Dementia Medication: How to Call it Quits

GHPCO 2017 Annual Conference
Session 5-2
January 31, 2016
# Faculty

<table>
<thead>
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<th>Jillian Baer, PharmD, BCPS</th>
<th>Lyla Correoso-Thomas, MD</th>
<th>Kathleen Jones, RN, BSN</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
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</tbody>
</table>
LEARNING OBJECTIVES

1. Describe a multifaceted approach to providing clinical education and cost-savings strategies employed during this intervention project across multiple hospice programs across multiple states.

2. Summarize the educational and financial impact seen as part of this intervention.

3. Describe the nurse trainer perspective on the intervention outcomes and clinical care.
OBJECTIVE 1:
Describe a multifaceted approach to providing clinical education and cost-savings strategies employed during this intervention project across multiple hospice programs across multiple states

Jillian Baer, PharmD, BCPS
Advanced Dementia

Advanced dementia is characterized by a range of physical and psychosocial impairments.

Advanced dementia has:

1. Exaggerated decrease in total body water and muscle
2. An increase in relative adipose tissue
3. Changes are in addition to alterations due to aging resulting in a direct & variable impact on drug metabolism
ADVANCE DEMENTIA PATIENTS

- May be more prone to adverse drug effects and drug-drug interactions than other older people
- Less able than others to report adverse effects
- Less involved in decision-making about whether to initiate or withdraw medications
- Typically been excluded from research examining quality use of medications in older populations, limiting evidence regarding benefits and harms

CONCEPT OF POLYPHARMACY

Polypharmacy refers to the combination of multiple medications which may lead to cumulative adverse effects and antagonistic drug-drug interactions where a worse adverse effect is produced than either drug could have caused alone.

Polypharmacy in Adv. Dementia

Polypharmacy should be minimized due to:

- Swallowing and eating difficulties make giving medication burdensome & difficult for the residents and the nursing home staff

- Adverse drug effects (ADEs) are common in patients with dementia

Polypharmacy in Adv. Dementia

Polypharmacy should be minimized due to:

- ADEs are difficult to detect because patients have difficulty expressing the symptoms they feel
- Population has frequent clinical complications associated with a high risk of 6-month mortality
- The time to benefit from many medications exceeds this life expectancy

Dementia Medications

- Acetylcholinesterase inhibitors (AchEIs)
  - Donezepil – Aricept®
  - Rivastigmine – Exelon®
  - Galantamine – Razadyne®

- NMDA receptor antagonists
  - Memantine – Namenda®
<table>
<thead>
<tr>
<th>Medication</th>
<th>Starting Dose</th>
<th>Target Dose</th>
<th>Adverse Effects</th>
<th>FDA Approved Indication</th>
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<tbody>
<tr>
<td><strong>Acetylcholinesterase Inhibitors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donepezil (Aricept®, tablet, Aricept® ODT)</td>
<td>5mg daily</td>
<td>10mg daily; 23mg daily, if tolerated</td>
<td>Anorexia, diarrhea, nausea, bradycardia, heart block, urinary incontinence, insomnia, headache, hallucinations, agitation, confusion</td>
<td>Mild, moderate, or severe dementia of the Alzheimer's type</td>
</tr>
<tr>
<td>Rivastigmine (Exelon® capsule, Exelon® transdermal system)</td>
<td>1.5mg BID; 4.6mg/24h transdermal</td>
<td>6mg BID; 9.5-13.3mg/24h transdermal</td>
<td>Anorexia, nausea, bradycardia, heart block, urinary incontinence, insomnia, headache, hallucinations, agitation, confusion, dizziness, fatigue</td>
<td>Mild, moderate, or severe dementia associated with Alzheimer's disease; Mild to moderate dementia associated with Parkinson disease</td>
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<tr>
<td>Galantamine (Razadyne® tablet, Razadyne® ER capsule, galantamine oral solution)</td>
<td>IR: 4mg BID; ER: 8mg daily</td>
<td>IR: 12mg BID; ER: 24mg daily</td>
<td>Anorexia, diarrhea, nausea, bradycardia, heart block, urinary incontinence, insomnia, headache, hallucinations, agitation, confusion, dizziness, fatigue, depression; caution in renal, hepatic impairment</td>
<td>Mild to moderate dementia of Alzheimer's disease</td>
</tr>
<tr>
<td><strong>NMDA Receptor Antagonist</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memantine (memantine tablet, Namenda XR® capsule, Namenda® oral solution)</td>
<td>IR: 5mg daily; XR: 7mg daily</td>
<td>IR: 10mg BID; XR: 28mg daily</td>
<td>Dizziness, headache, constipation, headache, hallucinations, confusion; caution in renal, hepatic impairment</td>
<td>Moderate to severe dementia of the Alzheimer's type</td>
</tr>
<tr>
<td><strong>Acetylcholinesterase Inhibitor/ NMDA Receptor Antagonist</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memantine/Donepezil (Namzaric® ER capsule)</td>
<td>ER: 14mg/10mg HS</td>
<td>ER: 28mg/10mg HS</td>
<td>Anorexia, diarrhea, nausea, bradycardia, heart block, urinary retention, insomnia, headache, hallucinations, agitation, confusion, dizziness, caution in renal, hepatic impairment</td>
<td>Moderate to severe dementia of the Alzheimer's type in patients stabilized on memantine and donepezil</td>
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</tbody>
</table>
**PIP Historical Background**

- Hospice cost analysis performed due to rising medication utilization and costs
  - Dementia medications = major culprit to increased cost per patient day (CPPD)
    - Acetylcholinesterase inhibitors (AChEIs) and NMDA receptor antagonists

- Cost savings potential highest for dementia medications vs. other medication-related culprits
  - Discontinuation vs. switch to more cost-effective alternative
Medicare Conditions of Participation

- Medicare CoPs require hospices to review patients’ medication regimens.
  - One requirement is to evaluate effectiveness of therapy
  - If the medication is no longer beneficial, it should be discontinued

- Hospice evaluation showed D/C of ineffective medications was not occurring consistently due to continued use of medications with limited benefit at the end of life
  - > 75% of patients with primary dx. of dementia had claims for dementia medications

**CONCERNS OF DEMENTIA MEDICATION USE AT EOL**

- **Limited clinical benefit**
  - FAST score of 7b or greater
  - Pt. decline despite therapy
  - Pt. no longer able to make needs known or ambulate by themselves

- **Increased risk for adverse effects**
  - GI: Diarrhea, N/V, anorexia
  - CNS: confusion, hallucinations, agitation
  - CV: bradycardia, hypotension, orthostasis, syncope

- **Increased pill burden**

- **Financial burden**
Potential Reasons for Lack of D/C

- Limited knowledge on what medications can be discontinued safely at EOL
- Limited knowledge on when & how to discontinue medications
- Patient, family, and/or prescriber unwilling to discontinue medications
  - Misinformation regarding efficacy leading to unrealistic expectations
  - Poor communication techniques
SOLUTION

- Develop and implement multi-factorial clinical initiative to address:
  - Knowledge gaps about dementia medications and appropriate use at EOL
  - Rising dementia medication utilization and associated costs
**Initiative Goals**

- **Financial**
  - Reduce overall utilization costs
  - Reduce dementia medication utilization costs
  - Decrease hospice’s overall cost per patient day (CPPD)

- **Educational**
  - Advise programs on high cost medications or medication classes and the potential to discontinue or switch to an alternative
  - Address appropriate use of commonly used dementia medications in hospice patients
  - Provide techniques on how to initiate difficult conversations with family and/or the prescriber to discuss medication discontinuation (i.e. BUILD model)
**APPROACH**

- Top 20% programs with highest utilization

- Why multi-factorial?
  - Adult learning principles
    - Interactive
    - To affect longitudinal change
  - Multiple issues contributing to hospice utilization of dementia medications
    - Not understanding impact of dementia medication use in hospice
    - Not being comfortable discussing discontinuation of medications with patient, family and/or prescribers
    - Not understanding how to best review and utilize utilization data/reports

INITIATIVE COMPONENTS

- Train-the-trainer presentation with recorded audio case scenarios

- Built-in role play scenarios using BUILD model
  - To foster discussion between the nurse trainer and learner
  - Learn effective communication techniques

- Supportive, concise clinical documents
  - Quick reference tools for learner while in the field
  - Training document for the nurse trainer

- Program specific customized reports
  - (e.g., dementia medication drug utilization evaluation)

- Follow-up conference calls
  - Regularly scheduled bi-weekly to monthly
IMPLEMENTATION PROCESS

- Choose a “champion” who will act as the trainer
  - Pharmacist to review and present the train-the-trainer presentation w/ champion (30 mins)

- Champion to educate staff
  - Clinical facts about dementia medications at the EOL
  - Communication strategies for families & clinicians
    - BUILD model
  - Role playing exercises
  - Case discussions
  - How to review utilization reports
TRACKING PROGRESS

- Dementia DUEs sent monthly
  - Expectation that program will review report to evaluate impact and need for additional support

- Utilization report monitored by pharmacists and area/regional hospice leadership

- Bi weekly conference calls
  - Hospice Area VP, pharmacist & program management
  - Discuss utilization, review barriers, & need for additional education
EFFECTIVE COMMUNICATION STRATEGY

- Consistent and systematic approach

- **BUILD** model
  - **Build** - a foundation of trust and respect
  - **Understand** – What the family/prescriber knows about patient’s current condition
    - Including medication use - when and how they work and when no longer beneficial
  - **Inform** – about evidence-based information regarding disease state and medications
  - **Listen** – to family’s or prescriber’s goals and expectations for the patient
  - **Develop** – a collaborative plan of care

OBJECTIVE 2:
SUMMARIZE THE EDUCATIONAL AND FINANCIAL IMPACT SEEN AS PART OF THIS INTERVENTION

Lyla Correoso-Thomas, MD
How are we doing?

The biggest room in the world....

...the room for improvement!!!
BUILD MODEL

Build: Establish a foundation of trust and respect
• Assure the family your goal is to provide them with information regarding their options so they can make the most informed decision possible

Understand: Determine what the family knows about these medications including when and how they work and when they are no longer beneficial
• Ask the family what they feel like their loved one will look like when these medications are no longer likely to be helping

Inform: Fill in any gaps in knowledge with regards to the disease state and the medications
• Provide education regarding any misinformation the family may have
• Address any concerns the family may have with regards to stopping these medications

Listen: Understand the family’s goals for their loved one
• Clarify what the patient’s wishes would have been had they been able to tell us

Develop: Agree upon a plan of care in collaboration with the family and caregivers
• Review with the family their options for medication adjustments, reinforcing that they do have choices

TALKING POINTS FOR MEDICATIONS FOR DEMENTIA

• No curative therapies exist for dementia; no medications will stop the progression of dementia.

• If family is hesitant to discontinue dementia medications, consider reducing dose by 50% for 1-2 weeks and then discontinue.

• Continuing medications with no therapeutic benefit places the patient at risk of adverse effects, drug interactions, increased pill burden, and financial burden.

TALKING POINTS FOR MEDICATIONS FOR DEMENTIA

- Misinformation about effectiveness medications for dementia may create false hope or the impression that stopping these medications will hasten the patient’s death.

- Focus discussion with the family and caregivers on goals of care, perceived benefits of treatment, patient prognosis, FAST score, and eventual discontinuation of these medications.
3 SCENARIOS

• Scenario 1: Case manager discussion with caregiver about discontinuing medications
  – Caregiver does not wish to discontinue medications

• Scenario 2: Window of opportunity allows nurse to reopen the discussion with caregiver
  – Caregiver agrees to medication discontinuation

• Scenario 3: Case manager discussion with physician
  – Physician agrees to medication discontinuation
SAMPLE KEY BUILD PHRASES: CLINICIAN TO FAMILY

B: Build a foundation of trust and respect. Listen more than you talk. Affirm the patient and caregiver.

- “Thank you for taking the time to talk with me.”
- “You do a great job advocating for your mother.”
- “It sounds like this has been a very challenging time for you.”
SAMPLE KEY BUILD PHRASES: CLINICIAN TO FAMILY

U: Understand what the family knows about the medication. Ask open ended questions

- “How is the medication helpful to you?”
- “What has the doctor told you about how this medicine works?”
- “Can you help me understand what is scary about stopping or changing this medication?”
SAMPLE KEY BUILD PHRASES: CLINICIAN TO FAMILY

I: Inform the family of evidence-based information about the medication. Use a neutral tone.

- “Here’s what we know about this medicine.”
- “As your disease progresses it may be useful to make some adjustments to your medications.”
- “What worked before may not work now.”
- “Medications can’t cure or stop progression of this disease; we can choose medications to help with symptoms.”

**SAMPLE KEY BUILD PHRASES: CLINICIAN TO FAMILY**

L: Listen to the family’s goals and expectations. Learn what is important to the patient/family.

- “What are you hoping hospice can do for your mother?”
- “What is most important to you now? What are you hoping for?”
- “Did your mother ever share her thoughts about what she would want if she had dementia?”
**Sample Key BUILD Phrases: Clinician to Family**

**D:** Develop a plan of care in collaboration with the family. Being part of the process empowers the patient.

- “We work in collaboration with your doctor, who still guides your care and wants you to be comfortable.”
- “We will not do anything to hasten your mother’s death but we also don’t want to prolong the dying process. Our goal is to provide comfort and quality-of-life, while allowing for a natural, peaceful death.”
- “You’re not alone; we’ll walk this path with you. I’d like to come back on Tuesday; we can talk more about this.”
- “Our goal is to provide comfort and quality of life, while allowing for a natural, peaceful death.”
SAMPLE BUILD CONVERSATION: Nurse to Prescriber

B: Build trust and respect

Nurse:

“Thank you for responding so quickly to my page. I’ll try to be brief but concise regarding Mr. R, whose home I just left. He has been on our hospice program about 3 months now and has declined significantly. After much discussion today his daughter is interested in continuing only comfort meds. I know he hasn’t been in to see you for several months. Would it be helpful for me to provide you with an update on his current physical condition and then review his medication profile?”
SAMPLE BUILD CONVERSATION: Nurse to Prescriber

U: Understand what the prescriber knows about the patient’s current condition.

Prescriber:

“I haven’t seen him for 4 months but I do read the monthly updates you send. I see from the most recent one that he is now bedbound. I’m also aware that we’ve treated him for possible aspiration pneumonia twice in the past 2 months.”
SAMPLE BUILD CONVERSATION: 
NURSE TO PRESCRIBER

I: Inform prescriber of factual information

Nurse:
“Yes, that’s correct. Despite aspiration precautions and his daughter’s very attentive care, he continues to have increasing difficulty with swallowing and decreased oral intake. She crushes his medications and gives in bites of applesauce, but this is increasingly challenging. In addition to his comfort meds he is also receiving donepezil, a multivitamin and simvastatin. I’m wondering if we could streamline his med profile to focus on comfort meds. The only symptom he seems to be having at this time is some generalized discomfort with repositioning and occasional restlessness.”
SAMPLE BUILD CONVERSATION:  
**NURSE TO PRESCRIBER**

L: Listen to the prescriber’s goals & expectations

Prescriber:

“It sounds like it’s time to stop the donepezil, simvastatin and the multivitamin if the daughter is ok with that. Since he’s having difficulty swallowing let’s just use the meds in the comfort care kit for pain and restlessness.”
SAMPLE BUILD CONVERSATION: 
NURSE TO PRESCRIBER

D: Develop a collaborative plan of care

Nurse:
“Yes, I spoke with the daughter about the possible changes, and mentioned that it may include discontinuing the donepezil and the other non-essential meds. Her primary goal is that he be at peace. I will call her and let her know that I’ve spoken with you and what you have recommended. Thank you for your input.”
PROGRAMS CHOSEN

Interventions
- 20% of top utilizing sites chosen
- Evaluated over 12 months
- Monthly call with each site to review progress
- Continuous monitoring to track progress
PROCESS

- Review and discuss patients on these dementia medications upon admission and during IDG

- Follow-up schedule

- Monthly calls with dedicated pharmacist, regional or area leadership and program management to monitor progress, review barriers, and provide support
Pharmacy Performance Improvement Plan

Program Number: XXXX  Program Name: XXXX

Plan Focus: Dementia Medication  Plan Owner*: Rhett Butler

<table>
<thead>
<tr>
<th>Date</th>
<th>Target Area</th>
<th>Program Plan &amp; Strategies</th>
<th>Responsible Person</th>
<th>Due Date</th>
<th>Status/Comments</th>
</tr>
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<tbody>
<tr>
<td>10/10/14</td>
<td>Discontinuation of Dementia Medications when clinically indicated</td>
<td>QM will complete the Dementia Medication Train the Trainer module</td>
<td>ED Name</td>
<td>10/24/14</td>
<td>QM completed Train the Trainer 10/15/14</td>
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<tr>
<td>10/16/14</td>
<td>Discontinuation of Dementia Medications when clinically indicated</td>
<td>QM will present Dementia Medication training to clinical staff</td>
<td>QM and ED</td>
<td>11/7/14</td>
<td>QM presented Dementia Medication training to clinical staff 10/29/14</td>
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<tr>
<td>10/31/14</td>
<td>Discontinuation of Dementia Medications when clinically indicated</td>
<td>Close review of all dementia medications for new patients and discussion with PMD prior to placing order</td>
<td>QM</td>
<td>Ongoing starting 10/31/14</td>
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Executive Director Signature: ______  Date: ______

AVP Signature: ______  Date: ______

*The Plan Owner is the final authority and is ultimately responsible for the Pharmacy Performance Improvement Plan. They may delegate any and all plan operations to the program staff.
<table>
<thead>
<tr>
<th>Call Date</th>
<th>Target Area</th>
<th>Oversight Follow-up</th>
<th>Attendees</th>
<th>Program Trends</th>
<th>Status/Ongoing Plan/Comments</th>
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</thead>
<tbody>
<tr>
<td>10/10/14</td>
<td>Discontinuation of Dementia Medications when clinically indicated</td>
<td>Introductory call with the Shangrila Program; outlined the expectations and next steps for QM Train the Trainer</td>
<td>HS PharmD, CC&amp;R team members, AVP name, DCO name, BD name, etc...</td>
<td>List Metrics</td>
<td>Note next steps or plan changes</td>
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# Sample Program Level DUE Report

Patient Details (sorted by dementia med drug costs: high to low)

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Patient</th>
<th>Diagnosis</th>
<th>Label Name</th>
<th>Fill Date</th>
<th># of Dementia Medications</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>STROKE/COMA</td>
<td>NAMENDA XR CAP 28MG</td>
<td>10/23/2015</td>
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<td>HEART DISEASE</td>
<td>MEMANTINE TAB HCL 10...</td>
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<td>HEART DISEASE</td>
<td>MEMANTINE TAB HCL 10...</td>
<td>10/22/2015</td>
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<td></td>
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<td>DEMENTIA</td>
<td>MEMANTINE TAB HCL 5MG</td>
<td>10/14/2015</td>
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<td>DEMENTIA</td>
<td>MEMANTINE TAB HCL 5MG</td>
<td>10/28/2015</td>
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<tr>
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<td>DONEPEZIL TAB 10MG</td>
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<tr>
<td></td>
<td></td>
<td>DEMENTIA</td>
<td>DONEPEZIL TAB 10MG</td>
<td>10/24/2015</td>
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<tr>
<td></td>
<td></td>
<td>DEMENTIA</td>
<td>DONEPEZIL TAB 10MG</td>
<td>10/30/2015</td>
<td>1</td>
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# Dementia Initiative Outcomes Summary

<table>
<thead>
<tr>
<th>Month-Year</th>
<th>Dementia Med Claims</th>
<th>Total Utilizers</th>
<th>% Dementia Costs**</th>
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<tbody>
<tr>
<td>Oct-2014</td>
<td>421</td>
<td>2,591</td>
<td>10.74%</td>
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<tr>
<td>Oct-2015</td>
<td>368</td>
<td>4,317</td>
<td>4.52%</td>
</tr>
</tbody>
</table>

* Programs included in Dementia Initiative Phase I and II

** % dementia costs = dementia med costs / total med costs
Dementia Initiative Outcomes Summary


- % Dem med costs (Inc. programs)
- % Dem med costs (Programs NOT Inc.)
FINANCIAL IMPACT

From Oct. 2014 to Oct. 2015

- The dementia med cost per utilizer was reduced 3x more than programs not included in the initiative
- Overall cost per utilizer was reduced about 2x more than programs not included
- % dementia med costs decreased by 6% for programs included vs. 2% for programs not included
- Overall CPPD trendline mirrored the decrease in dementia medication costs and hit CPPD goal during this period
Let’s take a look at the feedback from the train the trainer program for the staff!
OBJECTIVE 3:
DESCRIBE THE NURSE TRAINER PERSPECTIVE ON THE INTERVENTION OUTCOMES AND CLINICAL CARE

Kathleen Jones, RN, BSN
Facilitator Evaluations

- An evaluation was sent to the participating programs using survey monkey with a 50% response rate reported.
Facilitator Assessment Questions

- The facilitator assessments asked several questions related to the dementia initiative training.

- These questions incorporated how many full time and PT/per-diem employees received the training.

- The understanding of the dementia pharmacy reports provided for monitoring progress.

- The train the trainer education that was provided for the program champion.

- An opportunity to provide feedback with open ended question.
Survey Response

- The collective responses were generally very positive and encouraging.
- The educational learning objectives were met.
- Thorough open ended responses were given.
- A commitment to change current practice was noted.
SURVEY RESPONSE

- 92% agree or strongly agree that the content of the training kept them engaged
- 100% agree or strongly agree in confidence of ability to train staff
- 92% agree or strongly agree in new strategies learned
- 92% agree or strongly agree in the staff ability to have meaningful conversations about discontinuing medication
- 92% agree or strongly agree that the reports were helpful to achieve goals
STATEMENTS MADE BY RESPONDERS

“Earlier review of med profiles....more confidence with approaching d/c possibility”

“Bringing up with families more discussions about dementia meds”

“We now look over medication coverage closely and discuss more medications during our interdisciplinary meetings”

“More attention planting the seed at admission for expecting potential discussion of meds and identifying what meds they are, routinely addressing in IDG meetings”
SUMMARY
Teaching & evaluation Tools
3 practice scenarios
BUILD
Every 2 weeks progress reports
Continuous monitoring
FAQ
Medication education
3 types of dementia progression
CLINICIAN FOCUSED EDUCATION

- Update on function, action and potential undesirable and harmful effects of the medication

- Increase knowledge base around appropriate use of medication

- Provide framework for tying in evidence supporting proper use of the medication with clinical status of the patient
**Clinical Pearls**

- Consider adding to conversation, while utilizing BUILD structure, to support discontinuation:
  - No curative therapies exist for dementia; no medications will stop the progression of dementia
  - If family is hesitant to discontinue dementia medications, consider reducing dose by 50% for 1-2 weeks and then discontinue
  - Continuing medications with no therapeutic benefit places the patient at risk of adverse effects, drug interactions, increased pill burden, and financial burden
  - Misinformation about effectiveness of medications for dementia may create false hope or the impression that stopping these medications will hasten the patient’s death
  - Focus discussion with the family and caregivers on goals of care, perceived benefits of treatment, patient prognosis, FAST score, and eventual discontinuation of these medications
THANK YOU FOR YOUR PARTICIPATION!

QUESTIONS?


