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Selected Topics in Hospice Care

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April 10, 2018

Disclosures

- Presenters have no conflict to interests to disclose

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Overview of Hospice

- Demonstrate understanding of overall goals and purpose of hospice care
- List common challenges and concerns of hospice pharmacists
- Identify palliative care approach for hospice patients with chronic disease states

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Overview of Hospice

- Health care model that provides a wide variety of services to patients with terminal illnesses
- Eligibility for hospice
  - Diagnosed by hospice doctor and regular doctor/NP to be terminally ill and have life expectancy of 6 months or less
- Services include medical care, pain management, emotional/spiritual support and counseling
- Support is also provided to family during hospice process and after patient's death

Overview of Hospice

- Focus changes from curing disease to providing symptom relief and overall comfort
- Hospice team
  - Physicians
  - Spiritual counselors
  - Bereavement counselors
  - Social workers
  - Home health aids
  - Occupational/physical therapists
  - Nurses
  - Pharmacists
  - Volunteers
  - Family
  - PATIENT

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Overview of Hospice

- Hospice provided at different locations depending on level of care
  - Medicare Hospice Benefit provides specific levels
    - Routine Hospice Care: most common, care at home
    - General Inpatient Care: symptom management inadequate in other settings
    - Continuous Home Care: nursing/aids help at home during pain/symptoms crisis
    - Inpatient Respite Care: 24 hour nursing care, relieve regular primary caregiver

Overview of Hospice

- Principal diagnosis:
  - Cancer (27.2%)
  - Cardiac and other circulatory diagnoses (18.7%)
  - Dementia (18%)
  - Respiratory (11%)
  - Stroke (9.5%)
- Average length of service: 71 days
- Median length of service: 24 days
- In 2016, over half of the patients (54.2%) were enrolled in hospice for 30 or less days

Hospice vs. Palliative Care

- Palliative Care
  - Symptom management for any phase of life-limiting disease
  - Always part of hospice care but involved in other phases of care
- Similarities
  - Focus on symptom management
  - Provide expanded services to both patients and their families (emotional, spiritual)
- Differences
  - Palliative care can include patients receiving active treatment
  - Hospice is for patients expected to live 6 months or less

Family Concerns

- What does the family/patient want?
- Need to treat and care for the whole family, not just the patient
- Can family get involved in patient's care?
- Establish a primary caregiver

Pharmacologic Goals of Treatment

- Life-extending drugs are not appropriate
- Drugs for primary and secondary prevention usually have no place
- Limit prescribing of medications
- Patient and caregiver are important in determining relevance of symptoms in order to focus on what symptoms to treat first
- Treatment plan is dynamic and patient dependent
- Choose simple and convenient dosing schedules and use different formulations to tailor treatment to special needs of patient

Goals of Care (cont.)

- Pharmacist Goals/Interventions
  - Decrease medication burden
  - Medication tapering
  - Avoid duplications of therapy
  - Route of medications based on patient status
  - Monitoring (blood glucose, BP, etc.)
  - Recommend new medication to alleviate symptom
  - Staff/patient and family education

Hospice Challenges

- Lack of good studies and guidelines regarding hospice care
- As patient status changes, medication route becomes a concern
  - Suppositories
  - Patches
  - Suspensions
  - Topical gels
  - Tablets given rectally
  - Eye drops given sublingual

Top 10 Medications Prescribed in Hospice

1. Acetaminophen
2. Lorazepam
3. Morphine
4. Atropine
5. Haloperidol
6. Prochlorperazine
7. Albuterol
8. Docusate
9. Bisacodyl
10. Scopolamine

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Selected topics

- Disease States:
  - Diabetes
  - Heart disease
  - Liver disease
  - COPD
  - Alzheimer's
- Symptom Management
  - Pain management
  - Terminal restlessness/delirium
  - Dyspnea
  - Constipation
  - Nausea/vomiting
  - GI protection
  - Excessive secretions
  - Anorexia/cachexia
  - Xerostomia

Disease State Management: Diabetes

- More relaxed glucose control, blood glucose <200 mg/dL
- Hyperglycemia may be asymptomatic
- Patients at higher risk for hypoglycemia, decreased oral intake
- May be appropriate to discontinue hyperglycemic agents unless patient experiencing symptoms of hyperglycemia, Type 1 diabetic, patient preference
- Some medications contraindicated with declining organ function (metformin, Invokana)

Disease State Management: Heart Disease

- Antihypertensive medication
  - Typically continued for symptom management of underlying disease state or symptomatic hypertension
  - General systolic BP goal is 90-180 mmHg
  - Patients usually at higher risk for hypotension
- Loop diuretics may be continued longer in HF patients for dyspnea/edema issues
- Some BP meds should be tapered (duration of taper can be about 7-10 days; shorter if patient very hypotensive)
  - Clonidine
  - Beta-blockers

Disease State Management: Liver Disease

- Continue lactulose regimen
- Analgesia
  - NSAIDS/COX-2 Inhibitors/ASA: avoid use in patients with advanced liver disease or cirrhosis
  - Acetaminophen:
    - Chronic use: limit to 2 grams/day
    - Short term use: limit to 3 grams/day
  - Opioids: use cautiously and titrate slowly (consider 25-50% less dose with repeated dosing)
    - Avoid codeine and meperidine
    - Not recommend use of hydrocodone or oxycodone

Disease State Management

- COPD
  - Continue inhalers
  - May switch to nebulized solutions when patient can no longer use inhaler effectively
  - Steroids
  - Oxygen

- Alzheimer's Disease
  - Aricept, Namenda
    - Limited to no benefit in advanced Alzheimer's disease patients
    - Increased risk for GI side effects, loss of appetite, sedation

End-of-life Symptom Management: Pain management

- ~40% of hospitalized dying patients have moderate to severe pain in the last 3 days of life
- Nociceptive pain
  - Mild (1-3):
    - Acetaminophen or NSAID recommended
  - Moderate/Severe pain:
    - Opioids first line, using breakthrough first, then creating regular dosing schedule when pain is controlled

End-of-life Symptom Management

- Neuropathic pain:
  - Opioids
  - Glucocorticoids
    - Especially helpful for neurologic injuries, like nerve or spinal compression from a tumor
  - TD lidocaine patch for localized area of pain
  - Gabapentin or pregabalin
  - TCAs

End-of-life Symptom Management: Terminal restlessness/delirium

- Delirium very common in patients with terminal illness
- Referred to as terminal restlessness within last few days prior to death
- Delirium: acute disturbance of consciousness and change in cognition with fluctuating symptoms and evidence of organic etiology
    - Hyperactive: hallucinations/inappropriate behavior
    - Hypoactive: reduced motor activity
    - Mixed: alternating

End-of-life Symptom Management: Terminal restlessness/delirium

- Pathogenesis poorly understood
  - Combination of neurotransmitter imbalance, hormone levels
  - Precipitating factors: electrolyte imbalance, infection, organ failure, medications, unfamiliar environment
  - Medications that may contribute:
    - Benzodiazepines
    - Opioids
    - Steroids
    - Anticholinergics

End-of-life Symptom Management: Terminal restlessness/delirium

- Management
  - Assess temporal relationship of delirium onset and medication use
    - If not medication induced – make environment more comfortable (lighting, pictures/familiar objects, reduce noise)
      - Can add medication if not responding (benzos, antipsychotics)
    - If medication induced – try to reduce/avoid it, environment changes, possibly add med to help with hallucination
      - Haloperidol 0.5-1 mg PO or IV every hour PRN, once symptoms are relieved, give total daily dose in 3-4 divided doses

End-of-life Symptom Management: Dyspnea

- Opioids
- Benzodiazepines: for treating the anxiety associated with dyspnea
- Oxygen
  - If used, titrate to patient comfort ONLY (subjective relief of dyspnea)
- Non-pharmacological options:
  - Cooling face with a fan decreases breathlessness
  - Open windows
  - Decreasing room temperature
  - Breathing humidified air
  - Elevation of head of the bed

End-of-life Symptom Management

- Nausea/Vomiting:
  - Promethazine gel
  - Ondansetron ODT
  - Metoclopramide
  - Prochlorperazine suppository
  - Scopolamine patch
  - Haloperidol
  - Dexamethasone 4-8 mg PO daily) in patients with N/V due to ↑ ICP
- Constipation:
  - Assess for possible medication side effect (discontinue drug if possible)
  - Opioid-induced common cause of constipation
    - Senna/docusate, bisacodyl, Miralax, magnesium citrate
    - Vaseline balls
- GI protection:
  - May be considered for patients on chronic steroids and/or scheduled NSAIDs

End-of-life Symptom Management

- Excessive secretions
  - Can lead to gurgling sounds from throat that is sometimes termed “death rattle”
    - Repositioning the head may decrease the sounds
  - Pharmacologic Treatment:
    - Atropine 1% ophthalmic 1-2 drops every 2 hours as needed
    - Hyoscyamine 0.125 mg PO, PR, or subQ every 4 hours as needed

- Anorexia/Cachexia
  - Do not force patient to eat or drink unless PATIENT desires
  - Glucocorticoids may transiently increase appetite and energy
    - Dexamethasone 2-4 mg PO once daily

End-of-life Symptom Management: Xerostomia

- Can be caused by specific medications, previous radiation to the head or neck, and dehydration
- Discontinuing offending medications
  - Pilocarpine 5-10 mg TID (MAX: 30 mg/day)
    - Could consider using pilocarpine 2% ophthalmic solution swish and swallow/spit 4 drops of solution TID
- Antimicrobial mouthwashes
- Saliva substitutes
- Non-pharm options:
  - Sugarless gum
  - Lip balm
  - Humidifier

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Conclusion

- Hospice shifts focus of care to symptom management instead of curative therapy
- Team approach
- Each patient is different and care needs to be tailored to specific situation
- Pharmacists can make impactful recommendations to reduce unwanted effects and maximize patient benefit of therapy

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Review Question #1

- Which of the following is NOT a goal for patient care in the hospice setting?
  A. Symptom management
  B. Adjusting treatment plan as patient goals of care change
  C. Weighing the risks and benefits of medications prior to adding any new medication
  D. All of the above are considered goals of treatment for hospice patients

Review Question #2

- What is the maximum amount of acetaminophen per day that a patient with advanced liver disease who is not drinking can take chronically?
  A. 1 gram/day
  B. 2 grams/day
  C. 3 grams/day
  D. 4 grams/day

Review Question #3

_____ is a recommended treatment for neuropathic pain in a patient whose life expectancy is less than a few days.

A. Gabapentin
B. Opioids
C. TCAs
D. None of the above

Review Question #4

True or False: All diabetes and hypertension medications should be discontinued as soon as a patient begins hospice.

Review Question #5

What are some additional things to consider when making medication recommendations for hospice patients?

A. Routes of medication administration
B. Dosing frequency
C. Patient preference
D. None of the above

References

- Facts and Figures: Hospice Care in America. National Hospice and Palliative Care Organization. 2017 Edition. https://www.nhpco.org/sites/default/files/public/Statistics_Research/2017_Facts_Figures.pdf
- Medicare Hospice Benefits. Centers for Medicare & Medicaid Services. https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF
- Hospice & Palliative Care. Center for Hospice Care Southeast Connecticut. https://www.hospicesect.org/hospice-and-palliative-care
- Herndon CM, Nee D, Atayee RS, et al. ASHP Guidelines on the Pharmacist's Role in Palliative and Hospice Care. *Am J Health Syst Pharm*. 2016 Sep 1;73(17):1351-67
- Liu E. Discontinuing Medications for Hospice Patients. Hospice Pharmacy Solutions. http://www.hospicepharmacysolutions.com/wp-content/uploads/2016/12/discontinuing-medications-for-hospice-patients_el_20161219_final.pdf
- Barbee J, Kelley S, Andrews J, et al. Palliative Care: The Role of the Pharmacist. *Pharmacy Times.* 2016 Nov. http://www.pharmacytimes.com/publications/health-system-edition/2016/november2016 /palliative-care-the-pharmacists-role
- Harris D. Delirium in advanced disease. *Postgrad Med J*. 2007 Aug; 83(982): 525–528
- Hamilton JP, Goldberg E, Chopra S. Management of pain in patients with advanced chronic liver disease or cirrhosis. *UpToDate* [Internet]. [cited 8 Apr 2018; updated 2017 Jan]. Available from: https://www.uptodate.com/contents/management-of-pain-in-patients-with-advanced-chronic-liver-disease-or-cirrhosis#H1
- Longo, DL, Blinderman CD, Bilinga JA. Comfort care for patients dying in the hospital. *NEJM*. 2015 Dec 24;373(26):2549-61.
- Cruz-Jentoft AJ, Boland B, Rexach L. Drug therapy optimization at the end of life. *Drugs Aging*. 2012;29(6):511-521.
- Sera L, McPherson ML, Holmes HM. Commonly prescribed medications in a population of hospice patients. Am J Hosp Palliat Care. 2014 Mar;31(2):126-131.

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