A Graduation in Medicine:

Deprescribing

November 16, 2017

Putting Care at the Center 2017

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Developed by Lynn Deguzman, PharmD, Michael Mason, MD, Chris Chang, PharmD.

Deprescribing
50,000 foot view

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Change will not come if we wait for some other person or some other time.

We are the ones we've been waiting for.

We are the change that we seek.

Barack Obama

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Mrs. G is a 81 yo female

HTN, HLD, CAD, DM2, osteoporosis, OA and Alzheimer's Dementia. A1C is 6.7

She lives in a board & care and is unsteady ambulatory.

She has had an advanced steps discussion.

Her care goal is to have a comfortable quality of life.

Medication list

Aspirin	Plavix	Atenolol
Simvastatin	Glipizide	Metformin
Alendronate	HCTZ	Lisinopril
Donepezil	Memantine	Sertraline
Docusate	MVI/minerals	Omeprazole
Gabapentin	PRN APAP	PRN Mylanta
PRN Bisacodyl		

Polypharmacy
Hyperpolypharmacy

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Scope and Benefits?

Size of this issue…

Direct and indirect costs (national numbers)

Polypharmacy and hyperpolypharmacy in KP

Benefits of less medications-

Improved compliance

Less ADR

Reduced morbidity/mortality/cost?

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Costs associated with ADRs

- **$136 BILLION yearly**
- **Greater than total costs of cardiovascular or diabetic care**
- **ADRs cause 1 out of 5 injuries or deaths per year to hospitalized patients**
- **Mean length of stay, cost and mortality for ADR patients are DOUBLE that for control patients**

Johnson JA et al. Arch Intern Med 1995;155(18):1949–1956
Leape LL et al. N Engl J Med 1991;324(6):377–384
Classen DC et al. JAMA 1997;277(4):301–306

Solutions

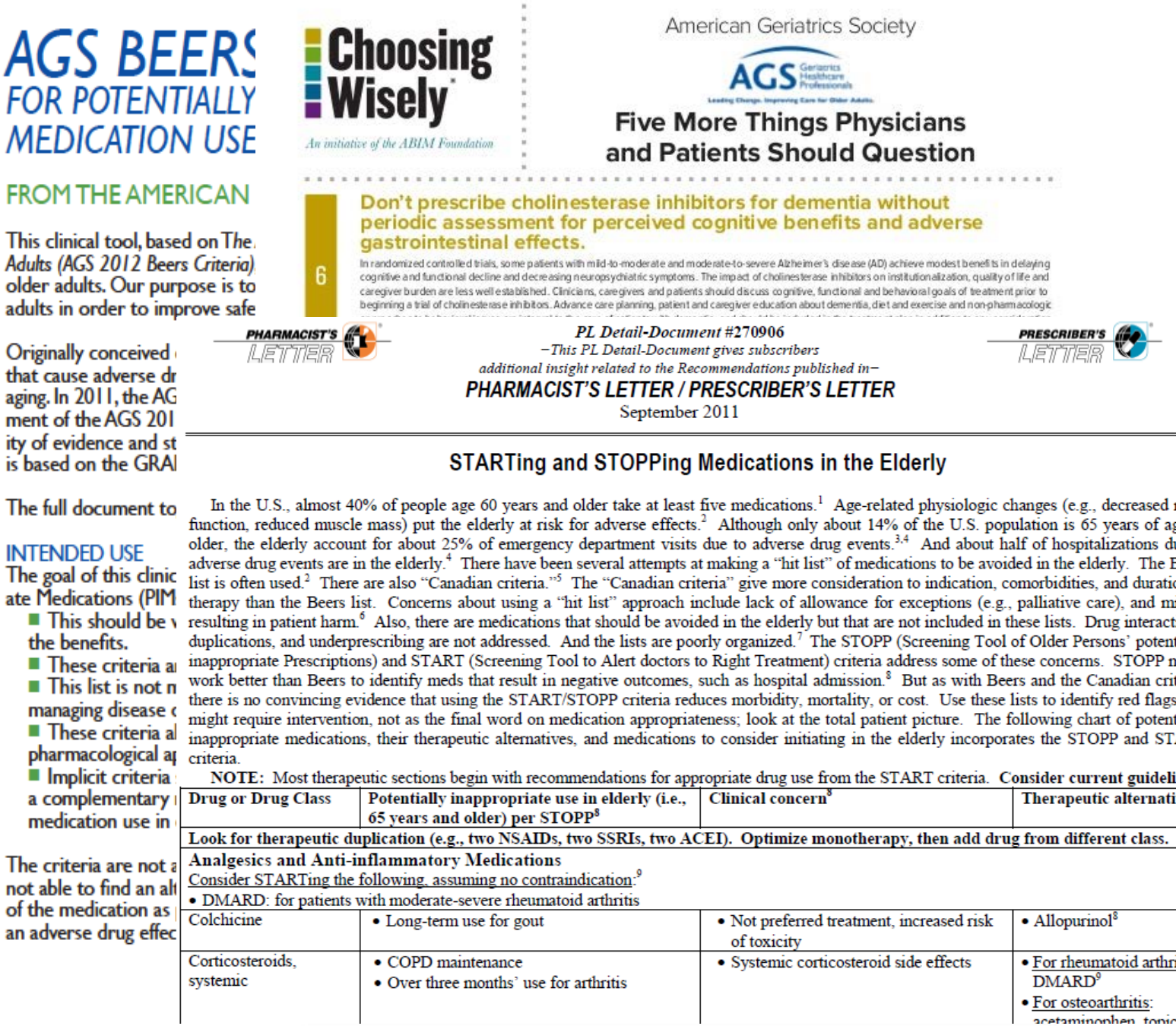
Choosing Wisely.

AGS BEERS List.

STOPP and START

PLOS One …

Deprescribing



AGS BEERS
FOR POTENTIALLY
MEDICATION USE

FROM THE AMERICAN

This clinical tool, based on The
Adults (AGS 2012 Beers Criteria)
older adults. Our purpose is to
adults in order to improve safe

Originally conceived
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The full document to

INTENDED USE
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Choosing Wisely
An initiative of the ABIM Foundation

American Geriatrics Society
AGS Geriatrics Healthcare Professionals

Five More Things Physicians and Patients Should Question

6 Don't prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects.

In randomized controlled trials, some patients with mild-to-moderate and moderate-to-severe Alzheimer's disease (AD) achieve modest benefits in delaying cognitive and functional decline and decreasing neuropsychiatric symptoms. The impact of cholinesterase inhibitors on institutionalization, quality of life and caregiver burden are less well established. Clinicians, caregivers and patients should discuss cognitive, functional and behavioral goals of treatment prior to beginning a trial of cholinesterase inhibitors. Advance care planning, patient and caregiver education about dementia, diet and exercise and non-pharmacologic

PHARMACIST'S LETTER

PL Detail-Document #270906
–This PL Detail-Document gives subscribers additional insight related to the Recommendations published in–
PHARMACIST'S LETTER / PRESCRIBER'S LETTER
September 2011

PRESCRIBER'S LETTER

STARTing and STOPPing Medications in the Elderly

In the U.S., almost 40% of people age 60 years and older take at least five medications.[1] Age-related physiologic changes (e.g., decreased renal function, reduced muscle mass) put the elderly at risk for adverse effects.[2] Although only about 14% of the U.S. population is 65 years of age or older, the elderly account for about 25% of emergency department visits due to adverse drug events.[3,4] And about half of hospitalizations due to adverse drug events are in the elderly.[4] There have been several attempts at making a "hit list" of medications to be avoided in the elderly. The Beers list is often used.[2] There are also "Canadian criteria."[5] The "Canadian criteria" give more consideration to indication, comorbidities, and duration of therapy than the Beers list. Concerns about using a "hit list" approach include lack of allowance for exceptions (e.g., palliative care), and misuse resulting in patient harm.[6] Also, there are medications that should be avoided in the elderly but that are not included in these lists. Drug interactions, duplications, and underprescribing are not addressed. And the lists are poorly organized.[7] The STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions) and START (Screening Tool to Alert doctors to Right Treatment) criteria address some of these concerns. STOPP might work better than Beers to identify meds that result in negative outcomes, such as hospital admission.[8] But as with Beers and the Canadian criteria, there is no convincing evidence that using the START/STOPP criteria reduces morbidity, mortality, or cost. Use these lists to identify red flags that might require intervention, not as the final word on medication appropriateness; look at the total patient picture. The following chart of potentially inappropriate medications, their therapeutic alternatives, and medications to consider initiating in the elderly incorporates the STOPP and START criteria.

NOTE: Most therapeutic sections begin with recommendations for appropriate drug use from the START criteria. **Consider current guidelines.**

Drug or Drug Class	Potentially inappropriate use in elderly (i.e., 65 years and older) per STOPP[8]	Clinical concern[8]	Therapeutic alternative
Look for therapeutic duplication (e.g., two NSAIDs, two SSRIs, two ACEI). Optimize monotherapy, then add drug from different class.			
Analgesics and Anti-inflammatory Medications Consider STARTing the following, assuming no contraindication:[9] • DMARD: for patients with moderate-severe rheumatoid arthritis			
Colchicine	• Long-term use for gout	• Not preferred treatment, increased risk of toxicity	• Allopurinol[8]
Corticosteroids, systemic	• COPD maintenance • Over three months' use for arthritis	• Systemic corticosteroid side effects	• For rheumatoid arthritis: DMARD[9] • For osteoarthritis: acetaminophen, topicals[6]

Our Goal-

Lead the Nation!

Right Drug, Right Disease, Right Time!

Our Solution-

Collaboration- task force

Education- best practice

Support for prescribers

New Normal

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Deprescribing

- Planned supervised process of dose reduction or stopping of medications that may be causing harm or are no longer providing benefit.
  - Non-additive
  - Removal

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deprescribing.org

Can J Hosp Pharm. 2015 May-Jun; 68(3): 201–202.

PMCID: PMC4554545

Deprescribing: What Is It and What Does the Evidence Tell Us?

Wade Thompson, HBSc, Research Assistant and Barbara Farrell, BScPhm, PharmD, FCSHP, Scientist

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Inappropriate prescribing and polypharmacy in older persons are associated with increased risks of falls, adverse drug events, hospital admissions, and death.[1–3] Given these potential risks, it is imperative to find ways to manage the care of such patients. One approach to handling unnecessary medication use and polypharmacy has been coined "deprescribing". Our recent presentation at the 2013 Professional Practice

OCTOBER 18, 2016

How 'Deprescribing' Could Change Your Medical Routine

Is it time to clean out your medicine cabinet? We'll look at the new push to get you to take fewer medications. It's called "deprescribing."

▶ Listen · 46:38 + Queue ···

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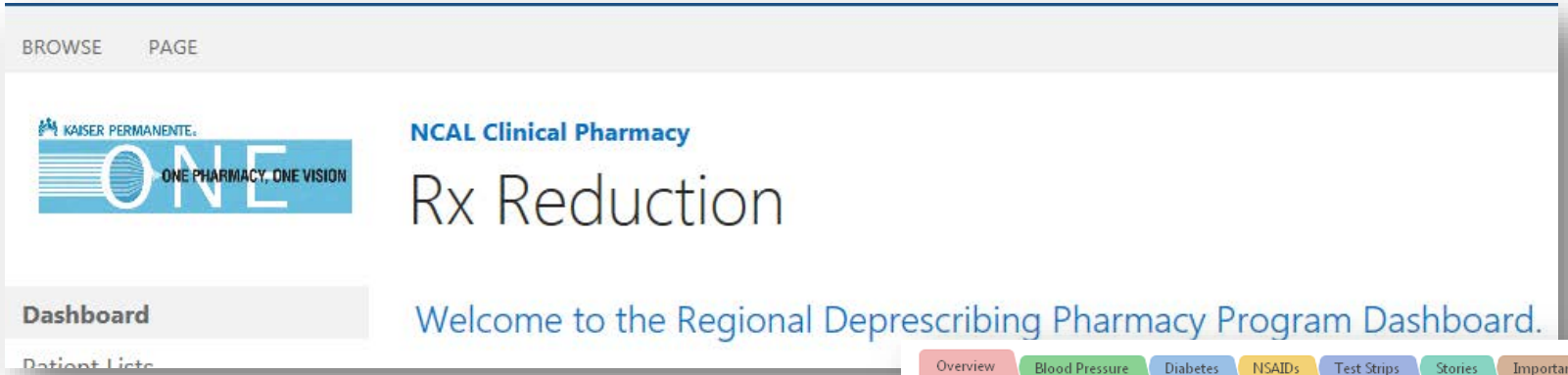
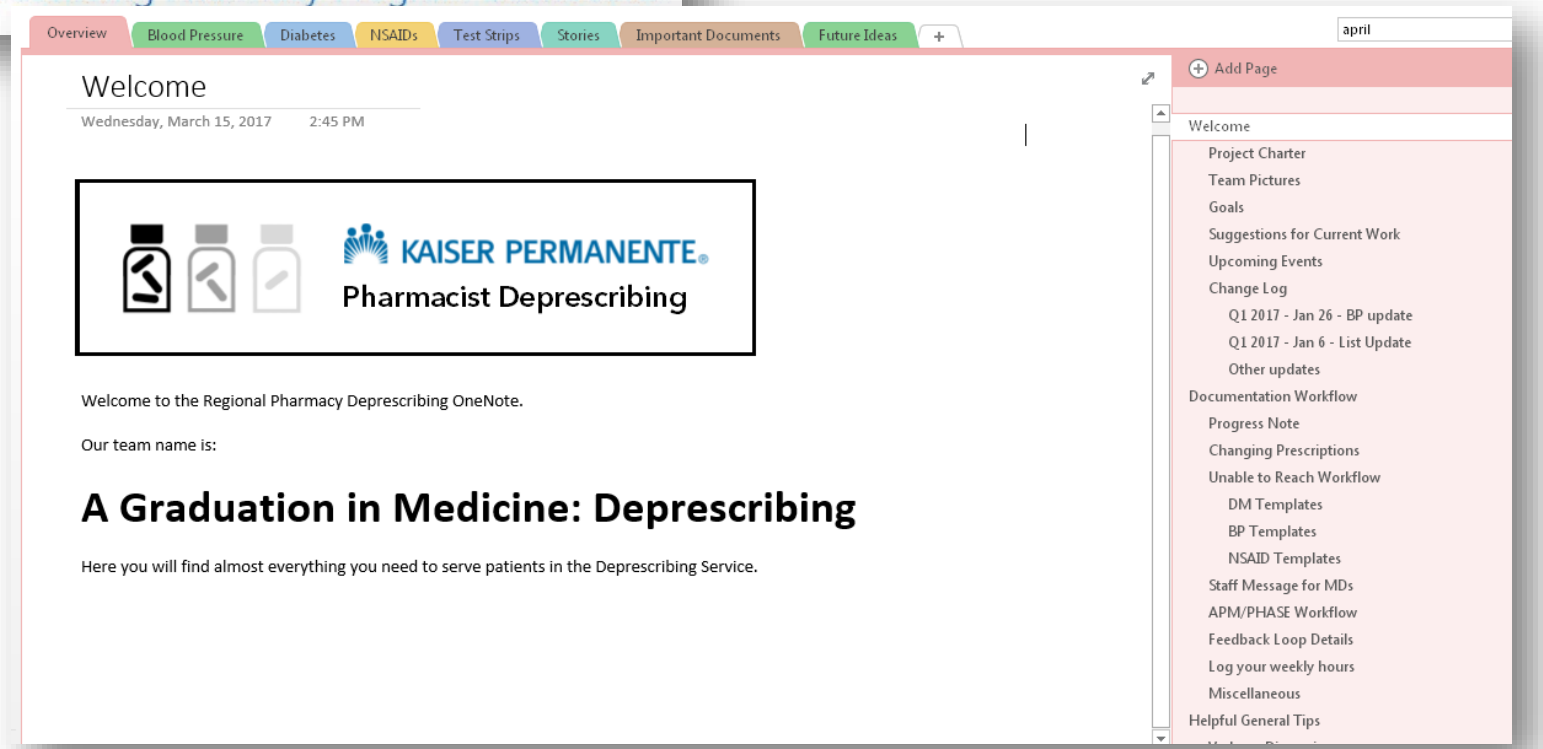
KP Experience





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THE EXPERTS

Health Care Needs a Better System for Importing Ideas From Abroad

WSJ Health Expert David Blumenthal says the U.S. is not taking advantage of health-care delivery innovations ar
ISTOCK PHOTO

By DAVID BLUMENTHAL
Mar 3, 2017 1:05 pm ET

Dr. David Blumenthal (@DavidBlumenthal) is the president of the Commonwealth national health-care philanthropy based in New York.

With political winds potentially changing the U.S. health-care system—yet again tempting to look inward, rather than outward for solutions. That means opportu may be lost to learn from innovations abroad in the delivery of health-care servi

Assessments Are Crucial for Patient Care

large-scale new models of care delivery.

But some organizations are trying to change that. Recently, Ascension, the nation's largest nonprofit health-care system, has begun experimenting with replicating an Indian approach to cardiac surgery. The Narayana Health System performs coronary artery bypass surgeries of comparable quality to developed nations at a cost of less than $2,000, compared with a typical cost of $50,000 in the U.S. Ascension has partnered with Narayana to create a facility in Cayman Islands that will serve patients from North and South America. Based on that experience, Ascension will see whether elements of that innovative model could be transferred to the U.S. mainland.

THE EXPERTS

The Experts are a group of industry and academic thought leaders who weigh in on topics covered in the The Journal Report.

Working with 15 leading U.S. delivery systems including Ascension, Kaiser Permanente and CareSouth Carolina, the Cambridge-based Institute for Healthcare Improvement has led a global search for health care innovations that hold promise for resolving persistent problems at U.S. facilities. A variety of international models are now being tested, with the backing of my organization, the Commonwealth Fund.

http://blogs.wsj.com/experts/2017/03/03/health-care-needs-a-better-system-for-importing-ideas-from-abroad/

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KP Collaboration with IHI on deprescribing

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Lets find a starting point…

At each patient encounter, let's ask ourselves:

Can I take
one medication away?

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Questions?

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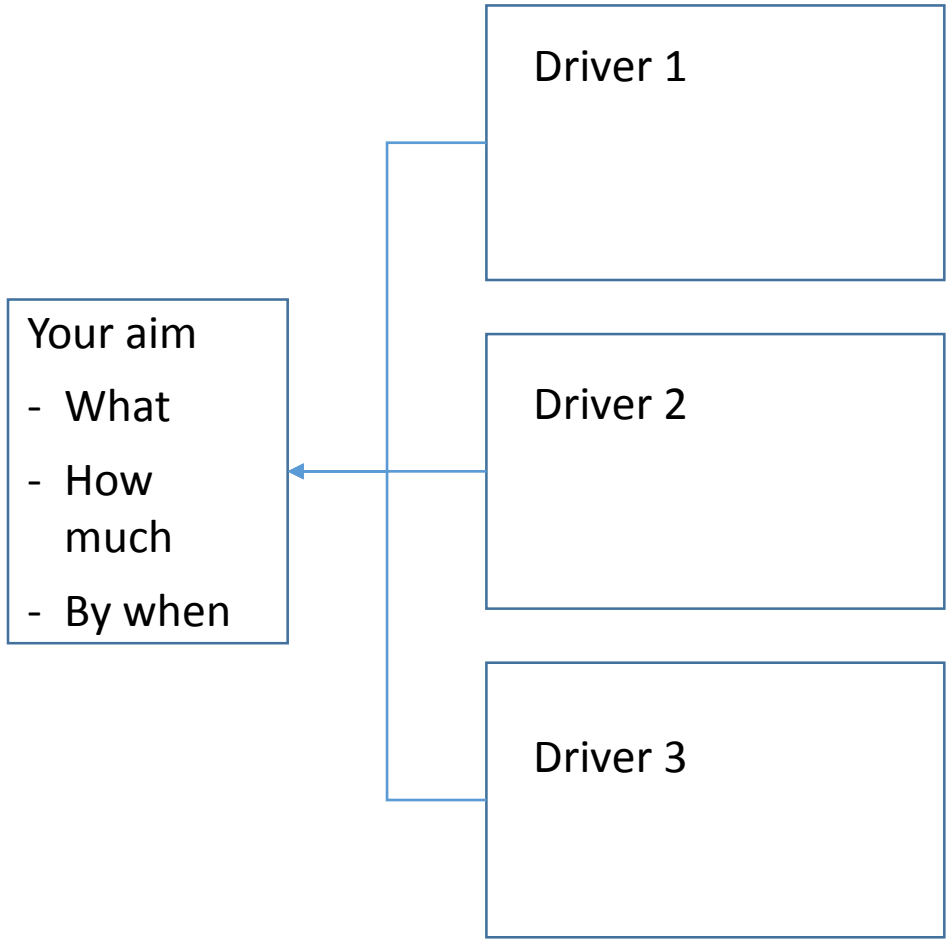
Workshop exercise

Theory of Change (To be completed by each system)



"Driver Diagram." *Institute for Healthcare Improvement*, 2017, www.ihi.org/resources/Pages/Tools/Driver-Diagram.aspx.