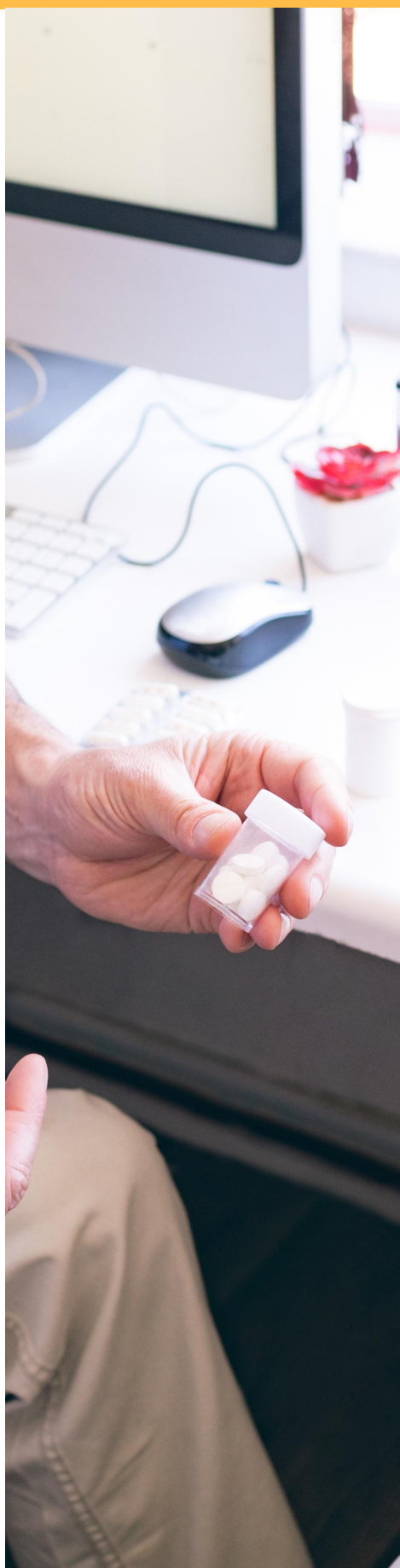
Current medications : undertake a medication reconciliation

Elevated risk : consider the potential risk from each medication

Assess : assess the potential benefit and harm from each medication, and the patient values and preferences

Sort : prioritize medications for cessation

Eliminate : implement cessation and monitor



REGULATORY CENTER

CMS MEDICAL REVIEW AUDITS RESUME

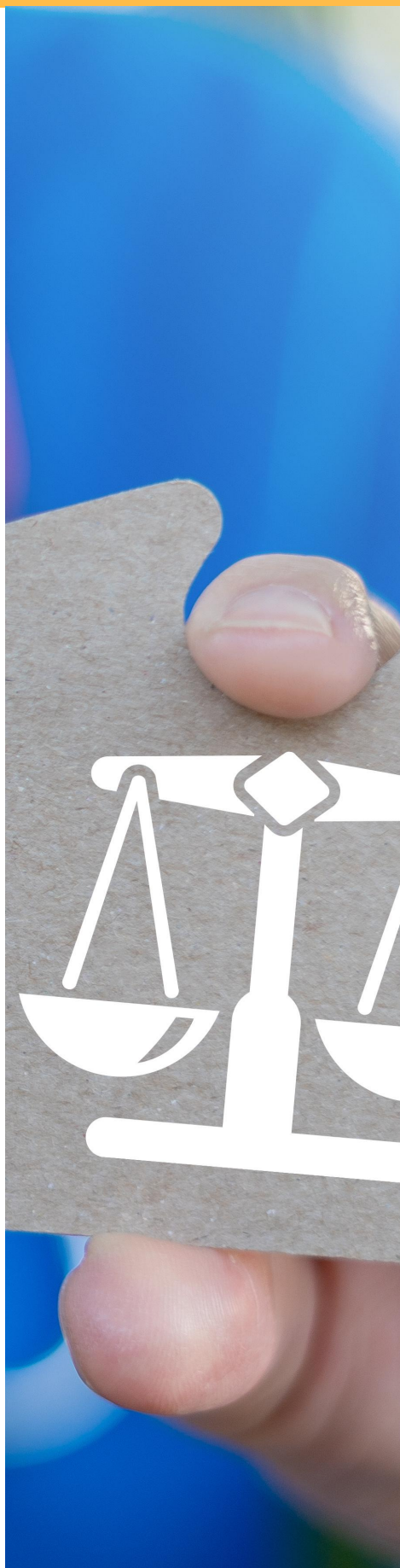
As states reopen and given the importance of medical review activities to CMS' program integrity efforts, CMS expects to discontinue exercising enforcement discretion beginning on August 3, 2020, regardless of the status of the public health emergency. If selected for review, providers should discuss with their contractor any COVID-19-related hardships they are experiencing that could affect audit response timeliness. CMS notes that all reviews will be conducted in accordance with statutory and regulatory provisions, as well as related billing and coding requirements. Waivers and flexibilities in place at the time of the dates of service of any claims potentially selected for review will also be applied.

REQUEST FOR DELAY IN IMPLEMENTATION OF ELECTION STATEMENT & ADDENDUM

NHPCO and NPHI have requested that CMS delay the implementation of the NOE and Addendum. Both organizations have informed the MACs of their request to CMS. However, the MACs reported that they have not received any communication from CMS regarding a delay; they are planning educational sessions in August regarding the implementation of the election statements and addendum.

PUBLIC HEALTH EMERGENCY EXTENSION

Health and Human Services (HHS) officials have announced an extension of the public health emergency brought on by COVID-19 through October 22, 2020. Officials anticipate that HHS will grant another extension of the public health emergency through January 20, 2021. This means that any of the waivers granted to hospice will remain in place through these dates.



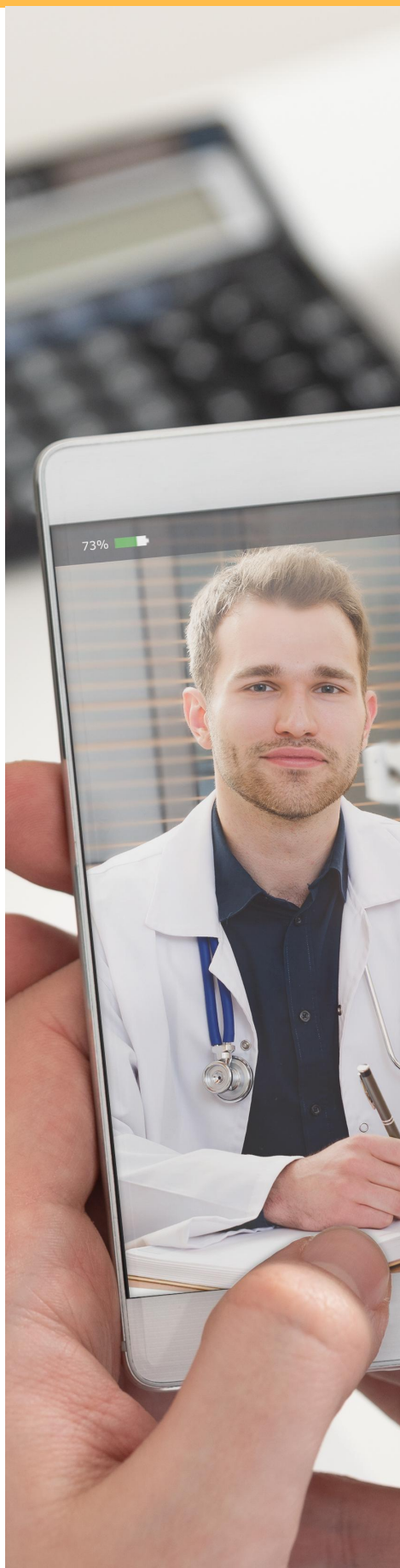
IN CASE YOU WERE WONDERING

THE IMPACT OF TELEHEALTH DURING COVID-19

The Centers for Medicare and Medicaid Services (CMS) administrator Seema Verma shared the following information in an article in the July 15th Health Affairs blog:

KEY COMMENTS:

- More than 9 million Medicare beneficiaries received telehealth services between March and mid-June.
- Thirty-five percent of beneficiaries in the Northeast received telehealth services, compared to fewer than 17% in the Midwest and West.
- There was little difference related to the use of telehealth by age group or ethnicity.
- The use of audio-only telecommunications has proven helpful for patients who have not had access to or comfort with video encounters.
- Telehealth will not replace the "gold standard" of in-person care but will serve as an additional access point for patients.
- CMS is "assessing the temporary changes made and assessing which of these flexibilities should be made permanent through regulatory action" based on health outcomes, spending, and impact on the healthcare delivery system.
- CMS is assessing how Medicare payments should be established in the future and how program integrity can be protected from the potential for abuse of telehealth services.
- **There is no mention of support for future legislation that would enable payment for home health or hospice telehealth services.**



Updated August 2020

DRUG SHORTAGE LIST

- **Albuterol (MDI)** — **7/2/20**
- **Atropine (Inj/Opth)** — **7/21/20**
- **Azithromycin (Inj)** — **7/16/20**
- **Dexamethasone (Inj)** — **7/20/20**
- **Dicyclomine (oral)** — **6/26/20**
- **Doxycycline Hyclate** (Inj) — **6/30/20**
- **Enoxaparin** (Inj) — **6/5/20**
- **Erythromycin** (Inj/Opth) — **6/23/20**
- **Famotidine** (Inj/Tabs) — **6/30/20**
- **Fentanyl** (Inj) — **6/26/20**
- **Furosemide** (Inj/Oral) — **7/20/20**
- **Heparin** (Inj) — **7/20/20**
- **Hydromorphone** (Inj) — **7/20/20**
- **Hyoscyamine** (Inj) — **7/20/20**
- **Ketamine** (Inj) — **7/20/20**
- **Ketorolac** (Inj — **7/20/20**
- **Levetiracetam** (Inj/Tablets) — **7/14/20**
- **Lorazepam** (Inj/Oral) — **5/26/20**
- **Losartan** (Tabs) — **7/17/20**
- **Methadone** (Inj) — **6/26/20**
- **Metronidazole** (Inj) — **5/21/20**
- **Midazolam** (Inj) — **7/20/20**
- **Morphine** (Inj/PCA vials/IR/tabs) — **7/14/20**
- **Nitrofurantoin** (Suspension) — **7/1/20**
- **Octreotide** (Inj) — **7/29/20**
- **Ondansetron** (HCL (Inj) — **6/19/20**
- **Pantoprazole** (Inj) — **6/19/20**
- **Prednisone** (Tablets) — **7/1/20**
- **Prochlorperazine** (Tablets) — **6/30/20**
- **Promethazine** (Inj) — **5/28/20**
- **Sertraline** (Tablets) — **7/7/20**
- **Temazepam** (Capsules) — **7/9/20**
- **Tramadol** (Tablets) — **4/22/20**
- **Valsartan** (Tablets) — **6/12/20**
- **Vancomycin HCL** (Inj) — **7/14/20**
- **Venlafaxine HCL** (Tablets ER) — **7/10/20**
- **IVBags/Solutions** (various) — **7/20/20**