Long Term Care Social Workers of Iowa

Fall 2024

Deprescribing at the End of Life

By Scott Janssen, MA, MSW, LCSW

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Excessive polypharmacy erodes quality of life and undermines safety, comfort, and well-being.

Inside this issue:

For years, Bill's type 2 diabetes had been well controlled using a stable dose of insulin. After he was diagnosed with lung cancer, he started chemotherapy, added a couple medications to his daily routine, and continued managing his diabetes with the same reliable effects.

Unfortunately, Bill's cancer proved incurable. As the disease progressed, his appetite diminished, and he began losing weight. One day his wife called the hospice nurse very distressed. Bill was acting strangely. When she checked his blood sugar level it was 30, low enough to be life threatening.

Thinking about the case, Jared Lowe, MD, HMDC, medical director of University of North Carolina Hospice, notes that "in an older patient, particularly when there's a terminal illness, we can often relax our goals for blood sugar and allow higher levels, so at an earlier point Bill's insulin dose could have been lowered. This is particularly true when someone starts eating and drinking less; their body begins to change, and the same medications can be very harmful. In fact, if someone isn't eating much as they get sicker, insulin can drop their blood sugars so low it kills them or causes neurologic harm."

Older patients with a limited life expectancy, like Bill, are at an increased risk for polypharmacy, commonly defined as the use of five or more medications.1 One retrospective study, for example, looked at more than 4,000 patients at 11 hospices and found that patients took an average of 15.7 medications.2

Joshua McCullough, DNP, APRN, AGPCNP-BC, an advanced practice provider at University of North

Continued on Page 3

Long Term Care Social Workers of Iowa Fall Conference
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Guidelines for Licensees: How to Choose and Document Continuing Education

The Bureau of Professional Licensure does not pre-approve continuing education providers, sponsors or individual programs. It is the licensees' responsibility to determine if the continuing education programs they attend meet the requirements of their professional licensure board.

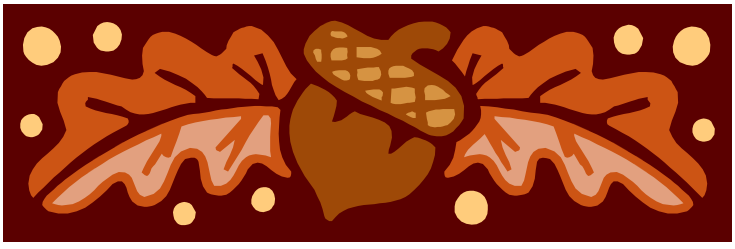
A percent of licensees are randomly audited following each license renewal cycle. If selected, the licensee must submit to the board office an individual certificate of completion issued to the licensee or evidence of successful completion of the course from the course sponsor. These documents must contain the course title, date(s), contact hours, sponsor and licensee's name. In some instances, licensees will be requested to provide to the board additional information, including program content, objectives, presenters, location and schedule. Many times an inclusive brochure meets this requirement.

When selecting continuing education programs, licensees need to make sure they are compliant with administrative rule requirements. Some professions require specific conditions to exist such as presentation method (home study, ICN, etc.), specific hours on ethics and Iowa law and rules, certification status by national associations or boards, clinical content, and hours required in a specific practice discipline, as well as other items. To ensure compliance, each licensee must understand the continuing education administrative rules for their profession prior to choosing and attending a particular program. **No matter what a program brochure indicates, it is the responsibility of the licensee to ensure compliance with licensing requirements.**

In summary all licensees should:

- Be familiar with the continuing education requirements of their professional boards
- Obtain inclusive written materials about continuing education programs from program sponsors for post-renewal auditing purposes

Maintain certificates of completion that includes the program or course title, date(s), contact hours, sponsor and licensee's name for four years.



Depresscribing ~ Continued

Continued from Page 1

Carolina Hospice, says it is not surprising that older patients often wind up taking multiple drugs. “The older you get, the more things go wrong with you, the more support you need from medications to keep going or prevent further decline. It often comes down to the fact that our bodies get tired and don’t function as well; the older we get the more help we need to help our body maintain homeostasis.”

As diseases progress and other changes occur in an older patient’s body, the efficacy and impact of medications may be affected, and interactions between drugs may change.

Consequences of Polypharmacy

The potential negative consequences of polypharmacy in geriatric patients nearing the end of life include the following:

• increased risk of adverse side effects and detrimental medication-to-medication or medication-to-illness interactions;

• higher “pill burden”—the stress and challenges taking medications cause in a patient’s life;

• medication errors or poor adherence due to drug regimens that may require a combination of pills, liquids, injections, transdermal patches, and inhalers;

• increased likelihood that multiple prescribers and pharmacies are involved, which could undermine communication and shared care planning;

• ever increasing polypharmacy as more medications are added to address symptoms associated with end of life; and

• social and family impacts, such as increased need for assistance with medication administration or increased financial stress.3-6

Addressing the Problem

One way geriatric practitioners seek to address these concerns is by identifying and eliminating—deprescribing—medications that are no longer necessary or may cause harm. This can be a complex and nuanced process that factors in the likely impact of one or more disease processes, shortened life expectancy, and the ways the risk/benefit profiles of medications under scrutiny may have changed.

For example, increased physical impairment can undermine safe and effective medication administration. Jason A. Webb, MD, section chief and an associate professor of palliative medicine at Oregon Health & Science University Hospital, points out that “many drugs are burdensome at the end of life due to the volume of pills, especially because dysphagia, or difficulty swallowing, is a symptom of dying.” Reducing the number of pills for patients with dysphagia not only simplifies their medication regimens and reduces drug side effects but also increases safety by lessening the potential for choking or aspiration.

As patients become frailer or experience sensory or cognitive changes such as loss of vision or impaired memory, managing medications can become more difficult, even overwhelming. Lowe gives the example of using respiratory inhalers, which require a steady hand, and a patient’s ability to coordinate their breathing with dispensing the medicine. “This can be difficult as patients become increasingly frail, so we often recommend switching to nebulized medicines, which are easier to administer.”

Disease-related changes in metabolism and organ function may reduce the efficacy of medications in dying patients or even render them harmful. “As people get sicker,” Lowe says, “their organ function can change—things like how well their kidneys are working. Medications are typically processed by the liver or kidneys, so in kidney or liver failure we would want to decrease or stop certain medications to avoid them building up and causing harm.”

In an article in the ***Journal of Palliative Medicine***, Meyer-Junco points out that “unpredictable changes in medication pharmacokinetics (how a patient’s body affects the drug) and pharmacodynamics (how a drug affects a patient’s body) can occur in end-of-life patients and lead to medication intolerances and side effects, which may be inaccurately attributed to the underlying disease process.”7

Shortened life expectancy can undermine the benefits of medications intended for use over longer periods of time. Should a patient who has a prognosis of six months continue taking an anticoagulant intended to reduce the risk of a stroke over the course of years? What if that patient becomes unsteady and is at an elevated risk of falling, in which case an anticoagulant could cause potentially life-threatening bleeding?

When talking with patients about reducing polypharmacy, Lowe considers a medication’s expected “time to benefit that patient vs time it might risk harming them. Basically, if someone on hospice is on a medication that provides benefit over years but not the short term, we generally talk about stopping it.”

McCullough says, “the two biggest reasons I open the conversation about deprescribing are: Why take a pill that will no longer meaningfully prolong a hospice patient’s life, instead of taking a bite of a favorite food that one is truly going to enjoy? And because medications are not benign; most have side effects which can be relieved by stopping unnecessary medications in a safe manner.”

Another problem with side effects is that they may require another drug just to manage them. “As a geriatric trained provider, I am always looking for opportunities to deprescribe.

Continued on Page 4

Continued from Page 3

Patients often start medication "B" to help control a side effect from medication "A," however, forget to stop medication "B" when medication "A" is no longer needed."

This cycle of adding medications to address side effects from other medications, referred to as a prescribing cascade, is a common contributor to polypharmacy.

Given the complexity, Lowe says there is no one-size-fits-all blueprint for determining which medications to discontinue. "It has to be highly individualized—for some people stopping insulin may be recommended for safety, but for others depending on their specific diabetes history, we may want to continue some insulin to avoid dangerously high blood sugar levels. For many terminally ill people we can stop blood pressure medicines without issue, but for patients with certain heart diseases we would actually continue those same medicines to avoid worsening symptoms."

A retrospective audit of terminally ill patients conducted by the palliative care team at University Hospitals of North Midlands NHS Trust in Great Britain found that the most frequently deprescribed drug classes in terminally ill patients included "opioids, antiemetics, benzodiazepines, laxatives, other analgesics, anticoagulants, and statins."8

"Generally, in the final year of life," Lowe says, "we can be much more relaxed about goals for things like blood pressure or blood sugar and [patients] are no longer likely to receive benefit from osteoporosis drugs or vitamins."

How to Deprescribe

Webb suggests starting with medications that can be safely eliminated and that have little to no clinical benefit when the prognosis is terminal. "Drugs such as multivitamins, herbal supplements, things like vitamin D, and 'baby 81mg Aspirin' are often the first to go."

Lavan et al suggest that other medications falling into this category include "any drug that the patient persistently fails to take or tolerate despite adequate education and consideration of all adequate (medication) formulations."9

McCullough takes a hard look at statins. "Statins are an effective and important drug class for lowering cholesterol, but their use is based on a 10-year cardiovascular risk, whereas hospice is generally focused on the next six months. Other medications I might start with include DOACs [direct oral anticoagulants] (the newer anticoagulants for atrial fibrillation), antidiabetic/glucose controllers, antihypertensives, vitamins, and minerals. It really is a case-by-case basis but, in general, these are where I look first."

Meyer-Junco agrees that statins should be on the radar but underscores McCullough's point about taking things on a case-by-case basis. She notes that there may be instances where statins offer benefits for some terminally ill patients, including "those with recent ACS (acute coronary syndrome) or recent ischemic stroke, as well as patients with unstable, symptomatic cardiovascular disease, and frequent angina."7

Guidance from the National Hospice and Palliative Care Organization suggests looking at antiplatelet and anticoagulants intended to prevent blood clots and reduce the likelihood of a cardiovascular event, stroke, or peripheral arterial disease. "The decision to discontinue antiplatelet and anticoagulant medications should always be an individualized approach, weighing the risks vs benefits, and the patient and family's goals of care. Discontinuing these medications is generally considered acceptable in any patient with a life-limiting illness, especially when adverse effects are possible."3

These adverse effects include disease-related risks of bleeding (eg, due to liver or kidney impairment), increased risk of falling, and decreased nutritional intake, which can lower vitamin K and albumin levels and potentially lead to adverse drug reactions.

One of the challenges when deprescribing medications is the simple fact that many things cannot be predicted with precision. "The biggest challenge I have," McCullough says, "is not knowing how someone is going to tolerate not taking the medication anymore. For example, a patient is on hospice for cancer but also has heart failure requiring digoxin. Eventually they are going to be at high risk for digoxin toxicity, but will my stopping their digoxin, at an appropriate time, put them in cardiac overload causing new or exacerbated symptoms? Everyone reacts differently when medications are stopped. It's the fear of the unknown that makes deprescribing so challenging."

Moreover, deprescribing carries risks. "While we may recommend stopping a medicine because it is less risky than taking it," Lowe says, "there still can be some risk of a bad outcome. If we stop something like an acid blocker, the person may have recurrent symptoms like heartburn. We can always resume the medication if that is the case."

Webb cautions that "certain classes of medications need to be tapered off to avoid inadvertent withdrawal or discontinuation syndromes. Classes of medications we worry the most about are the

Continued on Page 5

Continued from Page 4

benzodiazepines (like Valium and Xanax), which can cause seizures if stopped abruptly, or the SSRI [selective serotonin reuptake inhibitor] or SNRI [serotonin and norepinephrine reuptake inhibitor] class which can have a discontinuation syndrome, so these need to be tapered slowly."

"Another class which needs to be tapered are the medications often prescribed for pain instead of opioids such as gabapentin and pregabalin (Lyrica) which can also precipitate a withdrawal. Patients can develop severe delirium, confusion, or seizures if these are stopped abruptly."

Of course, deprescribing must also ensure that decisions are made in collaboration with the patient or their health care surrogates and accurately reflect their concerns, wishes, and care plan goals.

"Because these are nuanced conversations," Lowe says, "it takes time. And, in general, our health system doesn't promote spending more time, so that can be a challenge. We try to involve the family in shared decision making. If people have heard for three decades how important it is to control their blood pressure, they can feel attached to specific medicines and not want to stop them."

McCullough puts it his way: "How would you react if I told you to stop a medication that your primary care provider has told you is important for you to take every day for the last five or 10 years to prevent a heart attack or stroke? Of course you will pause and hesitate."

Such conversations can be especially challenging when a patient is newly referred to a medical team specializing in palliative and end-of-life care. "In hospice patients specifically," Lowe finds, "there can be an issue of trust. You're starting care with a new clinical team, and all of a sudden, they recommend making multiple medication changes. When I teach other health care workers about hospice, I include teaching about deprescribing and recommend that when they refer patients to hospice they provide anticipatory guidance that medication changes will be made. My hope is that hearing from their primary care provider in advance can help families be more receptive to new recommendations."

Webb reassures patients that "their previous doctors helped them live a long and healthy life, and that my role now is to help in the next phase, and when it's appropriate I may talk with them about stopping some of their medications to improve the final months of life."

If patients or caregivers are interested, he points them to some of the research. "For example, if we are talking about stopping statins, I may point to a great study10 which examined the safety of stopping statins near the end of life and showed benefits to quality of life as well as decreasing costs to patients."

One of McCullough's favorite strategies for helping patients who are anxious is what he calls the setting aside method. "I explain to my patients and their families that just because we are stopping a medication doesn't mean we cannot add it back if something unexpected arises. We are just going to set the medication aside for the next "x" amount of days or weeks and see how the patient tolerates it. If it goes well, then we can eliminate the med; if it doesn't, we just restart it."

Lowe says it's also important to include other members of a patient's medical team. "Deprescribing should be on everyone's radar as an important clinical issue—nurses, social workers, chaplains, anyone likely to have a conversation with that patient. If anyone sees that a patient is taking over 10 medications, the interdisciplinary team should, at the least, review that each of those medications is appropriate. In some studies that is the threshold for 'excessive polypharmacy.'"

"It is helpful for all team members to have the same messaging," McCollough adds. "For nonclinicians, that messaging may be as simple as: As your body is changing, you may need adjustments to your medications to reduce your risk of harm from medications, and often that means stopping medications, particularly as you get closer to the end of life."

It makes sense that older patients reaching the end of their lives are more likely to be experiencing polypharmacy. For years these medications may have improved and extended their lives. It makes sense that prescribers and others on their medical teams will continue to rely on new and existing medications to ensure that symptoms are managed and patients remain comfortable.

Pharmaceuticals are a powerful tool in end-of-life care but excessive polypharmacy can decrease a patient's quality of life and undermine safety, comfort, and well-being. In these cases, deprescribing is another powerful, often underappreciated, tool. It ensures that as patients' bodies change, they are only on medications they need and are not burdened with unnecessary side effects, other adverse drug effects, or the time-consuming stress of high pill burdens.

According to the National Hospice and Palliative Care Organization, reducing polypharmacy in those who are dying "often leads to improvements in patient-reported well-being without significant adverse reactions."3 Lowe agrees. "Medication management is a critical piece of end-of-life care, including stopping medications that are no longer necessary. Many patients report feeling better overall after reducing their medications. Stopping medications can have multiple benefits, such as decreased pill burden and more energy to eat and drink foods the person enjoys, and it's something that should be discussed with everyone at the end of life."

Scott Janssen, MA, MSW, LCSW, is a social worker at University of North Carolina Hospice. He frequently writes about transpersonal experiences at the end of life and is a member of the National Hospice and Palliative Care Organization's Trauma-Informed Care Work Group

For a list of references: https://www.todaysgeriatricmedicine.com/archive/MA23p14.shtml

~Submitted by Lorene Austin-Bennett

PASRR Tip of the Month

Maximus is contracted to complete ServiceMatters reviews on behalf of the State of Iowa, of care planning and service delivery for all individuals in the PASRR population. ServiceMatters (SM) reviews will take place for 100% of PASRR LII outcomes where one or more specialized service has been identified for the individual, and for 50% of PASRR LII outcomes where no specialized services have been identified. SM reviews are triggered by Maximus within the Iowa PASRR database and the facilities are given one week to reply to each notification, with FOUR opportunities to participate in the two rounds of review across several weeks.

When responding to a SM review, be sure to include a PASRR compliant care plan AND specific and current evidence of delivery of all Specialized Services (disability specific services) as part of the ServiceMatters Review.

For more information, contact the Help Desk

Phone:	833.907.2777
Fax:	1 (877) 431 9568
Email:	IowaPASRR@maximus.com

Psychiatry for Non-Psychiatrists November 1, 2024

Psychiatry for Non-Psychiatrists will be held on November 1, 2024, in person at Des Moines University Medicine and Health Sciences in Des Moines, IA, and streamed live via Zoom. Registration fee is $99 whether you are attending in-person or online. All healthcare professionals are invited to attend.

For more information:
https://cme.dmu.edu/PNP-2024

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

__ 1. I am happy.
__ 2. I am preoccupied with more than one person I *[help]*.
__ 3. I get satisfaction from being able to *[help]* people.
__ 4. I feel connected to others.
__ 5. I jump or am startled by unexpected sounds.
__ 6. I feel invigorated after working with those I *[help]*.
__ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
__ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
__ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
__ 10. I feel trapped by my job as a *[helper]*.
__ 11. Because of my *[helping]*, I have felt "on edge" about various things.
__ 12. I like my work as a *[helper]*.
__ 13. I feel depressed because of the traumatic experiences of the people I *[help].*
__ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
__ 15. I have beliefs that sustain me.
__ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
__ 17. I am the person I always wanted to be.
__ 18. My work makes me feel satisfied.
__ 19. I feel worn out because of my work as a *[helper].*
__ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
__ 21. I feel overwhelmed because my case [work] load seems endless.
__ 22. I believe I can make a difference through my work.
__ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
__ 24. I am proud of what I can do to *[help]*.
__ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
__ 26. I feel "bogged down" by the system.
__ 27. I have thoughts that I am a "success" as a *[helper]*.
__ 28. I can't recall important parts of my work with trauma victims.
__ 29. I am a very caring person.
__ 30. I am happy that I chose to do this work.

For additional information: https://proqol.org/proqol-measure

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Many thanks to Lorene Austin-Bennett for the many years she served as our Treasurer!

Sign up for the Fall Conference!

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NEW LOCATION...2300 Northcrest Parkway

Hospice or Palliative Care??: Understanding the Unique Power of a Multidisciplinary Approach
Dr. Tom Mouser, MD, Chief Medical Officer, EveryStep

Frontotemporal Dementia (FTD): Misdiagnosed and Misunderstood
Deb Scharper, FTD Support Group Leader, Alzheimer's Association

Medicare Update for Social Workers
Cynthia Letsch, JD, Attorney at Letsch Law

Financial Elder Exploitation
Crystal Doig, Director, LifeLong Links/Aging Resources.

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