# When Less is More

## How Less Medication Makes End of Life More.....


Rebecca Smith, PharmD

**A better way.**

# A Prescription Taking Nation

- 2.9 billion prescriptions written in 2016 by clinic prescribers
- 40% of Americans 65 years and over take 5 or more prescription medications.
- 30% take 8 or more prescription medications.
- Americans 65 years and over average 18 prescriptions per year.
- Hospice patients average 11.5 medication per patient on admission
- At discharge, hospice patients average 20 medications

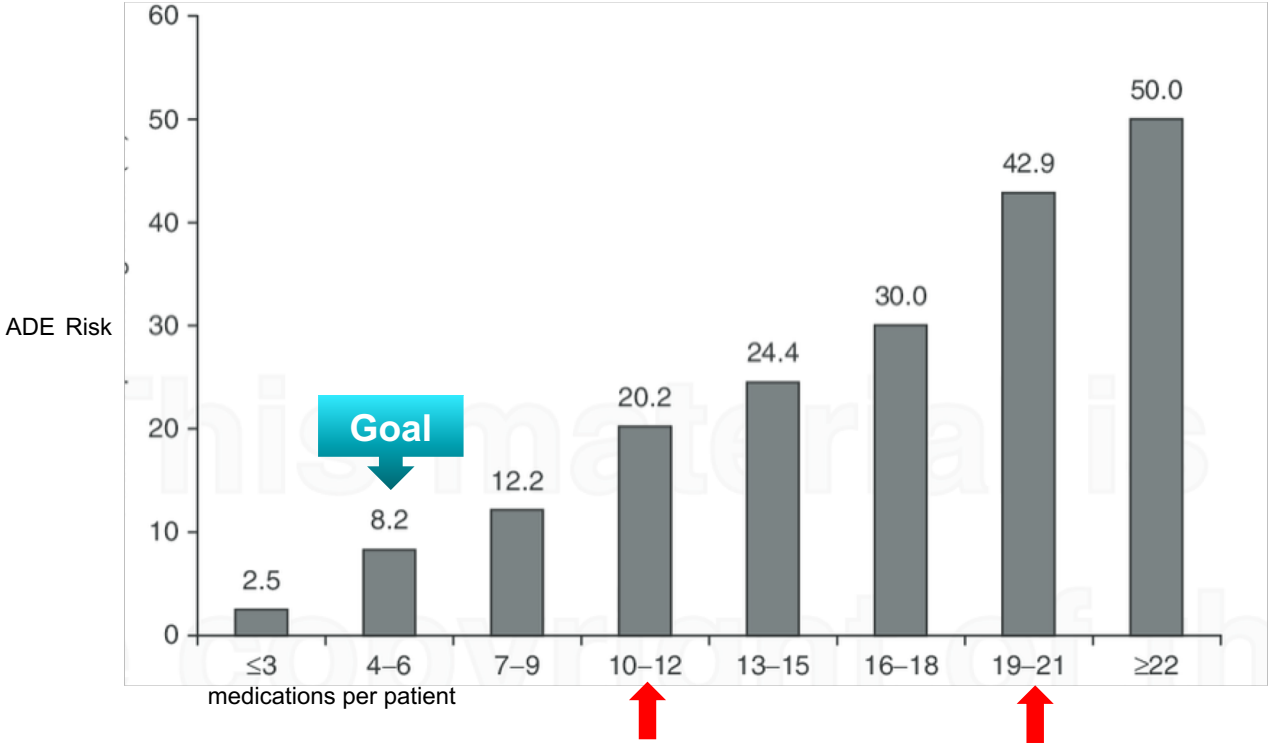
https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2013_namcs_web_tables.pdf


"You said 'fill all of them,' so we did. Next time maybe you should think about what you're saying?"

# Why does this matter?

| | | | |
|---|---|---|---|
| 5 medications | 6% | Heart Failure<br>+ 5 medications | 10% |
| +2<br>= 7 medications | 16% | Renal Failure<br>+ heart failure<br>+ 7 medications | 30% |
| +5<br>= 15 medications | 32% | Decreased food intake<br>+ renal failure<br>+ heart failure<br>+ 15 medications | 47% |

# Stopping medications is not for the bottom line



# Why should hospice be concerned with polypharmacy?

Polypharmacy is associated with a 2.3 fold increase in ADEs

Risk doubles if taking 9+ medications

ADEs are found in 35% of older people and 2 out of 3 nursing home residents

28% of hospital admissions are due to adverse drug reactions

# A few definitions....

## Polypharmacy

taking 5 + prescriptions, supplements, herbs each day

## Deprescribing

process of thoughtfully reducing a patient's pill burden

## Adverse Drug Event (ADE)

unwanted event or reaction caused by or due to a medication side effect

## Prescription Cascade

new drugs added for a new "disease" that in reality is an ADE

# The Numbers

13% Risk of an interaction with 2 medications

82% Risk of an interaction taking >7 medications

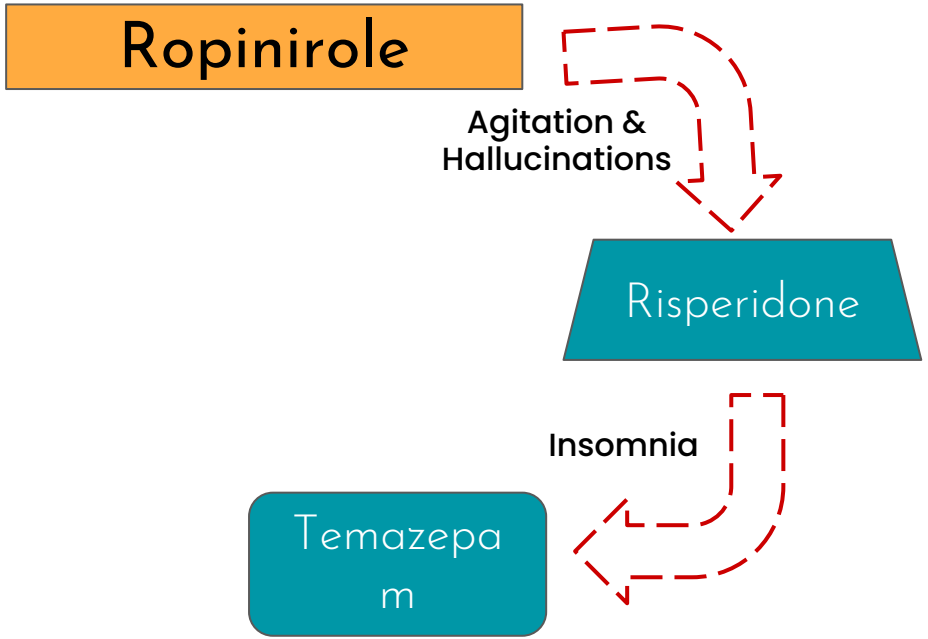
100% Risk of an interaction taking >10 medications

Risk of falls increases 3 fold if taking 6 or more medications

Risk of falls in dementia patients increases 7% for every medication over four

**16.4 medications daily**

# The Prescription Cascade



Namenda + Aricept

Urinary Incontinence

Oxybutynin

Angioedema, tachycardia and dizziness

Furosemide + Potassium + amiodarone

HERMAN®

by Jim Unger


"I feel a lot better since I ran out of those pills you gave me."

# How to deprescribe?

or

# How to convince patients life will be better without all those pills!

# There are many tools and algorithms

- CEASE Protocol
- Good-Palliative Geriatric Practice Algorithm
- STOPPFrail Criteria
- LESS-Chron Criteria
- Beers List of Inappropriate Medications
- Palliative and Therapeutic Harmonization Program
- FortA List
- The 5 Step Deprescribing Program
- The 10 Step Deprescribing Framework
- CMS targeted medication classes and prescribing habits

# Turn a negative into a positive.....

- ★ You outlived the benefits of this medication.
- ★ One of our primary focuses is your safety. As we goes forward we will make changes for your safety.
- ★ How many more scoops of ice cream can you get each day if we stop these medications?

# CMS and Medications

Provide medications that are REASONABLE AND NECESSARY for the palliation and management of [the] terminal illness and related conditions. Including drugs in these 4 categories analgesics, antiemetics, laxatives, and anti-anxiety drugs.

## What does CMS consider appropriate versus inappropriate?

1. Is the dose excessive?
2. Is the medication a duplication of therapy?
3. Is the duration of therapy excessive?
4. Is there an indication for the medication?
5. Is proper monitoring occuring?
6. Is the patient experiencing adverse effects?
7. Or a combination

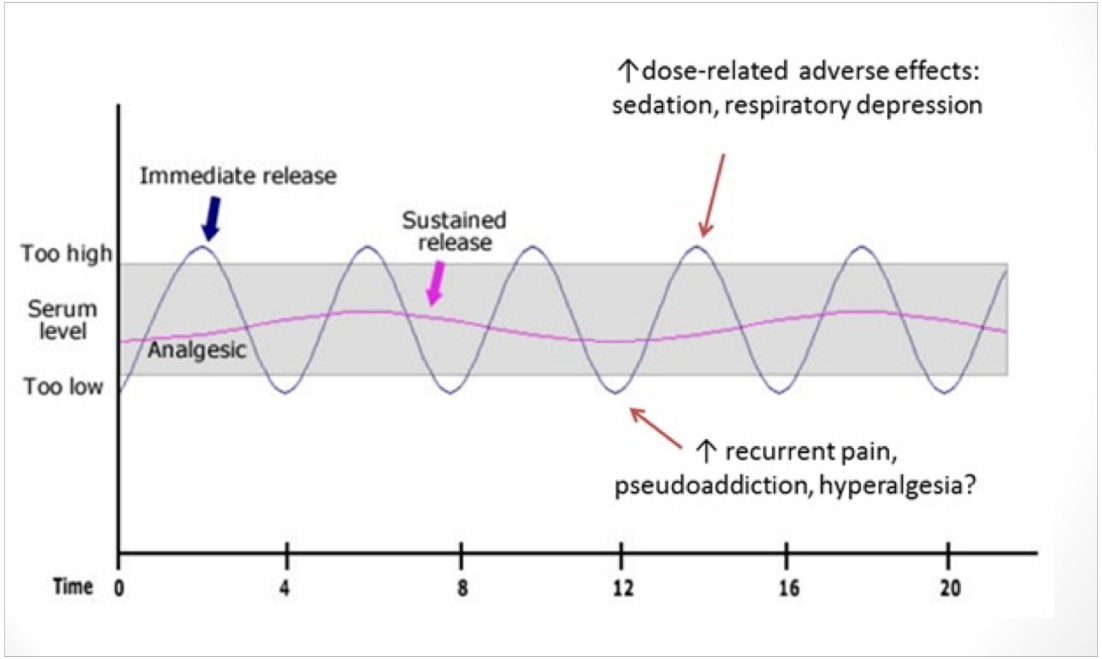
# Indication for Medications

**Unnecessary medications provide no benefit to:**

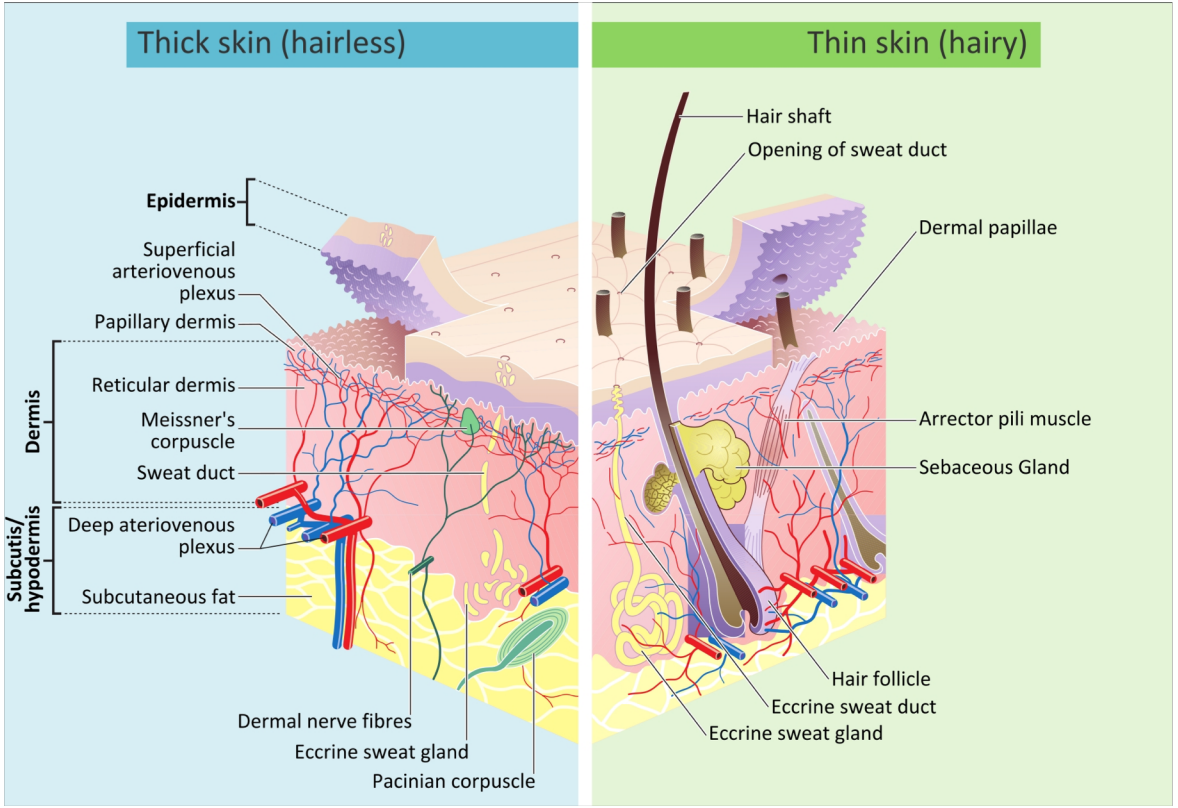
- ★ Duration of life
- ★ Quality of life
- ★ Symptom management

- Vitamins and Minerals
- Herbal supplements
- Cholesterol medications
- Osteoporosis medications
- Singulair and others
- Comtan
- Entresto
- Docusate

# Excessive Dose - Pain Management



# Excessive Dose - Pain Management



# Duration of Therapy - Anticoagulants/Antiplatelets

**Anticoagulants**

- Risk of Fall/bleed vs Risk of Clot
- Except for a few cases indicated for short term use only <12 months
- Only Warfarin has a reversal agent

Duration of Antiplatelet Therapy

(based on individual risk)

| Bleed Risk \ Ischemic Risk | Low | Moderate | High |
|---|---|---|---|
| Low | 6 months | 12 months | ≥ 30 months |
| Moderate | 3-6 months | 6-12 months | 12 months |
| High | ≤ 3 months | 3-6 months | 6-12 month |

# Duration of Therapy – GERD Medications

**Proton Pump Inhibitors**

- Approved for short term use only
- B12 deficiency
- Iron, calcium and magnesium deficiencies
- Hip, femur, spine and wrist fractures
- Clostridium Difficile infections
- Community acquired pneumonia
- Rebound gastric reflux requires tapering
- Use H2 blocker + antacid prn

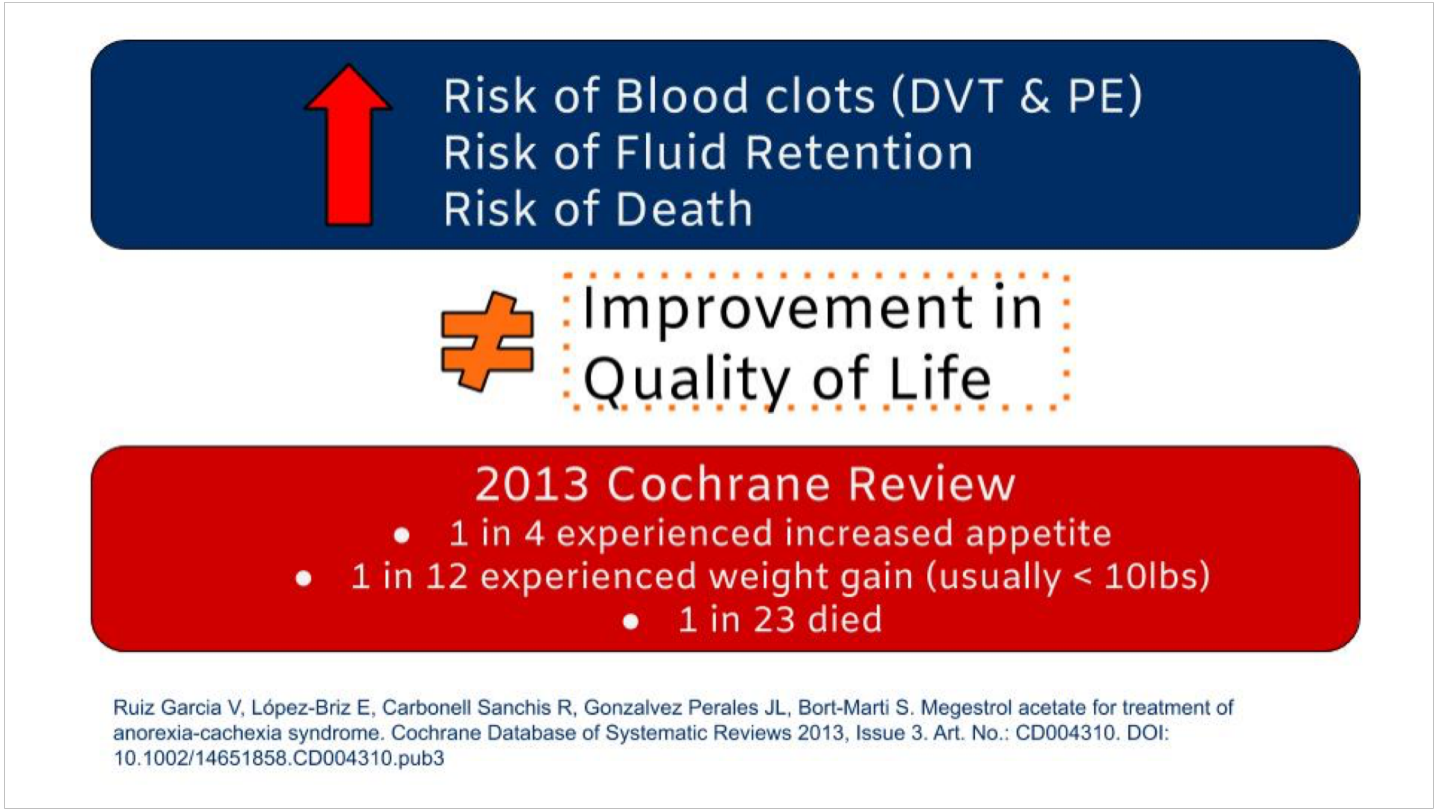
| Indication | Duration |
|---|---|
| **GERD** | Indefinite period of time or use on demand |
| **HP eradication** | 7 – 10 – 14 days |
| **Duodenal ulcer** | 4 wks – duration increased in refractory cases |
| **Gastric ulcer** | 8 wks – duration increased in refractory cases |
| **Bleeding PU** | IV PPIs for 72 hours (**consensus**) |
| **Gastroprotection** | As long as patient requires NSAIDs or ASA |
| **Dyspepsia** | Depend on symptomatic response |
| **ZES** | Indefinite period of time |

# Risk vs Benefits

**Is it possible this medication is doing more harm than good?**

- Iron supplement
- Fiber laxatives
- Milk of Magnesia
- Atropine
- Antibiotics
- Megace
- Ropinirole
- Namenda + Aricept

# Risk vs Benefits: Megace




Ruiz Garcia V, López-Briz E, Carbonell Sanchis R, Gonzalvez Perales JL, Bort-Marti S. Megestrol acetate for treatment of anorexia-cachexia syndrome. Cochrane Database of Systematic Reviews 2013, Issue 3. Art. No.: CD004310. DOI: 10.1002/14651858.CD004310.pub3

# Risk vs Benefits: Atropine

0

Not one study found a pharmacological management better than placebo.

Some studies found secretions resolved spontaneously without intervention.

# Risk vs Benefits: Ropinirole

How many of your patients take this medication for something other than Parkinson's Disease?

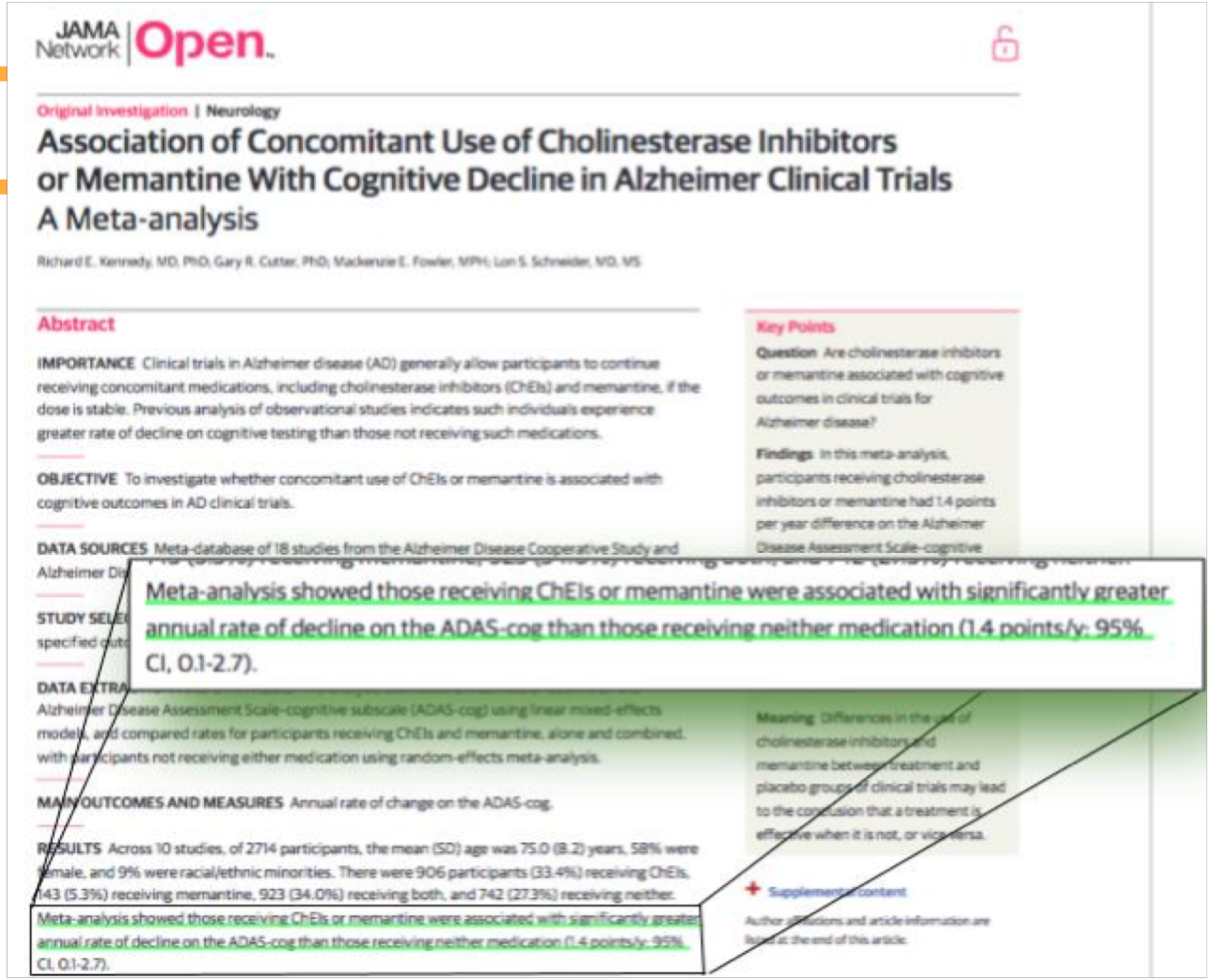
| | |
|---|---|
| Nausea | 49% |
| Somnolence | 27% |
| Insomnia | 25% |
| Disease Aggravation | 22% |
| Dyspepsia | 21% |
| Dizziness | 20% |
| Hallucination | 17% |
| Vomiting | 16% |
| Tremor | 16% |
| LE edema | 14% |
| Headache | 14% |
| Ataxia | 14% |
| Anxiety | 12% |
| Hypotension | 12% |
| Dyskinesia | 9% |
| Dystonia | 7% |

# Risk vs Benefits: Antibiotics

"Given significant treatment burdens, potential for adverse effects such as CDI, and public health risks, antibiotic therapy should be viewed as aggressive care in the end-of-life setting."

-Infectious Disease Society of America

# Risk vs Benefits



JAMA Network | Open

Original Investigation | Neurology

## Association of Concomitant Use of Cholinesterase Inhibitors or Memantine With Cognitive Decline in Alzheimer Clinical Trials
### A Meta-analysis

Richard E. Kennedy, MD, PhD; Gary R. Cutter, PhD; Mackenzie E. Fowler, MPH; Lon S. Schneider, MD, MS

**Abstract**

**IMPORTANCE** Clinical trials in Alzheimer disease (AD) generally allow participants to continue receiving concomitant medications, including cholinesterase inhibitors (ChEIs) and memantine, if the dose is stable. Previous analysis of observational studies indicates such individuals experience greater rate of decline on cognitive testing than those not receiving such medications.

**OBJECTIVE** To investigate whether concomitant use of ChEIs or memantine is associated with cognitive outcomes in AD clinical trials.

**DATA SOURCES** Meta-database of 18 studies from the Alzheimer Disease Cooperative Study and Alzheimer Di

**STUDY SELE** specified out

**DATA EXTRA** Alzheimer Disease Assessment Scale-cognitive subscale (ADAS-cog) using linear mixed-effects models, and compared rates for participants receiving ChEIs and memantine, alone and combined, with participants not receiving either medication using random-effects meta-analysis.

**MAIN OUTCOMES AND MEASURES** Annual rate of change on the ADAS-cog.

**RESULTS** Across 10 studies, of 2714 participants, the mean (SD) age was 75.0 (8.2) years, 58% were female, and 9% were racial/ethnic minorities. There were 906 participants (33.4%) receiving ChEIs, 143 (5.3%) receiving memantine, 923 (34.0%) receiving both, and 742 (27.3%) receiving neither. Meta-analysis showed those receiving ChEIs or memantine were associated with significantly greater annual rate of decline on the ADAS-cog than those receiving neither medication (1.4 points/y; 95% CI, 0.1-2.7).

**Key Points**

**Question** Are cholinesterase inhibitors or memantine associated with cognitive outcomes in clinical trials for Alzheimer disease?

**Findings** In this meta-analysis, participants receiving cholinesterase inhibitors or memantine had 1.4 points per year difference on the Alzheimer Disease Assessment Scale-cognitive

Meta-analysis showed those receiving ChEIs or memantine were associated with significantly greater annual rate of decline on the ADAS-cog than those receiving neither medication (1.4 points/y; 95% CI, 0.1-2.7).

**Meaning** Differences in the use of cholinesterase inhibitors and memantine between treatment and placebo groups of clinical trials may lead to the confusion that a treatment is effective when it is not, or vice versa.

Supplemental content

Author affiliations and article information are listed at the end of this article.

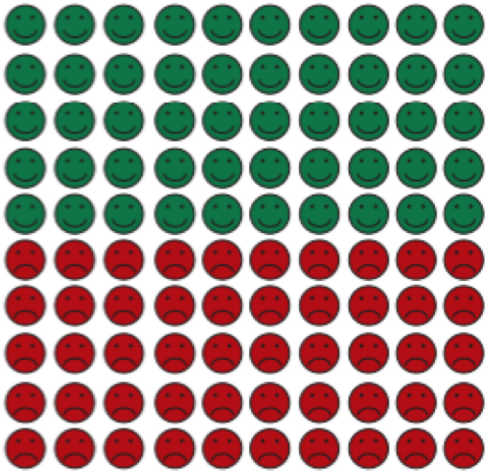
# Risk/Benefit Decision Aid

## NO STATIN

50 people **DO NOT** have a heart attack (green)

50 people **DO** have a heart attack (red)

The risk for 100 people like you who **DO NOT** take statins.



## YES STATIN

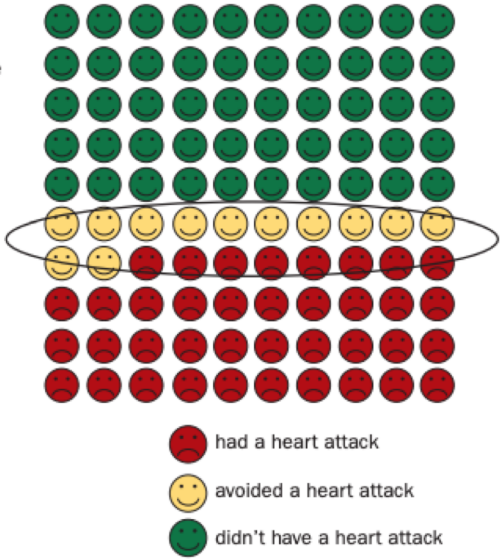
50 people still **DO NOT** have a heart attack (green)

12 people **AVOIDED** a heart attack (yellow)

38 people still **DO** have a heart attack (red)

88 people experienced **NO BENEFIT** from taking statins

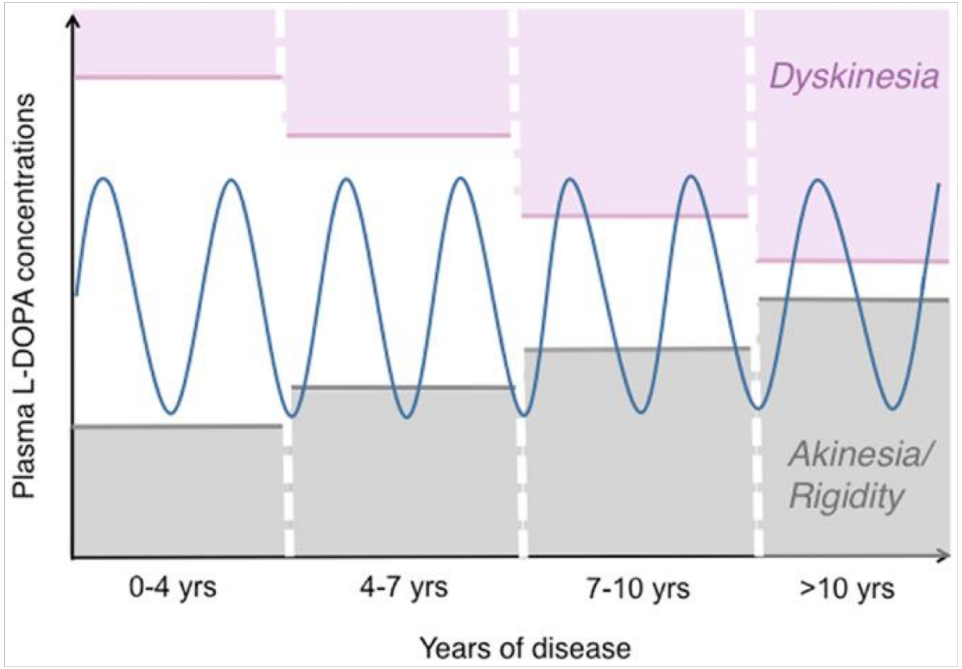
The risk for 100 people like you who **DO** take statins.




Decision Aid Courtesy of Mayo Clinic

# Time to Benefit

What was once preventive is now past it's helpfulness or even harmful.



# It’s all about Quality not Quantity

The time for tight schedules, frequent monitoring, and narrow ranges is over.

BS closer to 200 than 120

BP closer to 150/90 than 120/70

O2 closer to 90 than 100

No discomfort? No anxiety?

No worries!


"This probably won't work, but we do have medications that will take care of the side effects."

# Comfort,
# Made better.

**Robin Van Sickle**
**National Sales Director**
rvs@BetterRX.com
(254) 290-9285

**www.BetterRX.com**