Drive to Deprescribe Journey: Just Getting Started
By Joanne Kaldy

When AMDA – The Society for Post-Acute and Long-Term Care Medicine launched its Drive to Deprescribe (D2D) initiative in May 2020, the goal was a 25% reduction of medication use in PALTG. What evolved was a movement that united interdisciplinary teams, empowered practitioners, and generated energy and positive change. It took a proactive approach to an issue that members are passionate about addressing.

“This is quite a unique program. This wasn’t triggered by mandates. This is an issue that our membership have strong feelings about and want to address in a significant way,” said Arif Nazir, MD, CMD, chief medical officer at Signature Healthcare (SCH) and president of SHC Medical Partners. In fact, he suggested, “It’s actually not an initiative anymore. Initiatives are nice but not sustainable. This has become part of our day-to-day work at Signature and elsewhere. We talk about it all the time. We have meetings with our directors of nursing every week, and they say it’s one of the most important things we’ve done.”

Michael Cinque, PharmD, senior vice president of pharmacy management at Genesis, noted, “One of the most rewarding aspects of D2D has been hearing from other disciplines because the medication use process is not just about prescribing. We can make greater strides toward improvement when teams work together.” He added, “D2D drives performance.”

Sabine von Preyss-Friedman, MD, FACP, CMD, chief medical officer of Avalon Healthcare, said, “There is a lot of evidence out there, but it takes time to implement it in practice. We want to speed this up. Through our monthly meetings, there is an opportunity to share the latest evidence and data quickly.”

Although this is a Society effort, Dr. Nazir said, “Many people participating in D2D aren’t AMDA members, but this issue resonates with them. It is important for AMDA to find issues that speak to people beyond our membership. We’ve consistently had 90–100 people on our webinars, but the same individuals didn’t always participate every time.” This, he suggested, indicated D2D’s breadth and reach.

From How-To to How-to-Track
The D2D program made available deprescribing pamphlets that align with evidence-based deprescribing guidelines and algorithms to provide lay-level information that helps patients and caregivers have conversations with their prescriber about safe deprescribing. To date, there are pamphlets on deprescribing for proton pump inhibitors, benzodiazepines and Z-drugs, antihyperglycemics, and antipsychotics. There also are deprescribing guideline infographics on these topics.

“Medical directors set the expectations, and operations managers set the framework. Then there needs to be a great deal of teaching and collaboration as a team,” said Dr. von Preyss-Friedman. Getting the buy-in of team leaders is essential, but this calls for some encouraging data. “This is where our pharmacy dashboard comes in. We can look at this and see where there are outliers and problems. Incorporating this into our QAPI [Quality Assurance Performance Improvement] process also helps.”

It is challenging to collect data from an initiative like D2D where many facilities and practitioners are involved and not all of them on a monthly basis. Dr. Nazir observed, “We are getting good feedback from the D2D participants, but defining the impact on paper has been challenging. We have created much needed awareness of polypharmacy and deprescribing issues, but we don’t yet have the data we need.” Dr. Cinque said, “We need to focus on specific D2D participating organizations that are truly engaged and work with their pharmacies to collect needed data.”

Dr. Cinque has created a scorecard in spreadsheet form for his organization that captures a variety of details, including how quickly the prescriber responds to the pharmacist’s recommendation and the percentage of residents taking a specific medication (e.g., antipsychotics). From this scorecard, facilities can see if they are better than average, average, 10% below average, 10% to 25% below average, or more than 25% below average. He said, “I am targeting data points that I know our centers are seeing from their pharmacies. I’m color coding and rolling it out to enable clinical leaders at the market level to see where they stand and where improvements can be made.”

According to Dr. Cinque, anyone can build a scorecard for their facility or practice related to specific issues that matter to them. This doesn’t have to be complex. “It’s perfectly okay to start with a few metrics,” he said. At the least, he suggested, “Every facility should be looking at the number of scheduled, PRN [as needed], and total medications for patients.” He added, “Facilities can do this with what they have, but we need to create tools that allow leadership to guide and influence the performance of their facilities wherever they are and however larger or small they are. Then we need to recognize and praise great performers and help those at the bottom figure out where changes and improvements can be made.” He stressed that there needs to be accountability across the board.

Shoring Up Staffing
D2D not only is helping participants reduce polypharmacy and improve care for residents but also is helping staff. For instance, throughout the pandemic, nurse managers often found themselves consumed by medication administration. Thanks to D2D, facilities have been able to reduce the number of medications residents are taking. Dr. Cinque said, “Reducing med pass time is a business imperative. It is a hard win.” For instance, he worked with one facility that went from an average of 12 scheduled medications to 9.8. This is improving med pass time, which is critical to improving patient care and frees nurses to do the work they love.

Maximizing teamwork, engagement, and communication is another benefit of D2D. As Dr. Cinque said, “This initiative has helped bring pharmacists, nurses, advanced practice practitioners, and physicians together. The consultant pharmacist is doing work that is valuable, and the prescribers need to work with them — they are your partners.”

In addition to improving staffing relationships and teamwork, D2D also has helped improve communication with families. Dr. von Preyss-Friedman said, “The tools and resources we’ve provided help practitioners develop good channels of communication with families and encourage empathetic listening. This is what goes into successful family communication.”

The Road Ahead
Although much has been accomplished, Dr. von Preyss-Friedman stressed, “We aren’t done yet.” She indicated there are other medications that the initiative could address. “We got tied down by COVID. We have to catch up, and this model can go further.” She suggested, “We have a lot of knowledge at AMDA, but we can do more in terms of providing guidance on taking this effort and implementing it in practice.”

As patients move through the continuum often quicker and sicker, nursing homes see higher acuity, and staff turnover is at all-time highs, D2D needs to be ongoing. “It isn’t one and done. The demand and need will continue to exist.”

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Higher Breakfast Protein Quality Is Associated With Reduced Incidence of Sarcopenia

Clinical Quandary
- Increasing the amount of protein intake is recommended as age to counteract the effects of age-related sarcopenia; however, most older adults decrease their protein intake over time. Although sarcopenia is increasingly being recognized as an important geriatric syndrome in long-term care (LTC), little is known about the type or amount of protein intake that is best for the prevention and treatment of sarcopenia.

Clinical Question
- Does the amount and/or quality of protein intake at breakfast affect the development of sarcopenia in older adults, as measured by grip strength?


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said Dr. von Preys-Friedman. “We have many patients coming from the hospital on numerous medications and sometimes some potentially dangerous ones. This is constant.”

D2D will live on through the many resources and tools developed through the initiative that are available on the Society’s website. In addition, the members of the D2D Leadership Team will continue to publish articles and make presentations about D2D and issues related to deprescribing. At the same time, the program has already created a legacy. As Dr. Nair observed, “This initiative has validated the fact that there is no one person with a Superman cape to save the day. We need participation from all disciplines.” He added, “By the time we started this initiative, people were worn out by the pandemic. People didn’t have energy for a new initiative, yet many participated in D2D.” He added, “This effort made people feel empowered. At Signature, for example, we have more than 20 buildings that have cut pills by 10% to 20%, and they take great pride in this. They feel like they’re doing something good. They were able to get engaged, and they found it to be meaningful.”

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Bottom Line
In a study of community-dwelling older adults in Japan, higher intake of high-quality, bioavailable protein at breakfast was associated with 50% lower incidence of low-grip strength (a marker of sarcopenia), even after adjusting for baseline grip strength. There was no association between total daily, lunch, or dinner protein quality and grip strength, suggesting that breakfast protein is the most important for maintaining muscle strength and preventing sarcopenia. Although this study was performed in healthier community-dwellers, LTC residents are at high risk of sarcopenia, and safe interventions to reduce this risk are needed. LTC providers should consider increasing the highly bioavailable protein intake of LTC residents at breakfast as an intervention to prevent sarcopenia.

Summary
A recent meta-analysis of 59 randomized controlled trials of sarcopenia interventions found that physical activity and protein or nutrition supplementation were the most effective interventions for improving muscle strength and preventing sarcopenia. This study explores the relationship between the type and amount of protein ingested at meals and grip strength, which is used to evaluate for the presence of sarcopenia.

The researchers enrolled people aged 60 and older between 2004 and 2012 who were participants in an ongoing longitudinal study of aging conducted every two years in people in the Aichi Prefecture of Japan. For this study, the researchers randomly sampled community-dwelling older adults and performed various geriatric assessments, including dietary intake and grip strength: 1,202 people had a baseline assessment; 1,006 had a follow-up assessment, and 701 were included in the final analysis. People were excluded from the analysis if they had missing data, already had poor grip strength at baseline, or had a condition that would cause low grip strength potentially unrelated to sarcopenia, such as stroke, arthritis, or Parkinson’s disease.

The 3-day average dietary protein intake at baseline was assessed by comparing a food diary with meal pictures and telephone interviews. Registered dieticians reviewed the protein intake and calculated the protein quality (i.e., bioavailability) using a well-established scoring method called the Protein Digestibility Corrected Amino Acid Score (PDCAAS). The quality of protein intake was classified into tertiles of low (T1), middle (T2), and high (T3). The primary outcome was grip strength, but they also collected data on body mass index (BMI), daily total physical activity, and cognitive function using the Mini Mental State Examination (MMSE). The follow-up evaluations only included assessments of BMI and grip strength.

Similar to a previous study that was reviewed in Caring (“Peer-Led Pain Management Program to Relieve Chronic Pain,” 2022;23[1]:10), generalizing estimated equations (GEE) were used to evaluate the association between PDCAAS and incident low grip strength. GEE is a statistical model that uses all available data even if some are missing (intention to treat) to see whether the intervention affects the respective outcome(s) over time. It models the average response among the population and accounts for both time and individual differences. In this study, they accounted for sex, age, follow-up time, grip strength at baseline, BMI, physical activity, MMSE score, education, smoking status, household annual income, comorbidities, PDCAAS values for lunch and dinner, and total calories and protein intake at all three meals.

Figure 1 shows the foods that were associated with significant baseline differences of consumption at breakfast between the low and high tertiles of PDCAAS intake. There were no statistically significant differences in the baseline breakfast consumption of meat, nuts, vegetables, or fruits between the PDCAAS tertiles. The results of adjusted analyses showed that across the eight years of follow-up (mean 6.9 years), the participants in the high tertile of PDCAAS at breakfast (higher quality protein intake) had a 50% lower risk (odds ratio) of developing low grip strength (sarcopenia). Interestingly, there was no association between low grip strength and total daily, lunch, or dinner protein quality. This suggests that protein intake (both amount and quality) at breakfast is the most important for preventing sarcopenia.

The limitations of this study included (1) PDCAAS was only assessed at baseline, so changes in dietary protein intake over time were not considered in the analysis; (2) the enrolled cohort was healthier than those who were excluded, so they are not necessarily representative of a LTC population; (3) assessments of physical function were not performed at follow-up, so it is unclear if higher grip strength can be correlated with activities-of-daily-living preservation and independence.

Despite the study’s limitations, the evidence is sufficiently compelling to recommend increased high-quality protein intake at breakfast to LTC residents who are at risk of developing sarcopenia. Facility medical providers and dietitians should work together to develop both individualized and facility-wide interventions to improve the dietary intake of protein, such as beans, fish, eggs, and dairy, to meet residents’ health goals.

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