Discontinuing Medications: Dialogues for Nurses, Physicians, Patients & Families

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T&NMHO Annual Conference April 26, 2014
Objectives

• Identify principles of decision making about drug treatment in end of life care
• Describe strategies for communicating discontinuation of medications with patients/caregivers
• Describe communication strategies when addressing changes or discontinuing medications with healthcare providers
Why Is This Important?

- Medication risk outweighs benefit
- Lack of evidence to support continuation of therapy
- Does not meet patient plan of care
- Therapeutic benefit is diminished
- Polypharmacy
- Meeting Conditions of Participation (CoP) requirements for Medicare
Why Is This Important?

Cost of therapy

• For patients & families
• For hospice
• Hospice medication coverage and hospice payment structures
Discontinuing Medication Late in Life

Prioritize based on the following information:

- Remaining life expectancy
- Time until benefit
- Goals of care
- Treatment targets
A Model for Appropriate Prescribing

Medication Evaluation

The Medication Appropriateness Index:

- Indication?
- Effective?
- Correct dose and directions?
- Practical directions?
- Interactions? (with drugs or disease states)
- Duplications?
- Duration acceptable?
- Less expensive alternative available?
Medications: When to Stop?

Medications that either:

- Have limited evidence to be continued at end of life
  - Vitamins
  - Statins
- Lose efficacy as the disease trajectory changes
  - Acetylcholinesterase inhibitors
  - Pulmonary medications
  - Anticoagulants
  - Antidiabetic medications
What Medications Could be Considered for Discontinuation?
Antihyperlipidemic Medications

- Statins could reduce risk for vascular events after about 2 years of treatment and significantly reduce cardiovascular events at 5 years of therapy
- No additional palliative benefit
- Limited prevention of atherosclerotic heart disease with short prognoses
- Increased pill burden: patients with difficulty swallowing
- May require liver function testing
- Potential side effects: myopathy/rhabdomyolysis
Anticoagulants

Evaluate:

- Indication
- Prognosis
- Route of administration
- Bleeding risk
- Nutritional status
- Appropriate monitoring
- Medication adherence
- Medication changes
- Patient/family preferences

Will a new clot impair patient’s function or quality of life?
Anticoagulants

Prepare the patient and family

• Discuss “early”
• Provide options for potential changes in therapy
• Educate on patient decline (to help patient and family make their decision)
  o Decreased renal function
  o Decreased nutritional intake
  o Swallowing status
  o Increased bleeding risk
Dementia Medications

Typically, dementia has progressed beyond the point of benefit with these agents when:

- Patient has declined rapidly despite therapy
- Patient is no longer able to regularly make their needs known and/or ambulate by themselves
- Patient can no longer complete activities of daily living (ADLs) without assistance
- Functional Assessment Staging (FAST) score has progressed to a 7b or greater
Dementia Medications

• Appropriateness of these medications should be evaluated routinely

• Discussions should include:
  o Goals of care
  o Perceived benefit of treatment
  o Patient prognosis
  o FAST score
  o Eventual discontinuation when no longer beneficial
Dementia Medications

• What if there is resistance from family members?
  o Try a trial of a decreased dose and monitor for changes in the patient’s status or symptoms
  o If no change or improvement witnessed with decreased dose, the medication is no longer providing benefit and could be discontinued

• Should you titrate doses when discontinuing?
  o May consider titration, if possible
  o If patient is not swallowing, it may be appropriate to stop abruptly
Anti-Diabetic Medications

• The American Diabetes Association and the American Geriatric Society have stated that blood sugars need not be held to less than 180-200mg/dL for patients near the end of life. Many clinicians set the threshold at 250mg/dL.

• Tight glycemic control (fasting glucose <= 110mg/dL) near end-of-life carries the risk of hypoglycemic episodes.

• Managing blood sugar to 180-250mg/dL allows for lower doses or elimination of anti-diabetic medication and reduces risk of hypoglycemia.
Bisphosphonates

• It is not necessary to treat osteoporosis in hospice patients
• Esophageal erosions can occur if not taken with a full glass of water with patient remaining straight up for 30-60 minutes after administration
• Potential residual therapeutic effect after discontinuation appears to be sustained 2-5 years
• Patients should take calcium and vitamin D supplementation during therapy
Pulmonary Medications

Major concerns:

• Inability to properly use inhalers
  o Inhaler technique
  o Cognition

• Over utilization of beta-agonists and anticholinergics
  o Duplications of therapy
  o Increased risk of adverse effects
Pulmonary Medications

Signs and symptoms that a patient may have poor inhaler technique:

- Thrush
- Pneumonia
- Exacerbation
- Increased utilization
- Bed bound
- Agitation or delirium
Pulmonary Medications

End stage respiratory cycle

- Over use of beta-agonists and anticholinergics leads to increased systemic absorption and CNS stimulation
- Increases in release of catecholamines leads to increases in HR, decrease in oxygen exchange, and anxiety

↑ = Shortness of Breath

Image via Google images http://healthplusmi.kramesonline.com/Medications/3.C.82484
Vitamins and Supplements

- Limited evidence to be continued at end of life
- Offer little or no additional palliative benefit
- Increased pill burden
  - Troublesome for patients with difficulty swallowing
- Increased potential for drug-drug interactions
  - Calcium and iron can decrease absorption of other medications
  - Many herbal supplements increase bleeding risk with concomitant anticoagulants/anti-platelet medications
- Increased potential for side effects
  - Iron supplements can worsen constipation and nausea
Vitamins and Supplements

When might it be appropriate to continue vitamins and supplements?

• Folic acid during methotrexate therapy
• Thiamine and folic acid during acute alcohol withdrawal syndrome
• Iron supplementation during erythropoietin-stimulating agent therapy
Medications That May Need Tapering

• **Anti-depressants**
  - Paroxetine (Paxil®) and venlafaxine (Effexor®) are most difficult to discontinue
  - Fluoxetine (Prozac®) may not require taper because of long half-life

• **Anti-psychotics**
  - May need to taper one while titrating up another
  - Gradual dose reductions

• **Anti-epileptics**
  - Taper after new agent is at effective dose
  - Regardless of use for seizures, neuropathy, or behaviors
Medications That May Need Tapering

• **Beta-blockers**
  - Taper over 1-2 weeks

• **Clonidine (Catapres®)**
  - Taper over 1 week
  - If also taking beta-blocker, taper beta-blocker first

• **Tizanidine (Zanaflex®)**
  - Taper over 1-2 weeks if on longer term, higher doses

• **Baclofen**
  - Taper over 1-2 weeks
Corticosteroids, benzodiazepines, opioids

- All three classes should be tapered
- Unusual to discontinue in hospice
- Equivalent dosing strategies allow for rotation to alternative agents
- Ask for assistance from your medical director and/or pharmacist
What If There’s No Time to Taper?

• Be alert to side effects of abrupt withdrawal:
  o Rebound hypertension, tachycardia
  o Agitation
  o Seizures
  o Pain
  o Nausea
  o Sweating

• Rely on supportive care and comfort meds

• Contact medical director or pharmacist if concerned
How Do You Have These Conversations?

Communicating with patients, families, and other practitioners about letting go of medications
Communication Barriers

• Patient sense of abandonment
• Fear of losing control
• Fear of losing hope
• Importance of maintaining attending physician relationship
• Cultural concerns
  – Who is decision-maker?
  – Herbal supplements, home remedies?
How Do These Discussions Occur?

Patient Centered Care

Building

Understanding

Patient Centered Care

Informing

Listening

Developing
The BUILD Model

**B:** Build a foundation of trust and respect.

**U:** Understand what the patient and caregiver know about the medication and disease progression.

**I:** Inform the patient and caregiver of evidence-based information.

**L:** Listen to the patient’s and caregiver’s goals and expectations.

**D:** Develop a plan of care (POC) in collaboration with the patient and caregiver.
B-BUILD
A foundation of trust and respect with the patient and caregiver

Goal: affirm the patient and caregiver; listen more than you talk.
B-BUILD
A foundation of trust and respect with the patient and caregiver

Key phrases:

• “Thank you for taking the time to talk with me.”

• “You do a great job advocating for your mother.”

• “As you know, cancer doesn’t just happen to the patient; it impacts the entire family. This must be very difficult for you.”
Goal: learn the patient’s and caregivers’ understanding and expectations of the medications.

- Ask open-ended questions
- Facilitate the patient/family drawing their own conclusion that the medicine may no longer be effective
U – Understand
What the patient and caregiver know about the medication, disease

Key phrases:

• “What has your doctor told you about how this medicine works?

• “What do you think your mother will look like when the medicine is no longer effective?

• “How will you know it’s time to stop or change the medicine?”
Goal: provide evidence-based information in a non-threatening, non-coercive way.
I – Inform

The patient and caregiver about appropriateness of medications

Key phrases:

• “Here’s what we know about this medicine.”

• “As your disease progresses we will probably need to make some changes in your medications. What worked before may not work now.”

• “There are other medications that may be more helpful for you at this time.”
L – Listen
To the patient and caregiver as they share goals and expectations

**Goal**: learn what is important to the patient and family.
L – Listen
To the patient and caregiver as they share goals and expectations

Key phrases:

• “How can I be of help to you at this time?”

• “We can’t reverse or cure your disease, but there are many things we can do to provide comfort and quality-of-life. What does quality of life look like to you?”

• “Did your mother ever share her thoughts about what she would want if she had dementia?”
D – Develop
A POC in collaboration with the patient and caregiver

Goal: empower the patient/caregiver to direct their care

• Increases compliance with the POC
• Offers choices for the patient and caregiver
Key phrases:

• “Here are some choices: we can continue with the current regimen and not make any changes. Or, we can decrease the Aricept and re-evaluate your mother’s condition in one week.”

• “My job is not to make decisions for you, but to provide you with information so that you can make informed decisions. What questions do you have about what we’ve talked about?”

• “We will work in collaboration with you and your doctor. S/he still guides your care.”
Planned Discussions

• At time of admission
• Prior to recertification
• During a family or facility care conference
• When it’s time to re-order a medication that is regarded as delaying disease progression or no longer effective, i.e. riluzole, donepezil
• When filling the patient’s pillbox or ordering refills
Planned Discussions

• Change in location or level of care due to a change in patient condition:
  o Transfer to inpatient unit (IPU)
  o Transfer to an extended-care facility (ECF)
  o Continuous care initiated

• Whenever there is a need to change medications due to patient condition:
  o Patient having difficulty swallowing
  o Patient less responsive
Seizing the moment:

- “He takes pills all day long. No wonder he doesn’t have an appetite.”
- “It takes 20 minutes to get his pills in him.”
- “I’m having to use my inhaler more often, sometimes every 2 hours.”
- “I can’t even walk to the door anymore because I’m so short of breath.”
- “Mom doesn’t even say my name anymore.”
Creating the moment:

• “You take a lot of medications, I’m wondering if some may be causing side effects?”
• “With so many medications, I’m wondering if you ever prioritize the ones that are most important and skip others.”
• “I’m wondering if it’s difficult for you to think about discontinuing medications that your mother has taken for a long time.”
BUILD: Clinician Communication

- Building
- Patient Centered Care
- Understanding
- Informing
- Listening
- Developing
BUILD: Clinician Communication

• Collaboration with clinician

• Trust as a skilled practitioner
  o Both of you are doing the best for the patient

• Respect for the patient/prescriber relationship
  o Affirm the prescriber’s efforts, knowledge and commitment to the patient

• Evidence-based practices
  o Ask questions in IDT

• Information on patient condition
  o Paint a clear, succinct picture
Mrs. Shirley

- 80 y/o with lymphoma, anemia
- Primary caregiver for husband with dementia
- Recently stopped chemotherapy and considering hospice admission for extra help at home
- Weak, tired, short of breath
- Hgb not improving despite use of erythropoiesis stimulating agent, Procrit®

**How can you use the BUILD model to start a conversation about discontinuing Procrit®?**
Mrs. Shirley

Your discussion with Mrs. Shirley was effective, and she has agreed to stop Procrit®

*How can you use components of the BUILD model to effectively communicate with the prescriber?*
Summary

• Evaluate every medication for appropriateness
• Use resources to practice evidence-based medicine
• Practice effective communication
• Use the BUILD Model as a tool
  o Build, Understand, Inform, Listen, Develop!
Questions?

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References & Further Readings

- Cramer C. How to have difficult conversations with patients, families. Oncology Nursing Society, 37th Annual Congress.
References & Further Readings


• Common oral medications that may need tapering. Pharmacists Letter 2008;24:241208