Addressing Polypharmacy

DocTalks
a Doctors of BC production

NEW HABITS FOR EFFECTIVE DEPRESCRIBING

featuring family Physician Dr Mark Lawrie

About Dr. Lawrie

Dr Lawrie is a family physician with extensive experience in polypharmacy and mentoring physicians through his local Division of Family Practice Long Term Care Initiative, and his involvement in Shared Care's Polypharmacy Risk Reduction Initiative. Dr Lawrie is now applying knowledge and strategies he's developed since 2012, to effectively deprescribe for patients in his family practice.

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Deprescribing is:

> **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.**
>
> — Ian Scott et al, JAMA 2015

How to Use This Document

The following document shares useful information to support the content of a new Doctors of BC podcast and video series 'DocTalks', which engages physicians on timely, relevant topics impacting the medical community, and those they care for in British Columbia.

In this first video in the DocTalks series, brought to you by the Shared Care Committee's Polypharmacy Risk Reduction Initiative (a partnership of Doctors of BC and the BC government), Dr Lawrie shares his expertise on the topic of developing new habits to reduce risks from Polypharmacy. This accompanying document has been created to take learning one step further with the provision of additional resources and reflective exercises to inform Group Sessions or ongoing individual development.

A Message from Dr Lawrie

I am pleased to be part of the first DocTalk in the video series to share some strategies on developing new habits to address polypharmacy—a subject I'm passionate about, and one that is a very rewarding part of my work in Penticton where I live.

I hope you'll find this DocTalk useful, and that you're inspired to incorporate some or all of the ideas I've shared as part of your daily practice.

Learning Objectives

The content of this video should allow viewers to further their learning to achieve the following:

1. Recognize indications for Medication Reviews and develop a practical structure for these reviews, to facilitate the Deprescribing of inappropriate medications, with a plan and suitable monitoring.
2. Appreciate the importance of the patient-centred teamwork and shared decision-making necessary for effective Deprescribing, and develop habits to do this reliably.
3. Use Deprescribing and inappropriate Polypharmacy assessment strategies when prescribing new medications.

REFLECTIVE EXERCISES

These exercises have been designed to facilitate your understanding and intention to improve your knowledge, satisfaction, and effectiveness, around Practical Deprescribing.

Many of these can be discussed in a group learning session, but can also be useful to individuals.

1. **Discuss Patient-Centred vs. Disease-Centred care and how Polypharmacy arises.**
   - What guidelines/resources should you use for reliable disease-management, particularly in the frail elderly?
   - Discuss the roles of various caregivers in Deprescribing (Including pharmacists, physicians, facility staff, family) in a more family-centred approach. How would better shared decision-making look in your team's practice?
2. **Review the Indications for Medication Reviews—as many as you can.**
   - Discuss current and future opportunities for Medication Reviews, for your group and yourself.
   - Review the elements necessary for effective Medication Reviews (accurate drug list, current patient condition, diagnoses/functional issues, goals of care, life expectancy, communication, appreciation of harm/appropriateness, collaboration, resources, teamwork, time management, delegation of monitoring, etc.)
   - Discuss how online resources eg. MedStopper, SharedCarebc.ca, and pharmacists, can improve your Deprescribing.
   - Discuss how you can make your Deprescribing Plan practical and easily communicated.
3. **Discuss the differences between indication and appropriateness for a given medication.**
   - Contrast various patient situations to make this clearer i.e., goals of care, life expectancy, functional status, age-related changes in drug effects.

- Differentiate between current and future harms from drugs, and how to weigh these more objectively, despite the uncertainties.
- Discuss how these ideas might improve your prescribing habits.

4. **Discuss your previous challenges, difficulties, around communication related to Deprescribing.**
   - Role play discussions with an anxious family/patient to practice better conversations around Medication Reviews and Deprescribing.
   - Examine your communication with colleagues, staff members, family, patients. What would you do now to improve your effectiveness, and reduce difficulties.
   - Discuss your care transfers and how to reduce harm from polypharmacy through better communication (verbal, written, documentation, etc.)
5. **Discuss how Practical Deprescribing and Safer Prescribing would affect your workload, efficiency, practice patterns.**
   - Consider how your Deprescribing Plan can be efficiently implemented, and how you can monitor the changes and results of your Deprescribing.
   - Discuss concerns of potential harms of Deprescribing, and recall unpleasant experiences to appreciate safer practices.
   - Recall and appreciate good outcomes related to Deprescribing, and consider what lessons can be recognized for future success.
   - Explore strategies to be a Practical Deprescriber, including helpful resources/Pharmacists, to make this work enjoyable, manageable, and safe.

Edna's Case Study

EDNA'S MEDICAL DIAGNOSES

1. Hypertension
2. Diabetes Mellitus
3. Osteoarthritis- Knees
4. Depression
5. Macular Degeneration
6. Osteoporosis
7. Delirium/Agitation
8. Left Hip Fracture

EDNA'S FUNCTIONAL ISSUES

- Unsteady + Falls
- Constipation
- Dry Mouth
- Light-Headed/Dizzy
- Confusion
- Knee Pain
- Weight Loss / Poor Appetite
- Heartburn
- Urinary Incontinence
- Muscle Aches /Stiffness
- Visual Problems

EDNA'S MEDICATION LIST

B.I.D. = twice daily dosing Q.I.D. = four times a day dosing PRN = as needed

MEDICATION	DOSAGE
HYDROCHLORTHIAZIDE	50MG ONCE DAILY
NAPROXEN	250MG T.I.D.
TYLENOL	500MG Q.I.D.
RAMIPRIL	10MG ONCE DAILY
MULTI-VITAMINS	2 IN A.M.
OXYBUTININ	2.5MG B.I.D.
VITAMIN D	1000 I.U. ONCE DAILY
ZOPICLONE	7.5MG AT BEDTIME
METFORMIN	2 X 500MG B.I.D.
CITALOPRAM	20MG DAILY
CALCIUM CARBONATE	500MG B.I.D.
ASPIRIN	81 MG ONCE DAILY
QUETIAPINE	25MG AT BEDTIME
QUETIAPINE	12.5MG Q6HRS. PRN
ATORVASTATIN	40MG DAILY
ALENDRONATE	70MG ONCE A WEEK
SENNOKOT	12MG B.I.D.
PEG	17GMS DAILY
GAVISCON	1 TAB-TID.
PANTOPRAZOLE	40MG ONCE DAILY.

TOTAL = **32 TABLETS** DAILY + EYEDROPS + LAXATIVE + PRN'S
= **896 TABLETS** EVERY 4 WEEKS

RANKING DRUGS TO STOP/TAPER (1 – 4)

Ranking is a way to review the drug list critically from several angles, and to prioritize your Deprescribing, as you develop a Deprescribing Plan. Each person's choice of ranking will be different.

Below is my Ranking of Edna's Drugs

As you review my ranking, note that a number of drugs will fit in several categories. Their priority to deprescribe will depend on the particular patient's condition, goals of care, life expectancy.

TIP: *Rank a drug as high as suitable to focus on the urgency to STOP/TAPER.*

Feel free to expand on what I have indicated. There are layers of potential harm and drug interaction possibilities. A drug that fits in any of the 4 ranks should be considered for Deprescribing. Look beyond the obvious, but always focus on the patient with all their complexity to determine your first and next steps when Deprescribing.

RANKING #1

No benefit – i.e. no indication, harmful, contraindicated, could be part of cascade

- MULTI-VITAMINS – 2 IN A.M. **(NO BENEFIT)**
- OXYBUTININ –2.5MG B.I.D. **(ANTICHOLINERGIC/TOXIC!)**
- QUETIAPINE – 12.5MG Q6HRS. PRN **(PRN=DANGER!)**
- SENNOKOT – 12MG B.I.D. **(2+3+12+4+5=CASCADE!)**
- PEG – 17GMS DAILY
- GAVISCON – 1 TAB-TID.
- PANTOPRAZOLE – 40MG ONCE DAILY. **(10+19+20=CASCADE!)**

RANKING #2

Does harm outweigh benefit – present or future?

- RAMIPRIL – 10MG ONCE DAILY **(LOW BP!)**
- HYDROCHLORTHIAZIDE – 50MG ONCE DAILY **(HIGH DOSE!)**
- NAPROXEN – 250MG T.I.D. **(8+9+10=TRIPLE WHAMMY=RENAL TOXICITY!)**

- ZOPICLONE – 7.5MG AT BEDTIME **(2,3+11+15= SEDATION!)**
- CALCIUM CARBONATE – 500MG B.I.D. **(2+3+12+15=CONSTIPATED!)**
- ASPIRIN – 81 MG ONCE DAILY **(BLEEDING >BENEFIT)**
- ALENDRONATE – 70MG ONCE A WEEK
- QUETIAPINE – 25MG AT BEDTIME **(HIGH RISK DRUG/BETTER OPTIONS)**

RANKING #3

Are drugs for symptom/disease still necessary?

- TYLENOL – 500MG Q.I.D. **(REASSESS PAIN MANAGEMENT)**
- METFORMIN – 2 X 500MG B.I.D. **(GLUCOSE OK)**
- CITALOPRAM – 20MG DAILY **(NO DEPRESSION FOR YEARS)**

RANKING #4

Are preventive drugs beneficial at this stage of life?

- ATORVASTATIN – 40MG DAILY **(19+16+10=CASCADE, STATIN BENEFIT?)**
- D – 1000 I.U. ONCE DAILY

Your Deprescribing Plan

The Deprescribing Plan is your blueprint for Deprescribing. It includes a prioritization of drug changes—what to change (Stop, Taper, Substitute), and monitoring of changes. You should consider the following with your Deprescribing Plan:

- Generally, the Plan is sequential and takes several steps until goals around the drugs and patient condition are reached.
- Documenting your rationale, and targeting symptoms and conditions to monitor is a necessary step. Delegation of the monitoring roles of others, including family, prescriber, patient, and facility staff, should be clear, with prompts for the deprescriber about when to review the Plan's progress, or be notified of any surprises.
- The Plan once formulated should always be checked for practicality and simplicity. In many situations, multiple drugs can be safely stopped or tapered initially, and at each subsequent Deprescribing step. Proceed at a rate that ensures monitoring is effective, and outcomes are assessed before moving on.
- The assistance of monitoring persons, and the involvement of Pharmacists greatly improves many plans' effectiveness.

A Note about PRN Medications

In my opinion, the use of PRN (as needed) medications for behaviour management in our frail elderly, contributes to drug overuse and potential harms. I now elicit help from others to use various tools for assessing and monitoring psychological symptoms, pain, and behaviours, and then decide about regular use of these potentially harmful medications. This avoids the overly subjective use of these drugs, and helps clarify the need (or not) to prescribe these regularly. These same tools are helpful in Deprescribing, for clarity, and conversations with family, facility staff, to monitor symptoms and justify maintaining, restarting, or even beginning these drugs.

Good Conversations and Teamwork with Patients', Families and Caregivers

I appreciate more and more that what I achieve for my patients relies on my patients, their family and caregivers. My success in Deprescribing has been partly due to educating these stakeholders about Medication Benefits/Harms, and giving them real input into these decisions. This doesn't take a lot of time, but I do it when I anticipate that an explanation might facilitate a reasonable change. Changes are challenging for us as prescribers/deprescribers and patients. My appreciation of the benefits to my patients is magnified by the positive and exciting stories and feedback from my teammates. This feeds my intention to continue, and validates my impression that despite uncertainties around reducing Polypharmacy, surprising benefits occur often, and the process is safe and practical.

Not a new idea...

> **"It is an art of no little importance to administer medications properly: but it is an art of much greater and more difficult acquisition to know when to suspend or altogether omit them."**
>
> — Phillipe Pinel (1745 – 1825)