THERAPEUTICS INITIATIVE Evidence Based Drug Therapy

Practical Deprescribing for Residential Care

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Faculty/Presenter Disclosure

I, Jessica Otte, have no sponsorships, honoraria, monetary support, relationships or other conflict of interest from any commercial source.

I have/do receive honoraria from non-profit organizations:

THERAPEUTICS INITIATIVE Evidence Based Drug Therapy

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CADTH Evidence Driven.

(Frailty Guidelines)

PROBLEMS WITH POLYPHARMACY

Greater number of medications, greater incidence of:

- Adverse drug reactions
- Falls, fall outcomes (fractures), incontinence
- Measures of function and cognition
- Hospitalizations, ER visits
- Mortality

The more medications a person takes, the greater the:

- Cost to the patient and system
- Burden of care
  - Feeling “medicalized”
  - Poorer adherence to (necessary) prescribed medications
  - “Hassle factor”: cascades of prescribing, appointments and lab tests to monitor medications

TACKLING POLYPHARMACY

David Alldred
@MedicinesDavid

Colleague reduced medicines from 9 to 2 for a 92 year old. Patient was taking none of their meds due to concerns over side effects - now happy to take the essential ones. Here's a week's worth before and after #deprescribing

Best not to prescribe in the first place…

CASE: MR Z

58 y/o man with quadriplegia described as "oversedated" by his counsellor

Drug list:

- gabapentin 1600 mg/d
- loxapine 75 mg/d
- amitriptyline 150 mg/d
- mirtazepine 30 mg/d
- baclofen 60 mg/d
- oxycodone 45 mg/d
- lorazepam prn

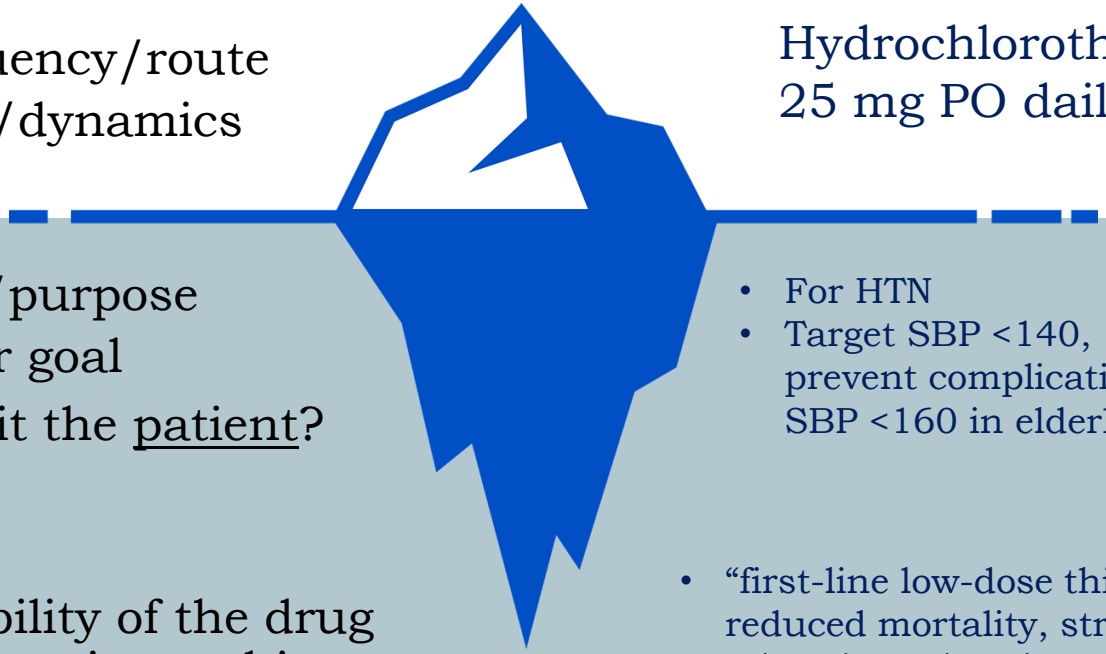
First Impressions?

Which, might you modify?

ANATOMY OF A DRUG

- The drug
- Dose/frequency/route
  - Kinetics/dynamics

Hydrochlorothiazide
25 mg PO daily



- Indication/purpose
  - Target or goal
  - Does it fit the <u>patient</u>?

- For HTN
- Target SBP <140, (ultimately to prevent complications eg. MI, CVA) or SBP <160 in elderly

- Efficacy (ability of the drug to help the patient achieve that goal)

- "first-line low-dose thiazides reduced mortality, stroke, and MI. No other drug class improved health outcomes better than low-dose thiazides."

- Side effects, Adverse Events? Interactions?

- **SEs:** elyte changes, hypotension, rash, → Stevens-Johnson, pancreatitis
- **Interactions:** eg. lithium (elytes), amitriptyline (SIADH)

DEPRESCRIBING: A PROCESS

1. **START WITH THE PATIENT**
   - Make the time, establish patient's goals, current concerns

2. **GATHER MED INFORMATION**
   - Medical history, Best Possible Medication History

3. **REVIEW MEDS & MAKE A PLAN**
   - Deprescribe

4. **CONTINUE**
   - Don't stop stopping

MAKING THE TIME

Any time you are (thinking of) prescribing something new:

- Consider symptoms of concern
  - Could these be medication-related?
  - Could a new medication increase the number of problems?
  - Is there anything on the med list that is no longer needed or might be causing harm?

Case Conference:

- Review goals of care, symptoms for patient, family/representative's concerns
  - Prioritize medications to stop/change
  - STOP one or two medications, more if very straightforward (eg. those where no taper required)

The burden of proof should be on whether to continue a medication, not on whether to discontinue it.

GOALS, CONCERNS

CASE: MRS NEWS

78 year old, lived in Assisted Living with Home Support QID:

- Newly admitted to Residential Care because of frequent falls and not able to cope safely at home
- Devoted niece lives ~30 mins away
- Mobilizes with 4WW

You are asked to take over as this patient's GP and are doing your first visit/assessment.

"Big Picture" Goals:

- Avoid falling again!
- "Live as long as possible, if I'm independent"

Current concerns:

- Light-headed feeling on standing is worrying
- Some nausea in the mornings
- Tends to constipation; some occasional bleeding from hemorrhoids

GATHERING MED HISTORY

- **HTN** (BP 110/56 sitting, 100/58 standing)
- **CHF** (mild AoS & TR, EF is 45%)
- **Atrial Fibrillation**, **anticoag'd** (INR 1.8, EKG: a fib, rate controlled HR = 62)
- **L THA 2008 for hip #**
- **Constipation and Hemorrhoids**
- **Frequent UTIs**
- **Hypothyroidism** (post-thyroidectomy, TSH 2.7)
- **STML/Mild Cog Impairment**
- **Hx of depression** (when husband died 2y ago)
- **Recent falls and decreased mobility**

BEST POSSIBLE MEDICATION Hx

- Warfarin 3-5mg PO daily
- Diltiazem 240mg ER PO daily
- HCTZ 25mg PO daily
- Ramipril 5mg PO BID
- Rosuvastatin 20mg PO daily

- Acetaminophen long acting 650mg PO BID
- Ibuprofen 400mg PO rarely

- Calcium Citrate 250mg PO TID
- Vitamin D 1000u PO daily
- Alendronate 70mg PO qweekly

- Citalopram 20mg PO daily
- Levothyroxine 75mcg PO daily

- Vitamin E 1 capsule PO daily
- Dimenhydrinate 50mg PO qAM PRN nausea

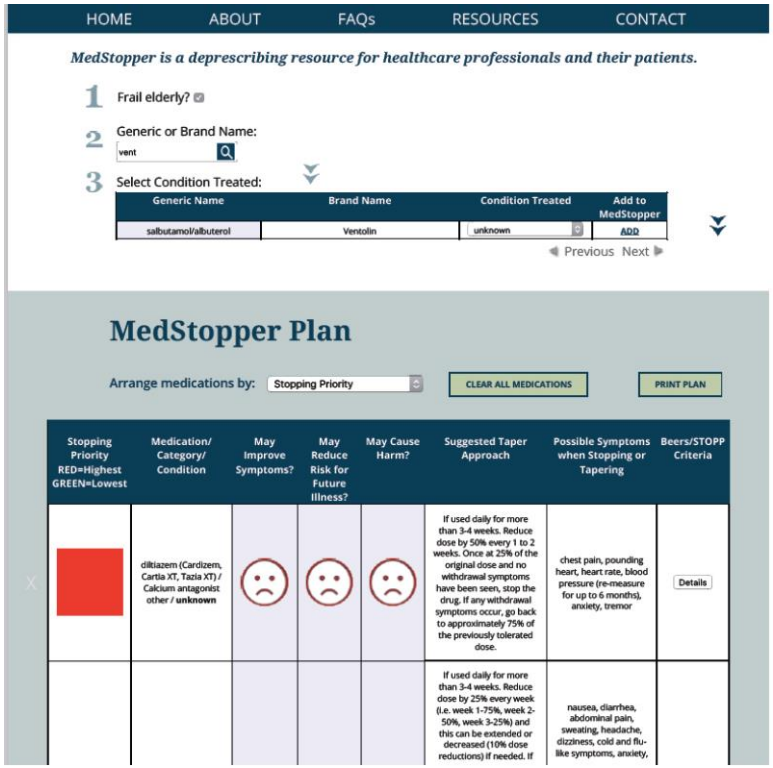
- Cephalexin 250mg PO daily

POSSIBLE QUESTIONS

- What kind of heart failure did/does she have? How did it present?
- Was her grief "medicalized"?
  - "Bereavement is a depressive disorder if it has lasted more than:
    - 1 year (DSM-III from 1980)
    - 2 months (DSM-IV from 1994)
    - 2 weeks (DSM -V from 2013)"
- How long has she been on that bisphosphonate?
- What is her renal function?
- How often did she get UTIs? Is there suspicion overtreated colonization? Interstitial cystitis?

REVIEW MEDS & MAKE A PLAN

- Can start by removing the most egregious
  - www.medstopper.com – rank by stopping priority
  - BEERS, START/STOPP ?
- Gently?
  - One medicine at a time
  - Taper gradually
  - Consider evidence-based deprescribing algorithms
    - www.deprescribing.org: PPIs, oral hypoglycemics, antipsychotics, benzodiazepines & Z-drugs, cholinesterase inhibitors
- Quickly?
  - "low hanging fruit" - easy-to-stop
  - dangerous (toxic) medications



ONE WAY

Drug	Purpose/ Indication /Goal?	Effective?	Problematic?	KEEP?	STOP, Decrease, Substitute?
Warfarin					
Diltiazem					
etc.					

YOUR TURN!

- Review medications and make a plan

Drug(s)	Action/Reasoning
Warfarin	Replaced by rivaroxaban for ease
Diltiazem	Replaced by metoprolol 12.5 mg BID – better in CHF, won't contribute to constipation
HCTZ	Stopped - hypotension
Ramipril bid	Decreased to 2.5mg daily (hypotension, small dose for CHF benefit as BP/symptoms allow)
Rosuvastatin	Stopped, no indication
Acetaminophen bid	Changed to as needed
Ibuprofen	Stopped (rarely used, risk with anticoagulation)
Alendronate	Stopped, was on >5y, ?nausea
Ca/Vit D/Vit E	Stopped – constipation/not useful/harmful
Citalopram	Reduced to 10 mg/d, plan to further decrease - ?causing nausea, not indicated
Levothyroxine	Unchanged
Dimenhydrinate	Stopped - (? Mental clarity)
Cephalexin	Stop once constipation Tx'd / ?sub topical estrogen

DON'T STOP STOPPING…

- Follow a plan that includes clear tapering and monitoring (just like you would starting a drug!)
  - Set a follow up appointment at the end of each deprescribing session
- Make a plan for rebound symptom withdrawal
  - You can *ALWAYS* restart a med! (happens 2-18% of the time)
- Keep communicating with other providers, especially pharmacists
  - Include the whole med list
  - START / STOP / CONTINUE / CHANGE, and reasons WHY
- YES sometimes when you stop the warfarin they have a stroke the next day
  - Shared decision-making

AWARENESS & SKILL

- Awareness of own skills/deficits: A+

- Taking responsibility
  - “the most noteworthy barrier to deprescribing was devolving responsibility, that is, the passing of blame and responsibility to other health care professionals.”

HOW TO DO IT SAFELY:

<u>When deprescribing, CMPA recommends that you:</u>

- assess the patient
- make a monitoring & follow up plan
- demonstrate knowledge about the medication/context
- discuss and document informed consent (risks and benefits)
- use care in Rx with dependence

(Dr Tino Piscone, Therapeutics Initiative conferences, Oct 2018)

…. The same as prescribing!

CASE: MR Q

86 year old in Residential Care, "spry" wife living next door at Assisted Living facility

- Not a complainer, doesn't really like pills
- Was resuscitated once but has never had great quality of life since then
- Spends most of his time in bed as sitting makes him feel awful

It's care conference time and his nurse is concerned about Mr Q's high blood pressure.

"Big Picture" Goals:

- Prefers feeling well over longevity
- Would like to play cards with his family when they visit

Current concerns:

- Dizzy (spinning) feeling all the time
- "Just don't feel well."
- Thinks he is on too many pills

MEDICAL HISTORY

- Bladder cancer, in remission
- Urinary Retention (recent indwelling catheterization for obstructive uropathy)
- CKD (GFR ~30)
- COPD
- CVA, R hemiparesis; CEA x 1
- HTN (BP 180/90 usual for him, declines some Rx)
- Dyslipidemia (intol of statin)
- IHD with CABG
- Glaucoma
- Intermittent complete heart block and type 2 second-degree AV block; cardiac arrest 5 years ago (resuscitated; now has pacemaker. HR 62)
- IDDM (HbA1c 5.9% 6 months ago)
- Mild cognitive impairment
- Insomnia
- Hx Right Hip fracture with IM nail (no pain lately)

MEDICATION LIST

- Acetaminophen/caffeine/ codeine 300mg-15mg-30mg i PO BID PRN
- ASA 81mg PO daily (often declines because of bruising)
- Amlodipine 10 mg PO daily
- Bisoprolol 5 mg PO daily
- Fluticasone/Salmeterol 500 Diskus 1 puff BID
- Furosemide 40 mg PO BID
- Hydralazine 25 mg PO QID
- Insulin isophane-Insulin regular 30/70 using 10u SQ BID
- Ramipril 5mg PO daily (refuses "those capsules" because he doesn't like how they make him feel)
- Senna 2 tabs PO QHS PRN
- Tiotropium 18 mcg inhaled QHS
- Tamsulosin 0.4mg PO daily
- Tramadol 50 mg PO BID
- KCl 8 mEq / 600 mg PO BID
- Nitro Patch 0.6 mg/hr transdermal daily
- Zopiclone 7.5 mg PO QHS

QUESTIONS?

- How bad is his COPD? Was it confirmed on spirometry? Any dyspnea? Has he had any exacerbations?
- Does he get angina?
- Has he had low sugars?
- Is his urinary retention due to BPH? Something else? Has he seen a urologist? Should he?
- What is his sleep hygiene like? Is he tired during the day?
  - Has he seen the "How to get a good night's sleep without medication" handout?

6 STEPS TO ENSURE A GOOD NIGHT'S SLEEP

STEP 1 - Start a sleep diary

Familiarize yourself with your baseline sleep profile to help you determine the best strategy to implement.

STEP 2 - Develop good sleep habits

Developing good sleep habits will improve your sleep.

STEP 3 - Dispel myths

Correct any false beliefs you may have concerning sleep.

STEP 4 - Manage daily stress

Various issues have an impact on sleep as you age: medical and psychological issues, medications, lifestyle changes (retirement for example), biological factors, or pain.

STEP 5 - Benefit from good sleep hygiene

Avoid caffeine, nicotine, alcohol and exercises before going to bed. The bedroom should be sleep-inducing: dark, quiet and at a comfortable temperature.

STEP 6 - Taper off sleeping pills

Follow the tapering-off program provided on page 19 under the supervision of your doctor or your pharmacist, if you are currently taking sleeping pills.

YOUR TURN

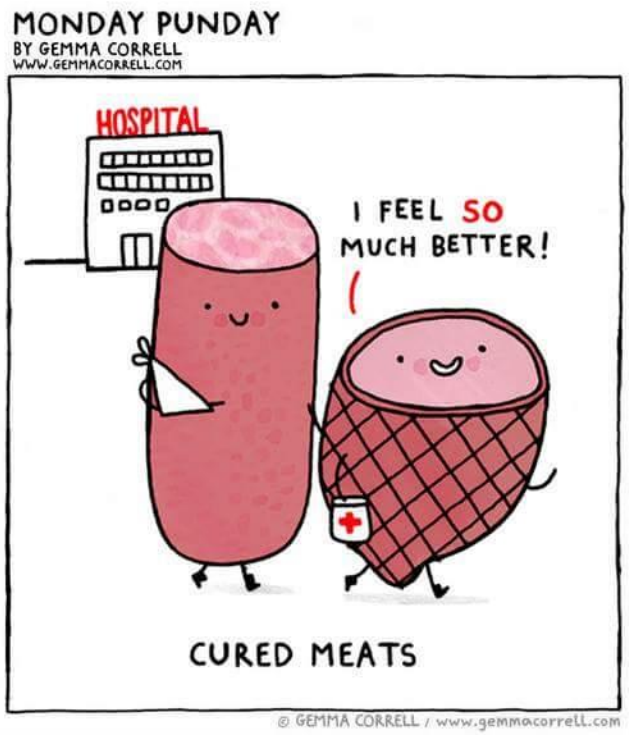
Drug(s)	Action/Reasoning
Acetaminophen/caffeine / codeine	STOP (no pain)
ASA	STOP, patient declines it
Amlodipine	STOP, may be causing dizziness
Bisoprolol	STOP, dizzy, unwell feeling
Fluticasone/Salmeterol	CHANGE to salbutamol PRN
Furosemide	TAPER
Hydralazine	STOP
Insulin 30/70	STOP, no hyperglycemia, could be having hypoglycemia
Ramipril	KEEP if
Senna	? Mat stop if STOP tramadol
Tiotropium	STOP, may contributing to urinary retention
Tamsulosin	KEEP. STOP if Foley will be used indefinitely
Tramadol	STOP, not needed, not safe; consider sub morphine/HM
KCl	STOP if tapering furosemide
Nitro patch	KEEP for now if angina, titrate down/sub morphine
Zopiclone	TAPER slowly

CHECK IN

What is one thing will you do differently tomorrow?

MORE TOOLS

- GPAC Frailty Guideline: Med Review Appendix: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/frailty-medreview.pdf
- More practice: Online Module with sample case: https://www.bruyere.org/patientsafetymodules/Deprescribing/story.html
- A practical guide to stopping medicines in older people: https://bpac.org.nz/BPJ/2010/April/stopguide.aspx
- Patient handouts: EMPOWER brochures https://deprescribing.org/resources/deprescribing-information-pamphlets/
  - Sedative-hypnotic brochure
  - Proton pump inhibitor brochure
  - Sulfonylurea brochure
  - Antipsychotic brochure
  - Antihistamine brochure
  - Non-steroidal anti-inflammatory drugs or NSAIDs
- Alternatives e.g. for insomnia
  - https://mysleepwell.ca



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