De-prescribing: Reducing Inappropriate Medications in Older Adults

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Overview

• Why is polypharmacy bad and what is deprescribing?

• Clinical tools for deprescribing

• Resources

Disclosure

I have no relevant financial relationships with any companies related to the content of this course.

Polypharmacy or Inappropriate Medications in Older Adults

• Polypharmacy: more than 5 or more than 10 meds
• Almost 20% of community-dwelling adults >65 yo take 10 or more medications
• Adverse drug events affect 5-35% of community-dwelling adults >65 yo per year
• Adverse drug events are responsible for ~10% of hospital admissions in older adults

Problems with Polypharmacy

- Non-adherence
- Cost (higher with less insurance), schedule
- Falls
- Weight loss
- Med-med interactions and adverse drug events
  - Increase risk of adv drug event 7-25% with each drug added
- Cognitive decline
- Mortality


Deprescribing

= remove a med (or dose)

“Deprescribing is the process of withdrawal of an inappropriate medication, supervised by a health care professional with the goal of managing polypharmacy and improving outcomes.”

- Focus on individual medications (e.g. benzodiazepines)
- Focus on reducing # of medications

Deprescribing: be proactive!

Inappropriate medications in older adults

- Harms > benefits
  - Unnecessary, ineffective, potentially or actually harmful, not goal-concordant
- Older adults need deprescribing: this should be an active concern
  - 50-60% use ≥1 med ineffective, not indicated, or duplicative
  - 20-30% take ≥1 med to avoid in older adults (Beers, STOPP)
  - 40-50% taking PPIs have no discernible indication


What interferes the most in your ability to deprescribe?

1. Not enough time to review meds
2. Inertia: harder to stop than to NOT start a med
3. Other MDs prescribe meds that I don’t want to stop
4. Not sure what is appropriate vs inappropriate
5. Don’t have bandwidth to work with patients on tapers or discontinuation plan
6. Patients don’t want to stop their meds

January 2017 Division of Geriatrics
Why don’t we do better?

- Practical barriers
  - Workflow & awareness
  - Time & effort
  - Coordination with other clinicians
  - Patient education/support throughout the discontinuation process

Relational or emotional reasons: how we frame discontinuation

What you say:
- Your Hemoglobin A1c is 7.2. There is no benefit to being that low, so let’s stop your glipizide.
- The zolpidem you are taking increases your risk of falling – and studies show it actually doesn’t help much with sleep. I think we should stop it.

Patient may experience:
- Cognitive dissonance
- Fear of change
- Bad prior experience
- Trust
- Abandonment

Where is there evidence? Settings

- Nursing homes – best evidence
  - Polypharmacy + potentially inappropriate meds
    - Mortality: OR 0.74 (0.65 – 0.84)
    - Falls: OR 0.76 (0.62-0.93)
    - Hospitalization: OR 0.64 (0.30 – 1.39)

- Ambulatory care and hospital settings
  - Highly variable; limited quality and quantity of evidence

Oh, Canada

Thillaimadavan Drugs Aging 2018; Kue J Amer Med Dir Assoc 2019
Not focused on physician

- D-PRESCRIBE Trial
- Community pharmacies
- Age >65, chronic benzodiazepines, glyburide, chronic NSAIDs
- Booklet
  - Education
  - Questions to induce cognitive dissonance, peer champion stories to increase self-efficacy, alternative treatments, practical advice (tapering schedules)
- Pharmacists
  - Evidence-based pharmaceutical opinion to physicians

Martin JAMA 2018

Tools I use to Deprescribe

1. The Beers List
2. START/STOPP
3. Deprescribing.org
4. Anticholinergic Burden Calculator
5. MedStopper
6. A pharmacist
7. A letter from the insurance plan
Practical approach to deprescribing

Practical algorithm for deprescribing

Provider
- Drugs-to-avoid criteria (Beers, STOPP)
  - Benzodiazepines & “Z-drugs”
  - Anticholinergics
- Over-aggressive control: e.g. DM, HTN
- Medications without indication: is there a problem that is on the list that this is treating?
- Medications treating side effects of other meds (prescribing cascade)
- Meds for stable symptoms

Patient
- Meds causing adverse effects (ask)
- Difficulty with adherence
- Financial toxicity
- “Don’t like”

Step 1: Comprehensive medication history
Step 2: Identify potentially inappropriate medications

- Brown bag review: patient brings EVERYTHING they are taking in to their visit in a “brown bag”
  - Every visit?
  - Arrange a separate visit
  - Prioritize at beginning of visit
  - Pharmacists

Step 1: Comprehensive medication history
Step 2: Identify potentially inappropriate medications

Step 3: Determine if medication can be ceased and prioritization

Step 4: Plan and initiate withdrawal

Step 5: Monitoring, support and documentation
Practical algorithm for deprescribing

Step 1: Comprehensive medication history
Step 2: Identify potentially inappropriate medications
Step 3: Determine if med can be ceased, and prioritization

- **Patient willingness**
  - **Listen!**
  - “Forever” decision → reassure that can restart at any time
  - Giving up → frame as optimizing attentive care; think colonoscopy
  - Adverse drug withdrawal effects → slow taper, monitoring plan
  - Proceed when the patient is on board

Division of Geriatrics

Step 1: Comprehensive medication history
Step 2: Identify potentially inappropriate medications
Step 3: Determine if med can be ceased, and prioritization

- **Proper timing**
  - Need to be able to determine if withdrawal reaction
  - One drug at a time
  - Record what you do so you can decide in the future

Division of Geriatrics

Step 1: Comprehensive medication history
Step 2: Identify potentially inappropriate medications
Step 3: Determine if med can be ceased, and prioritization

- **Plan taper if necessary**
  - Prevent withdrawal reactions
  - Early detection of re-emergence
  - Symptom action plan
  - Rule of thumb – if requires tapering up of dose, will need taper down
    - CNS meds, opioids
    - Some exceptions: PPIs, clonidine, etc.

Division of Geriatrics

Step 1: Comprehensive medication history
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Step 4: Plan and initiate withdrawal
Step 5: Monitoring, support, and documentation

- **Monitoring & support**
  - Telephone
  - Nurses, pharmacists, family
  - Document outcome
Resources

- Deprescribing is a team sport
  - Pharmacists, nurses, patient’s support system
- Canadian Deprescribing Network (CaDeN)
  - www.deprescribing.org
  - Benzodiazepine receptor agonists
  - PPIs
  - Antipsychotics
  - Antihyperglycemics
  - Cholinesterase inhibitors and memantine

Check them out!

- The Beers List
- START/STOOP
- Anticholinergic Burden Calculator
  http://anticholinergicscales.es/
- MedStopper
If it’s not doing any harm then it’s ok to leave a medication on.

1. True
2. False

Don’t do that.

If it’s not benefitting someone, then it is only causing harm. (Polypharmacy in and of itself is harmful.)

Case

- 84yo M w/ CHF, CKD, h/o distal aortic dissection with large intra-aortic stent, HTN, afib, DM, HLD, CAD/equiv, BPH s/p TURP x2, gout, COPD, insomnia, inguinal hernia, OA.
- C/o fatigue and difficulty sleeping from neck pain. Also “unsteady”.
- Exam: BP 88/47, HR 56

Case: His Meds at brown bag review

- furosemide 20
- torsemide 150 QHS
- lisinopril 40
- diltiazem 120
- metoprolol 100 XL BID
- digoxin 0.125
- imdur 30 QD
- clonidine 0.1mg BID
- coumadin
- asa 81 daily
- rosuvastatin 20
- glipizide 10 BID
- acarbose 50 TiD AC
- finasteride 5
- terazosin 5
- allopurinol 300mg
- combivent 2 puffs QID
- albuterol 2 puffs Q4h PRN
- Benadryl PRN (OTC)
- Temazepam 7.5mg QHS
- colace 2 cap BID
- MVI (NOT ON MED LIST)
- KCL 8Meq BID
- Recently discontinued: trazodone 50mg QHS (not effective)
My plan is to:

1. Discontinue some BP meds today and have him come back soon for a recheck
2. Discontinue those and inappropriate meds: Benadryl, temazepam today and have him come back soon for a recheck
3. Have him see the pharmacist to help sort it all out, discontinue some meds and make taper plans
4. Admit him

Case
- Goals: always been aggressively managed, unsure if he wants to "loosen control"
- Discontinue several meds:
  - d/c furosemide (on torsemide)
  - d/c lisinopril
  - d/c dilatiazem
- Check digoxin level
- Consider at next visit:
  - d/c benadryl, temazepam, acarbose, KCL, MVI
  - Change metoprolol dosing, torsemide time of day
- F/u in 1 week

Take Home
- Deprescribing is proactive, not just reactive
  - If it’s not helping, it’s hurting.
- Can have major impact on clinical outcomes
- Attend to practical and emotional barriers
- Systematic process
  - Tapering and monitoring can be essential
- Make use of resources