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1. COMMON DRUG-DRUG INTERACTIONS AMONG MEDICATIONS USED AT THE END OF LIFE.

The average elderly person is taking 7 or more prescription medications per day.1 As the number of medications increase, so does the incidence of drug-drug interactions. It is estimated that 46% of elderly patients are at risk of a drug-drug interaction with their current medication regimen. Being aware of the most common drug-drug interactions as well as reviewing each medication with a pharmacist can help decrease the risk of a patient experiencing an adverse drug event due to a drug-drug interaction.

A severity rating is often used with drug-drug interactions to provide the healthcare professional a quick reference as to the severity of the interaction. For this article, the severity rating for each drug-drug interaction was obtained from LexiComp Online Drug Interaction Checker Database accessed June 2014. The chart in TABLE 1 below provides a key to the severity rating for the rest of this article. The LexiComp Online medication database is available to all Delta Care Rx clients at no charge via the eTools link.

<table>
<thead>
<tr>
<th>SEVERITY RATING</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>No known drug-drug interaction.</td>
<td>No action needed for this drug-drug interaction.</td>
<td>Monitor therapy for this drug-drug interaction.</td>
<td>Consider therapy modification for this drug-drug interaction.</td>
<td>Avoid combination of these medications.</td>
</tr>
</tbody>
</table>

As healthcare professionals, we are quick to start an antibiotic for a patient who displays the signs or symptoms of an infection. In an attempt to start the antibiotic as soon as possible, it is easy to overlook a potential drug-drug interaction between the antibiotic and the patient’s current medication regimen. more
This interaction appears to be more prominent with erythromycin compared to other macrolide antibiotics. However, the interaction between all macrolide antibiotics and warfarin is highly probable and often delayed. Monitor the patient for any signs or symptoms of a bleed. Consider decreasing the warfarin dose by 25-50% during the antibiotic administration.

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>INTERACTION</th>
<th>SEVERITY RATING</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoroquinolone Antibiotics (ciprofloxacin, levofloxacin) - Supplements Containing Aluminum, Calcium, or Magnesium</td>
<td>Decrease the efficacy of the antibiotic.</td>
<td>D</td>
<td>When taken within 2 hours of each other, the calcium will bind (called chelation) to the antibiotic resulting in decreased absorption of the antibiotic in the body. This can lead to treatment failure of the antibiotic and continued infection. Avoid taking any calcium containing products (including dairy and multivitamins) within 2 hours before or after the administration of the quinolone antibiotic.</td>
</tr>
<tr>
<td>Fluoroquinolone Antibiotics (ciprofloxacin, levofloxacin) - Theophylline</td>
<td>Decreased theophylline clearance resulting in toxicity.</td>
<td>D</td>
<td>Fluoroquinolone antibiotics can inhibit the ability for theophylline to be excreted from the body resulting in increased theophylline levels. The drug-drug interaction appears to be more prominent with ciprofloxacin than with levofloxacin or moxifloxin. The recommendation would be to decrease the theophylline by 25-50% while on a fluoroquinolone antibiotic.</td>
</tr>
<tr>
<td>Macrolide Antibiotics (azithromycin, erythromycin) - Warfarin (Coumadin)</td>
<td>Increased effects of warfarin.</td>
<td>C</td>
<td>This interaction appears to be more prominent with erythromycin compared to other macrolide antibiotics. However, the interaction between all macrolide antibiotics and warfarin is highly probable and often delayed. Monitor the patient for any signs or symptoms of a bleed. Consider decreasing the warfarin dose by 25-50% during the antibiotic administration.</td>
</tr>
<tr>
<td>Metronidazole (Flagyl) - Alcohol</td>
<td>Nausea, vomiting, abdominal cramping, and flushing</td>
<td>X</td>
<td>The co-administration of metronidazole and an alcohol beverage will lead to significant GI upset. Advise patients of this potential drug-drug interaction as they might not always disclose alcohol consumption to the health care professional. Recommend to wait for 24 hours after the last dose of metronidazole prior to having an alcoholic beverage.</td>
</tr>
<tr>
<td>Sulfamethoxazole/Trimethoprim (Bactrim) - Warfarin (Coumadin)</td>
<td>Increased effects of warfarin.</td>
<td>D</td>
<td>This interaction is considered a delayed interaction and you might not see an increase in INR until after the patient has finished the course of the antibiotic. It is best to try to avoid this combination. If this is not possible, then reduce the dose of warfarin by 50% during the antibiotic administration and for one week following completion of the antibiotic.</td>
</tr>
</tbody>
</table>

Many hospice patients have a diagnosis of end stage cardiac or have a comorbid condition of cardiac disease. As these patients decline, many cardiac medications are adjusted as their condition declines. Adding or discontinuing a cardiac medication can affect the systemic concentration of another medication.

## TABLE 3: COMMON CARDIAC-DRUG INTERACTIONS

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>INTERACTION</th>
<th>SEVERITY RATING</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE Inhibitors (lisinopril) – Potassium Supplements</td>
<td>Elevated serum potassium levels</td>
<td>C</td>
<td>Potassium levels greater than 5.0 mmol/L should be monitored carefully due to risk of severe hyperkalemia and EKG changes. Watch renal function (BUN, SCr) also. Adjust potassium supplementation if levels increase.</td>
</tr>
<tr>
<td>ACE Inhibitors (lisinopril) – Spironolactone (Aldactone)</td>
<td>Elevated serum potassium levels</td>
<td>C</td>
<td>Potassium levels greater than 5.0 mmol/L should be monitored carefully due to risk of severe hyperkalemia and EKG changes. Watch renal function (BUN, SCr) also. Adjust potassium supplementation if levels increase.</td>
</tr>
<tr>
<td>Anticholinergic Medications (benzodiazepines, oxotremorine, scopolamine, TCAs) – Potassium Supplements (tablet dosage from only)</td>
<td>Anticholinergic Agents may enhance the ulcerogenic effect of potassium chloride.</td>
<td>X</td>
<td>Solid oral dosage forms of potassium chloride are contraindicated in patients with impaired gastric emptying (e.g., due to the effects of drugs such as many anticholinergics). Patients on drugs with substantial anticholinergic effects should avoid using any solid oral dosage form of potassium chloride; liquid or effervescent potassium preparations are possible alternatives.</td>
</tr>
<tr>
<td>Digoxin (Lanoxin) – Amiodarone (Cordarone, Pacerone)</td>
<td>Potential for digoxin toxicity</td>
<td>D</td>
<td>Monitor for signs and symptoms of digoxin toxicity (abdominal pain, anorexia, bizarre mental symptoms in the elderly, blurred vision, bradycardia, confusion, delirium, depression, diarrhea, disorientation, drowsiness, fatigue, hallucinations, halos around lights, visual acuity, mydriasis, nausea, neuralgia, nightmares, personality changes, photophobia, restlessness, vertigo, vomiting, and weakness).</td>
</tr>
<tr>
<td>Digoxin (Lanoxin) – Verapamil (Calan)</td>
<td>Potential for digoxin toxicity</td>
<td>C</td>
<td>Monitor for signs and symptoms of digoxin toxicity (abdominal pain, anorexia, bizarre mental symptoms in the elderly, blurred vision, bradycardia, confusion, delirium, depression, diarrhea, disorientation, drowsiness, fatigue, hallucinations, halos around lights, visual acuity, mydriasis, nausea, neuralgia, nightmares, personality changes, photophobia, restlessness, vertigo, vomiting, and weakness).</td>
</tr>
</tbody>
</table>

Submitted by: Lorin Yolch, PharmD, CGP, FASCP, Director of Professional Education at Delta Care Rx.

References:
2. DEMENTIA & NEW ONSET OF SEIZURES: AN OFTEN UNRECOGNIZED EVENT.

Dementia is a common terminal diagnosis and significantly contributes to a patient’s cognitive decline. There are many signs and symptoms of dementia including memory loss, impaired judgment, difficulties with abstract thinking, faulty reasoning and inappropriate behavior. However there is another symptom that is common with advanced dementia that is often over looked. That event is seizures. Seizures are most likely to arise in the later stages of Alzheimer’s disease, the most common cause of dementia.

Seizures are likely to begin 6 years after the onset of dementia and often go undiagnosed. In dementia patients a protein called beta amyloid collects in the brain and forms a plaque. Researchers suggest the plaque changes brain chemistry therefore resulting in increased risk of seizure.

The signs and symptoms of these types of seizures are often misdiagnosed and associated with disease progression. This can be a very traumatic event for these patients. The most likely type of a seizure for a dementia patient to experience is a partial complex seizure. These seizures can last for 1 to 2 minutes and may include blank stare with loss of awareness, lip smacking, picking at clothing, rapid eye movement. When these events occur, we often consider this a behavioral disturbance. However this is not the correction assumption most of the time.

Treatment of seizures in dementia patients can be difficult due to the fragile nature of the patient. When considering treatment for elderly patients with dementia it is imperative to remember it may be difficult for them to tolerate the medication regimen. The benefit of anti-epileptic drug therapy needs to outweigh the risk. Elderly patients are more inclined to develop drug induced cognitive impairment. Particularly in these patients it may be difficult to recognize the adverse effects of anti-epileptic drugs and therefore mistaken with disease advancement. Patient should be initiated on lower doses of drug therapy. Reduced protein binding, hepatic, renal function and nutrition should all be considered for proper dosing of medication.

Submitted by: Irene Petrides, PharmD, Hospice Clinical Pharmacist at Delta Care Rx.

References:

3. PALLIATIVE SEDATION: A LAST RESORT FOR SYMPTOM MANAGEMENT.

Palliative sedation remains a legal option for terminally ill patients that are experiencing intractable suffering at the end of life. While there remains much debate over euthanasia and physician assisted suicide, palliative sedation allows the patient to die from the underlying disease. Though the interdisciplinary hospice team is well equipped to manage and help alleviate a patient’s pain and suffering, this is not attainable for every patient all the time. In diseases such as Huntington’s chorea, ALS, cancer and even those with severe psychological disorders, palliative sedation can come into play when first line therapies fail to relieve suffering. Symptoms that palliative sedation can alleviate include: pain, nausea, delirium, and dyspnea. In June of 2008, The American Medical Association gave their approval of the use of palliative sedation for terminally ill patients as a last resort. They also report that “between 5% and 35% of hospice patients have intractable symptoms in the last week of life.”

Before palliative sedation can occur, there are legal requirements that must take place. First, there must be informed consent: the physician explains to the patient and family what will happen and discusses the risks and benefits. Informed consent is documented and the patient or power of attorney must sign. Congress has mandated that Risk Evaluation and Mitigation Strategies (REMS) also takes place. In some cases, an evaluation by an ethics committee may also be done. Once the patient has been deemed appropriate and all legal proceedings have occurred, sedation may begin.

Benzodiazepines are the drug of choice for palliative sedation, and the most commonly used is midazolam (Versed). Midazolam has a short half-life (1-5 hours) and therefore may be titrated easily. It also is water soluble, however, metabolized to a lipophilic compound that can easily penetrate the CNS to cause sedation. Midazolam should be administered IV or SQ continuously for desired effect.

Another rapidly acting drug that can be used to achieve sedation is propofol (Diprivan), though is more labor intensive than midazolam. Propofol is both quick to titrate as well as washout. The drug is available as an emulsion, which can grow microorganisms. Patients on propofol therapy are at risk of developing Propofol Infusion Syndrome (PIS), which can be fatal. Propofol should only be administered in the hospice inpatient or hospital setting.

Other drugs of note include chlorpromazine (Thorazine), phenobarbital, and lorazepam (Ativan). Chlorpromazine would be appropriate for a patient that has delirium, however, it has the risk of many side effects including paradoxical reactions and extrapyramidal symptoms. This drug also may lower the seizure threshold. Phenobarbital is more common in hospice and is useful when a patient is unresponsive to or intolerant of benzodiazepines. Lorazepam has a longer onset of action as well as longer half-life, which makes it more difficult to titrate. Also, lorazepam injectable vials contain benzyl alcohol and cannot be used on a pediatric patient.
The level of sedation maintained should be the lowest effective dose that relieves suffering. This practice is twofold: it reduces the risk of adverse effects as well as increase the change of remaining interactive with family and practitioners. It is important to remember that opioids are not to be used as sedatives in palliative sedation, however they are still administered for pain control and to prevent withdrawal.\textsuperscript{2,3}

\textbf{Submitted by:} Michelle Mikus, PharmD, Hospice Clinical Pharmacist at Delta Care Rx and Pharmacy Manager at ProCure Pharmacy.

\textbf{References:}
4. PREVENTING INFECTION: USING GOOD TECHNIQUE WITH MULTI-DOSE VIALS.

The Joint Commission recently published a Sentinel Event Alert reminding healthcare professionals of the risk of infection from the misuse of injectable vials. A sentinel event is defined as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury includes loss of limb or function. The term ‘sentinel’ is used as these events signal the need for immediate investigation and response.

The Joint Commission reports that thousands of patients have been adversely affected by the misuse of injectable vials. The misuse of these vials has led to sentinel events including outbreaks of bloodborne pathogens and associated infections which include hepatitis B and C virus, meningitis and epidural abscesses. These type of infections have been seen in both the inpatient and outpatient settings.

We all need to remember to practice safe and aseptic techniques in regards to multi-dose vials to decrease the risk of infection related sentinel events.

EFFECTIVE PROCESS & PROCEDURE for MULTIPLE-USE VIALS

- Only vials clearly labeled by the manufacturer for multiple use be used more than once.
- Limit the use of a multiple-dose vial to only a single patient, whenever possible, to reduce the risk of contamination.
- When multiple vials are used more than once, use a new needle and new syringe for each entry. Do not leave needles or other objects in the vial entry diaphragm between uses, as this may contaminate the vials contents.
- Disinfect the vial’s rubber septum before piercing by wiping (and using friction) with sterile 70% isopropyl alcohol, ethyl/ethanol alcohol, iodophor or other approved antiseptic swab. Allow the septum to dry before inserting a needle or other device into the vial.
- Once a multiple-dose vial is punctured, it should be assigned a “beyond-use” date. The beyond-use date for an opened or entered (eg: needle punctured) multiple-dose container with antimicrobial preservatives is 28 days, unless otherwise specified by the manufacturer.
- Store multiple-dose vials outside of the immediate patient treatment area; observe the manufacturer’s storage recommendations.

Submitted by: Lorin Yolch, PharmD, CGP, FASCP, Director of Professional Education at Delta Care Rx.

Reference:

5. DISCONTINUING LIPID LOWERING AGENTS IN END OF LIFE CARE.

Hyperlipidemia is a chronic condition that is often managed pharmacologically. Statin medications that are often used to treat hyperlipidemia include atorvastatin (Lipitor), pravastatin (Pravachol), rosuvastatin (Crestor) and simvastatin (Zocor). Hyperlipidemia is not considered to be life threatening nor contribute to a hospice patients 6 month or less prognosis. This condition does not present its self with symptom management issues that would need to be palliated. However, most patients in the hospice setting continue to be treated with lipid lowering medications. Hospice Clinical Pharmacists often make the following statement in their recommendations, “Please consider discontinuing this cholesterol medication as it is considered non-essential in end of life care.”

A few questions arise as to why we should discontinue statin therapy and if we have any information to validate this difficult conversation with the prescriber, the patient and the caregiver. This can be especially true now that most of these medications are available generically and are fairly in-expensive.

In a population where poly-pharmacy and dysphagia can be an issue, we are presented with an opportunity to discontinue unnecessary medications. Several reasons contribute as to why we should discontinue a statin medication including side effects, minimal benefit in a time frame of 6 months, and now recent findings have shown a possibility of increased onset of diabetes. A statin or other lipid lowering agents are considered a preventative medication and not palliative in nature. Lipid management medications do not provide any comfort or symptom relief.

In the elderly population, there are several pharmacokinetic and pharmacodynamic changes that should be considered. All patients on statin therapy require periodic lab work including liver function tests. A blood draw is considered invasive and not routinely preformed in end of life care. Also, elderly patients have decreased serum protein levels, and are therefore more susceptible to adverse effects. Because statins are highly protein bound a decrease in serum protein results in higher concentrations of the drug, resulting in an increased risk for toxicity. One of the symptoms of statin toxicity include muscle pain. A patient experiencing severe muscle pain, and on statin therapy, should have the statin discontinued.
Pharmacists at Delta Care Rx.

Submitted by: Irene Petrides, PharmD, Hospice Clinical Pharmacist at Delta Care Rx.

References:

6. ABH TOPICAL GEL: A COMBINATION CONUNDRUM.

For terminally ill patients that experience nausea and vomiting, or those that are unable to swallow oral medications, using a topical formulation of drugs seems like a viable option. In fact, topical ABH gel has become quite common for patients to use because of just that. ABH (or any combination of A, B, H, and sometimes R) contains Ativan (lorazepam), Benadryl (diphenhydramine), Haldol (haloperidol), and Reglan (metoclopramide) – drugs that are commonly used orally to treat nausea and vomiting, however, are these drugs absorbed topically? Pharmacokinetics (what the body does to a drug after it is administered) goes hand in hand with absorption and distribution in the body. This begs the question: “are the drugs in ABH gel absorbed from the skin?”

In May 2012, The Journal of Pain and Symptom Management published an article titled “ABH Gel Is Not Absorbed From the Skin of Normal Volunteers.” This article details a controlled trial that Johns Hopkins Medical Center and the Virginia Commonwealth University Massey Cancer Center completed in order to answer the above stated question. After volunteers were administered the topical formulation, blood levels of drug were taken at baseline, 30, 60, 90, 120, 180 and 240 minutes. Since the endpoints were objective, no bias was present. The results of this study showed, with statistical significance, that sub-therapeutic levels of each drug was measured. In layman’s terms: not enough of the drugs are absorbed for it to be effective at reducing nausea and vomiting.

Another study, published in 2006 and titled “Initial Selection of Antiemetics in End-of-Life Care: A Retrospective Analysis,” concluded that both topical ABHR gel and ABHR suppositories were effective at reducing a patients nausea and vomiting. The difference between the two studies are the end points. In the 2012 study, blood levels of drug were measured, whereas the 2006 study used nausea and vomiting relief as an end point. If sub-therapeutic concentrations of the ingredients in ABH gel were absorbed, then why does it seem like the compound is effective at reducing the incidence of some patient’s symptoms? There are postulated answers concerning this question surrounding the inner wrist (where ABH/ABHR gel is most commonly applied) being an acupressure point – this is recognized by the National Institute of Health. This hypothesis was tested in a pilot study where patients were randomized and one group given motion sickness bands. Those with the bands utilized antiemetics less frequently and required less frequent dose increases.

Another finding conducted by pharmacists concluded that there was an increased risk of diabetes that was not dose dependent of statin therapy, particularly in the elderly population. This study included over 470,000 patients aged 66 and older for a time span of almost 3 years. In a population where diabetic testing and lab work is not routine and rather invasive and uncomfortable, this presents yet another reason to discontinue lipid lowering agents.

It is important to remember to ask ourselves if we are treating short term goals versus long term goals in the hospice population. Does the benefit outweigh the risk of staying on these lipid lowering drugs? These are all questions we need to be asking ourselves as health care providers. When making a bold statement such as discontinue this medication as for this is not essential, it is important to remember many patients and family member are not ready to do so. However providing valid information may ease the decision process and therefore improve patient quality of life. This should be handled as a case by case scenario and every patient should be looked at individually.

Submitted by: Michelle Mikus, PharmD, Hospice Clinical Pharmacist at Delta Care Rx and Pharmacy Manager at ProCare Pharmacy.

Reference:
Anthracyclines are a class of chemotherapy used to treat a variety of cancers. This class of chemotherapy, however, has a well-documented cardiotoxicity that limits its long-term use. This cardiotoxicity presents as a heart failure-like cardiomyopathy, with left ventricular dysfunction and a decreasing left ventricular ejection fraction (LVEF). Specifically, cardiotoxicity is defined by the international oncological guidelines as a decrease in left ventricular ejection fraction greater than 10 percent below its normal limit of 50 percent. The mechanism by which this toxicity is caused is not fully understood. It is thought to be due to anthracyclines producing free radicals, causing mitochondrial dysfunction and iron- and calcium-handling abnormalities, resulting in apoptosis.

Research has focused on the use of angiotensin-converting enzyme (ACE) inhibitors for the prevention of anthracycline-induced cardiomyopathy. Although the mechanism by which ACE inhibitors improve outcomes is not fully understood, it is proposed that ACE inhibitors affect the course of disease by their ability to limit oxidative stress and inhibit angiotensin II. Of the studies that have looked at prevention of anthracycline-induced cardiomyopathy with ACE inhibitors, these agents were started one month after the end of the last cycle of high-dose anthracycline chemotherapy and continued for one year. Enalapril was initiated at a dose of 2.5 mg once daily and increased gradually in three steps (5, 10, 20 mg, respectively) to 20 mg once daily. The dose was reduced for those who presented with hypotension. Results showed no clinically significant decrease in LVEF among all patients receiving ACE inhibitor therapy, as compared to 43 percent of patients not receiving therapy who experienced cardiotoxicity.

Additional research has been conducted studying the use of ACE inhibitors and beta blockers in the treatment of cardiomyopathy once a decrease in LVEF has occurred. One study conducted by the American College of Cardiology found that the use of ACE inhibitors alone or possibly with beta blockers, initiated after detection of LVEF impairment, was successful in achieving LVEF recovery and associated cardiac events reduction. Enalapril at a dose of 2.5 to 5 mg once or twice daily, gradually up-titrated to 20 mg per day, or to a maximal tolerated dose was studied. Carvedilol was also given if the patient was taking at least 5 mg per day of enalapril. In conclusion, early detection and treatment with an ACE inhibitor, with or without a beta blocker, are necessary for successful treatment of anthracycline-induced cardiomyopathy. Hospice clinicians should be diligent about determining the indication of a cardiac medication for an oncology patient who has been on an anthracycline chemotherapy.

Submitted by: Michael Stettner, PharmD, Hospice Clinical Pharmacist at Delta Care Rx.

References:
2013 and 2014 are proving to be very difficult times for a hospice industry experiencing CMS driven change at exponential rates.

Delta Care Rx clients are having no problem handling the mandatory transitions that became effective early in 2014.

In regards to CR 8358, our clients already have the necessary data, electronic medical record integrations, and custom report generation needed for support of their growing requirements. We have adapted quickly in a number of ways by our ability to precisely control every aspect of our state-of-the-art hospice specific pharmacy solution, and the proprietary software that operates it.

Delta clients are also easily & efficiently managing recent CMS directed changes to determining payment responsibility for drugs for patients, and changes to the complex relationship that exists between the hospice benefit and Medicare Part D.

If you’re a hospice struggling with the challenges listed above, we strongly encourage you and your team to take a look at Delta Care’s TRULY transparent and pass-through HOSPICE TAPER® Pharmacy Benefit Management (PBM) Services and our On-Demand Pharmacist Solutions (ODPS). The combination of these two core services, among many others available and included, are able to put YOUR hospice in a position to manage any challenges that present as this chaotic situation for the industry continues to evolve. Delta Care Rx can put your organization at ease from a clinical, financial, regulatory, and workflow efficiency perspective.

STORM SHELTER CHECKLIST:

Delta provides access to ALL of the data needed to be compliant with CMS CR 8358. Delta will help you get this information into your patient claim form in an automated fashion. Are you currently purchasing medications through a per diem? If so, how does your current provider manage the claim-by-claim cost requirements of CR 8358?

Are you certain that you can afford medications well into the future in light of the recent CMS directed changes to determining payment responsibility for drugs for hospice beneficiaries? Delta has demonstrated that traditional AWP discount-based pricing models, along with per diems, no longer work financially for the hospice industry. We can quantify this for you with a very simple apples to apples price comparison.

If you’re using a pharmacy benefit manager (PBM), do they offer TRUE transparency and the pass-through of all pharmacy network discounts? (Meaning: What YOU pay as the hospice is exactly what the dispensing pharmacist is reimbursed?) If so, are these terms clearly specified in your contract and fully auditable on-demand? Transparency is powerful, but very limited if not coupled with a fully auditable Rx purchasing contract that ensures the complete pass-through of ALL acquisition costs, rebates, and/or network discounts that the provider has access to.

Does your current provider have control over their pharmacy network obligations? Do they have their own proprietary software that manages patient’s pharmacy coverage? Do they have their own online reporting system that is NOT operated by a third party? Do you as the client have access to this software via tablet, smartphone, PC or MAC?

Does your current provider currently have a supplemental quality assessment program? Are they able to provide you with reporting that benchmarks you against other hospice organizations?

Does your current provider offer FREE DEA and SureScripts™ certified electronic prescribing, capable of creating and sending BOTH controlled and non-controlled medication orders directly to the dispensing pharmacy?

Delta has you covered.

Weather the growing storm. Contact Delta Care Rx to setup an informational webinar. www.deltacarerx.com / 1-855-335-8219