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

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Objectives

• Identify principles of decision making about drug treatment in end of life care
• Construct communication strategies for discussing medication discontinuation with patients & caregivers
• Synthesize communication tactics for addressing changes or discontinuing medications with healthcare providers
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<tr>
<th>Why Is This Important?</th>
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<tr>
<td>• Medication risk outweighs benefit</td>
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<td>• Lack of evidence to support continuation of therapy</td>
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<td>• Does not meet patient plan of care</td>
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<td>• Therapeutic benefit is diminished</td>
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<td>• Polypharmacy</td>
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<tr>
<td>• Cost of therapy</td>
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<td>– For patients &amp; families</td>
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<td>– For hospice</td>
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<td>• Medicare Hospice Benefit: Drugs and biologicals related to the palliation and management of the terminal illness and related conditions identified in the hospice individualized plan of care must be provided by the hospice for the patient</td>
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<td>– Pending CMS clarification of hospice medication coverage and hospice payment structures</td>
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Discontinuing Medication Late in Life

• Prioritize based on the following information:
  – REMAINING LIFE EXPECTANCY
  – TIME UNTIL BENEFIT
  – GOALS OF CARE
  – TREATMENT TARGETS

Examples

• What do we know about medication therapies and regimens patients are on?
• Did you know that....
  – Treatment with an angiotensin converting enzyme (ACE) inhibitor may show benefit on average after about 10 years, which is when about 25% of patients with type II diabetes mellitus develop proteinuria and/or significant renal damage.

Examples

• Did you know that...
  – Statins could reduce the risk for vascular events after about 2 years of treatment and significantly reduce cardiovascular events at 5 years.

  – Aspirin for primary prevention could reduce one’s risk of myocardial infarction at 5 years.
So how do we address these issues?

Medication Reconciliation

- When?
  - At hospital/facility admission
  - When transferring to a new location
  - Upon discharge home
Medication Reconciliation

- 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?

The Interdisciplinary Group

It starts at “home”!

- IDG is a place for education and learning in addition to providing good care
- IDG is a great place to start
  - Ask questions! Ask why!
    - Does every med in profile have a diagnosis associated?
    - Does every diagnosis have a med associated?
    - Are there any symptoms that could be a med side effect?
    - How is the patient managing all of the meds?
The Interdisciplinary Group

• Stay up-to-date
  – Be a “life long learner”

• Championing Education
  – Build a support system
  – Journal clubs
  – Certifications
  – Learn through teaching

Medications... When to Stop

Medications that either:
  – Have limited evidence to be continued near end of life
    – Statins
    – Vitamins
  – Can be stopped as the disease trajectory changes
    – Cholinesterase inhibitors
    – Antihypertensives
    – Anti-diabetic medications
    – Pulmonary medications
Dementia Medications

• What do you mean dementia medications aren’t appropriate to continue?

• They are indicated for SEVERE dementia – isn’t hospice severe dementia?

Dementia Medications

• There are many studies addressing this, but let’s take a look at one!

Dementia Medications

- Enrolled 128 into Donepezil (Aricept®) Group
- Enrolled 120 in Placebo Group
- Inclusion:
  - MMSE 1-10
  - FAST 5 through 7c
  - 50 years or older & can walk alone or with help
- Only 19 patients/128 in the Donepezil Group had a FAST 7B or worse
- 22% drop out rate
- Where did the rest go?
  - #1 reason: side effects
  - If they were in the MMSE 1-10, FAST 5 through 7c, 50 years or older & can walk alone or with help, then we have smaller numbers then we think!

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Dementia Medications

- Statistical significance was seen in mean score change from baseline for the following test:
  - SIB & ADCS-ADL
  - Within the domain- statistical significance was seen for the following types of measures:
    - Language; Visuo-spatial; Bowel and Bladder; Getting Dressed; Turning off the water
Discontinuing Medications Late in Life

• What do you do when the model isn’t able to be sliced?
  — Ex: Medication time to benefit is longer than life expectancy however goals of care are aggressive?

Pulmonary Medications

• End Stage COPD
  — Inhalers
  — Dry powder vs. Propellant
  — Examples:
    • Tiotropium (Spiriva®)
    • Fluticasone (Flovent®)
    • Fluticasone/salmeterol (Advair®)
    • Budesonide/formoterol (Symbicort®)
    • Ipratropium/albuterol (Combivent® Respimat®)
Pulmonary Medications

Two major concerns:

– Inability to use inhaled medications correctly
  • Inhaler technique
  • Performance status

– Over-utilization of beta agonists and anticholinergics
  • Increased side effects
  • Duplications of therapy

End stage Respiratory Cycle

– Over use of “beta agonists” and “anticholinergic” medications can lead to increased systemic absorption causing elevated HR and CNS stimulation

– Increases in the release of catecholamines leads to increases in HR, decrease in oxygen exchange and anxiety

↑ Shortness of Breath
Medications That May Need Tapering

- Anti-depressants
  - Paroxetine (Paxil®) & 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
- Baclofen
  - Taper over 1-2 weeks

Medications That May Need Tapering

- Beta-blockers
  - Taper over 1-2 weeks
- Anti-epileptics
  - Taper after new agent is at effective dose
  - Regardless of use for seizures, neuropathy, or behaviors
- Clonidine (Catapres®)
  - Taper over 1 week
  - If also taking beta-blocker, taper the beta-blocker first
- Tizanidine (Zanaflex®)
  - Taper over 1-2 weeks if on longer term, higher doses
Medications That May Need Tapering

- 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
  - Rebound hypertension
  - Tachycardia
  - Agitation
  - Seizures
  - Pain, Nausea, 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
- Importance of maintaining attending physician relationship
- Cultural concerns
  - Who is decision-maker?
  - Herbal supplements & home remedies use?
- Fear of losing control
- Fear of losing hope
The BUILD Model™

In Home Care & Hospice we BUILD many things:
– Relationships
– Teamwork
– Plan of Care (POC)
– Trust
– Medication profiles

The BUILD Model

Provides a framework for discussions with the patient and family:
• Treatment options
• Disease progression
• Resuscitation status
• Medication appropriateness
The BUILD Model

- “B” represents **Building** a foundation of trust and respect.
- “U” signifies **Understanding** what the patient and caregiver know about the medication.
- “I” reminds you to **Inform** the patient and caregiver of evidence-based information.
- “L” encourages you to **Listen** to the patient’s and caregiver’s goals and expectations.
- “D” guides you to **Develop** a Plan of Care (POC) in collaboration with the patient and caregiver.

How Do These Discussions Occur?
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:
  - Transfer to IPU
  - Transfer to an ECF
  - Continuous Care Initiated
- Whenever there is a need to change medications due to patient condition:
  - Patient having difficulty swallowing
  - Patient less responsive
Windows of Opportunity

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.”

Windows of Opportunity

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.”
B – Build
A foundation of trust and respect with the patient & caregiver

GOAL: Affirm the patient and caregiver; listen more than you talk.

• 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.”
U – Understand
What the patient & caregiver know about the medication & disease

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

<table>
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<td>- “What has your doctor told you about how this medicine works?”</td>
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<td>- “What do you think your mother will look like when the medicine is no longer effective?”</td>
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<tr>
<td>- “How will you know it’s time to stop the medicine/change the medicine?”</td>
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**I – Inform**
The patient and caregiver about appropriateness of medications

**GOAL:** Provide evidence-based information in a non-threatening, non-coercive way.

- **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 & caregiver as they share goals & expectations

GOAL: Learn what is important to the patient and family.

• 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 & caregivers

GOAL: Empower the patient/caregiver to direct their care

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

D – Develop
A POC in collaboration with the patient & caregivers

• Key phrases:
  – “Here are some choices: We can continue with the current medications and not make any changes. Or we could decrease the Aricept and re-evaluate in 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.”
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?

BUILD: Clinician Communication

- Building
- Developing
- Understanding
- Patient Centered Care
- Informing
- Listening
Mrs. Shirley

• Agreed to stop the Procrit

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

BUILD: Clinician Communication

• Collaboration with clinician
• Trust as a skilled practitioner
  – Both of you are doing the best for the patient
• Respect for the patient/prescriber relationship
  – Affirm the prescriber’s efforts, knowledge and commitment to the patient
• Evidence-based practices
  – Ask questions in IDG
• Information on patient condition
  – Paint a clear, succinct picture
Summary

- Evaluate every medication for appropriateness
- Use resources to practice evidence-based medicine
- Practice effective communication
- Use the BUILD Model as a tool

- Build, Understand, Inform, Listen, Develop!

Medication Appropriateness at End of Life

A New Tool for Enhancing Medicine and Communication for Optimal Outcomes—
the BUILD Model

The BUILD model was developed to provide a comprehensive framework for preparing, delivering, and evaluating evidence-based care with patients and families, as well as facilitating end-of-life care conversations with families and primary caregivers. Although this article focuses on implementation, the principles can also be applied when developing comprehensive care plans, guiding care, and improving the quality of end-of-life care. The BUILD model provides a structured approach to improving care and enhancing patient outcomes.
Article Freely Available at...

- Home Healthcare Nurse journal homepage:
  http://journals.lww.com/homehealthcarenurseonline/pages/default.aspx

- Freely available for reading
- Nurse CE available for a fee

QUESTIONS?
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References & Further Readings

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

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