
# Medication Management: Art of Deprescribing Medications in HBPC

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**HCCIntelligence™ Webinar and Virtual Office Hours**

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# Introductions

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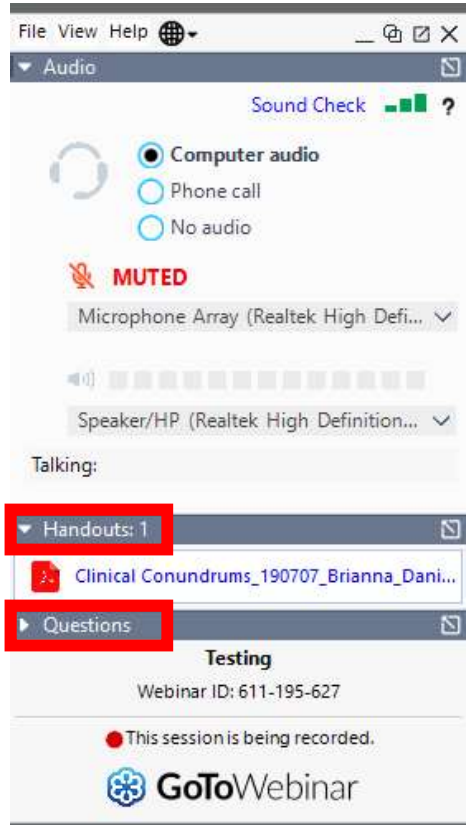
# Housekeeping

- The first 30 minutes of today's Webinar will consist of a slide presentation and all participants will be muted during this time.
- The following 30 minutes will be Virtual Office Hours, and all participants will be able to submit questions via the question box.
- To submit a question, click on the arrow next to Questions, type in your question, press send.
- Handouts can be accessed in the handout box.
    - Click on the name of the file and save to your computer
- All participants will receive a copy of the slide deck, question and responses, and a recording of the presentation.

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# Objectives

1. Describe the importance of appropriate prescribing and the need to reduced polypharmacy in this at-risk population.
2. Cite evidence-based methods to deprescribe medications and reduce polypharmacy and the prescribing cascade.
3. Identify potential barriers to medication adherence.

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# Case Example

- 82 y/o female with severe respiratory problems from chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF)

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# Problem List

1. Chronic Obstructive Pulmonary Disease (COPD)/Respiratory Failure (O2)
2. Steroid Myopathy
3. Coronary Artery Disease (CAD) (Stent)
4. Congestive Heart Failure (CHF)
5. Bilateral Leg edema
6. Atrial Fibrillation
7. Hypertension
8. Hyperlipidemia
9. Gastroesophageal Reflux Disease / Barrett esophagus
10. Osteoporosis with vertebral compression fractures / back pain
11. Vertigo (Occluded basilar artery)
12. Constipation
13. Tremors
14. Depression/Anxiety
15. Peripheral Neuropathy
16. Insomnia
17. Iron deficiency anemia
18. Urine Incontinence

# Medication List

1. Albuterol 2.5 mg/3 ml neb every 4 times a day; Prednisone 30 mg daily; Montelukast 10 mg every evening; Tiotropium 18 mcg inhaled daily
4. Furosemide 40 mg daily; Potassium 10 mEq daily; Isosorbide MN 60 mg QD; Aspirin 81 mg daily
6. Warfarin to INR of 2-3; Dofetilide 250 mg twice a day
7. Verapamil 240 mg daily
8. Atorvastatin 20 mg daily
9. Esomeprazole 40 mg twice a day
10. Alendronate 70 mg weekly; Vit D 50000 units weekly; Hydrocodone/APAP 5/325 1-2 every 6 hours as needed pain
11. Meclizine 25 mg every 8 hours as needed
12. Polyethylene Glycol 17 gm daily
14. Sertraline 50 mg daily; Alprazolam 0.25 mg every 8 hours as need (also for tremors)
15. Gabapentin 300 mg three times a day
16. Trazodone 100 mg at night; Zolpidem 5 mg at night as needed
17. Iron Sulfate 325 mg daily
18. Solifenacin 10 mg daily

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# Geriatric 5Ms[1] Framework

**Matters Most**

**Mind/Mentation**

**Mobility**

**Medications**

**Multi-Complexity**

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[1]*https://www.healthinaging.org/tools-and-tips/5ms-geriatrics*

# Polypharmacy in the U.S.


## When less is more…

- Although elderly patients comprise <13% of the US population, they use almost 33% of prescription medication annually
- Approximately 50% of hospitalized or ambulatory care patients or nursing home residents receive 1 or more unnecessary drugs
- Adverse drug events occur in at least 15% of older patients which contributes to ill health, disability, and hospitalization

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*J Res Pharm Pract. 2015 Apr-Jun; 4(2): 85–88. doi: 10.4103/2279-042X.155755*

# Challenges in Medication Therapy in the Elderly

- Multiple chronic conditions (lead to polypharmacy).
- Physical impairment (cognition, vision, dexterity), and physiological impairment in hepatic and or renal functions
- Many studies exclude elderly, multi-complex patients

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# Risks of Polypharmacy

- Adverse drug reactions (Drug to Drug interaction, dose related events, impairment in cognition and mobility)
- Prescribing cascade
- Poor adherence to medical therapy
- Cost
- Inconsistent with goals of care

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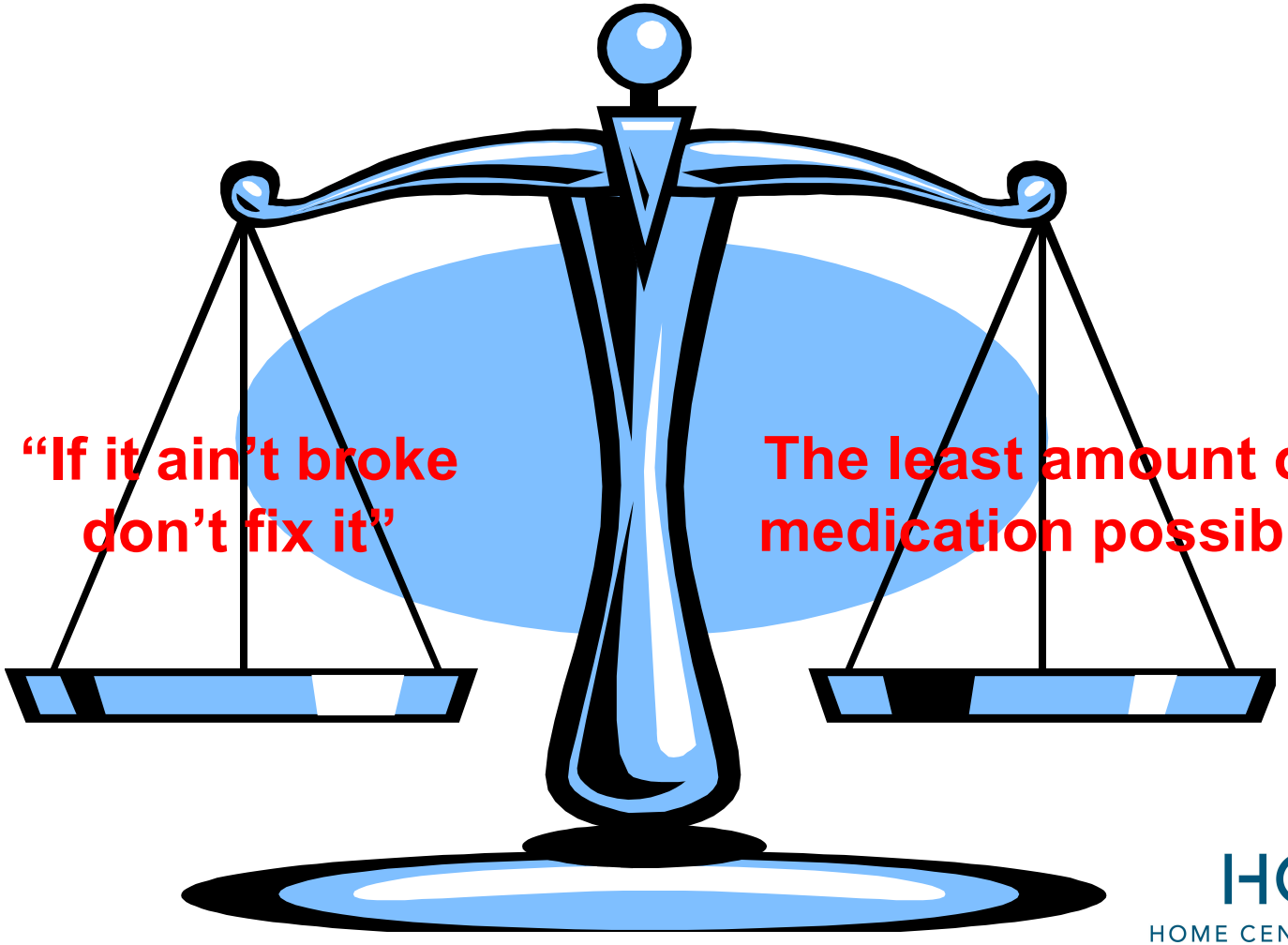
# Polypharmacy:
# Desire "Perfect Medicine"

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# Medication Management

- **Reconcile:** **verify** the list of medications including prescription, over-the-counter, herbs and supplements (vitamins); **clarify** the dosage, frequency and route; **document** any recent changes (new medications, dose changes, discontinued medications)
- **Justify:** Based on the medical history determine benefit or harm of all medications and does evidence support their use
- **Optimize:** Avoid under prescribing, overprescribing, mis prescribing; Establish a compliance plan with patient
- **Demonstrate:** Having the knowledge and ability to follow the prescription regimen (able to read, understand, manual dexterity (injections, inhalers). Good communication and clear instructions are critical (including contingency plans such as for missed pills)

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# Deprescribing

**Deprescribing is the systematic process of identifying and discontinuing medications 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.**

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# Deprescribing

**Deprescribing is not about denying care but a shared decision making process regarding the benefits and risks of multiple medications within the context of the patient's goals**

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# Guidelines for Deprescribing

- **Beers Criteria**
  https://qioprogram.org/sites/default/files/2019BeersCriteria_JAGS.pdf
- **The Screening Tool for Older Person's Prescriptions (STOPP) criteria**
  https://www.ncbi.nlm.nih.gov/pubmed/18218287
- **Deprescribing.org, Choosing Wisely**
- **These provide guidelines for potentially inappropriate medications for older adults**
- **Does not mean medication should never be prescribed**

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# Deprescribing Algorithm

## Algorithm

1. Reconcile all medications and indications paying attention to possible prescribing cascade
2. Review the overall risk of the medications using Beers/STOPP and clinical knowledge of the patient's pharmacokinetics (i.e., renal disease) and adherence

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JAMA Intern Med. 2015;175(5):827-834. doi:10.1001/jamainternmed.2015.0324

# Deprescribing Algorithm

## 3. Assess each drug for its ability to be discontinued

- Step 1 found no indication
- It is part of a prescribing cascade and was prescribed to treat an adverse drug reaction
- Preventative drug that is unlikely to confer patient benefit based on their prognosis
- Burdensome drug for the patient – e.g., financial, complicated monitoring, difficult to adhere to, etc.

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JAMA Intern Med. 2015;175(5):827-834. doi:10.1001/jamainternmed.2015.0324

# Deprescribing Algorithm

4. Prioritize drugs for discontinuation
   - First those with greatest potential harm
   - Easiest to discontinue, minimal withdrawal
   - Change / Stop one medication at a time
5. Implement and closely monitor
   - Give anticipatory guidance for what to watch for and when to call
   - Timely follow-up visit
6. Example protocol
   - There are different deprescribing algorithms available; however, HCCI has an example protocol available for download at HCCIntelligence™ Webinar

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JAMA Intern Med. 2015;175(5):827-834. doi:10.1001/jamainternmed.2015.0324

# Case Example

**82 y/o female with severe respiratory problems from chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF)**

- 1 Year before house calls: 17 emergency department visits, 13 hospitalizations (69 days), multiple rehabilitation stays
- 8-Months after house calls: 1 hospitalization, home health then hospice, passed away at home
- Goals of Care: Avoid hospital; Comfort; Reduce medications as able; support husband; reduce need for daughter's help
- Started home health with telehealth services (daily weights, pulse oximetry, blood pressure); later transition to hospice
- Frequent house calls and phone calls

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# Case Example

- COPD: Added Budesonide 0.5 mg/2 ml neb twice a day; Wean Prednisone 30 mg daily by 2.5 mg per day weekly for 8 weeks; reduce Albuterol to every 4 hours prn (tremors)
- Coronary artery disease: Reduce Isosorbide mononitrate from 60 mg to 30 mg daily given lack of symptoms
- CHF: Follow-up visit lowered Furosemide 40 mg to 20 mg daily and eventually to 20 mg daily prn and Potassium 10 mEq daily to prn
- Atrial Fibrillation: Discussed pros/cons of Warfarin using $CHA_2DS_2$-VASc and HAS-BLED; Continue Aspirin 81 mg daily; Patient concerned with cost of Dofetilide ($200/month) - weaned off over two weeks - dizziness immediately resolved and no longer needed Meclizine
- HTN: Decrease Verapamil 240 mg to 120 mg daily (Constipation); Add Metoprolol ER 50 mg daily (better for CAD and CHF) - later discontinue Verapamil

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# Case Example

- Hyperlipidemia: Continue Atorvastatin initially - later discontinued
- GERD: Esomeprazole 40 mg twice a day lower to 40 mg daily and continue in light of Prednisone / Aspirin
- Osteoporosis/Back pain: Discontinue Alendronate / Vit D; Continue Hydrocodone/APAP for pain (constipation); Try plain Acetaminophen if pain not severe
- Constipation: Discontinue Iron, wean off Verapamil, wean off Solifenacin, wean off Trazodone, try and decrease Hydrocodone, continue Polyethylene Glycol 17 gm daily but wean if tolerated
- Peripheral neuropathy: well controlled on Gabapentin - had been Depression Anxiety: Continue Sertraline, continue Alprazolam as needed for anxiety, tremors and insomnia;
- Insomnia: Wean off Trazodone (constipation, dry mouth); discontinue Zolpidem, Use Alprazolam
- Anemia: Hemoglobin good - discontinue Iron (Constipation)

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# Summary – Key Points

- Patients 65 years of age and older are commonly on one or more unnecessary medication which can cause Adverse Drug Reactions (ADRs)
- Utilize guideline algorithm can help providers identify medications that may not be appropriate or necessary

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# Summary – Key Points

- Drugs should be weaned off or discontinued if no definitive indication, they are part of a prescribing cascade, they are preventative with minimal chance of benefit, or are burdensome
- It is important to taper medications that should not be stopped abruptly

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# HCCIntelligence™ Virtual Office Hours: Ask the Experts

*An open forum for questions and answers*

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# Introductions

## Paul Chiang, MD

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# Questions

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# HCCIntelligence™ Resource Center

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email Help@HCCInstitute.org
9:00 am–5:00 pm (CST)
Monday through Friday

### Webinars

Every third Wednesday of the month, HCCI hosts a webinar on topics relevant to HBPC.

### Virtual Office Hours

Immediately following the monthly webinar, HCCI hosts Virtual Office Hours where experts address questions on any HBPC topic.

### Tools & Tip Sheets

Downloadable tools, tip sheets, sample forms and how-to guides on a variety of HBPC topics.

The John A. Hartford Foundation

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# HCCI Upcoming Events

**HCCIntelligence™ – Webinars**
Every third Wednesday of the month, HCCI hosts a free webinar on a clinical or practice management topic relevant to home-based primary care (HBPC). Visit www.HCCInstitute.org for more details.

- **Strategies for Growing Provider & Patient Referrals for Your Practice**
  Wednesday, April 15th, 4 pm – 5 pm CST

**HCCI Workshop at American Association of Nurse Practitioners (AANP) National Conference**
June 23 in New Orleans, LA

**HCCI Preconference at American Academy of Home Care Medicine (AAHCM) Annual Meeting**
October 22 in Orlando, FL

**HCCI Preconference at C-TAC National Summit on Advanced Illness Care**
October 27 in Dallas, TX

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# HCCI Consulting Services

## Relationship focused. Results driven.

HCCI is pleased to offer affordable consulting services that assist organizations in enhancing the patient experience, improve health outcomes, and reduce costs.

**Our consultants include:**

- **Providers** with extensive experience in HBPC.
- **Practice managers** skilled in running house call programs and recognized with national certifications in coding and medical auditing.
- **Other professionals** with expertise in strategic planning, marketing, education and training, and quality.

**To connect with HCCI, call 630.283.9222 or email help@HCCInstitute.org.**

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