SA3- To D/C or Not to D/C: Implementing Deprescribing Into Your Clinical Practice

Saturday, March 24
11:00 AM- 12:30 PM

Session Description
By reviewing the quality improvement (QI) process, this session will offer the PA/LTC health care provider evidence-based and practical suggestions to implementing deprescribing, or more specifically a deprescribing initiative, into clinical practice. It will also review communication techniques for deprescribing utilizing case-based vignettes.

Learning Objectives
Review the role of deprescribing in management of polypharmacy or potentially inappropriate medications in PA/LTC residents.
Explore and debate the elements of a successful PA/LTC deprescribing initiative within the QAPI format.
Practice communication strategies for deprescribing with residents, family and caregivers, and other practitioners.

Presenter(s): Jennifer Pruskowski, PharmD, BCPS, CGP; Steven Handler, MD, PhD, CMD; Wilson Brian, MD

Presenter(s) Disclosures: Steven Handler, MD, PhD, CMD: Has a financial disclosure; Curavi Health: Chief Medical and Innovation Officer, Salary Support; All other speakers have reported they have no relevant financial relationships to disclose.
To D/C or Not to D/C
Implementing Deprescribing into Your Practice

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Speaker Disclosures
• There are no financial relationships for Dr. Pruskowski or Dr. Wilson
• Dr. Handler is the Chief Medical and Innovation Officer for Curavi Health. He does not own any equity interests in Curavi Health, nor do I have any options or other interests that are convertible into equity interests in Curavi Health

Learning Objectives
By the end of the session, participants will be able to:
(1) Review the role of deprescribing in management of polypharmacy or potentially inappropriate medications (PIMs) in PA/LTC residents.
(2) Explore and debate the elements of a successful PA/LTC deprescribing initiative within the QAPI format.
(3) Practice communication strategies for deprescribing with residents, family and caregivers, and other practitioners.

True Goal

• “Deprescribing Workshop”
• Will utilize DE-PHARM (Discussion to Ensure the Patient-centered, Health-focused, prognosis-Appropriate, and Rational Medication regimen) as example:
  • Clinical-pharmacist driven deprescribing initiative in UPMC Seneca Place (Verona, Pennsylvania)\(^1\)
  • Will also lean on 2017 AMDA “Perceived Utility of Deprescribing”\(^2\) survey project findings as well

Discontinuing Inappropriate Medication Use in Nursing Home Residents…

• Design: Pragmatic cluster randomized controlled trial
• Setting/Participants: 59 Dutch nursing homes of residents with life expectancy >4 weeks
• Intervention/Outcome: Multidisciplinary Multistep Medication Review (3MR) (1 review); successful discontinuation of at least inappropriate drug
• Results: Of the 426 residents, medication[s] were successfully discontinued for 91 (39.1%) residents in the intervention group (adjusted relative risk, 1.37 [95% CI, 1.02 to 1.75]). Clinical outcomes did not deteriorate between baseline and follow-up

Deprescribing
TO COMBAT POLYPHARMACY AND/OR POTENTIALLY INAPPROPRIATE MEDICATIONS
The Start of the DE-PHARM Journey

- July 2014
- Medication-related issues in the Senior Communities discussed between JPruskowski and SHandler
  - Abundance of potentially inappropriate medications (PIMs) in the PA/LTC
  - Tools are available but...
  - No true implementation guidance

PIMs in the PA/LTC Setting

- PIMs in PA/LTC setting approximately 40%1
- Average: 8 medications/residents
- Polypharmacy linked to:2
  - Falls and fractures
  - Hospitalizations
  - Mortality
- Cost: for every $1 spent on medications, $1.33 is spent on drug-related morbidity and mortality3

Workshop Sidebar:

- What medication-related issues do you have in your building(s)?

Developing a Deprescribing Initiative

WHAT TO CONSIDER

The DE-PHARM Pre-Planning

- July to October 2014
- Discussed QAPI project details between JPruskowski and SHandler
  - Targeted PA/LTC building: UPMC Heritage Place
  - JPruskowski labeled as “enhanced pharmacist”
  - Went out to market idea...

QA+PI=QAPI

<table>
<thead>
<tr>
<th>Quality Assurance (QA)</th>
<th>Performance Improvement (PI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation</td>
<td>Measuring compliance with standards</td>
</tr>
<tr>
<td>Means</td>
<td>Inspection</td>
</tr>
<tr>
<td>Attitude</td>
<td>Required, reactive</td>
</tr>
<tr>
<td>Focus</td>
<td>Outliers, “bad apples” individuals</td>
</tr>
<tr>
<td>Scope</td>
<td>Medical provider</td>
</tr>
<tr>
<td>Responsibility</td>
<td>Free</td>
</tr>
</tbody>
</table>

**Action Steps to QAPI**

**STEP 1:** Leadership Responsibility and Accountability

**STEP 2:** Develop a Deliberate Approach to Teamwork

**STEP 3:** Take your QAPI “Pulse” with a Self-Assessment

**STEP 4:** Identify Your Organization’s Guiding Principles

**STEP 5:** Develop Your QAPI Plan

**STEP 6:** Conduct a QAPI Awareness Campaign

**STEP 7:** Develop a Strategy for Collecting and Using QAPI Data

**STEP 8:** Identify Your Gaps and Opportunities

**STEP 9:** Prioritize Quality Opportunities and Charter PI Projects

**STEP 10:** Plan, Conduct and Document PI Projects

**STEP 11:** Getting to the “Root” of the Problem

**STEP 12:** Take Systemic Action

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**A Visual Map**

**Greater Goal**

**Current Reality**

Build on Strengths

Overcome Barriers

80%

20%

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**Current Reality — Greater Goal**

- Considerations:
  - **Cost**
    - Direct: physical cost of medication
    - Indirect: nursing administration time, review time by other providers
  - **Burden**
    - Hospital readmissions
    - Presentation of adverse drug reaction(s)?
    - Quality of life
    - Functional ability

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**Build on Strengths**

- Consider what you have in your building(s):

**People**
- Champions
- Mission/Vision

**Product**
- CMS star ratings
- Referrals versus beds ratio
- Staff turnover

**Process**
- IDT meetings
- Resident reviews

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**Workshop Sidebar:**

- What strengths exist in your building(s)?

- How can you use these strengths as a focus of a deprescribing initiative?

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**The DE-PHARM Pre-Planning**

- Our strengths included:
  - Academically focused faculty (most clinicians served as faculty at School of Medicine, Geriatrics Department)
  - JPruskowski (non-traditional role, not confined to traditional consultant pharmacists regulations)
Overcome Barriers

• Some of the barriers to deprescribing:
  - Unclear Resident Population
  - Psychological Connections with Medications
  - Risk of Adverse Withdrawal Events
  - Time, and Confusion Over Discipline/Specialty
  - Lack of Evidence

Workshop Sidebar:

• What other barriers exist in your building(s)?

Developing Your Model

• Think about the:
  - Who: Eligible/Targeted Residents, Eligible/Targeted Medications
  - What: “Deprescribing”
  - When: Eligible/Targeted Residents
  - Why: (Outcome(s))
  - How: Operational Process

Defining Deprescribing:

• The systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient’s care goals, current level of functioning, life expectancy, values, and preferences.

Eligible/Targeted Residents

• Although could be any NH resident, some previous literature suggests:
  - Patients with a life-limiting, or debilitating, illness and have at least one of the following:
    - Documented comfort-focused goals of care
    - Reduced functional level, or manifesting advanced or end-stage disease
    - Presentation of a new symptom or clinical syndrome suggestive of a potential adverse drug effect
    - Receiving high-risk drug combinations
    - Receiving medications for comorbid conditions for scenarios associated with no increased disease risk despite drug cessation
Eligible/Targeted Medications

- Thoughts:
  - Resident-specific:
  - Evidence supports the use of 3MR in this setting

- Broad-classes:
  - Symptom medications:
    - GDR required for antipsychotics for residents
  - Deprescribing.org algorithms for PPIs, hyperglycemics, antipsychotics, and BZDs
  - Co-morbid medications:
    - Literature supports the safe deprescribing of statins

- 3MR: Multidisciplinary Multistep Medication Review; GDR: Gradual Dose Reduction; PPI: proton pump inhibitor; BZD: benzodiazepines

- 4. JAMA Intern Med. 2015 May;175(5):827-34.

Operational Process

Steps of Deprescribing

1. Ascertain all drugs the patient is currently taking and the reasons for each one
2. Determine the required intensity of deprescribing intervention
3. Assess each drug in regard to its current and future risk/benefit ratio
4. Prioritize drugs for discontinuation
5. Implement a discontinuation regimen and monitor

The Role of the IDT

- Who will lead these initiatives?
  - Physicians, Advance Practice Providers vs Pharmacists

- Tracking changes and/or recommendations:
  - CMS guidelines for formal consultant pharmacists recommendations
  - Secure (SBAR) emails outside of health record

The Role of the IDT

- CMS: Centers for Medicare and Medicaid Services; IDT: interdisciplinary team; SBAR: Situation, Background, Assessment, Recommendation

DE-PHARM Phase I

- October 2015 and April 2016
- Methods:
  - Targeted population: LTC residents with comfort-focused treatment (defined via DNR/DNI and either LAI or CMO on POLST)
  - Targeted medications: any comorbid (non-symptom) medication (scheduled); resident-specific
  - Clinical pharmacist driven model

Custodial Residents

- PSCF-CPS Chart Review and Direct Resident Interaction
- PSCF-CPS Chart Review and Direct Resident Interaction
- PSCF-CPS Chart Review and Direct Resident Interaction

Figure 1: Operational Process

Figure 2: Deprescribing “Tool”

- Rational prescribing for patients with a reduced life expectancy
DE-PHARM Phase 1 Results

- Typical LTC resident population
  - N=47 from 10 different primary providers
  - Average age: 87.5 years; mostly female (N=43 (88%)); most prevalent life-limiting illness: dementia (N=34 (72%))
- Medications:

<table>
<thead>
<tr>
<th>Scheduled Medications</th>
<th>Total Number: 464</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Number/Resident:</td>
<td>9.63; Range/Resident:</td>
</tr>
<tr>
<td>PRN Medications</td>
<td>Total Number: 260</td>
</tr>
<tr>
<td>Average Number/Resident:</td>
<td>5.38; Range/Resident:</td>
</tr>
</tbody>
</table>

Table 1: Clinician Responses

<table>
<thead>
<tr>
<th>Parameter</th>
<th>N=39</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician Response</td>
<td></td>
</tr>
<tr>
<td>Within 120 days</td>
<td>Accepted: 10 (37%)</td>
</tr>
<tr>
<td></td>
<td>Modified: 2 (7%)</td>
</tr>
<tr>
<td></td>
<td>Rejected: 2 (7%)</td>
</tr>
<tr>
<td></td>
<td>No Response: 15 (49%)</td>
</tr>
<tr>
<td>Additional Notes</td>
<td></td>
</tr>
<tr>
<td>Recommendations for Residents Who CTB During the Project</td>
<td>6 (15%)</td>
</tr>
<tr>
<td>Recommendations for Residents Who Were Admitted to the Hospital During the Project</td>
<td>4 (10%)</td>
</tr>
</tbody>
</table>

DE-PHARM Phase I Discussion Points

- Difficult to adapt model to 10 different providers
  - Decided to move initiative to UPMC Seneca Place
- Probably not time-effective yet; need clinical extenders
- Questions:
  - What other triggers exist? Is there another population we should target?
  - Does this model require all of these steps?
  - How should we prioritize medications?
  - What are valuable outcomes?

Workshop Sidebar:

- What other questions, or discussion points so you see from the Phase I results?
Perceived Utility of Deprescribing Survey Project

- Survey-based study conducted at the 2017 AMDA Conference in Phoenix, Arizona
- Aims:
  - Aim 1: To explore the knowledge and use of deprescribing in the nursing home setting.
  - Aim 2: To explore the perceived utility of deprescribing.
  - Aim 3: To describe the components of what would be considered a successful deprescribing program.

Workshop Sidebar:

- What were your thoughts regarding the survey-based study?
- Will come back to results!

DE-PHARM Phase II and III

- From July 2016 to June 2018
- Similar process except:
  - Only 4 primary providers
  - PGY2 Geriatric Pharmacy Residents as clinical extenders (4 hours/week)
  - Medication-focused goals of care discussion with LTC residents and/or PoAs led by pharmacy team

DE-PHARM Phase II Results

- Similar population...
  - N=44 from 4 different primary providers
  - Average age: 86.7 years; most females: (N=37 (84%)); most prevalent life-limiting illness: dementia (N=29 (65%))

<table>
<thead>
<tr>
<th>N=696 Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled Medications:</td>
</tr>
<tr>
<td>Total Number: 122</td>
</tr>
<tr>
<td>Average Number/Resident: 9.54</td>
</tr>
<tr>
<td>Range/Resident: 0-21</td>
</tr>
<tr>
<td>PRN Medications:</td>
</tr>
<tr>
<td>Average Number/Resident: 6.27</td>
</tr>
<tr>
<td>Range/Resident: 0-16</td>
</tr>
</tbody>
</table>

Table 2: Clinician Responses

<table>
<thead>
<tr>
<th>Parameter</th>
<th>N=69 Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician Responses</td>
<td>Within 120 days</td>
</tr>
<tr>
<td>Accepted: 49 (71%) – 41 for Deprescribing</td>
<td></td>
</tr>
<tr>
<td>Modified: 0</td>
<td></td>
</tr>
<tr>
<td>Rejected: 3 (4%)</td>
<td></td>
</tr>
<tr>
<td>No Response: 17 (25%)</td>
<td></td>
</tr>
<tr>
<td>Additional Notes</td>
<td></td>
</tr>
<tr>
<td>Recommendations for Residents Who CTB During the Project:</td>
<td></td>
</tr>
<tr>
<td>6 Residents (18%)</td>
<td></td>
</tr>
<tr>
<td>Recommendations for Residents Who Were Discharged During the Project:</td>
<td></td>
</tr>
<tr>
<td>1 Resident (1%)</td>
<td></td>
</tr>
<tr>
<td>Medications Reinitiated During Project:</td>
<td></td>
</tr>
<tr>
<td>1: Aspirin (per family request)</td>
<td></td>
</tr>
</tbody>
</table>
Figure 4: Medications Accepted to be Discontinued (N=41)

Perceived Utility of Deprescribing Survey Project

- Of surveys distributed (1,431 attendees), 637 surveys were returned (45% response rate)
- All surveys were included in final analysis
- Participants:
  - Male: N=350 (55%)
  - Physicians: N=563 (88%)
  - Certified Medical Directors: N=350 (55%)

Table 3: Perceptions of Deprescribing: Survey Results

<table>
<thead>
<tr>
<th>Statement</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprescribing can reduce cost to residents</td>
<td>637</td>
<td>3.75</td>
<td>0.96</td>
</tr>
<tr>
<td>Deprescribing may improve the quality of life for residents</td>
<td>634</td>
<td>3.33</td>
<td>0.77</td>
</tr>
<tr>
<td>Deprescribing may reduce nursing administration time and burden</td>
<td>634</td>
<td>3.15</td>
<td>0.78</td>
</tr>
<tr>
<td>Deprescribing may avoid resident transfers to the ED and hospital</td>
<td>635</td>
<td>3.41</td>
<td>0.75</td>
</tr>
<tr>
<td>Deprescribing may have unintended negative consequences</td>
<td>635</td>
<td>3.33</td>
<td>1.04</td>
</tr>
<tr>
<td>Deprescribing can cause unwanted adverse drug withdrawal events</td>
<td>634</td>
<td>3.89</td>
<td>1.73</td>
</tr>
<tr>
<td>Deprescribing can negatively affect relationships with residents</td>
<td>634</td>
<td>3.45</td>
<td>1.72</td>
</tr>
<tr>
<td>Deprescribing can hinder provider relationships</td>
<td>634</td>
<td>3.62</td>
<td>1.09</td>
</tr>
<tr>
<td>Deprescribing may be depersonalizing</td>
<td>636</td>
<td>4.00</td>
<td>0.91</td>
</tr>
</tbody>
</table>

Key: means and SD based on 5-point Likert scale (1: strongly disagree, 5: strongly agree)

DE-PHARM Phase II/III Discussion Points

- High administrative burden with QAPI process
- High percentage of residents included in Phase III were already reviewed in Phase II
- How to incorporate results of survey-based study?

Table 4: Components of a Successful Deprescribing Initiative – Most Agreed Upon...

<table>
<thead>
<tr>
<th>Statement</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A deprescribing program should target medications that are no longer indicated</td>
<td>637</td>
<td>4.25</td>
<td>0.48</td>
</tr>
<tr>
<td>A deprescribing program should target medications that are “high risk” (i.e., carry a high risk of adverse drug reactions)</td>
<td>637</td>
<td>4.33</td>
<td>0.56</td>
</tr>
<tr>
<td>A deprescribing program is successful if the resident reports an improvement in their quality of life</td>
<td>635</td>
<td>4.43</td>
<td>0.73</td>
</tr>
<tr>
<td>A deprescribing program should include discussions with the resident</td>
<td>635</td>
<td>4.42</td>
<td>0.84</td>
</tr>
<tr>
<td>A deprescribing program is successful if the resident’s family and/or caregivers report an improvement in their quality of life</td>
<td>634</td>
<td>4.48</td>
<td>0.82</td>
</tr>
</tbody>
</table>

Key: means and SD based on 5-point Likert scale (1: strongly disagree, 5: strongly agree)

Table 5: Components of a Successful Deprescribing Initiative – Most Disagreed...

<table>
<thead>
<tr>
<th>Statement</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A deprescribing program should target medications used for comorbid disease states, over symptom medications</td>
<td>637</td>
<td>3.82</td>
<td>1.44</td>
</tr>
<tr>
<td>A deprescribing program should include standardized order sets</td>
<td>635</td>
<td>2.85</td>
<td>1.08</td>
</tr>
<tr>
<td>A deprescribing program should be led by pharmacists</td>
<td>636</td>
<td>2.91</td>
<td>0.99</td>
</tr>
<tr>
<td>A deprescribing program should prioritize medications that are considered “low hanging fruit” (i.e., supplements) over “high risk” medication (i.e., carry a high risk of adverse drug reactions)</td>
<td>637</td>
<td>3.18</td>
<td>1.14</td>
</tr>
<tr>
<td>A deprescribing program should occur only at the provider’s discretion</td>
<td>637</td>
<td>3.81</td>
<td>1.07</td>
</tr>
</tbody>
</table>

Key: means and SD based on 5-point Likert scale (1: strongly disagree, 5: strongly agree)
Evolution: DE-PHARM Phase IV

- To start July 2018
- Plan is to:
  - Develop a deprescribing collaborative agreement between JPruskowski and BWilson
  - Expand population to target those residents with “high risk” medications
  - Develop IT support via SHandler
  - Collect QoL outcomes for residents and/or families

Overall

- Recognize current reality, define greater goal
- Build on strengths, overcome barriers
- Consider defining:
  - Eligible/targeted residents
  - Eligible/targeted medication
  - Operational process
- Lastly, (for formal QAPI projects) write aims of project utilizing SMART format

SMART Formulas:

| Specific | Describe the goal in terms of 3 "W" questions:
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• What do we want to accomplish?</td>
<td></td>
</tr>
<tr>
<td>• Who will be involved/affected?</td>
<td></td>
</tr>
<tr>
<td>• Where will it take place?</td>
<td></td>
</tr>
</tbody>
</table>

| Measurable | Describe how you will know if the goal is reached:
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the current data figure (i.e., count, percent, rate) for that measure?</td>
<td></td>
</tr>
<tr>
<td>• What do you want to increase/decrease that number to?</td>
<td></td>
</tr>
</tbody>
</table>

| Attainable | Describe the rationale for setting the goal measure above:
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Did you base the measure or figure you want to attain on a particular best practice/average score/benchmark?</td>
<td></td>
</tr>
<tr>
<td>• Is the goal measure set too low that it is not challenging enough?</td>
<td></td>
</tr>
<tr>
<td>• Does the goal measure require a stretch without being too unreasonable?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relevant</th>
<th>Briefly describe how the goal will address the business problem.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time-Bound</th>
<th>Define the timeline for achieving the goal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the target date for achieving this goal?</td>
<td></td>
</tr>
</tbody>
</table>

Workshop Sidebar:

How would you develop your deprescribing initiative at your building(s)?

Case: “Are you trying to kill her?!”

- JF is a 78 year old WF
- Currently residing in the nursing home
- PMH: AD (FAST: 7C – who would meet hospice guidelines for admission: >10% weight loss, and recent UTI), breast cancer, CAD, HTN, HLD, non-valvular Atrial fibrillation
- Repeated falls in the past 3 months, now max assist (Hoyer lift)
- Current Medications: donepezil 10mg PO once daily, memantine 10mg PO once daily, Lisinopril, atorvastatin, warfarin, MVI, ferrex, and Calcium and Vitamin D tablets PO TID
Antidepressant drugs: Evidence for Deprescribing

- Cholinesterase inhibitors are efficacious for only mild to moderate Alzheimer’s dementia\(^1\), while memantine only has a small benefit at six months to moderate to severe Alzheimer’s dementia\(^2\).
  - Most trials had a treatment duration of 6 months to 1 year, however most were only 12-24 weeks.
  - Think about the comparison between dementia scales.
  - Cochrane doesn’t say much for those near or at the end of life.
  - Very expensive agents.

Anti-Dementia Drugs: The Opposing View

- Previous literature has suggested negative impact upon discontinuation of ChEI on patients and their care\(^1\).
  - "Cholinesterase inhibitor discontinuation in patients with Alzheimer’s disease: a meta-analysis of randomized controlled trials."\(^2\)
  - Meta-analysis including R, DB, PC studies investigating the effects of ChEI discontinuation on patients with AD.
  - Objective: to examine the effects of discontinuation.
  - Results: 18 studies reviewed – 5 ChEI discontinuation R controlled studies (N=321 continued and N=332 discontinued; following patients for 1.5-24 months).

Deprescribing Theater

- How would you approach this case?
- What communication techniques would you utilize?
Communication Techniques

WORDS MATTER!

Acknowledgement:
Cara Tannenbaum, MD, MSc
Co-Director, Canadian Deprescribing Network
Professor, Faculties of Medicine and Pharmacy,
Université de Montréal, Québec

So How Willing Are Residents and Families?

- Older peoples' attitudes regarding polypharmacy, statin use and willingness to have statins deprescribed in Australia.¹
- Eighty-nine percent (95% CI 84.4–93.6) of participants reported that they would be willing to stop one or more of their medications.

Perceptions of Statin Discontinuation among Patients with Life-Limiting Illness.²

- Fewer than 5% of participants expressed concern that statin deprescribing indicated physician abandonment.
- About one in five participants reported being told to take statins for the rest of their life (18%).
- Many participants reported benefits of stopping statins, including spending less money on medications (63%), potentially stopping other medications (34%), and having a better quality of life (25%).

The Revised Patients' Attitudes Towards Deprescribing (rPATD) Questionnaire.

Factors include:

- Burden of medication taking:
  - I spend a lot of money on my medicines
  - Taking my medicines every day is very inconvenient
  - I feel that I am taking a large number of medications
  - I feel that my medicines are a burden to me
  - Sometimes I think I take too many medicines

- Belief in appropriateness of medication use (harms and benefits)
- Concerns about stopping the medication
- Level of involvement/knowledge of medications

To Start...

Deprescribing conversation can start:

During/After a Goals of Care Conversation

Goals of Care Discussions

- SPIKES:¹
  - Setting the Stage
  - Perception
  - Invitation
  - Knowledge
  - Empathy (or Respond to Emotion)
  - Strategy/Summary

During/After a Goals of Care Conversation

- Adapt SPIKES¹ to Medications
  - Setting the Stage
  - Perception
  - Invitation
  - Knowledge
  - Empathy (or Respond to Emotion)
  - Strategy/Summary

### Outside of a Goals of Care Conversation

There are 4 ways to start a deprescribing discussion:

- **Direct**
- **Indirect**
- **Emotional, Assertive**
- **“Reading for Next Time”**

#### Direct

**Example**

- "I see you/[resident] are taking [number of medications] of pills, I want to discuss getting you/[resident] off some of them"

- Use words that are abrupt or blunt can draw attention
- Goal is to spark a discussion
- Helpful for residents and/or families who require direction or structure

#### Indirect

**Example**

- "How’s your/[the resident’s] cholesterol?....There is some new research about cholesterol pills that I want to discuss with you"

- Can be helpful with those who appreciate research, or a “softer touch”
- Goal again is to spark a discussion

#### Emotional, Assertive

**Example**

- "About your/[resident’s] memory problems, falls, etc… I’m worried about that"

- Also referred to as, “planting the seed”
- Can be helpful with residents and/or families that requires more than one interaction

#### “Reading for Next Time”

**Example**

- "Here is some information regarding your/[resident’s] [medication] – read this for next time"

- Helpful for residents and/or families that need time to think through options
- Be sure to readdress during next interaction
- Literature has shown this method can lead to complete discontinuation of benzodiazepines in up to 50% of patients

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How do I elicit cognitive dissonance?

Deprescribing Theater

- How would you approach JF’s family now?

Last Points

- What other types of difficult cases have you experienced?
- What other questions/concerns do you have?

*Clinical Pearls*

- Deprescribing is the answer to polypharmacy or potentially inappropriate medications in PA/LTC residents
- There are many elements to a successful PA/LTC deprescribing initiative – adapt for your specific building(s)
- Consider your communication – communication is key!

Unclear Resident Population

- There are no JNC-7 guidelines for deprescribing
- Most of the time we are reactionary, instead of proactive
  - “If it isn’t broken, don’t fix it”
Patient Barriers to Deprescribing

- Systematic review\(^1\) suggest four themes:
  - Appropriateness' of cessation
  - Absence/presence of a 'process' for cessation
  - Negative 'influences' to cease medications
  - Fear
- Qualitative focuses group suggest\(^2\) willingness to be influenced by:
  - Perception of the appropriateness of that medication
  - Fear of outcomes of withdrawal
  - Dislike of taking medications
  - Availability of a process for withdrawal

Table: Patients' potential perceptions when discussing changes to drugs.

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconsistent advice leading to difficulties (trust)</td>
<td>&quot;But my other doctor told me I should never stop this drug. Are you saying (s)he was wrong? Do you know what you’re doing?&quot;</td>
</tr>
<tr>
<td>Further conformation with mortality</td>
<td>&quot;I was told to take this until I die. Are you saying I’m about to die?&quot;</td>
</tr>
<tr>
<td>Feelings of abandonment by the medical world</td>
<td>&quot;So it’s not worthwhile treating me anymore.&quot;</td>
</tr>
<tr>
<td>Exposure to the complications of the medical condition</td>
<td>&quot;But won’t I get sick without the tablet?&quot;</td>
</tr>
<tr>
<td>A sense of futility of previous efforts (with compliance)</td>
<td>&quot;So why did I bother with jabbing my finger and eating rabbit food for the last twenty years?&quot;</td>
</tr>
</tbody>
</table>

Risk of Adverse Withdrawal Events

- What are we all afraid of?

> "Your medical problems are more complicated than I thought – I am going to send you to another doctor with more medical insurance than I have."

Time over Discipline/Specialty

- Time is an enormous factor\(^1\)
- Specialty:
  - Where should deprescribing occur?
  - Who should lead deprescribing?
- Physicians need to take the lead in deprescribing
- Deprescribing in frail older people – Do doctors and pharmacists agree?\(^2\)

Factors influencing deprescribing habits among geriatricians.

• Study Design: Qualitative study exploring factors influencing deprescribing practices among geriatricians
• Methods: Electronic survey was sent to ANZGSM and NSWGMAT network.
• Results: 134 (14.4%) physicians responded.

Lack of Evidence: Acid Reflux Drugs

• Two classes:
  - Histamine receptor antagonists: ex: famotidine
  - Proton pump inhibitors: ex: pantoprazole
• Indicated for GERD and other various gastrointestinal diagnoses
• Specific administration instructions: without food (~30 minutes prior)

Acid Reflux Drug – Evidence for Deprescribing

• Treatment guidelines only recommend a trial of 8 weeks (of therapy with PPIs)\(^1\)
• Inhibits the absorption of other medications
• Maybe most pertinent?: Calcium and Vitamin D\(^2\)
• Retrospective reviews now speculate:
  - Prolonged use of PPIs with increased risk of chronic kidney disease\(^3\)
  - Prolonged use of PPIs with increased risk of dementia\(^4\)

Acid Reflux Drugs: The Opposing View

• These are symptom medications: GERD can dramatically decrease a resident’s quality of life\(^1\)
• GERD can be more prevalent in the elderly resident\(^1\)
• There is a risk of rebound GERD with discontinuation, although conflicting data currently exists\(^2\)
• What if the resident cannot verbalize presence of symptoms?
  - There is no “PAINAD” scale (to screen and monitor pain in nonverbal residents) for dyspepsia

GERD: gastroesophageal reflux disease; PAINAD: Pain Assessment in Advanced Dementia Scale