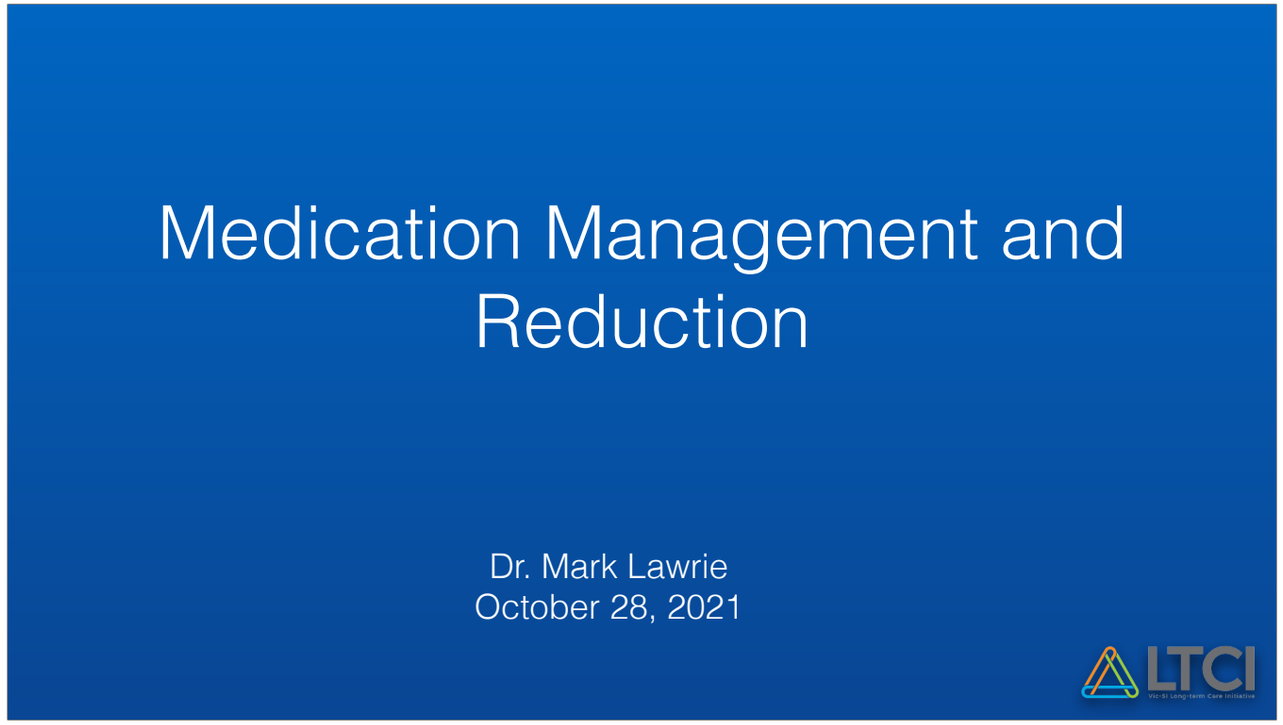

Thankyou for the introduction-I hope that what we can cover together tonight is of value to each of you. I will need your help to understand what your different expectations and needs are, around this important topic. Submitted questions, Chat remarks, and perhaps some verbal questions at the end will keep us connected and my remarks relevant.
So lets get started!

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

#216025

SLIDO activity

QR code will appear on the next screen for anyone who wants to scan to join

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Join at slido.com
#216025

ⓘ Start presenting to display the joining instructions on this slide.

What is the mix of the those here by profession?

Acknowledge wide range of experience and roles related to medication/elderly/deprescribing

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What is your Profession?

ⓘ Start presenting to display the poll results on this slide.

Comment on diversity and TEAM members

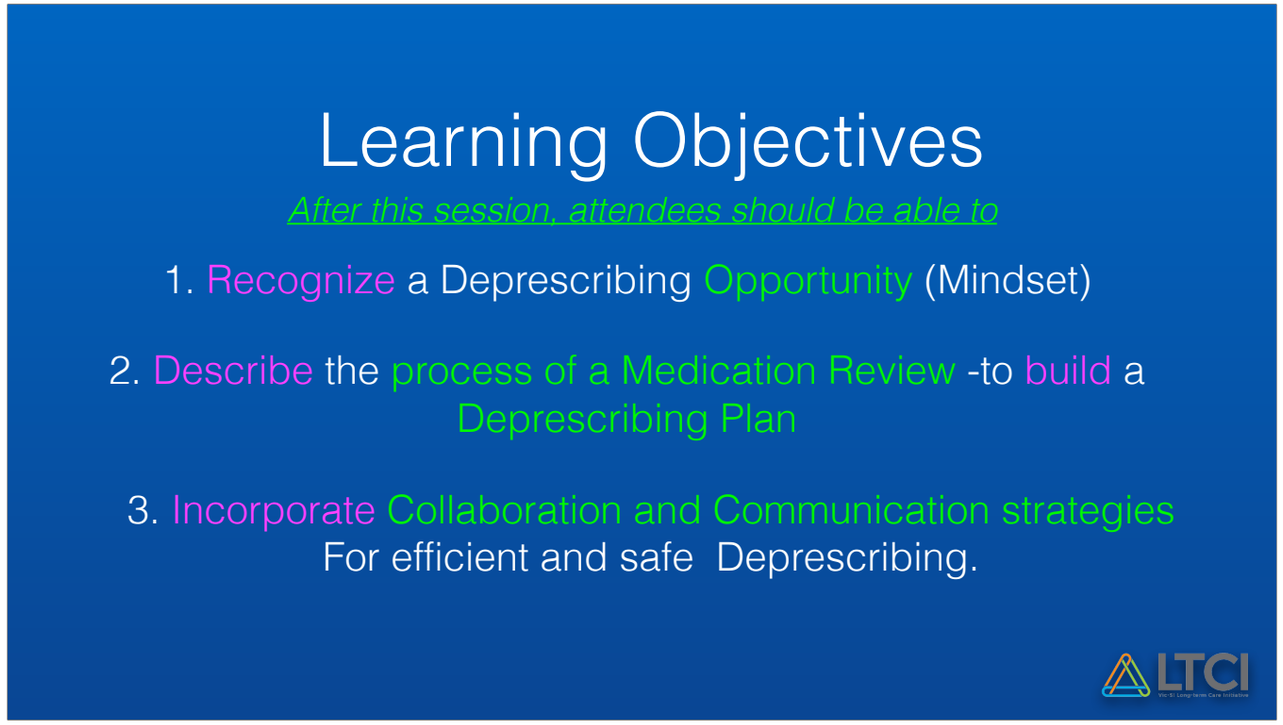
Agenda

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”?

Go through this quickly. ensure they know input needed and will have time. Audience will help rank what questions are most popular

What's in this for You?

Polypharmacy and its negative effects are well known, as is the safety of Deprescribing done well-How do we move forward effectively?
Wide range of confidence/skill in Deprescribing. (MOST OF US WANT TO DO BETTER)
Collaboration is essential/ non-physicians have key roles
My hope is you'll find confirmation of your effective habits, and perhaps raise awareness of areas for improvement, and the resources to aid you.



#1.-Often missing in how to deprescribe is the need for the **Mindset** (easier in LTC, harder elsewhere)
#2 is the process with many elements to coordinate
#3-Unique abilities of the Generalist-the family physician-in the longitudinal care and the relationships with patients/familitis

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)

ⓘ Start presenting to display the poll results on this slide.

Polypharmacy

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

Dozens of definitions.
Patient-Centred! Finally we get to this and focus on values/goals/relationships

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

I like these, but WE SHOULD APPRECIATE THE DEPTH OF THESE DEFINITIONS-SO WE HAVE A MORE COMPLETE ONE NEXT.

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”

Ian Scott-JAMA 2015
Highlight the positive-this is full of UNCERTAINTLY-Roll with it.

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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A state/condition we need to name in our records, and talk about out loud.
Unpredictability is the norm.

How much Deprescribing are people here doing currently?

SLIDO activity

See the group’s frequency of this practice.

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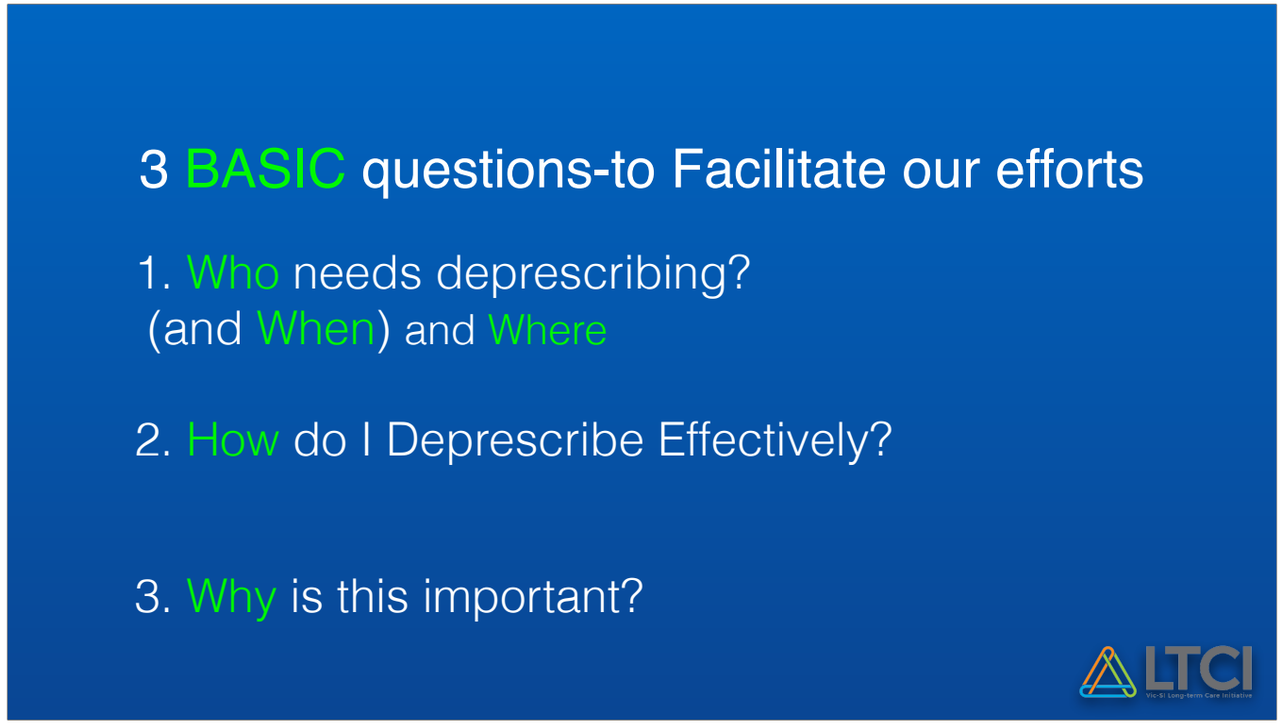
For how many patients did you deprescibe a medication(s) in the past 2 weeks?

ⓘ Start presenting to display the poll results on this slide.

Wild West Deprescribing?

In the movie-The Good, the Bad, and the Ugly, Clint Eastwood is the man to clean up the town, and get rid of the outlaws. His approach is to make decisions without discussion, act quickly and finally, and never question/assess the results. **I see this as a Metaphor for what can be Good/Bad/or Ugly about Deprescribing Habits!** We'll jump into the nuts and bolts of better Deprescribing after see a little of Clint in Action.


HD

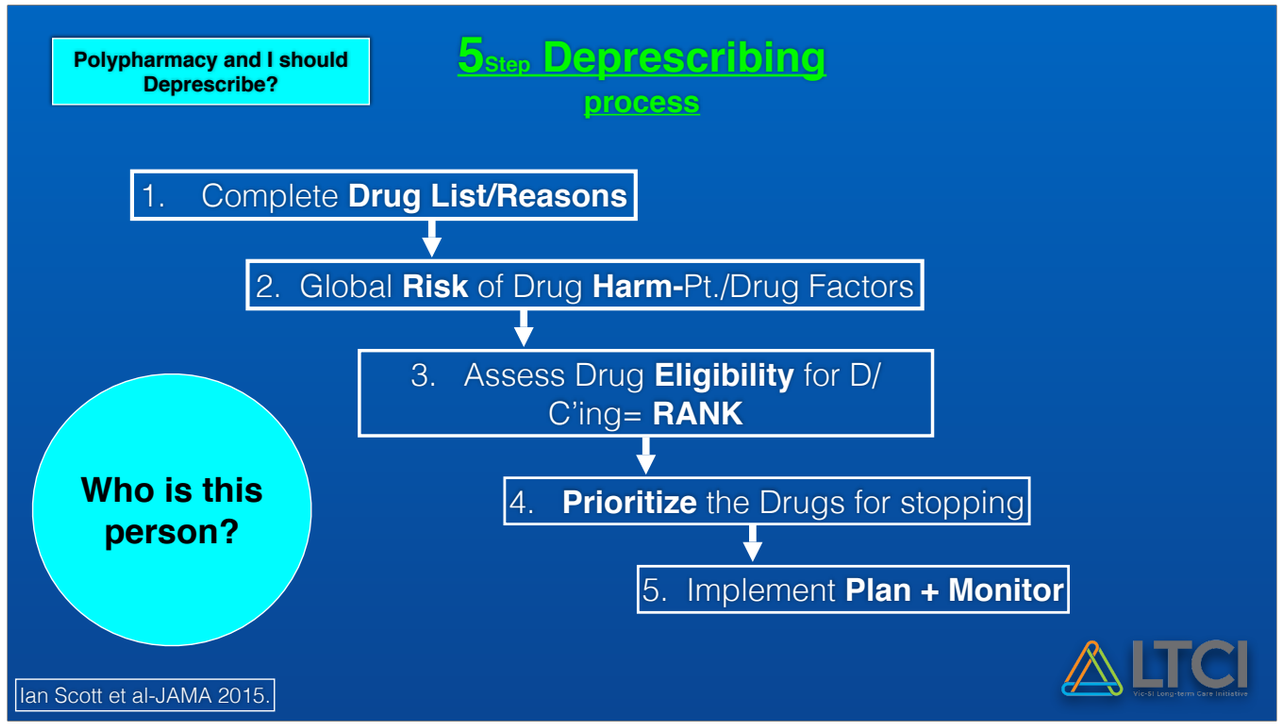


So definitive, no Uncertainty. **WHO** to consider?-drug #s, frailty, functional decline/new dx,sx**WHEN**-**transitions-*<u>You can't fix/correct what you don't see!</u>***
We need to Start any Med. Reduction-by improving our Recognition of who/when Polypharmacy needs addressing-(? the most important step)
How-is what's next -a framework to engage and make changes.
Why-for the patient/family, yourself, care staff, pharmacists!

5 step Deprescribing Process

(the **HOW?**)

Ian Scott again. Basic framework



Always a Med. review must be **individually focused**-and can only begin with the **Recognition of the need.**
Detective work-gather evidence, assess the suspects, be curious/suspicious, discuss and make prioritized changes -and revisit the scene.(an ongoing process)

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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Uncertainty often about indications for a drug(s)-Roll with it, this is NOW
Prescribing less carefully leads to DRUG CASCADES-name some.
Drugs should have “Best Before Dates”
Note -ALL these 4 criteria are indication to stop a drug!!

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?"

Focuses on the individual as a person, not separate diseases.
Curious question, needs answering!
Non-linear systems, unexplained outcomes/frailty-Must be Suspicious.

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Audience Q&A Session

ⓘ Start presenting to display the audience questions on this slide.

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)

Sudden change-could drugs play a role?
Family member with knowledge + need to be involved?

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**.

Diagnoses

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

Functional problem list

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

LTCI

Take 3-5 mins. " TAKE THE AUDIENCE INSIDE MY HEAD"-TALK THEM THROUGH IT
Appreciate the Complexity-take a breath or two
Recognize a need to address Polypharmacy
What matters most to Stanley and his Family?
Any obvious RED FLAGs-Risk level, and get sense of URGENCY to make changes.

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.

Agitated when Donepzil stopped-restarted 1/2 dos and ok-tapered off
Both Stan and daughter WANTED rx reduction-no opportunity before
Decision to stop Warfarin after discussion and Holter neg.

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.

this took 6-8 weeks
Next Goals?
Further tapering?

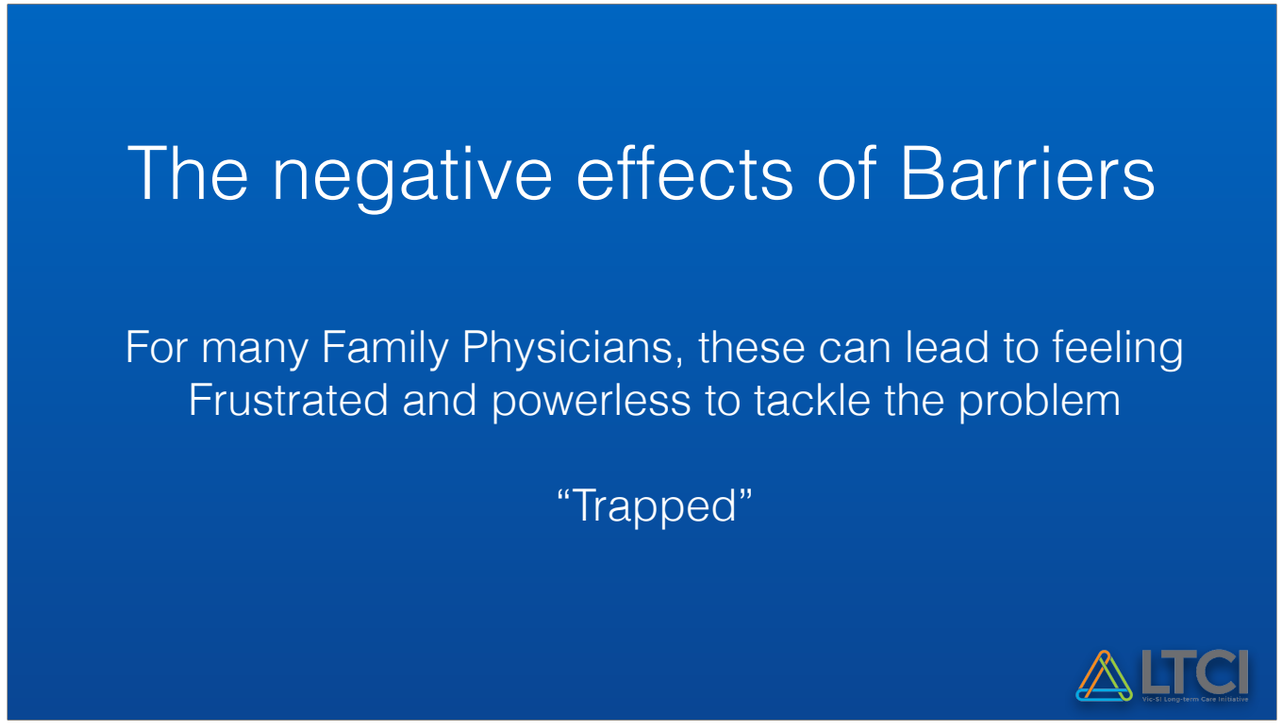
Barriers to (routine) Deprescribing

"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

DEPRESCRIBERS-MAY BE HAVING DRUG DISCUSSIONS/GOALS OF CARE FOR THE FIRST TIME-this needs to change, but is the norm currently!
The picture is CLEAR, the RESEARCH IS IN. Too many frail people are on too many drugs and are suffering the consequences-We need to have the intention to act differently. **WE NEED TO ADDRESS THE FEELING THAT STOPPING DRUGS=NOT CARING, OR LOSING HOPE**
Not a lack of informationn



This can lead to DEPRESCRIBING I**NERTIA, AND INACTION**

So, each of us can address our specific challenges-and look for solutions for routine Habit change. NEED TO UNDERSTAND YOUR FEELINGS/SENSE OF GIVING UP ON PATIENTS-THIS OK, WITH THESE WHO ARE MOST FRAIL!

Trapped feeling leads to inaction, or reactive decisions instead of PROACTIVE thinking.

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

ⓘ Start presenting to display the poll results on this slide.

Can you find something today to address a plan for reducing this-SMART goal.

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)

These are inevitable, but mostly avoidable and give us a chance to confirm if a drug(s) is needed! NOT A BAD THING.
Which ones are things that have affected your patients, and what can you Do About your responses/prevention.
LTC facilities allow 24 hr monitoring/intervention-ie a SAFE place to deprescribe.

To give us a feel for your current self assessment for improving your Deprescribing **results-Do you have some new things to focus on, do differently?**

Tools and Resources

PHARMACIST

STOPP / START

Medstopper

Shared Care B.C.

Beers List

GOOD NEWS, THERE IS PLENTY OF HELP AVAILABLE FOR DEPRESCIBING AND DISCUSSION.
Shared Care BC-good evidence for decision making-around a number of drug classes.
Also-Trevor Janz videos on Conversations around Palliative Care
MedStopper allows you to build a harm/benefit profile and has good Monitoring/Tapering notes.

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Audience Q&A Session

ⓘ Start presenting to display the audience questions on this slide.

Do you use any deprescribing resources, that are effective, and what doesn’t work well for you?

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.

Note-Sudden change in status-Pre-hospital/Post?
Geriatric syndromes?
6 weeks?-what was happening?
Lack of information common

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**

REVIEW COMMON ISSUES WITH STANLEY'S CASE
HIGHLIGHT DRUG/PARK.D. INTERACTIONS, PSYCHOTROPIC TAPERS, PRN CONCERNS
Can this be happening?-of course, one drug at a time…
Many of the usual "Bad actors"
What about the LABS, VITALS, etc?

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.

Would you try for more changes.
This is to highlight the end of life issues, and that the drugs may have little role in longevity, but Quality is important, symptom/disease control matters

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Audience Q&A Session

ⓘ Start presenting to display the audience questions on this slide.

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.

Different clinical course-slow decline/burned out spouse
Might need to be extra careful at first with some discussions with 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**

All pills are an issue-the HARMS of Polypharmacy are directly correlated with the absolute number of Pills (including vitamins/supplements, drops, laxatives etc.)
Anyone see any Drug Cascades?

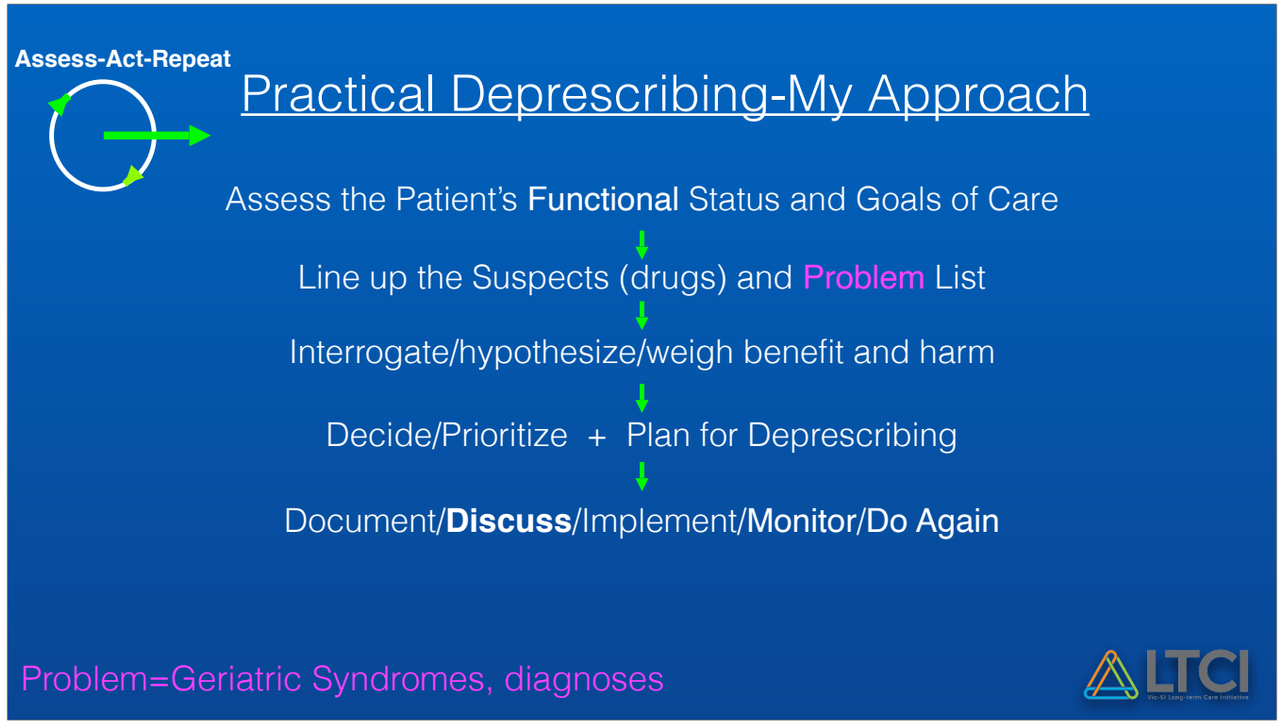
Case #3 - Edna

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.

What did Edna want-ASA, changes ahead-Probably -stop HTN med, change Tylenol to pan, tapering trial ?



Final review of a **routine,** r**epetitive** process of Polypharmacy evaluation, medication review and Deprescribing planning and assessment.
ALWAYS EXPECT MED. LIST FOR SYMPTOM/PROBLEM RESPONSE REQUEST.
Educate your TEAM members about good Deprescribing practices, they WANT to help, and are often frustrated with Polypharmacy-their input is valuable.

Communication-Shared Decision Making

Values,
feelings, Goals

Preferences

?

UBC CPD
CONTINUING PROFESSIONAL DEVELOPMENT
FACULTY OF MEDICINE

A REMINDER FOR US TO LISTEN AND UNDERSTAND WHAT IS IMPORTANT TO OUR PATIENTS AND THEIR FAMILIES-IN ORDER TO WORK COLLABORATIVELY AND TO COMMON GOALS-before we engage in the problem solving around Deprescribing.

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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THANKYOU, AND WE HAVE TIME FOR SOME DISCUSSION AND QUESTIONS.
MANY THANKS TO THE TECHNICAL SUPPORT OF JESSICA SWINBURNSON AND ALANA ROBERTSON, AND THE ASSISTANCE OF DR PETER NEWEDUK AND Dr. Dale Nicoll IN THE PLANNING STAGES FOR THIS PRESENTTION

Thankyou

MEDICATION DISCONTINUATION- PRIORITY AND PLAN

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

MEDICATION and DOSE	STEP 1 RANK	STEP 2 STOP	STEP 2 TAPER	STEP 3 TAPERING PLAN	STEP 4 REASESS - STABLE? Y-STOP, N-RESUME	PROBLEMS AFFECTING 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

SAFE PRESCRIBING QUESTIONS

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?

FINAL STEP:- SIMPLIFY

Dr. Mark Lawrie- marklawrie@shaw.ca