Medication Management and Reduction

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Disclaimers and Conflicts

NONE

To facilitate audience engagement, allow Q&A, and get Feedback during this session,

we will be using SLIDO
on your cell phone or on your computer
Please go to the Website: sli.do and enter the code for tonight
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SLIDO activity

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What is the mix of the those here by profession?

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What is your Profession?

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Agenda

SLIDO sign-in and Introduction
Learning Objectives
Polypharmacy, Deprescribing,and Frailty
“The Good, the Bad,and the Ugly”-a cautionary Tale
The Deprescribing Process/Medication review
Q&A
Case #1-Stanley
Barriers, Pitfalls, and Resources
Q&A
Case #2-Alice
Q&A
Case #3-Edna
Learning Objectives/Wrap-up/Takeaway tips
Questions/”Open Mike”?

What’s in this for You?

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Learning Objectives

After this session, attendees should be able to

1. Recognize a Deprescribing Opportunity (Mindset)

2. Describe the process of a Medication Review -to build a Deprescribing Plan

3. Incorporate Collaboration and Communication strategies

For efficient and safe Deprescribing.

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Polypharmacy

Deprescribing (med. reduction)

Frailty

(Our shared understanding for this session)

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Which of these terms do you have a clear definition for? (check all that apply)

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Polypharmacy

the use of more drugs in a given person, than are appropriate for that person

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Deprescribing-(practical)

1. Achieving better health outcomes for older people through reducing medications

and/or

2. Stopping as many non-life-saving drugs as possible with approval of the patient/family

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Deprescribing-(Long version)

-“The systematic **Process** of identifying and discontinuing drugs in instances in which existing or potential HARMS outweigh the existing or potential BENEFITS within the context of an individual patient’s care goals, current level of functioning, life expectancy values, and preferences”

-“A positive, patient-centred intervention, with inherent uncertainties, and requires shared decision making, informed patient consent and close monitoring of effects”

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Frailty

A clinically recognizable state of older adults, with increased vulnerability, resulting from age-associated declines in physiologic function and reserve across multiple organ systems, such that the ability to cope with everyday or acute stressors is compromised

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How much Deprescribing are people here doing currently?

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For how many patients did you deprescibe a medication(s) in the past 2 weeks?

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Wild West Deprescribing?

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3 BASIC questions-to Facilitate our efforts

1. Who needs deprescribing?
 (and When) and Where

2. How do I Deprescribe Effectively?

3. Why is this important?

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5 step Deprescribing Process

(the **HOW?**)

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Polypharmacy and I should Deprescribe?

5Step Deprescribing process

1. Complete **Drug List/Reasons**
2. Global **Risk** of Drug **Harm**-Pt./Drug Factors
3. Assess Drug **Eligibility** for D/C'ing= **RANK**
4. **Prioritize** the Drugs for stopping
5. Implement **Plan + Monitor**

Who is this person?

Ian Scott et al-JAMA 2015.

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Assessing The ORDER of Drugs to Stop?

Rank the Drugs 1-4 (Interrogate the Suspects)

All of these are drugs to be stopped

1 = No Benefit OR no Indication OR contraindicated OR Drug Cascade?

2 = Harm > Benefit (present or future)?

3 = Symptom or Disease Drug-Symptoms stable or nil?

4 = Preventive Drug- Potential benefit unlikely to be realized because of limited Life Expectancy?

Ian Scott et al-JAMA 2015

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The most important question to ask yourself when assessing a drug for deprescribing-

“Given all that I know about this person, in this condition, with these goals of care, at this time, would I prescribe this drug, at this dose, Now?”

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Audience Q&A Session

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CASE #1

Stanley Tufts is an 89 year old widower just admitted to your LTC facility. He has a daughter who works in LTC as an RN. Stanley is being transferred to the facility after being discharged from the hospital for a fractured hip-4 weeks ago. He was previously in assisted living, but functioning well. He remains confused, in pain and incontinent of urine. (You will be his MRP and responsible for his care)

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Stanley's Medication List

1. Amitriptyline- 25mg p.o. at bedtime
2. Domperidone-10mg p.o. QID
3. Donepezil-10mg p.o. daily
4. Ibuprofen-400mg p.o. every 8 hrs.
5. Lansoprazole-30mg p.o. daily
6. Lorazepam-1mg p.o. at bedtime
7. Sertraline-50mg p.o. daily
8. Warfarin-3mg p.o. daily
9. Acetaminophen with codeine-1-2 tabs p.o. Q6hrs PRN
10. Sennosides-2 tabs. p.o. at bedtime
11. Tamsulocin-0.6mg BID
12. Glyburide 5mg BID

+ SMELLY URINE

"Do we sent a C/S?"

Pill Burden

23 Pills a Day=644/4wks=**8,372/yr**.

Functional problem list

Falls/unsteadiness
Indigestion/Nausea
Constipation
Urinary Incontinence
Drowsiness
Poor oral health
Left Hip pain

Diagnoses

Frailty,BPH
Depression
A.Fib., HTN.,Diabetes

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Case #1-Stanley

	RANK
1. Amitriptyline- 25mg p.o. at bedtime	1-C
2. Domperidone-10mg p.o. QID	1-C
3. Donepezil-10mg p.o. daily	3
4. Ibuprofen-400mg p.o. every 8 hrs.	2
5. Lansoprazole-30mg p.o. daily	2-C
6. Lorazepam-1mg p.o. at bedtime	1,2,3
7. Sertraline-50mg p.o. daily	2,3
8. Warfarin-3mg p.o. daily	2,3
9. Tylenol #3-1-2 tabs p.o. Q6hrs PRN	2C
10.Sennosides-2 tabs. p.o. at bedtime	2C
11.Tamsulocin-0.6mg BID	2
12. Glyburide 5mg BID	2,3,4

Actions Taken

Reviewed information
met Stanley,daughter -phone call
Agreed to start Deprescribing
Many Risky drugs/cascades
Acute decline
Spoke with Caire Aide-first impressio
Priority drugs-1, 2,6,9 (problems/drug
Next-12, 3, 4, 8
Next-5, 7, 11, 10
Made a Plan/wrote instructions/discuss
Reviewed every 1-2 weeks
Followed up with daughter at 4/52
D/C issue with Donepezil
8 weeks-mostly sorted.

Case #1 - Stanley

Medication list after Deprescribing

1. Acetaminophen 500mg TID
2. Tamsulocin 0.6mg at HS
3. Melatonin 6mg at HS

More importantly, Stanley is walking with assistance, eating better, gaining weight, his pain is improving and he is not incontinent. He has some mild Dementia, and his daughter is **less anxious** and very happy with the deprescribing results.

Barriers to (routine) Deprescribing

"The main obstacle to (routine) Deprescribing is the psychological difficulty involved in making complex treatment decisions in the face of uncertainty"
(Patient/Family, Physician,Care Team,medical culture)

(Others-Safety, time, difficult conversations, negative outcomes, lack of information…)

Dorion Garfinkle, Eur.J. Geriatric Gerontology-2019

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The negative effects of Barriers

For many Family Physicians, these can lead to feeling Frustrated and powerless to tackle the problem

“Trapped”

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What is YOUR #1 barrier to more confident/effective Deprescribing?

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Deprescribing Pitfalls

Or "*Expect the Unexpected* "

1. Symptom or disease flare
2. Withdrawal syndromes
3. Lack of shared decisions ahead of time (Upsetting conversations)
4. Monitoring oversights (Crisis management)
5. Too Many, too quickly (Too little, too slowly)

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My Confidence in making these Habit Changes is:
(1 no confidence at all, 10 extremely confident)

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Tools and Resources

PHARMACIST

STOPP / START

Medstopper

Shared Care B.C.

Beers List

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Audience Q&A Session

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Case #2 - Alice

Alice Smith is a 95 yr. old woman- newly admitted to your nursing home from the hospital. She had a fractured pelvis from a fall 6 weeks ago. She had been in Assisted Living with supports.

She is more confused than her friends recall, and now is incontinent of urine. She has some pain, needs help to walk, and is slurring her words. She has a history of Mild Dementia, early Parkinson's, Diabetes, and depression after her son died 5 yrs ago. Things have drastically changed for Alice.

Case #2-Alice

Alice's Medication List

1. Glyburide-5mg p.o. BID
2. Olanzapine- 5mg p.o. BID
3. Acetaminophen with Codeine-30mg 1-2 tabs. QID PRN
4. Zopiclone-7.5mg p.o. at bedtime
5. Citalopram-20mg p.o. daily
6. Metformin- 500mg p.o. BID
7. Calcium-1200mg p.o daily
8. Vitamin D-1000 i.u. p.o. daily
9. Lactulose-30ml p.o. at bedtime
10. Olanzapine-2.5mg i.m./s.c. **PRN**
11. Lorazepam-0.5mg s/l TID **PRN**
12. Hydromorphone-1-2mg s.c. Q4hrs **PRN**
13. Levodopa/carbidopa 100/25mg QID

Actions Taken

Information gathering
Functional issues
Dx's
Clinical course
Discussions
Visit
Risks and Ranking
Set Priorities
Discuss/Plan/Monitor
Followup
REPEAT- until **Done**

Case #2 - Alice

Alice’s Medication List after deprescribing

1. Acetaminophen 500mg TID
2. Vitamin D 1000 I.U. daily
3. Lactulose 30mg e.o.d.
4. Hydromorphone 0.5mg at HS
5. Levodopa/Carbidopa- 100/25 TID

Alice is walking with a walker, is able to converse with fellow residents, and enjoys outings on the facility bus. She looks forward to spending her days reading and visiting with friends. Her diabetes was managed with diet, and her Parkinson’s improved greatly.

Alice died 6/12 after deprescribing.

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Audience Q&A Session

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Case #3 - Edna

Edna MacMillan is 86 yrs old, and had a stroke 2 years ago. She has been well supported by her husband Sam, and community help but she is requiring long term care now. Sam is very devoted to her care and medical management, and he is burned out. She is admitted from home to your facility. She has dense left sided weakness, some moderate dementia, and persistent neuropathic pain. She has lost her appetite. Her family physician gives you a handover, and cautions you about Sam.

Case #3-Edna

Edna's Medication List

1. Amitriptyline 50mg at HS
2. Restoralax 30mg twice daily
3. Tylenol #3-2 tabs TID
4. Amlodipine 10mg daily
5. ASA 81mg
6. Atorvastatin 40mg
7. Magnesium 500mg bid
8. Multivitamin
9. Vitamin C 1000mg
10. Omega 3 oil capsules TID
11. Furosemide 40mg daily

Actions taken

Information gathering
Functional issues
Dx's
Clinical course
Discussions **SAM**
Visit
Risks and Ranking
Set Priorities
Discuss/Plan/Monitor
Followup
REPEAT-until **Done**

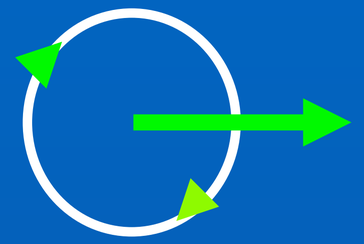
Case #3 - Edna

Edna’s Medication list after deprescribing

1. Gabapentin 100mg at HS
2. Acetaminophen 500mg QID
3. Sertraline 25mg daily
4. ASA 81mg
5. Amlodipine 2.5mg daily

Her pain is more controlled, and she is happier, with no edema, and Sam remains a devoted partner to her and appreciates your advice and care.

Assess-Act-Repeat



Practical Deprescribing-My Approach

Assess the Patient's Functional Status and Goals of Care

↓

Line up the Suspects (drugs) and Problem List

↓

Interrogate/hypothesize/weigh benefit and harm

↓

Decide/Prioritize + Plan for Deprescribing

↓

Document/**Discuss**/Implement/Monitor/Do Again

Problem=Geriatric Syndromes, diagnoses

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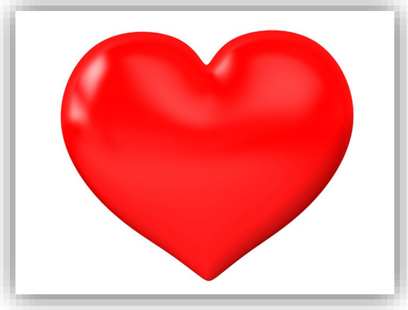
Communication-Shared Decision Making

?



Values,
feelings, Goals

Preferences

UBC CPD

CONTINUING PROFESSIONAL DEVELOPMENT
FACULTY OF MEDICINE

Learning Objectives

FOLLOWING THIS SESSION, ATTENDEES SHOULD BE ABLE TO

1. Recognize a Deprescribing Opportunity (Mindset)

2. Describe the process of a Medication Review -to build a Deprescribing Plan

3. Incorporate Collaboration and Communication strategies for efficient and safe Deprescribing.

Take Away Points

1. Residential Care = Palliative Care-focus on
   Symptom/Disease control vs Prevention (Appreciate Frailty)
2. The greatest predictor of **polypharmacy Harm**
   is the Absolute **number** of Medicatios (pills of **any kind)**
3. When in doubt, **TAPER** and **Monitor**
4. **Any new symptom/change** in condition may be
   due to a **medication/med. combination**
5. Look before you leap-avoid/address **Drug Cascades**
6. Enlist your **pharmacist and health team** to optimize
   your medication management and **Individualize** care.
7. Roll with Uncertainty (it's worth it, and it gets EASIER)
8. **Communicate** well
9. Be **reasonable** and **efficient** (Tools-MedStopper,SharedCareBC, STOPP/ START…)
10. Without Guidelines, **act anyway, Collaborate**

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Audience Q&A Session

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Thankyou

MEDICATION DISCONTINUATION- PRIORITY AND PLAN

PATIENT: _____ **DATE:** _____/_____/_____/M/D/Y

MEDICATION and DOSE	STEP 1	STEP 2		STEP 3	STEP 4	PROBLEMS AFFECTING
	RANK	STOP	TAPER	TAPERING PLAN	REASESS - STABLE? Y-STOP, N-RESUME	FUNCTION
1.					___/___/___/M/D/Y	1.
2.					___/___/___/M/D/Y	2.
3.					___/___/___/M/D/Y	3.
4.					___/___/___/M/D/Y	4.
5.					___/___/___/M/D/Y	5.
6.					___/___/___/M/D/Y	6.
7.					___/___/___/M/D/Y	7.
8.					___/___/___/M/D/Y	8.
9.					___/___/___/M/D/Y	9.
10.					___/___/___/M/D/Y	10.
11.					___/___/___/M/D/Y	11.
12.					___/___/___/M/D/Y	12.

RANKING:- 1= NO BENEFIT/TOXICITY/CASCADE/NO INDICATION, 2= HARM > BENEFIT, 3= SYMPTOM/DISEASE-NIL/STABLE, 4= PREVENTIVE DRUG

NOT VERY PRACTICAL?

MEDICATION APPROPRIATENESS INDEX -Questions to ask about each individual Drug

1. Is there an **INDICATION** for the individual Medication?
2. Is the medication **EFFECTIVE** for the condition?
3. Is the **DOSAGE** correct?
4. Are the **DIRECTIONS** correct?
5. Are the directions **PRACTICAL?**
6. Are there clinically Significant **DRUG-DRUG INTERACTIONS?**
7. Are there Clinically Significant **DRUG-DISEASE/CONDITION INTERACTIONS?**
8. Is there unecessary **DUPLICATION** with other medications?
9. Is ther **DURATION OF THERAPY** acceptable?
10. Is this medication the least expensive **ALTERNATIVE** compared to others of equal utility?

SAFE PRESCRIBING QUESTIONS

FINAL STEP:- SIMPLIFY

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