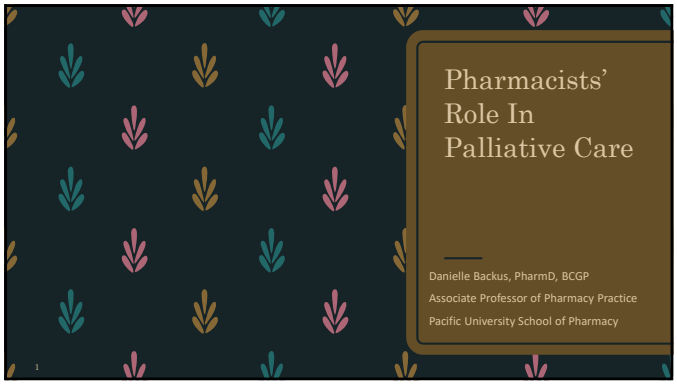
Pharmacists' Role In Palliative Care
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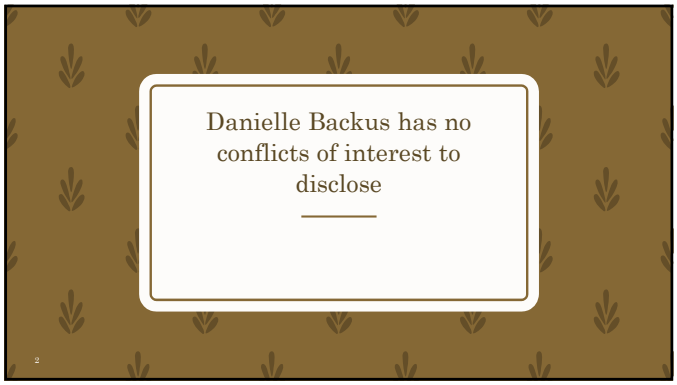
Danielle Backus has no conflicts of interest to disclose
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3 Learning Objectives
1. Assess your practice for opportunities to engage in palliative care.
2. Given a patient case, differentiate between "disease-directed" and palliative pharmacotherapy regimens, noting that many regimens can fit into both categories.
3. Tailor pharmacotherapy recommendations to fit the desires of a patient pursuing palliative care.

3

4 Outline

- Introduction: What is palliative care (PC)?
  - Compare to disease-directed care and hospice care
- Pharmacists' Role in PC: ASHP Guideline
  - Active learning: What are opportunities PC in your practice?
- Pharmacotherapy: Disease-Directed Care (DDC) and PC
  - E-Prognosis: helpful calculator for estimating life expectancy
  - Active learning: Case-based discussions

4

What is Palliative Care (PC)?

Compared to disease-directed care (DDC) and hospice care (HC)

5

(Buss, Rock and McCarthy, 2017)

6 What is palliative care?

Three key components:

- Symptom management
  - *Pain, nausea, delirium, fatigue, anorexia, anxiety, depression*
- Psychosocial-spiritual support
  - *Counseling, social work, pastoral care, caregiver support, bereavement*
- Decision making
  - *Prognostic awareness, advance care planning, understanding of outcomes, defining quality of life, eliciting values and goals*

Interprofessional PC specialty teams exist, but are rare

- Opportunity for internal medicine and primary care to provide PC

6

(Buss, Rock and McCarthy, 2017)

7 PC competencies for primary care providers

1. Recognition of palliative care needs
2. Prognostication
3. Advance care planning
4. Assessment and management of common symptoms in seriously ill
5. Referral to specialty palliative care
6. Appropriate and timely referral to hospice care

7

(Buss, Rock and McCarthy, 2017)

8 Comparing PC to disease-directed care (DDC)

Palliative Care:

1. Provide relief from symptoms and stress of **serious** illness
2. Improve **quality of life** for patient and family
3. Ideally, should begin at diagnosis of serious illness

Disease-Directed Care:

1. Provide curative and/or preventative therapy for illness
2. Improve **quantity of life** for patient
3. Usually begins at diagnosis of illness, when benefits of treatment outweigh risks

PC and DDC should occur concomitantly to manage serious illness

8

(Buss, Rock and McCarthy, 2017)

9 Comparing PC to hospice care

Palliative Care:

1. Provide relief from symptoms and stress of **serious** illness
2. Improve quality of life for patient and family
3. Ideally, should **begin at diagnosis** of serious illness
4. Depending on life-expectancy, **continue or de-escalate preventative therapy**
5. Depending on life-expectancy, **continue or de-escalate treatment**

Hospice Care:

1. Provide relief from symptoms and stress of **terminal** illness
2. Improve quality of life for patient and family
3. Ideally, should **begin when life expectancy is ~6 months**
4. Because of limited life expectancy, **discontinue preventative therapy**
5. Depending on life expectancy, **de-escalate or discontinue treatment**

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(Buss, Rock and McCarthy, 2017)

10 Palliative care should begin at diagnosis of serious disease

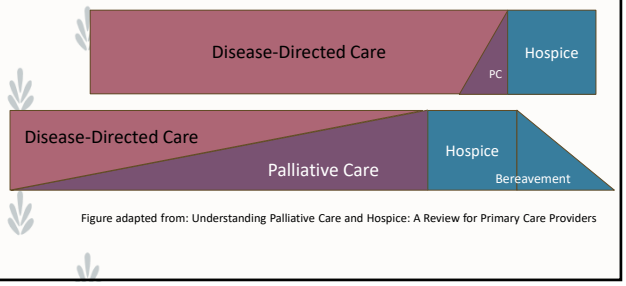

Figure adapted from: Understanding Palliative Care and Hospice: A Review for Primary Care Providers

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Pharmacists' role in palliative care

ASHP Guidelines on the Pharmacist' Role in Palliative and Hospice Care, 2016

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(Herndon et al., 2016)

12 Settings for pharmacists working in PC and HC

Hospitals	Clinics	Community Pharmacies
Home Care	Long-Term Care	Managed Care

12

(Herndon et al., 2016)

13 Essential roles and activities for PC/HC pharmacists

Direct Patient Care
- Provide evidence-based, patient centered medication on interdisciplinary team
- Serve as resource on optimal medication use for symptom management
- Anticipate transitions of care when recommending, starting, modifying, or stopping PC meds

Med order review and reconciliation
- Manage and improve the medication-use process (e.g., dispensing, facilitating REMS programs)

Education and Medication Counseling
- Counsel patients, caregivers, and families on PC meds

Administrative Roles
- Ensure safe use of PC meds
- Medication supply chain management

13

(Herndon et al., 2016)

14 Desirable roles and activities for PC/HC pharmacists

Direct Patient Care
- Conduct advanced pain and symptom assessment, including comorbid conditions
- Initiate, modify, discontinue, and monitor medication therapy
- Participate in or lead family meetings
- Establish goals of care and educate patient/family on medication therapy decisions
- Participate in or lead decisions on hospice or outpatient palliative care appropriateness and referral

Education
- Develop health profession students' and practicing professionals' understanding of PC and HC

Scholarship
- Contribute to the body of knowledge for PC and HC via writing, speaking, or research

Administrative Roles
- Practice development and management, interdisciplinary leadership

14

(Herndon et al., 2016)

15 Outpatient and transitions of care PC

Lack of access to palliative care providers in ambulatory clinic settings creates opportunities for PC/HC pharmacists to provide symptom management to a variety of patient populations

- Incorporating the PC/HC pharmacist to work within a clinic enhances interdisciplinary approach

Pharmacists assist with transition from aggressive treatment to comfort-focused care by evaluating risk : benefit ratio of current meds

- De-prescribe DDC meds with suboptimal ratios

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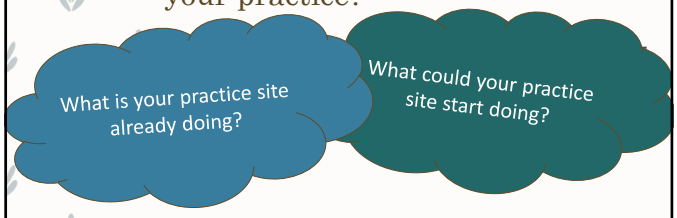
16 What are opportunities PC in your practice?



Introduce yourself and your practice to your neighbor(s).
Discuss the questions above.
Share your conversation with the larger group if you're willing!

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17 Check your understanding

Which type of pharmacist is best suited to improve the incorporation of palliative care into primary care?

a) Transition of Care Pharmacist
b) Ambulatory Care Pharmacist
c) Hospice Care Pharmacist
d) Infectious Disease Pharmacist

17

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Pharmacotherapy:
Disease-Directed and
Palliative Care
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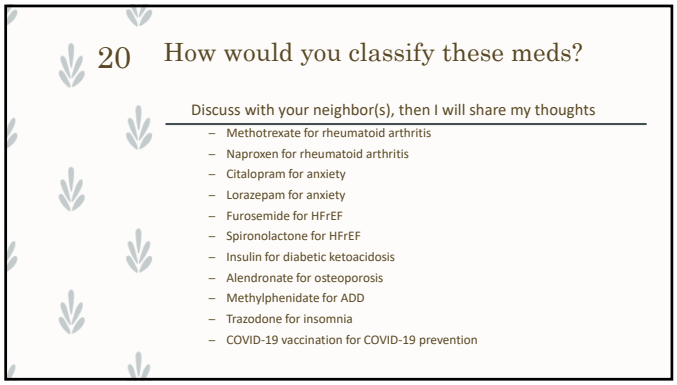
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How would you classify these meds?
Discuss with your neighbor(s), then I will share my thoughts
– Methotrexate for rheumatoid arthritis
– Naproxen for rheumatoid arthritis
– Citalopram for anxiety
– Lorazepam for anxiety
– Furosemide for HFrEF
– Spironolactone for HFrEF
– Insulin for diabetic ketoacidosis
– Alendronate for osteoporosis
– Methylphenidate for ADD
– Trazodone for insomnia
– COVID-19 vaccination for COVID-19 prevention

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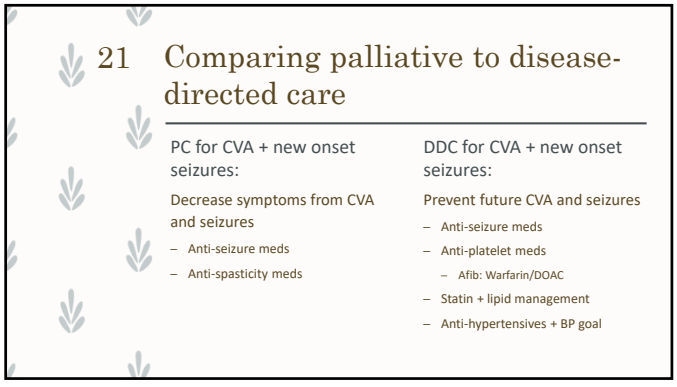
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Comparing palliative to disease-directed care
PC for CVA + new onset seizures:
Decrease symptoms from CVA and seizures
– Anti-seizure meds
– Anti-spasticity meds
DDC for CVA + new onset seizures:
Prevent future CVA and seizures
– Anti-seizure meds
– Anti-platelet meds
– Afib: Warfarin/DOAC
– Statin + lipid management
– Anti-hypertensives + BP goal

21

22 Incorporating PC concepts into chronic disease management (CDM)

Hx CVA + life expectancy > 10 yrs

Palliative Care:

- Continue anti-spasticity meds

CDM with emphasis on DDC:

- Continue anti-platelet meds
  - Afib: continue warfarin/DOAC
- Continue statin + lipid management
- Continue anti-hypertensives + BP goal
  - Modify BP goal if too many adverse effects

Hx CVA + life expectancy < 5 yrs

Palliative Care:

- Continue anti-spasticity meds

CDM with emphasis on PC:

- Continue anti-platelet meds
  - Afib: consider ASA instead of warfarin/DOAC if high bleed risk
- Continue or discontinue statin + decrease lipid management
- Continue or decrease anti-hypertensives + modify BP goal

22

23 Early hospice can be similar to palliative care

Hx CVA + life expectancy ~ 6 mos

HC for CVA + Terminal Illness:

- Continue anti-spasticity meds
- Add symptomatic relief from terminal illness

CDM for CVA + Terminal Illness:

- Continue or discontinue anti-platelet meds
  - Continue if patient prefers or high risk recurrence
- Discontinue statin + lipid management
- Decrease or discontinue anti-hypertensives + greatly increase BP goal

Hx CVA + life expectancy < 1 mo

HC for CVA + Terminal Illness:

- Continue or modify anti-spasticity meds
- Continue symptomatic relief from terminal illness
- Add end-of-life symptomatic relief medications

CDM for CVA + Terminal Illness:

- Discontinue DDC
  - Discontinue anti-platelet meds, statins, and antihypertensives

23

(Downar et al., 2017)

24 Prognosis is key for incorporating PC considerations into CDM

The "Surprise Question" is commonly used to screen for hospice referral

- "Would I be surprised if this patient died in the next year?"
- 2017 meta-analysis demonstrated poor-to-moderate predictability of 12-month mortality associated with a "no" response
  - Performed best for oncology patients

https://eprognosis.ucsf.edu/calculators/

- Repository of published indices to obtain evidence-based information on patients' prognosis
- Designed for older adults without a dominant terminal illness
- Intended as a rough guide to inform clinicians about possible mortality outcomes

24

25 E-Prognosis Calculator

Example: An 85 y/o female often has SBP exceeding 166 mmHg, despite taking three antihypertensive medications. Should we add more BP meds? Or increase her BP goal?

Knowing her risk of mortality can assist with choosing DDC vs. PC approach

- E-Prognosis result: 47-52% risk 5 yr mortality, 74-65% risk 10 yr mortality
  - *Factors included in calculator: age, sex, BMI, comorbidities suggestive of organ failure or future cancer, smoking status, ambulatory ability, strength, previous hospitalizations, autonomy with household chores, managing money, and bathing*

What else do we need to know in order to help make this decision?

25

26 Check your understanding

TF is a 74 y/o male with HFrEF and several other medical conditions. He takes metoprolol succinate, sacubitril/valsartan, furosemide, and rosuvastatin for his heart failure, in addition to ten other medications for various comorbidities. TF has to sleep in a recliner at night due to difficulty breathing while fully supine. His PCP would like your recommendations for reducing TF's pill burden, given his desire for an increased emphasis on palliative vs. disease-directed care.

How should TF's metoprolol succinate be classified?

a) Disease-directed only
b) Palliative only
c) Both disease-directed and palliative

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TF's 10-year mortality risk is estimated to be ~74-76%.

Which of TF's medications would be most appropriate to recommend for de-prescribing, based on his desire for greater emphasis on palliative care and his anticipated life-expectancy?

a) Rosuvastatin
b) Furosemide
c) Sacubatril/valsartan

28

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30 References

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