

Deprescribing 2.0: Harnessing the Power of Collaboration and Data to Achieve Goals of Care

By Christine Kilgore

The topics of polypharmacy and deprescribing have for years filled pages in *JAMDA* and *Caring* and rooms at the annual conferences of AMDA – The Society for Long-Term Care and Post-Acute Medicine, but a new working group of long-term care leaders believes deprescribing needs an implementation boost to become more achievable for facilities and impactful for residents' quality of life.

Under the leadership of the Society's past president Arif Nazir, MD, FACP, CMD, AGSF, a group of chief medical officers (CMOs), chief nursing officers, and pharmacy leaders has been readying plans to focus each month on optimizing use of or deprescribing a particular medication type or class in their companies' long-term care settings.

Part of a new deprescribing working group, the long-term care leaders hope that their organizations can collectively serve as a sort of incubator of best implementation practices. They hope to eventually “demonstrate to the Society's members that the needle is moving,” Dr. Nazir said, and to select practical educational tools to help physicians, nurses, families, and others at the bedside. In February, the Society was working to secure deidentified resident- and prescriber-specific data from two large long-term care pharmacies to help drive the effort.

The deprescribing working group is part of a larger group of CMOs and other leaders of long-term care companies and physician groups — known as the Society's Leadership Group — that has met for years to network and advance best practices. In 2019, polypharmacy/deprescribing ranked number one on a survey of potential issues for implementation initiatives. The COVID-19 pandemic added a new layer of urgency.

With the threats posed by the pandemic — and with widespread shortages of personal protective equipment in the spring of 2020 — “there was a big push for deprescribing,” said Gregory Johnson, MD, CMO of the Sanford Health and Good Samaritan Society, and a member of the working group. “Independently, many CMOs were asking, what can we do to help our medical directors, our rounding providers, our directors of nursing, and others to identify [deprescribing] opportunities and decrease the number of [medication passes]?” he said. “There was a gut check on medication lists.”

He and other CMOs “saw some pretty significant decreases in the spring when we each advanced various [deprescribing efforts],” Dr. Johnson said. “When we convened in the fall ... it felt collectively and anecdotally like we were seeing less administrative burden and passing of medications and fewer side effects.”

The literature on polypharmacy combined with geriatric clinical experience has shown that patients with increasing numbers of medications are at greater risk of adverse drug reactions, hospitalization and mortality, gait impairment and falls, weight loss, depression, mental status changes, fatigue and lethargy, and reduced quality of life. “We know this, but knowledge doesn't always translate to behavior change,” said Dr. Nazir, MD, CMO for Signature HealthCARE and president of SHC Medical Partners. Long-term care has ample clinical practice guidelines and educational tools, he said, but this is not enough. “We want to partner as long-term care chains and bring tools to [the frontline] that can be operationalized in our clinical workflow.”

Sabine von Preyss-Friedman, MD, CMD, the CMO and senior vice president of Avalon Healthcare and another member of the working group, said the question facing the group is “how can we organizationally achieve medication optimization and decrease polypharmacy? What do the processes look like that give everyone success?”

Deprescribing — and the new Society-sponsored project — is “not about slashing drugs,” Dr. von Preyss-Friedman emphasized, “but about optimizing medication regimens to avoid side effects — about taking the most essential medications at the optimal dosages, streamlining regimens, and taking away medications that are no longer useful” or no longer congruent with goals of care and patient values.

Facilitating Deprescribing

For years, Dr. von Preyss-Friedman has led or organized education on deprescribing — or medication optimization, as she prefers to call it — both as a certified medical director (CMD) of several nursing homes and for the CMDs of the Avalon facilities she oversees. Yet her advocacy for broad medication reviews and deprescribing in general never moved the needle to her satisfaction.

Inspired by the success of an affiliated provider group in implementing a pharmacist-led initiative, Dr. von Preyss-Friedman consulted with Avalon's chief nursing officer and decided to focus on one medication: sliding-scale insulin.

“It's not as effective in the nursing home setting, it takes a lot of nursing time, and it's a cruel thing to do for patients with dementia,” she said. “It checked all the boxes.”

She secured the commitment of medical directors and worked with Avalon's pharmacy partners on developing a dashboard of monthly usage. She also spent more time on diabetes management in monthly meetings with CMDs. “Our CMDs could see where they were [with the number of prescriptions], and over a year we made an astounding amount of improvement,” she said. “We reduced our use of sliding-scale insulin by 50% across dozens of facilities.”

A similar effort focusing on trazadone — often prescribed for sleep but with a significant risk of side effects — was just as successful. “Focusing on specific medications with simple data, dashboards, and education made a difference,” said Dr. von Preyss-Friedman, emphasizing that the “biggest barriers” to medication optimization may well be “a lack of focus and a lack of [targeted] data.”

Michael P. Cinque, PharmD, senior vice president for pharmacy management at Genesis HealthCare and a member of the working group, said now is the time for making big strides with deprescribing. There is “strong” evidence on the appropriateness of many medications in older adults, he said. And while pharmacists have long had good prescribing data, there is increasing appreciation for the “need to present that data in a way that helps physicians and prescribers see where decision-making opportunities lie.”

Physicians and other prescribers, meanwhile, are increasingly “used to looking at numbers and looking for process improvement,” he said. “Ten to 15 years ago, performance metrics weren't as integral a part [of practice] as they are today. That's really why we're going to make some progress here.” The metrics help facilitate awareness, conversations, and education, he said. “We're not looking for a cookie-cutter approach to managing [residents],” Dr. Cinque said. “We want to evaluate every medication and ask, What is the value of it? Is it still doing what we want it to do? Does it still need to be there? Is it causing a side effect that we might be addressing with another medication? Does it meet the treatment goals of the patient and family?”

Genesis HealthCare facilities have recently improved their use of anticholinergic medications, proton pump inhibitors, H2 antagonists, and vitamins — the latter three of which are medications that “work their way onto a profile appropriately but don't get reevaluated

ACTION POINTS

The deprescribing working group members who spoke with *Caring* encourage medical directors to institute an inter-professional polypharmacy focus in their facilities. They offer the following advice.

- Ask your consulting pharmacist for a polypharmacy consult and “be really critical of the number of medications on board,” said Dr. Johnson. Or propose collaborating on specific initiatives, such as reducing the use of sliding-scale insulin, and push for useful data and analytics, said Dr. von Preyss-Friedman.
- Pull in your entire staff and hear their concerns, Dr. von Preyss-Friedman said. Nurses may get pushback from family members about their loved ones discontinuing medications, and it will be important to emphasize the goals — achieving the best care and quality of life with the least side effects — and to reassure everyone that there will be careful monitoring and medication reintroduction if needed.
- Welcome inquiries from family members about medications and find ways to address questions. Linda Jahn of Davenport, WA, who is serving as a patient/consumer representative to the deprescribing initiative, said she often sought information, unsuccessfully, about the role and usefulness of medications for her family's elders who lived in assisted living facilities and were cared for in SNFs. For families, she said, “information is power, and communication is key.” Understanding the changes in condition and functional status that could occur with deprescribing is important, she said.
- Seek out resources. Dr. Johnson likes a guide for PALTC on optimizing medication management during the COVID-19 pandemic produced by the University of Maryland School of Pharmacy (<https://www.pharmacy.umaryland.edu/PALTC-COVID-19-MedOpt>). The guide recommends medications that may be discontinued, reduced, or changed and includes sample letters to prescribers, residents and their family and care partners. Additionally, a Canadian project has developed evidence-based guidelines and decision-support algorithms for proton pump inhibitors, antihyperglycemics, and other medications, as well as patient information pamphlets, and decision aids (<https://deprescribing.org>).
- Appreciate that long-term care admission is the time to focus on basic medication reconciliation—on looking for drug–drug interactions and problem medications. Deprescribing requires conversations that take place “once rapport and trust [are] built, and once the patient's medication journey is understood,” said Dr. Cinque.

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for possible change or discontinuation nearly enough,” Dr. Cinque said.

Within Signature HealthCARE, Dr. Nazir’s goal has been to change the culture, educate, and create an interdisciplinary dialogue about deprescribing. A group of 75 nurse practitioners and physician assistants have received training from Duke University geriatrics faculty in “the art of deprescribing and other geriatric care strategies,” Dr. Nazir said. They review monthly data on deprescribed medications and lead weekly grand rounds with the frontline staff in which they emphasize advance care planning and medication optimization. The conversations often center on Beers list medications, psychotropics, antihypertension regimens, and aggressive diabetes management, Dr. Nazir said.

Annette Wenzler, MBA, BSN, chief nursing officer at Signature HealthCARE and a member of the working group, said that education and metrics have created a culture in which medication orders and deprescribing opportunities come up regularly in daily and weekly interdisciplinary clinical meetings. The nurses are well positioned, she noted, to integrate the residents’ history, goals of care, and functional status into deprescribing and to educate and communicate with families along the way. Federal initiatives promoting reductions in antipsychotic usage — and more recently, antibiotic stewardship — have laid valuable groundwork for broader deprescribing, she emphasized.

To go broader — to move well beyond antipsychotics — collaboration with pharmacists is key, Dr. Nazir said. “We’ve generally lacked good collaborative care practices between physicians and pharmacists [in the PALTC setting],” he said. “I’m excited that with this initiative there will be considerable focus on the role of the consultant pharmacist to help promote deprescribing.”

Antibody

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Moving Forward: Lesson Learned

So far, mAbs do not seem to be subject to the same hesitancy and questions that plague the COVID-19 vaccine. “We haven’t gotten feedback regarding any questions or concerns on the part of patients or families,” said Dr. Worz. He suggested that there may be some confusion about the relationship between antibody treatment and the vaccine. However, there is a simple answer to this. A patient can’t receive the vaccine for 90 days after they are treated with mAbs. “We just have to educate everyone about this,” he said. It also may be helpful to explain to

Measuring outcomes

In addition to focusing on one medication per month, the long-term care companies participating in the deprescribing initiative will consider more than 10 medications (including vitamins and supplements and as-needed orders) per resident to be polypharmacy — and will strive to keep medication numbers at 10 or fewer.

“Our expert consensus,” said Dr. von Preyss-Friedman, “is that our goal should be to have the metric or 10 or few medications.” As the initiative progresses, she added, “we’ll also look to decrease medication frequency — something that as physicians and prescribers we’re not very attuned to. Right now in many places with orders written for [four and three times a day], it’s the wild west of medication administration.”

Although the focus of the project is on long-term care residents, the culture of medication optimization should “bleed over” and extend into post-acute populations, she said.

Dr. Johnson said that some of the working group members have expressed a desire to eventually measure some kind of patient-level outcome — such as the number of adverse events or a measure of frailty or quality of life, in the context of deprescribing — to demonstrate the impact of deprescribing that they observe and believe clinically. For now, however, the focus is on simple process metrics and implementation issues.

Studies of deprescribing have shown minimal evidence of benefit on clinical outcomes such as mortality or falls or hospitalizations, Dr. Nazir acknowledged. “But I don’t think it’s that deprescribing doesn’t help — I just think it’s extremely hard to study and evaluate.”

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patients and families that vaccines provide active immunity by triggering a natural immune response whereas antibody treatments give the body the antibodies it needs to protect itself from an active virus.

Dr. Nelson said, “We need to figure out a way to use this when we have staffing shortages. Hopefully, the vaccine will keep staff healthy if there is a new outbreak in three months, so this won’t be an issue. But we need to prepare for various scenarios.” He added, “We also need to continue to work on breaking down barriers between settings to maximize win-win situations regarding COVID-19 treatment and prevention.”

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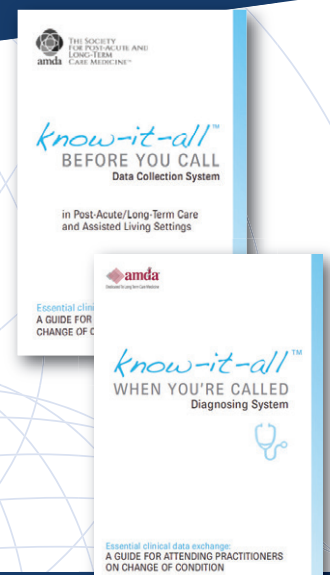
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