POLYPHARMACY IN PALLIATIVE CARE

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Learning Objectives:
- Define polypharmacy and how it impacts patients.
- Identify contributory factors and barriers to discontinuing medications.
- Discuss strategies for discontinuation of futile medications.

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Arizona Heat
Objectives
- Summarize the medication categories in the March 10th CMS letter to hospice providers and Part E Plans
- Define Polypharmacy and how it impacts patients.
- Identify contributory factors and barriers to discontinuing medications.
- Identify several common medication to target for discontinuation.
- Discuss strategies for discontinuation of futile medications.

In the News
- June 2012 OIG report on duplicate payment
- April 2013 CMS call letter to Part D Plans regarding four classes of medications and prior authorization.
- Fall 2013 CMS memos to Part D plans regarding analgesic recoupment.
- December 2013 CMS clarification and request for comments regarding Part D and Hospice Medications coverage
- March 2014 CMS final letter

Buckets of Medications
Why Is This Important

- The pharmacy issues in hospice have never been more complex and continue to change frequently
- Appropriate determination of medication status drives all aspects of hospice med coverage
- Focus on those unnecessary meds, reducing pill burden, lightening the load.

Polypharmacy

- Is not how many medications you are on….
- It is taking more medication than clinically indicated

What contributes to Polypharmacy in Hospice and Palliative Care?

- Need for additional medications to manage symptoms
- Lack of recognition of ADRs
  - Using more drugs to treat drug-related problems
- Lack of indication for prescribed drugs
- Multiple co-morbidities
- Multiple prescribers
Why worry About Polypharmacy

- 1 in 10 adult visits to ER are directly related to ADR
- 70% are preventable!
- 3 out of 4 medication side effects are dose related
- Start low and go slow!
- In older adults, a discontinuation study showed 4-5 medications per person could be stopped.
- 88% reported global improvement in health
- 2% needed to be restarted

Barriers to Discontinuation

- Physiological dependence
- Psychological attachments to a medication
- Perception of abandonment
- Clinician fear of damaging the patient relationship
- Covered vs. not covered - whose responsibility is it to discontinue certain drugs?
- Family/Physician resistance
Anything is Possible

Re-Evaluation of Medication Plan of Care
- Goals of care change
- Risk outweighs benefit
- ADRs occur

Challenging Medications And Strategies For Discontinuation
Thought Process

- Every medication:
- "What is this medication treating"?
- "What are my patient’s goals of care and does this med support that goal"?
- "What is the time until benefit compared with patient’s life expectancy"?
- "what is the risk versus benefit of the medication"?
- "Is the patient swallowing"?
- If discontinuation efforts are unsuccessful, decreasing dose may be beneficial

Evaluating the Med Plan of Care

- Duplicate therapy
- Tiotropium (Spiriva) and Ipratropium (Atrovent)
- Hydrocodone/apap and hydromorphone (Dilaudid)
- No current indication
- Proton Pump Inhibitors (PPIs)- omeprazole (Prilosec) and pantoprazole (Protonix)
- Futile medications (time to benefit)
- Vitamins / Herbs
- "statins"- atorvastatin (Lipitor) and simvastatin (Zocor)
- Bisphosphonate—alendronate (Fosamax), risedronate (Actonel), and ibandronate (Boniva)

Dementia
donepezil (Aricept) and memantine (Namenda)

- Inconsistent evidence for palliation of behavioral and psychological symptoms of dementia (BPSD)
- Approved for delaying progression of the disease
- Cognitive / functional benefits are modest at best and of uncertain clinical significance
- Risks of continued therapy:
- Adverse effects/events, drug-drug interactions
- Continued medication burden
- Other cholinesterase inhibitors only approved for mid-moderate disease
- Galantamine (Razadyne) and rivastigmine (Exelon)
Dementia
donepezil (Aricept) and memantine (Namenda)

- Discontinuation should occur in gradual, step-wise manner
- Titration over 4 weeks with 25% weekly reductions
- Patient should be monitored for any cognitive and/or functional decline during discontinuation
- If symptoms worsen, medication can be reinitiated at initial dose

Lung Diseases
Dry-powder & Meter Dose Inhalers

- Inhaled bronchodilators/corticosteroids are the mainstay of COPD treatment
- Most common agents are dry-powder inhalers (DPIs) and metered-dose inhalers (MDIs)
  - Tiotropium (Spiriva) = DPI
  - Fluticasone-salmeterol (Advair) = DPI
  - Formoterol (Foradil) = DPI
  - Albuterol-iptropium (Combivent) = MDI
  - Fluticasone (Flovent) = MDI
  - Budesonide-formoterol (Symbicort) = MDI

Lung Diseases
Dry-powder and Meter dose inhalers

- All inhalation devices (other than nebulizers) require:
  - Level of hand-inhalation coordination
  - Breath hold to obtain good delivery of respiratory medications.
- Studies have shown that improper administration technique occurs in close to 50% of COPD population
- Results in:
  - Poor delivery of medications to sites of actions within the lungs
  - Increased use of rescue medications
  - Decreased control of symptoms
### Gastrointestinal Agents
#### Proton Pump Inhibitors (PPI)
- Common agents are:
  - Omeprazole (Prilosec)
  - Esomeprazole (Nexium)
  - Pantoprazole (Protonix)
  - Lansoprazole (Prevacid)
- Important to assess history of symptoms as well as medication history on admission
  - Is there an indication?
  - Therapeutic duplication with an H2RAs such as ranitidine (Zantac) or famotidine (Pepcid)?

### Gastrointestinal Agents
#### Proton Pump Inhibitors (PPIs)
- Despite benign perception, therapy involving acid reduction has shown to have significant long-term adverse effects
- Long-term use should be limited to erosive esophagitis or pathologic hypersecretory conditions
- Potential risks with use of PPIs include:
  - Enteric infections
  - Respiratory infections
  - Vitamin/mineral deficiencies
  - Osteoporotic fractures
  - Drug interactions
  - Acute interstitial nephritis

### Amyotrophic Lateral Sclerosis (ALS)
#### riluzole (Rilutek)
- Shown to:
  - Prolong survival (2-3 months)
  - Extend time to tracheostomy in patients with a good prognosis
- Only demonstrated benefit for 18 months
- After 18 months, no difference between riluzole and placebo
- Contributes to significant fatigue in up to 25% of patients
- No known side effects from discontinuation

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Oncology Medications

- Patients are unlikely to benefit from chemotherapy when they have failed first line standard regimens, have poor performance status, and otherwise have a poor prognosis.
- These agents should be considered for discontinuation due to lack of studies, high cost, pill burden, and adverse effects. Tamoxifen (Nolvadex), anastrozole (Arimidex), erlotinib (Tarceva), bicalutamide (Casodex)

Anti-coagulant Medications

- It's not just warfarin anymore….
  - Lovenox
  - Pradaxa
  - Xarelto
  - Eliquis
- Are you treating a recent DVT/PE or preventing a future clot?
- Is the medication currently palliating a symptom?
- What is the patient’s status?
- Ambulatory patient with symptomatic DVT vs. bed bound patient with several week prognosis
- Risk vs. Benefits

Other Medications

- Vitamins
- Statins
- Bisphosphonates
- Antihypertensive
- Diuretics
- Antihyperglycemics
- Erythropoetin-stimulating Agents
- Ranolazine (Ranexa)
- Roflumilast (Daliresp)
Confounding Factors

- Patient/Family Reluctance
- Fears of hastening death
- Psychological attachment
- Lack of trust
- Lack of knowledge
- Nurse Reluctance
- Fear of damaging patient relationship
- Lack of confidence
- Physician Reluctance
- Clinical preference
- Lack of accountability

Recommendations working with prescribers

- Be prepared
- Consult a palliative care pharmacist
- Incorporate into admission process
- Have a plan such as non-pharmacologic interventions and/or time-limited trials
- Plan ahead for anticipated challenges
- Assess time-to-benefit for therapy
- Can you complete these two statements?
  - "The patient is on this medication because…"
  - "This medication is palliating the following symptoms…"
- If you can’t consider assessing the medication for discontinuation

Recommendations Working with Patients/Families

- Prepare
- Discuss changes with physician to ensure consistency
- Anticipate challenges/response
- Educate
- Ensure patient/family understand reasons for intervention
- Describe clinical benefits or ramifications
- Outline clinical plan and contingency plan
- Any intervention can be reversed if clinical symptoms require
- If possible, arrange meeting with patient, key family members, and prescriber
- Reassess
- If initially refused, establish plan to reevaluate decision at appropriate intervals
Process for Discontinuation

- Recognize indication for discontinuation
- Identify and prioritize the medications to be targeted for discontinuation
- Plan communicate and coordinate medication discontinuation with patient, caregivers and health care providers.
- Monitor the patient for beneficial and harmful effects

Questions?