Hospice Patients:
What Meds to Stop, to Keep, and to Start

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“You’ve gotta know when to hold ‘em,  
Know when to fold ‘em.  
Know when to walk away,  
Know when to run.  
You never count your money  
When you’re sitting at the table  
There’ll be time enough for countin’  
When the dealin’s done”
What Does Medicare Say Should Be Covered?

Depending on your terminal illness and related conditions, the plan of care your hospice team creates can include any or all of these services:

- Doctor services
- Nursing care
- Medical equipment, like wheelchairs or walkers
- Medical supplies, like bandages or catheters
- **Prescription drugs for symptom control or pain relief**
- Hospice aide and homemaker services
- Physical therapy services
- Occupational therapy services
- Speech-language pathology services
What Does Medicare Say Should Be Covered?

Depending on your terminal illness and related conditions, the plan of care your hospice team creates can include any or all of these services:

- Social work services
- Dietary counseling
- Grief and loss counseling for you and your family
- Short-term inpatient care for pain and symptom management
- Short term respite care.
- Any other Medicare-covered services needed to manage your pain and other symptoms related to your terminal illness and related conditions, as recommended by your hospice team.
What Does Medicare Say Should Be Covered?

Things to know

 Original Medicare will still pay for covered benefits for any health problems that aren’t part of your terminal illness and related conditions, but this is unusual. When you choose hospice care, you decide you no longer want care to cure your terminal illness and/or your doctor determines that efforts to cure your illness aren't working. Once you choose hospice care, your hospice benefit will usually cover everything you need.
What Does Medicare Say Should Be Covered?

Medicare won't cover any of these once your hospice benefit starts:

- **Treatment intended to cure your terminal illness and/or related conditions.** Talk with your doctor if you're thinking about getting treatment to cure your illness. As a hospice patient, you always have the right to stop hospice care at any time.

- **Prescription drugs to cure your illness** (rather than for symptom control or pain relief).
What Does Medicare Say Should Be Covered?

• For the duration of the election of hospice care, an individual must waive all rights to Medicare payments for the following services:
  • Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition
  • Medicare services for a condition completely unrelated to the terminal condition for which hospice was elected remain available to the patient if he or she is eligible for such care.
What Does Medicare Say Should Be Covered?

• To be covered, hospice services must meet all of the following requirements:
  • They must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions; and
  • A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program; and
  • That plan of care must be established before hospice care is provided; and
  • The services provided must be consistent with the plan of care
Before considering meds . . .

- What is the terminal diagnosis?
  - What condition ultimately will result in death?
- What are the comorbid conditions?
  - What other diseases will contribute to an accelerated trajectory toward death?
  - Do NOT list every disease that the patient has
  - Hypertension, hypothyroidism, vertebral compression fracture, a heart attack in 1972, a history of skin cancer in 1963, etc. do NOT meaningfully contribute to terminality
- Listing as many diagnoses as you can does NOT make someone more eligible! It just muddies the water
Before considering meds . . .

- If you list something as contributing to terminality, you are now responsible for all costs relative to that disease
  - Chronic kidney disease – you now pay for dialysis
  - Hypertension – you now pay for all antihypertensives
  - High cholesterol – you now pay for Lipitor
  - Dementia – you now pay for all of the meds related to that disease

- The questions to consider:
  - Does the condition impact terminal trajectory?
  - Does the condition impact symptoms or QOL?
Medication coverage in hospice

• Generally understood that medications related to the hospice diagnoses and those for symptom management are covered under the MHB.

• Meds to treat other conditions:
  • Does the condition impact terminal trajectory?
  • Does the condition impact symptoms or QOL?
Dementia

- Meds to control behavioral disturbance
  - Related to diagnosis
  - Treatment is consistent with symptom control and improvement of quality of life

- Meds to treat dementia (donepezil, memantine, rivastigmine)
  - Related to diagnosis
  - No impact on symptoms or QOL
  - Typically no clinical value in continuing
  - If continued, hospice covers (directly related to diagnosis)
Dementia

- Antihypertensives, diabetes meds, cholesterol lowering
  - Unrelated to diagnosis
  - No impact on symptoms or QOL
  - Hospice would not pay for these
- Anxiolytics, meds for spinal stenosis, insomnia
  - Unrelated to diagnosis
  - Impact on symptom burden
  - Should continue, hospice should consider covering
Diabetes

- Considerations:
  - What is the overall purpose in treating diabetes?
  - Is there any contribution of diabetes to symptom burden or QOL?
  - Did diabetes exist before the hospice diagnosis, or did it evolve as a result of the hospice disease (i.e., pancreatic cancer, therapeutic use of steroids)
  - If preexisting and not impacted by hospice disease, agency would not cover
Diabetes

- Given that the primary goal of treating diabetes is to prevent long term consequences, tight control is not necessary when in hospice.
- There is greater risk (safety and symptoms) of low sugar than high.
- A target BS of 250 is generally satisfactory – some patients tolerate up to 300.
Diabetes

- Keep the regimen as simple as possible:
  - Maintain PO regimen if tolerated and effective
  - If using insulin products, once or twice daily long acting agent (Lantus)
  - Sliding scales are typically not necessary
  - There is no clinical value in using newer (and typically more expensive) agents
  - If on stable dose, no indication for checking sugars more than 3-4 times/week
Anticoagulants

• Antiplatelet – aspirin, dipyridamole (Persantine), clopidogrel (Plavix)
• Dabigatran (Pradaxa), enoxaparin (Lovenox), warfarin (Coumadin), rivaroxaban (Xarelto), apixaban (Eliquis), heparin

• Why were anticoagulants started?
  • A fib – to prevent CVA; can replace with ASA 81
  • DVT – to prevent propagation of clot and PE; if remote (> 3 mo), can D/C or replace with ASA 81
Anticoagulants

- Why were anticoagulants started?
  - PE – if remote (> 3 mo), can replace with ASA 81 or D/C; if recent, continue anticoagulation, unless patient is transitioning to death or unable to swallow
  - MI or CVA prevention – replace with ASA 81
  - Other thrombotic disorders – usually would continue
  - Valve replacement – continue
- If condition related to hospice diagnosis or comorbidity that impacts prognosis, than hospice covers.
Congestive Heart Failure

• All meds that will be continued as part of the plan of care that relate to cardiovascular issues would be covered
  • Antihypertensives
    • ACE inhibitors, beta blockers, diuretics (and potassium supplements), ARBs,
  • Vasodilators
  • Vasopressors
    • Milrinone, dobutamine
  • Depends on the availability of that resource in your area
Infections

• While most infections are not directly related to the terminal diagnosis (i.e., UTI in patient with lung cancer, bronchitis in patient with Alzheimer’s disease), they have a direct impact on symptom burden and QOL.

• Most common, simple infections: cellulitis, respiratory infection (sinus, strep throat, bronchitis, pneumonia), UTI, fungal (thrush, topical candidiasis) should be treated and covered in most cases (not necessary if patient is transitioning).
Infections

- Quinolones are broad spectrum, and oral administration has similar effectiveness to IV – consider for lower respiratory infections (i.e., levofloxacin)
- Consider sulfamethoxasole/trimethoprim first line for UTI, or nitrofurantoin if sulfa allergy; ciprofloxacin for second line
- Cephalosporin appropriate for cellulitis (early generation is fine); clindamycin for second line
Chronic Lung Disease

- What to do with all those inhalers??!
- Short acting bronchodilators (5)
  - Beta 2 agonists (albuterol - $36/200 doses)
  - Anticholinergics (ipratropium - $388/200 doses)
  - Combination (Combivent - $402/120 doses; neb: $73/120 doses)
- Long acting bronchodilators (19)
  - Beta 2 agonists
  - Antimuscarinics
  - Combination
Chronic Lung Disease

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• Long acting bronchodilators (19) $212 - 1,030/mo
  • Beta 2 agonists
  • Antimuscarinics
  • Combination

• Inhaled steroids (17)
Chronic Lung Disease

Consider:

- Most primary pulmonary symptoms (dyspnea, cough) can be controlled with PO/SL meds (morphine, lorazepam, dexamethasone)
- O2 for dyspnea – NOT necessarily for hypoxia. Only use if there is subjective improvement with it.
- Don’t forget benzonatate (Tessalon) for cough – 200 mg TID
Chronic Lung Disease

Consider:

• If inhalants are needed:
  • Albuterol – MDI or nebulized. (Often nebulizer is easier and more effective in the end of life population.)
  • Primarily for bronchospasm.
  • Continue only if patient notes benefit.
  • If steroids have been of benefit, consider nebulized dexamethasone
Cancer

- Given the development of oral chemotherapeutic agents and tailored regimens with improved side effect profiles, patients with cancer are likely to have options for rational therapy even with a limited prognosis
  - If the regimen has a likelihood of extending prognosis (which it typically the expectation), then the patient may not be hospice eligible on the basis of prognosis
  - If the regimen is expected to improve symptom burden and improve QOL, then it should be continued
Cancer

• Any chemotherapy agent that is continued in a hospice patient would be covered by the hospice if it is part of the plan of care.

• The challenge comes when it is NOT part of the POC, but patient intends on taking it.
  • Since not part of the POC, hospice has no obligation to cover
  • However, since it is directly related to the terminal diagnosis, the MAC may presume that it will be covered. Clear documentation is essential, as is clear conversation with patient and family
Miscellaneous medications

- Supplements
  - Multivitamins, specific vitamins, iron, minerals
  - Typically not indicated – no impact on symptoms or quality of life
  - If patient feels that they have more energy or feel better with them, no harm in continuing

- Proton pump inhibitors (i.e., omeprazole)
  - Why started initially?
  - If not experiencing symptomatic GERD or other forms of heartburn, NOT indicated and potentially harmful
  - Should NOT be started as an adjunct to steroid or NSAID therapies
Other tips

• When D/C’ing meds,
  • It’s NEVER “we can’t afford them” or “they’re too expensive.”
  • It’s ALWAYS “these medications no longer have any value to you (your loved one). They were important in the past, but at this stage of illness, the risk of side effects is greater than any benefit.”

• When not covering,
  • It’s NEVER “we can’t afford them” or “they’re too expensive.”
  • It’s ALWAYS “it is not related to the hospice diagnosis. They will continue to be covered as they always have been.”
Cloaked in compassion
You entered her life
Adorned by skill
You knew just what to do
Every smile, every touch
Every everything that is the essence of you
You gave
She knew.
And the places that only God could see that might have been listening for the voice of a healer — Heard.

— Leta Cook, 06.06.02