Discontinuing Medications for Hospice Patients

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Objectives

- Understand CMS guidance on payment responsibility and expectation of discontinuing medications
- Recognize the patient factors when discontinuing medications
- Identify the common classes of medications being discontinued at end of life
  - Understand the reason for discontinuation
  - Identify the risks vs. benefits for using these medications

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General CMS Guidance

- “hospice programs to provide individuals under hospice care with drugs and biologicals related to the **palliation** and **management of the terminal illness** as defined in the hospice plan of care”

- Palliative medications:
  - Relieve current symptoms of disease
  - Provide comfort to the patient
  - No intention of prolonging life
  - No intention of promoting cure
  - No intention of achieving long-term positive outcomes

- Non-Palliative medications:
  - Curative only
  - Preventative or prophylaxis
  - Associated with long-term therapeutic outcomes

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CMS Clarifications[1]

- “Hospice beneficiaries generally experience common symptoms during the end of life, regardless of their terminal diagnosis. These symptoms include **pain, nausea, constipation, and anxiety**”
- “ For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment **unrelated to the terminal illness or related conditions**”
- “ After a hospice election **many maintenance drugs** or drugs used to treat or cure a condition **are typically discontinued** as the focus of care shifts to palliation and comfort measures”
- CMS recommend using Hospice Information for Medicare Part D Plans form (AKA “**Hospice A3 Reject**”)

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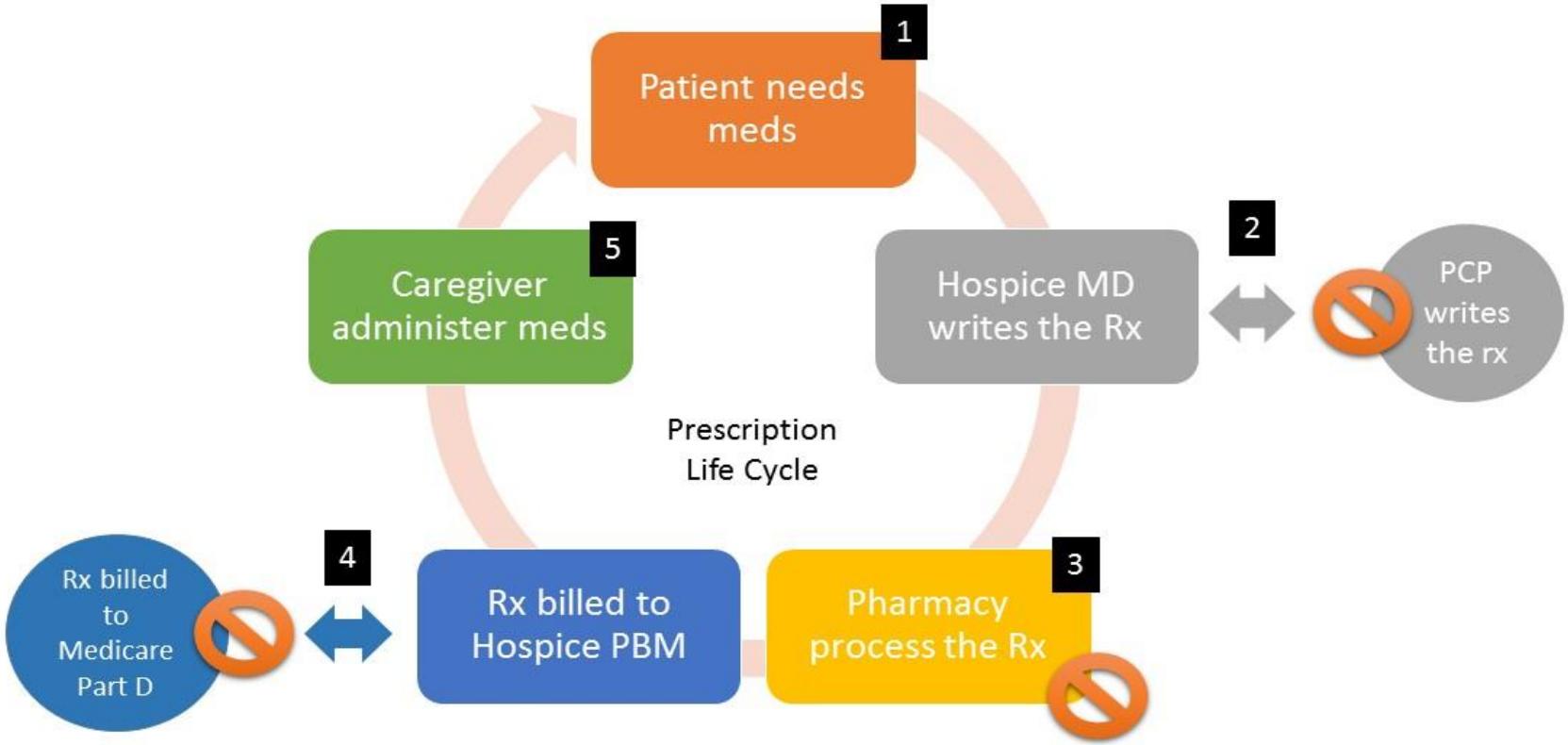
Maintenance Medication Life Cycles



PCP – Primary Care Physician
MD – Medical Director

Rx – Prescription
PBM – Pharmacy Benefit Management

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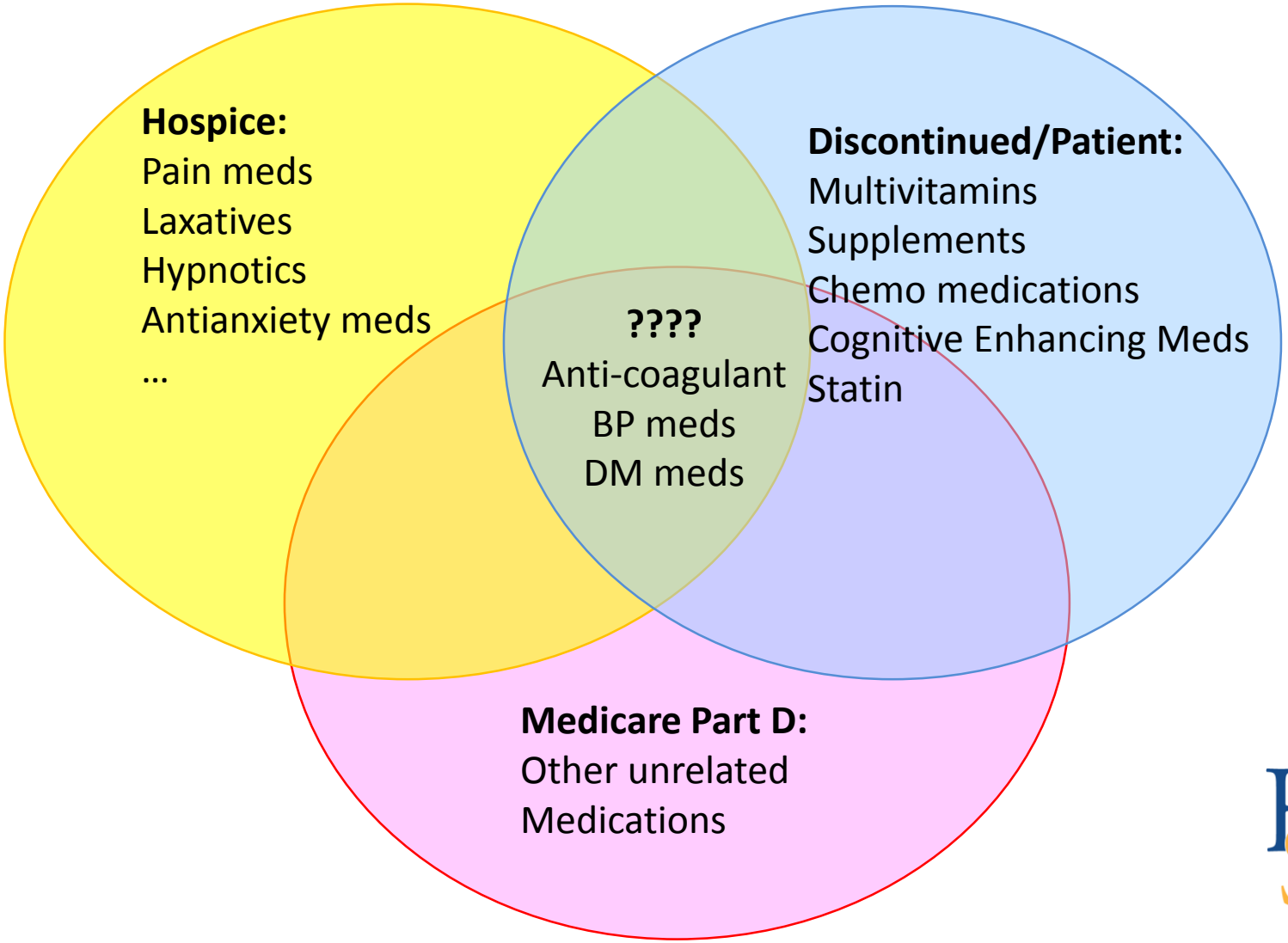
Medication Payment Responsibility



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Incentives for Discontinuing Medications

- Risk vs. benefit ratio increased for many medications at end of life
- Impact quality of life
  - Less side effects, less pills, less administration burden, etc
- Decrease medications cost
- Meet the expectation of CMS

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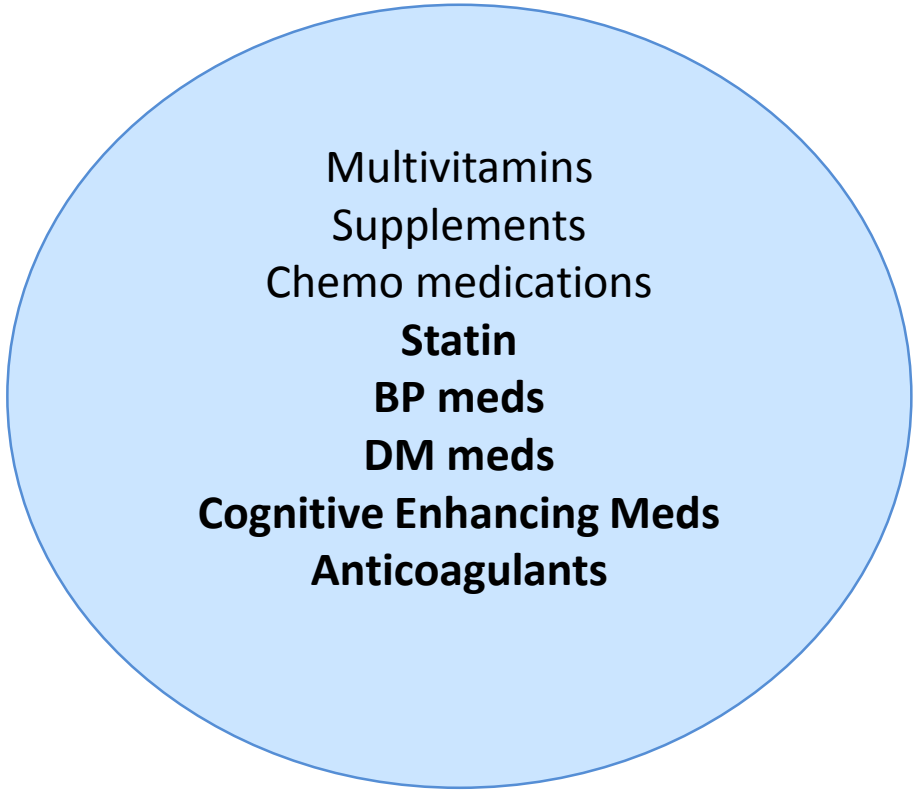
Medications that are commonly discontinued at end of life



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Patient Factors that Guide Medication Discontinuation

- The patient's terminal diagnosis (hospice diagnosis)
- Patient's current condition
  - functional status
  - quality of life
  - PPS (Palliative Performance Scale) score
  - Karnofsky score
  - Prognosis (months, days?)
- Goals of care
  - comfort only, non-invasive measures
  - preserving a level of functionality
  - maintaining current quality of life

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Cholesterol Medications

- Reason for Discontinuation
  - Long term benefit only, no benefit at end of life
  - D/C increases quality of life (QoL) for patient with terminal illness[2,3]
- Risks at end of life:
  - Pill burden for patient with difficulty swallowing
- Medications included:
  - Statin
  - Fibrates
  - Fish oil
  - Cholestyramine
  - Ezetimibe

Cholesterol Medications Examples:
Lipitor (Atorvastatin)
Crestor (Rosuvastatin)
Zocor (Simvastatin)
Tricor (Fenofibrate)
Zetia (Ezetimibe)

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Diabetic Medications

- Reason for Discontinuation
  - Supported by 2016 Diabetes's guideline from American Diabetes Association (ADA)
    "For the dying patients, most agents for type 2 diabetes may be removed"
  - Hyperglycemia in most cases are asymptomatic
  - Tight glucose control only have long term benefit

- Risks at end of life:
  - Terminal patients have a higher risk of hypoglycemic event with reduced intake
  - Medication burden for patient
  - Invasive frequent laboratory monitoring required
  - Many medications are contraindicated for patients with organ failure
    - Ex. Metformin, Actos

Diabetes medications Examples:
Insulin
Metformin
Glyburide
Januvia
Invokana
Byetta
Actos

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Diabetic Medications

- Diabetes management goal at end of life
  - If patient is still testing:
    - looser A1C target <8.5%, Random Glucose ~200mg/dL
  - If patient is not testing:
    - D/C as long as patient is comfortable

- Continue medications if:
  - Patient has high PPS score with reasonable intake
  - Patient wants to continue to test blood sugar
  - Patient has type 1 diabetes
  - Patient is symptomatic from hyperglycemia

Diabetes medications Examples:
Insulin
Metformin
Glyburide
Januvia
Invokana
Byetta
Actos

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Blood Pressure Medications

- Reason for Discontinuation
  - Hypertension in most cases are asymptomatic
  - Tight blood pressure control only have long term benefit
  - Indications for use matters

- Risks at end of life:
  - Pill burden, most only available as oral formulation
  - Risk of symptomatic HYPO-tension at end-of-life is higher
    - Dizziness, Syncope, Falls, Fatigue
  - Frequent monitoring required

Blood Pressure Medication Examples:
Beta-Blocker: Atenolol
ACE Inhibitor: Lisinopril
ARBs: Losartan
Calcium Channel Blockers: Diltiazem
Vasodilator: Hydralazine
Centrally Acting a-1 agonist: Clonidine
Peripheral acting a-1 agonist: Doxazosin
Diuretics: Hydrochlorothiazide

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Blood Pressure Medications

In the following situations, the medications may be considered palliative:

- Congestive heart failure (ACEI, beta-blockers, diuretics)
- Atherosclerotic heart disease (ACEI, beta-blockers)
- Coronary artery disease w/ or w/o angina (calcium channel blockers)
- Edema (diuretics)
- Chronic pain (clonidine)
- History of symptomatic hypertension or very high BP

- If continue and monitor:
  - SBP goal of <180 and >90

Blood Pressure Medication Examples:
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ACE Inhibitor: Lisinopril
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Diuretics: Hydrochlorothiazide

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Discontinuation of Blood Pressure Medications

Abrupt cessation of therapy is usually without consequence [4]

*Exceptions where taper may be recommended: **

- High dose beta-blocker or centrally acting adrenergic blocking drug:
  - Clonidine (Catapres)
  - Metoprolol (Lopressor)
  - Atenolol (Tenormin)
  - Carvedilol (Coreg)
- Combination therapy with multiple antihypertensive drugs
- Predisposing risk factors
  - Ischemic heart disease
  - Renovascular hypertension

*Gradual taper over 7-10 days is usually adequate

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Cognitive Enhancing Medications

- Reason for Discontinuation
  - No clinically significant benefit for FAST > Stage 7
  - Limited efficacy for FAST Stage 6 (few studies show marginal benefit)

- Risks at end of life:
  - Significant diarrhea, nausea, vomiting
  - Loss of appetite and weight
  - Medication burden

Cognitive Enhancing Agents Examples:
Aricept (Donepezil)
Namenda (Memantine)
Exelon (Rivastigmine)
Reminyl (Galantamine)

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FAST – Functional Assessment STaging

Anticoagulant Medications

- Reason for Discontinuation
  - Not relieving symptoms
  - Typically used for prevention
    - – Anticoagulant reduce stroke risk by about 4% per year on average[5]
  - Contraindicated for patient with organ failure

- Risks at end of life:
  - Risks of bleeding is higher at end of life
  - Laboratory monitoring
  - Numerous drug interactions

Anticoagulant/Antiplatelets Examples:
Coumadin (Warfarin)
Eliquis (Apixaban)
Pradaxa (Dabigitran)
Xarelto (Rivaroxaban)
Lovenox (Enoxaprin)

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Anticoagulants/ Antiplatelet Medications

Indicators for **continuing anticoagulant medications:**

- Symptomatic or high risk for thromboembolism
  (pleuritic chest pain, dyspnea, painful swelling of lower extremities)

AND

- PPS score of 40% or greater
- Low risk for bleeding.
- Reliable compliance with medication regimen

Anticoagulant/Antiplatelets Examples:
Coumadin (Warfarin)
Eliquis (Apixaban)
Pradaxa (Dabigitran)
Xarelto (Rivaroxaban)
Lovenox (Enoxaprin)

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Case Study #1

Patient Joe Smith is 89 YOM admitted to hospice 2 days ago for terminal diagnosis of Alzheimer's disease. Patient has reduced intake and his main care giver is his 79 years old spouse.

Upon admission, he is taking the following medications

- Lipitor for cholesterol
- Lisinopril for blood pressure
- Metformin for diabetes
- Aricept for Alzheimer's disease
- Acetaminophen for mild pain
- Warfarin for stroke prevention from atrial fibrillation

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Case Study #2

Patient Ima Payne is 68 YOF admitted to hospice 2 days ago for terminal diagnosis of end stage heart failure. Upon admission, she is taking the following maintenance medications:

- Lipitor for cholesterol
- Lisinopril for heart failure
- Metformin for diabetes not related to heart failure
- Aricept for Alzheimer's disease
- Norco for pain
- Warfarin for treating DVT 1 month ago

After 2 months admitted into hospice, she is significantly declined and have difficulty swallowing

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Summary

- Discontinuing maintenance medications can shift care focus to managing medications for symptom control and comfort care
- Consider discontinue medications that are no longer medically necessary: Statin, BP medications, DM medications, Cognitive enhancing medications, and anticoagulants, etc.
- Discontinuation decisions may be influenced by individual patient conditions: indications, QoL, level of function, overall prognosis, specific goal of care, etc.
- Remember to document and communicate your decisions to patient, Medicare part D plan and pharmacy to ensure successful discontinuation

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References

1. CMS Memo, Centers for Medicare & Medicaid Services, Department of Health & Human Services, issued 11/15/2016
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3. JS Kutner, PJ Blatchford, DH Taylor, et al. Safety and benefit of discontinuing statin therapy in the setting of advanced, life-limiting illness: a randomized clinical trial. JAMA intern Med, May 2015. https://www.ncbi.nlm.nih.gov/pubmed/25798575
4. Houston MC. "Abrupt discontinuation of antihypertensive therapy" South Med J. 1981 Sept;74(9):1112-23
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Questions?

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