Passing the Last Torch:
Pharmaceutical Transitions at the End of Life

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Objectives
1. Describe symptoms commonly experienced by patients nearing the end of life and medications frequently used to control these symptoms.
2. Describe specific medication considerations in patients who will be transitioning from an acute care facility to home-based hospice care.
3. Given a simulated case, determine which medications are related to the terminal and related condition, and must be provided by hospice.

IOM Recommendations
- Include coordinated, efficient, and interoperable information transfer across all providers and all settings;
- Seamless, high-quality, integrated, patient-centered, family-oriented, and consistently accessible around the clock;

Think Pair Share
Think about a recent advanced illness patient you were involved with during a transition
- Were you satisfied with the experience?
  - If so, what made it work?
  - If NOT satisfied, why not?
- What were some of the gaps in clinical care?
- What could have been done differently?

Who’s Going to Drop the Hand Off?

Goes by so fast- Blur
EOL transitions NH with Cognitive Issues

- Patients that died in NH setting (n=474,829)
- 19% had at least one burdensome transition (2.1% AK - 37.5% LA)
- Burdensome transitions defined as:
  - Transitions in the last 3 days of life
  - Lack of continuity in NH s/p hospital in last 90 days
  - Multiple hospitalizations in last 90 days
- >2 for any reason OR >1 for pna, UTI, dehydration, or sepsis

Variation in Rates of Burdensome Transitions among 474,829 Patients, According to State.

<table>
<thead>
<tr>
<th>Criterion for a Burdensome Transition</th>
<th>Overall Rate for NH Patients %</th>
<th>State with Lowest Rate*</th>
<th>State with Highest Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition 72 hours before death</td>
<td>4.4</td>
<td>Alaska (0.8)</td>
<td>Mississippi (22.7)</td>
</tr>
<tr>
<td>From acute hospital to NH</td>
<td>3.8</td>
<td>Vermont (0.3)</td>
<td>Missouri (2.7)</td>
</tr>
<tr>
<td>From hospital to NH</td>
<td>2.9</td>
<td>Alaska (0.8)</td>
<td>Missouri (2.9)</td>
</tr>
<tr>
<td>From NH to acute hospital</td>
<td>2.7</td>
<td>Alaska (0.8)</td>
<td>Louisiana (16.9)</td>
</tr>
<tr>
<td>Hospital admissions in the last 90 days of life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Episodes of pneumonia</td>
<td>3.1</td>
<td>Alaska (0.8)</td>
<td>Louisiana (16.9)</td>
</tr>
<tr>
<td>2) Episodes of urinary tract infection</td>
<td>3.9</td>
<td>Vermont (0.3)</td>
<td>Louisiana (16.9)</td>
</tr>
<tr>
<td>3) Episodes of dehydration</td>
<td>2.7</td>
<td>Alaska (0.8)</td>
<td>Louisiana (16.9)</td>
</tr>
<tr>
<td>4) Episodes of sepsis</td>
<td>2.1</td>
<td>Alaska, Idaho, and Wyoming (0)</td>
<td>Louisiana (16.9)</td>
</tr>
<tr>
<td>5) Hospitalizations for any reason</td>
<td>4.3</td>
<td>Oregon (0.8)</td>
<td>Louisiana (16.9)</td>
</tr>
</tbody>
</table>

*Values in parentheses are state names.

State Variations in the Proportion of Nursing Home Residents with Advanced Cognitive Impairment Who Had at Least One Burdensome Transition.
At What Expense?

• Consequences of failing to plan for the transition to EOL care include the following:
  • Increased psychological distress.
  • Medical treatments inconsistent with personal preferences.
  • Utilization of burdensome and expensive health care resources of little therapeutic benefit.
  • A more difficult bereavement

http://www.cancer.gov/cancertopics/pdq/supportivecare/transitiontoEOLcare/healthprofessional/page1

Comparing EOL trajectories

Cancer: Short period of decline
Organ failure (Heart, lung, kidney): Slow decline with intermittent acute episodes

Model of Palliative Care

Traditional Care Model

Life-Prolonging Therapy

Diagnosis of life-limiting illness

“Integrated” Care Model

Life-Prolonging Therapy

Palliative Care

Hospice benefit

Death

Collaborative interdisciplinary approach

Specialist palliative care service delivery based on a population based approach with four delineated levels of care

1. Primary palliative care
2. Shared care
3. Shared care
4. Direct care

Palliative Care Australia

McGregor and Porterfield 2009
How to Run a Relay Race

1. Prepare yourself - get plenty of rest
2. Know the course and which leg you are running, be prepared for the weather and hills
3. Cheer on your teammates
4. Be consistent to finish strong
5. Don’t wait till the last moment to prepare for the race (pack gym bag the night before)
6. Travel together as a team to keep focused
7. Be prepared for blind handoffs
8. Last runner has to make up the distance

In the Zone

• This is where a runner completing their leg passes the baton to the next runner beginning their leg.
  • The team can lose time and position, or be disqualified.
  • In the shorter races where the speed is greater, this becomes a delicate issue.
  • If the exchange goes smoothly, the team can continue without hesitation.
  • If not, the team will face the most difficulty.

Best Practices

• Health Literacy
  • Universal precautions, “teach back”
• Cognitively Impaired
  • Universal precautions, “teach back”
• External Transfers
  • Require:
    1. Patient’s list of home medications prior to their hospitalization.
    2. Medications that are being administered to the patient at the outside hospital prior to transfer.
    3. Medications ordered at the receiving hospital.

High Risk Situations

• Health Literacy
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Elements of Success

• Team effort and collaboration
• Pharmacy integration
• Data to justify resources
• Electronic patient informatics systems and data transfer process
• Strong partnerships

Medication Reconciliation in Hospice

• Regimented, documented review to avoid drug errors during transitions in care
• Where does hospice stand with this?
  • Survey of two hospice programs
  • An average of 8.7 medication discrepancies per patient
    • 81% omitted medications
    • 55 additional drug interactions rated moderate or severe

Engage Patient and Family

• Encourage keeping updated med list
  • Including herbals, OTC, allergy info
• Medication diaries for symptom management
• Bring medications with them or have in sight for visits


More than Med Rec?!

Include coordinated, efficient, and interoperable information transfer across all providers and all settings;
Seamless, high-quality, integrated, patient-centered, family-oriented, and consistently accessible around the clock;

Transferring to Potential Plans of Care

Four Critical Medication issues in Transitions in Care

1. Medication titration and monitoring
2. Formulary issues
3. Prioritizing medications based on benefit/burden and goals of care
4. Thinking ahead

Degree of concern

<table>
<thead>
<tr>
<th>Discharge to</th>
<th>Med Titration</th>
<th>Formulary / Insurance Considerations</th>
<th>Prioritizing Meds</th>
<th>Thinking Ahead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospice</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Home-based hospice</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>Moderate</td>
</tr>
<tr>
<td>LTC hospice</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>Moderate</td>
</tr>
<tr>
<td>Pall Care LTC</td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Pall Care home</td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

Assess Level of Concern

• Influencing Factors
  • Patient acuity
  • Prognosis
  • Risk of medications
  • Family support
  • Hand off site experience with specific situation of patient
**High Risk Medications**

- 67 yo female admitted with lethargy/pain, now in ICU
- PMH: advanced COPD (extubated 2 days ago), DM with severe neuropathy, s/p B/L THR
- Team is worried about her depression and pain, patient is writhing in pain most of the day
  - Started methadone 2.5 mg BID
  - Started Ritalin (methylphenidate) 2.5 mg am/noon and Effexor (venlafaxine)
- Dispo in am...

**Heading to Where?!**

**Considerations:**
- Experience with methadone
  - Protocol
  - Pharmacy support
- Support services for counseling and assessment of depression

**Four Critical Medication issues in Transitions in Care**

1. Medication titration and monitoring
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**Making the Case for Formulary Issues**

- Mr. C is a 49 year old man with end-stage lung cancer discharged from the hospital to home-based hospice.
- His analgesic regimen is as follows:
  - OxyContin 20 mg po q12h
  - Fentora 800 mcg four times daily
  - Morphine 10 mg po q2h as needed for additional pain
  - Zofran 8 mg q8h prn nausea
  - He has not been on any additional medications

**How it all began...**

- Cover Related Drugs (COP 418.106)
  - “Drugs and biologicals related to the palliation and management of the terminal illness and related conditions; as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.”
What sounded the alarm?

- ...there has been some concern, as noted by the [OIG], that some hospices are not providing the full range of required hospice services, most notably drugs
- Some hospice-related drugs for Medicare hospice beneficiaries are being submitted through Part D prescription programs instead of being covered under the [MHB]...
- ...it is evident that many drugs used for hospice pain management are being "unbundled" from the hospice per diem rate...

So what put the ball in play?

- ...there has been some concern, as noted by the [OIG], that some hospices are not providing the full range of required hospice services, most notably drugs
- Some hospice-related drugs for Medicare hospice beneficiaries are being submitted through Part D prescription programs instead of being covered under the [MHB]...
- ...it is evident that many drugs used for hospice pain management are being "unbundled" from the hospice per diem rate...

How did we get here?

- OIG report issued in 2012
  - 198,543 hospice beneficiaries received 677,022 prescription drugs through the Medicare Part D
  - Part D paid pharmacies $33 M in claims and beneficiaries paid $3,835,557 in copayments after election of Medicare Hospice Benefit (Part A)
    - Analgesics, anti-emetics, laxatives, anxiolytics
    - Additional analysis by CMS Center for Program Integrity
  - Final guidance issued by CMS on March 10 2014

CMS Memo 12-06-2013

- 4 Medication Scenarios
  - Meds started prior to admission; related; hospice provides
  - Meds started prior to admission; no longer medically necessary; DC med
  - Med is either related but not formulary, or not necessary but patient wants to continue
  - Medication is unrelated

July 2014 Revised Interim Guidance

- Prior authorization is required ONLY for 4 classes of drugs when the drug is NOT related to the terminal prognosis
  - Analgesics
  - Anti-emetics
  - Laxatives
  - Anti-nausea

Who pays for what?

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Who provides medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to terminal diagnosis</td>
<td>Hospice</td>
</tr>
<tr>
<td>Unrelated, Part D eligible</td>
<td>Part D process for payment (no hospice PA process)</td>
</tr>
<tr>
<td>Unrelated in 4 categories, may be Part D eligible</td>
<td>Part D hospice submits PA process for payment</td>
</tr>
<tr>
<td>Related but no longer medically necessary</td>
<td>Patient</td>
</tr>
<tr>
<td>Related and medically necessary, but not formulary and patient refuses formulary therapeutic alternative</td>
<td>Patient</td>
</tr>
<tr>
<td>Unrelated but no longer medically necessary</td>
<td>Patient</td>
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Thinking Ahead

<table>
<thead>
<tr>
<th>Original Order</th>
<th>Amended Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>OxyContin 20 mg po q12h</td>
<td>MS Contin 30 mg po q12h (or patient must pay for OxyContin)</td>
</tr>
<tr>
<td>Fentora 800 mcg four times daily</td>
<td>Increase morphine oral solution</td>
</tr>
<tr>
<td>Ondansetron 8 mg</td>
<td>Haloperidol, prochlorperazine</td>
</tr>
</tbody>
</table>

Cost Effective Medications

- Ondansetron vs. haloperidol
- Tiotropium vs. ipratropium
- Methadone vs. branded LA opioid
- Citalopram vs. escitalopram
- Esomeprazole vs. omeprazole

Four Critical Medication issues in Transitions in Care

- Medication titration and monitoring
- Formulary issues
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- Thinking ahead

Goals of Care/ Benefits and Burdens

- Mrs. J is a 78 year old woman in a LTC facility with dementia who meets hospice guidelines for admission (FAST scale 7C, > 10% weight loss, recent infection)
- She has had repeated falls in past 3 months
- Patient is receiving donepezil (Aricept) and memantine (Namenda)
- Patient has dry heaves after taking donepezil
- Other medications include:
  - Lisinopril 10 mg po qd
  - Pravachol 20 mg po qd

Fast Criteria

- Normal adult
- Normal older adult
- Early dementia
- Mild dementia
- Moderate dementia
- Moderately severe dementia
- Severe dementia

Fast Criteria

7a. Ability to speak limited to approximately a half dozen different words or fewer, in the course of an average day or in the course of an interview.

7b. Speech ability limited to the use of a single intelligible word in an average day or in the course of an interview (the person may repeat the word over and over).

7c. Ambulatory ability lost (cannot walk without personal assistance).

7d. Ability to sit up without assistance lost (e.g., the individual will fall over if there are no lateral rests (arms) on the chair).

7e. Loss of the ability to smile.

Adverse Effects of Dementia Drugs

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Drug Name(s)</th>
<th>Adverse Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholinesterase Inhibitors</td>
<td>Donepezil (Aricept), Galantamine (Reminyl), Rivastigmine (Exelon)</td>
<td>Insomnia (up to 14%), Nausea (up to 19%), Diarrhea (up to 15%), Accidents (up to 13%), Infection (up to 11%), Headache (10%), Pain (9%), Fatigue (8%), Dizziness (8%), Hallucinations (3%), Anorexia (2%), Vomiting (9%)</td>
</tr>
<tr>
<td>NMDA Antagonist</td>
<td>Memantine (Namenda)</td>
<td>Hypertension (4%), Dizziness (7%), Confusion (6%), Hallucinations (3%), Diarrhea (5%), Back pain (3%)</td>
</tr>
</tbody>
</table>

Stopping Statins?

- 381 patients (49% cancer) with life expectancy less than 1 year
- All taking statin for primary or secondary prevention for at least 3 months (69% used > 5 years)
- Randomized to continuing or stopping statin
- Days till death after stopping statin:
  - 229 days with discontinuation
  - 190 with continuation
- Estimated to save $603 million in US

Assess: Goals of care

Goals of care change over time and may include:
- Maintaining and improving function.
- Staying in control.
- Relief of suffering (pain and symptom management).
- Prolonging life for as long as possible or until a specific event (time limited trials of care).
- Quality of life/fighting well.
- Relieving burden for family members.
- Strengthening relationships.
- Preferences for location of care or death.
- Life closure/dying well.
- Personal wishes for management of dying.

Four Critical Medication issues in Transitions in Care

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Making the Case to Think Ahead
- Pt leaving hospital s/p extubation with stage IV lung ca (mets to bone, brain, liver)
- Comfortable on BiPAP currently but planning to discharge in the next day
- Patient has been bed bound for 3 months
- Current meds:
  - Morphine 10 mg q4h prn (x4-6/day) for SOB
  - Ativan 0.5 mg q6h prn (x3-4/day)
- Family afraid morphine will kill him and wants it stopped, nurse feels “on the spot” for every dose

Heading to Where?!

Considerations:
- Common symptoms for EOL picture for this patient
- Response time for quickly emerging sx
- Prognosis/ sx burden

Predictable Challenges in the Final Days

What is happening to Patient
- Functional decline- transfers, toileting, fall risk
- Can’t swallow meds- route of administration
- Terminal pneumonia
  - dyspnea
  - congestion
  - delirium> 80% (+ agitation)
- Concerns of family and friends

Approach to Care
- Prepare caregivers with proactive” communication
- Anticipate questions and concerns
- Be available
- Don’t present “non-choices” as choices
- Aggressive pursuit of comfort
- Don’t be caught off-guard by predictable problems

Basic Medication Toolkit
- Opioids
  - Pain, SOB
- Anticholinergic
  - Secretions
- Benzodiazepine
  - Agitation, Seizures
- Antipsychotic
  - Delirium, N/V

Heading to Where?!

Actions:
- Addition of prn meds for sx that may emerge
- Optimize dosing for current meds
- Follow up phone calls to monitor
- Family education

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Signs of Opioid Overdose

- pinpoint pupils
- Sedation/ unable to arouse
- gradual slowing of the respiratory rate
- breathing is deep (though may be shallow) and regular

Common Chronic Disease Model

**Common Family Concerns:**
- How could this be happening so fast?
- What about food & fluids?
- Things were fine until that medicine was started!
- Isn’t the medicine speeding this up?
- Too drowsy! Too restless!
- Confusion… he’s not himself, lost him already
- What will it be like? How will we know?
- We’ve missed the chance to say goodbye

Modified from Lunney JR et al. JAMA 2003; 289: 2387.

Family Education

- Prioritized medication list
- External teamwork: Starting the conversation early
- Symptoms to expect
- Anticipate barriers

How to Run a Relay Race

1. Prepare yourself - get plenty of rest
2. Know the course and which leg you are running, be prepared for the weather and hills
3. Cheer on your teammates
4. Be consistent to finish strong
5. Don’t wait till the last moment to prepare for the race (pack gym bag the night before)
6. Travel together as a team to keep focused
7. Be prepared for blind handoffs
8. Last runner has to make up the distance

From the Patient’s Point of View

What is our responsibility to them during this challenging time?
Runner’s Kick- We need to remember to save something for the last leg of the race!

Key Takeaways
1. Make a specific plan for high risk medications to provide continued monitoring and titration during transitions
2. Engage in goals of care discussions to ensure medications are in line with goals and setting of care
3. Determine need for proactive prescribing for patients at risk for uncontrolled symptoms

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