Dartmouth Health

Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)

Inside the Mind of a Hospice Medical Director: 10 Things Hospice Providers Wished You Knew

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Title of Program: What's Old is New: A Fresh Take on Some Classics

Title of Talk: Inside the Mind of A Hospice Medical Director: 10 Things Hospice Providers Wished You Knew

Speaker/Moderator: Cristine Maloney, MD, HMDC

Date: June 5, 2024

Workshop #: 21-3

Planning Committee Members: Cindy Bruzzese, Diana Barnard, Cristine Maloney, Kelly Elwell, Bernie Bandman

Learning Objective: see next slide

Purpose Statement/Goal of this activity: see next slide

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No

Did this activity receive any support from ineligible companies (grants or in-kind)? No

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This program has been reviewed and is acceptable for up to 1 Nursing Contact Hours.

This course has been approved for _0_ hours of pharmacy continuing education credit.

This activity was planned by and for the healthcare team, and learners will receive __0 Interprofessional Continuing Education (IPCE) credit for learning and change.

IPCE CREDIT™

Learning Objectives

1. Name at least 2 medications that are preferred for hospice patients.
2. Name at least 2 procedures that are ideally performed prior to hospice admission.

THANKS to my fellow hospice physicians:

David Dumont, MD, HMDC

Diana Barnard, MD

Lori Richer, MD, HMDC

#1: Hospice does not provide in-home care 24/7

- Hospice CAN provide

1. Nurse phone support 24/7 with nursing visits as needed for acute issues
2. Provider support 24/7 for nurse consultation, new prescriptions
3. LNA (licensed nursing assistant) support on a regular basis, i.e. 3x per week or 5x per week

- Hospice provides episodic visits but not “block coverage” i.e. someone stays in home for 4 hours (exception: continuous care—short term for intensive symptom management)

#2: Hospice is paid a per diem rate to take care of patients

- 4 levels of hospice care--vast majority of patients on “routine home care”
- Current per diem rate: approximately $210 for days 1-60, $165 for days 61+
- Hospice is required to provide all services related to the medical diagnoses that contribute to a 6 month or less prognosis for patients with this amount of money (examples):

1. Staff
2. Medications
3. Supplies
4. Durable medical equipment (DME)

- This influences what hospices can and cannot afford to pay for

Fiscal Year 2024 Hospice Wage Index Final Rates (Vermont rural counties)

#3: Talk to the hospice nurse/medical director

- Hospices often use a mail order hospice specific pharmacy for patient medications
- Local fills of medications often require calling the pharmacy to ensure that appropriate medications are billed to the hospice NOT the patient
- Hospices often have preferred medications and/or formulary medications
- Non-formulary medications may require approval to be filled

- Costs for 2 week supply: Morphine Extended Release (MS Contin) 15mg po BID=$33, Fentanyl patch 12mcg q72 hours=$102, Oxycontin 10mg po BID=$173, (Methadone 2.5mg po BID: $15)
- Source: Enclara Pharmacia--VNH

#4: Hospice commonly uses concentrated liquid medications—rare to need a fentanyl patch

- Common for hospice to use morphine 20mg/ml (NOTE the concentration)
- Many hospices use a hospice specific mail order pharmacy that can do compounded medications
- Examples of medications available from hospice compounding pharmacy:

1. Morphine 40mg/ml ($23 for 30ml)
2. Hydromorphone (Dilaudid) 4mg/ml ($30 for 30ml), 10mg/ml, 50mg/ml
3. Methadone 10mg/ml ($25 for 30 ml), 50mg/ml

Source: Enclara Pharmacia--VNH

#5. Nebulizer treatments are preferred over powder inhalers

- Patients with end stage chronic obstructive pulmonary disease (COPD) have very impaired lung capacity, lessening the effectiveness of powder inhalers. These inhalers require a strong inspiratory effort and coordination with breathing to deliver the proper dose.
- Sample script: “we often find that people with severe lung disease can’t benefit as well from their inhalers like they once did. I’d like to make some suggestions about changing your medications….”
- Preferred: albuterol-ipratropium (DuoNebs) via nebulizer. Additions include: oral steroid, morphine, benzodiazepine (if anxiety component also exists)
- Costs per 2 week supply: albuterol-ipratropium nebulized solution $33 vs Combivent Respimat (ipratropium bromide and albuterol) $513

Inhaled Therapy Case: Selecting the Best Device and Mixing Nebs. Palliative Pearls by Enclara Pharmacia. January 2018; Cost source: Enclara Pharmacia--VNH

#5. Nebulizer treatments are preferred over powder inhalers

- If the answer is YES to one or more of the questions below, switching to nebulized therapy is recommended to optimize treatment and reduce symptoms:

1. Is the patient frail and debilitated with poor inspiratory effort and/or unable to hold their breath for up to 10 seconds?
2. Is the patient unable to coordinate their breath during inhalation?
3. Does the patient have inadequate symptom relief with their inhaler?
4. Does the patient have cognitive impairment and/or unable to follow instructions?
5. Does the patient have decreased strength or presence of arthritis or joint pain in their hands?

Inhaled Therapy Case: Selecting the Best Device and Mixing Nebs. Palliative Pearls by Enclara Pharmacia. January 2018

#6: Re-evaluate the use of anti-coagulants for prevention (and likely deprescribe)

- Common scenario: patient with atrial fibrillation
- In patients with significant nutritional impairment, impaired swallowing, and prognosis in the range of days to weeks (50% of hospice patients enrolled 17 days or less, 75% for 79 days or less), discontinuing anti-coagulation should be strongly considered given the low absolute risk of venous thromboembolism (i.e. blood clot)
- Tools to use: CHA2DS2-VASc, HAS-BLED to weigh the risk of bleeding vs new thromboembolic events
- Limited evidence for the hospice population
- Discuss patient's prognosis, values and preferences
- Cost per month: warfarin (coumadin) $30, apixaban (Eliquis) $620

NHPCO Facts and Figures 2023; Hilton R, Hayes M, Somers E, Brooten J and Gabbard J. Anticoagulation for Non-Valvular Diseases in Patients with a Limited Prognosis. Fast Facts and Concepts. April 2023; 461. Available at https://www.mypcnow.org; Cost source: Enclara Pharmacia--VNH

#7: Re-evaluate medication for dementia (and likely deprescribe)

- If the answer is YES to one or more of these questions, discontinuing dementia medications is recommended:

1. The patient/caregiver chooses to stop treatment
2. The patient declines the medication
3. The patient does not adhere to the medication regimen
4. There is no response after a reasonable trial
5. The potential benefit is no longer clinically significant in terms of the overall disease severity/stage (i.e. now hospice eligible with prognosis of 6 months or less)

Discontinuing Dementia Medications Case. Palliative Pearls by Enclara Pharmacia. April 2017

#7: Re-evaluate medication for dementia (and likely deprescribe)

- Patient is experiencing side effects:

1. For cholinesterase inhibitors i.e. donepezil (Aricept), galantamine (Razadyne), rivastigmine (Exelon):

Nausea, vomiting, diarrhea, anorexia, weight loss, abdominal pain, muscle cramps, tremor, dizziness and headache

2. For NMDA antagonists i.e. memantine (Namenda):

Dizziness, confusion, constipation and increased blood pressure

Discontinuing Dementia Medications Case. Palliative Pearls by Enclara Pharmacia. April 2017

#7: Re-evaluate medication for dementia (and likely deprescribe)

- Sample script: “Your mother’s dementia medication is most likely no longer contributing to her comfort and may be causing unwanted side effects such as nausea and poor appetite. These medications also increase the burden of taking pills each day. For these reasons, I suggest that we slowly decrease these medications over the next few weeks while we carefully observe for any changes. Are you OK with that?”
- How to taper:

1. Begin discontinuation with only 1 medication at a time (usually start with cholinesterase inhibitors)
2. Decrease dose by half every 2-4 weeks and then stop
3. Once first drug is tapered, same process with second drug

Discontinuing Dementia Medications Case. Palliative Pearls by Enclara Pharmacia. April 2017

#8: Use non-pharmacologic measures first line for oral secretions at end of life (i.e. death rattle)

- Death rattle is a good predictor of near death in the terminally ill
- Median time from onset of symptoms to death was 16 hours
- Non-pharmacologic measures include:

1. Reposition the body in a lateral position on the side to facilitate drainage
2. Address family and caregiver fears and interpretations associated with death rattle
3. Counsel caregivers that noisy breathing may not bother the patient even if it bothers them

Bickel K, Kareem L, Bui T and Arnold R. Death Rattle and Oral Secretions. Fast Facts and Concepts. February 2019; 109. Available at https://www.mypcnow.org.

#8: Use non-pharmacologic measures first line for oral secretions at end of life (ie. Death rattle)

Scopolamine patch has on onset of +/- 12 hours with 24 hours until steady state

- Would need to start prior to symptom to be effective!
- Cost: package of 4--$70 (each patch lasts 3 days so package would last 12 days…)

Atropine sulfate 1% eye drops (given sublingual) have an onset of 30 minutes, lasts 2 hours

- Cost: package of 2--$44

**Hyoscyamine (Levsin) 0.125mg has an onset of 30 minutes, lasts 4-6 hours

- Cost: 4 tablets--$11 (for 24 hours)

Cost source: Enclara Pharmacia--VNH

#9: Insert a tunneled catheter for malignant ascites BEFORE hospice enrollment

- Tunneled catheters (ex: PleurX) are:

1. Used in patients with a life expectancy of at least one month
2. Considered after a patient has had at least 2 prior paracentesis
3. **Can also be considered in patients for whom disease burden makes clinic visits difficult (i.e. most hospice patients)
4. “Even considering the cost of drainage containers plus placement cost, tunneled indwelling catheters can have a potential financial benefit over large volume paracentesis in as early as 1 week”
5. The costs of repeated paracentesis are often NOT financially viable for a small hospice

Burleigh J, Mehta Z and Ellison N. Tunneled Indwelling Catheters for Malignant Ascites. Fast Facts and Concepts. March 2019; 308. Available at: https://www.mypcnow.org

#10: Turn off the defibrillator PRIOR to hospice enrollment

- Indications for deactivation of implantable cardioverter-defibrillators (ICD):

1. Continued use is inconsistent with patient goals
2. Patient's condition is worsening and death is anticipated
3. The patient has a do not resuscitate (DNR) order since ICDs attempt to resuscitate patients by shocking their hearts back into a life-sustaining rhythm

- Conversation tips:

1. Turning off the ICD will not cause death and will not be painful
2. Legal and ethical as patients can request withdrawal of any life sustaining intervention
3. ICD function can be independently turned off (i.e. does not effect pacing function)

#10: Turn off the defibrillator PRIOR to hospice enrollment

- How to turn off the defibrillator:

First choice: in a cardiac device/cardiology clinic or while inpatient in the hospital

Second choice: device representative may go to patient's home to turn off (needs to be scheduled so can be lag time, usually needs a provider order and may need hospice nurse present)

Third choice: temporary deactivation by placing a special magnet over the ICD site (need to have magnet available, if magnet removed then device resumes functioning)

Harrington M, Luebke D, Lewis W, Aullisio M, Johnson N. Implantable Cardioverter-Defibrillators at End of Life. Fast Facts and Concepts. February 2019; 112. Available at: https://mypcnow.org

Questions?