What role can policy play in implementing deprescribing initiatives?

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#deRx2018

Session resources available at deprescribing.org/resources
Learning Objectives

1. To gain a more detailed understanding of the challenges and opportunities related to the use of policy to support the implementation of deprescribing guidelines

2. To generate new ideas that could be used to inform participant plans to connect with and influence policy makers

Session resources available at deprescribing.org/resources
Why focus on policy?

Figure 1: Ecological model of health system change.

Pop quiz!

TASK: “If you were the health minister, what could you do to facilitate deprescribing of unnecessary and inappropriate medications?”

Time: 2 minutes
Potential Drug Policy Leavers

• Withdraw from market *
• Making prescribing more difficult
  • Limiting use / special authorisation *
  • Restrict to prescriber group
  • Re-scheduling *
  • Dose restriction
  • Quantity restriction
• De-listing / increase patient expense *
• Monitor use *
• Pay doctors to review medications*
• Public education programs *

* = examples in this presentation
Which policies can reduce benzodiazepines?

Which colour represents:
1. Prescriber monitoring
2. Prescriber payments
3. Public Awareness
4. Restricting coverage
5. Other
Evidence-Based Deprescribing Guidelines

• Where do Evidence-Based Deprescribing Guidelines fit in this list?

• more on that later, first lets see how well the suggested policy's works...
• In 2004, Rofecoxib was withdrawn from the market

What happened?
Limiting Use

Proton Pump Inhibitor Claims

No Policy restricting PPI prescribing

What happened?
Interrupted Time Series Analysis of the Effect of Rescheduling Alprazolam in Australia: Taking Control of Prescription Drug Use
Rescheduling of Alprazolam

What happened?

Schaffer AL et al. JAMA Intern Med 2016;176(8):1223
Beware of unintended consequences
Alprazolam: Unintended consequences

- 22% ↓ in alprazolam prescribing
- 50% ↓ in poison center calls

BUT, at what cost?

- 216% ↑ other benzodiazepines;
- 142% ↑ antidepressants
- 129% ↑ antipsychotics
- Overdose deaths involving 1 or more benzodiazepines increased from 42.2% to 52.5% (2009 – 2015)

Schaffer AL et al JAMA Int Med 2016;176(8):1223
The Effect of Deinsuring Chlorpropamide on the Prescribing of Oral Antihyperglycemics for Nova Scotia Seniors’ Pharmacare Beneficiaries

Ingrid S. Sketris, Pharm.D., George C. Kephart, Ph.D., Dawn M. Frail, M.Sc., Chris Skedgel, M.D.E., and Michael J. Allen, M.D.
Delisting

Glyburide was the most popular replacement medication despite also being inappropriate.

What happened?

Figure 1. Monthly use rates for antihyperglycemic drug. A = chlorpropamide; G = insulin; H = acarbose; A = tolbutamide.
The Impact of Medicare Part D on Psychotropic Utilization and Financial Burden for Community-Based Seniors

Hua Chen, M.D., Ph.D.
Afram Nwangwu, Pharm.D., M.S.
Rajender Aparasu, M.Pharm., Ph.D.
Ekere Essien, M.D., Dr.P.H.
Shawn Sun, Ph.D.
Kwan Lee, Ph.D.
Delisting: Medicare Part D and benzodiazepines

What happened?

Monitoring

- Triplicate Prescription Program implementation

Effects of state surveillance on new post-hospitalization benzodiazepine use

ANITA K. WAGNER¹, STEPHEN B. SOUMERAI¹, FANG ZHANG¹, CONNIE MAH¹, LINDA SIMONI-WASTILA², LEON COSLER³, THOMAS FANNING⁴, PETER GALLAGHER⁴ AND DENNIS ROSS-DEGNAN¹

¹Department of Ambulatory Care and Prevention, Harvard Medical School and Harvard Pilgrim Health Care, Boston, MA, ²Department of Pharmacy Practice and Science, University of Maryland School of Pharmacy, Baltimore, MD, ³Albany College of Pharmacy, Albany, NY, ⁴Management Reports and Research Unit, Office of Medicaid Management, New York State Department of Health, Albany, NY, USA

Monitoring

- Triplicate Prescription Program implementation

Proportion of patients with new benzodiazepine prescription on hospital discharge

What happened?
Did the new French pay-for-performance system modify benzodiazepine prescribing practices?

Cédric Rat¹,²*, Gaëlle Penhouet¹, Aurélie Gaultier³, Anicet Chaslerie⁴, Jacques Pivette⁴, Jean Michel Nguyen²,³ and Caroline Victorri-Vigneau⁵

Pay-for-Performance

- Quality improvement program

- 4 priorities: practice organization, chronic disease management, prevention, prescribing

- Total incentive payment of €5000 (€490 for prescribing component)
### Pay-for-Performance

What happened?
Achieving a sustained reduction in benzodiazepine use through implementation of an area-wide multi-strategic approach

W. B. Dollman*†  MAppSc FSHP, V. T. LeBlanc*  BA, L. Stevens*, P. J. O’Connor* MA PhD, E. E. Roughead†‡  MAppSc PhD and A. L. Gilbert†‡  BPharm PhD

*Department of Health, Rundle Mall, SA, †Quality Use of Medicines and Pharmacy Research Centre, University of South Australia, Adelaide, SA and ‡School of Pharmacy and Medical Sciences, Adelaide, SA, Australia
What happened?
Reducing Prescriptions of Long-Acting Benzodiazepine Drugs in Denmark: A Descriptive Analysis of Nationwide Prescriptions during a 10-Year Period

Sophie Isabel Eriksen¹ and Lars Bjerrum²

¹Research Unit of General Practice, University of Copenhagen, Copenhagen, Denmark and ²Research Unit of General Practice, University of Copenhagen, Copenhagen, Denmark

The policy: rules for renewal of drivers’ licences

- For long-term users of a BZD with a half-life >10 hr, renewal of, or to regain, ones driving license is not possible. Furthermore, driving licenses can be confiscated if the GP reports the patient to the Medical Officer of Health.

- For BZD with a half-life of exactly 10 hr, the patient’s driving license will have a 1-year time limit, resulting in a yearly test of the patient’s cognitive functions.

- If starting treatment with, or increasing the dose of BZD, the patient is recommended not to drive for 4 weeks.

- When using a single dose of BZD with a half-life <10 hr, it is recommended not to drive after consumption, considering the half-life of the drug.
Danish Drivers Licence

• So what happened?
Danish Drivers Licence

Benzodiazepines

54% long acting

35% short acting
Rapid Realist Review

“What works, for whom, under what circumstances?”

Global Deprescribing Policies

• Reducing benzodiazepines and Z-drugs?
  • What policies *work* and in *whom*?
  • What were the *mechanisms*?
  • What were the influences of *context*?
Possible Policy Mechanisms


Pay-for-Performance

• Why?

• Mechanism: Fiscal

• Contexts: highly paid physicians, prescribing patterns, other competing practice priorities
Medicare Part D

• Why?

• Mechanism: Legislation + Fiscal measures

• Contexts: Low income population versus multiple payment sources, prescribing practices, and patient expectations
Danish Drivers Licence

• Why?

• Mechanism: Legislation and Regulation + Guidelines, Communication (engaging both physicians and patients)

• Contexts: single payer health system, population driven toward independence (driving), political will
Which Policies Provided Positive Outcomes?

• Withdraw from market *??
• Making prescribing more difficult
  • Limiting use / special authorisation * ✓
  • Restrict to prescriber group ✓
  • Re-scheduling *? ✓
  • Dose restriction
  • Quantity restriction
• De-listing / increase patient expense *? ✓
• Monitor use ✓
• Pay doctors to review medications ✗
• Public education programs * ✓
• Thinking outside the box: Danish Drivers License ✓

[deprescribing.org Bruyère Research Institute]
Policies to reduce benzodiazepine use

- Long-acting drugs: 54% less
- Short-acting drugs: 54% less
- 35% less
- 34% less
- 22% less
- 19% less
- 14% less
- 12% less
- 11% less
- 5% less
- 1% more
- 4% more
Regulation and Evidence-Based Deprescribing Guidelines

TASK: “How can we facilitate implementation of evidence-based deprescribing guidelines using regulation?”

Time: 2 minutes
Education

• Include deprescribing as a mandatory component for all national guidelines

• Enforce deprescribing content in all undergraduate, postgraduate and continuing professional education

• Develop a deprescribing competency framework for professional certification programs (e.g. Gerontological Nursing Certification)

• Include how to start and stop a medication in Product Information
Workflow Enhancement

• Mandate Electronic Medical Record Software to include easy access to deprescribing algorithms
• Mandate Pharmacy Dispense software to include the steps of deprescribing algorithms as part of the workflow
Promote Clinical Review

• Professional body audit and feedback
• Academic Detailing
• Fund collaboration between health care providers
  • Medication reviews in community pharmacies
  • Pharmaceutical opinions
• Pharmacists in family medicine clinics
Influencing Decision Makers

TASK: “How can we influence decision makers to ensure there is implementation of deprescribing guidelines?”

Time: 2 minutes
Influencing Decision Makers

• This is up for discussion...
  I don’t have absolute answers!

• Improving patient outcomes
• Reducing adverse drug events
• Reducing medication cost
• Reducing hospitalisations and burden on health system
• Saving money
• Dependent on the political cycle
Summary

• Policy interventions seem to perform poorly when other contextual influences not considered (e.g. other payment sources, competing practice priorities, poor knowledge, availability of alternatives)

• Regulatory change with health care provider and patient education and engagement worked in Denmark (combined mechanisms)

• Policies that target valued privileges are more effective

• Strategies exist beyond de-listing
Actionable Steps

• What can you do?

• The patient must be at the centre of any policy change

• Ensure appropriate alternatives are available

• Regulation involving professional bodies may improve deprescribing guideline implementation

• Combined mechanisms may be required
  • Change in public opinion
  • Change in professional skills
  • Improved access to deprescribing guidelines
"I feel a lot better since I ran out of those pills you gave me."

For more information: Justin.Turner@criugm.qc.ca
Evidence-based Pharmaceutical Opinion

Evidence-Based Pharmaceutical Opinion

Date (dd/mm/yy):

To the attention of Dr. _______________________

Pharmacist name: ______________________

Address: ______________________

Tel: (____) Fax: (____)

Your patient, ______________________ (DOB dd/mm/yy), is currently taking

To treat his/her insomnia and/or anxiety. The use of sedatives-hypnotics is associated with an increased risk of falls, fractures and memory impairment and is not recommended in adults over the age of 65, safer alternatives may be considered. Your patient is at risk because: ______________________

Suggested alternatives: indicate all that apply:

☐ Provide information to this patient on cognitive behavioral therapy (e.g. download this brochure: http://www.csrgm.qc.ca/fichiers/pdf/sleep_brochure.pdf, see http://sleepwell.ca), which has been shown to be effective for the treatment of both insomnia and anxiety and helps patient with sedative-hypnotic discontinuation.

☐ Provide this patient with information on other behavioral changes to treat insomnia and anxiety such as relaxation exercises, managing eating habits, etc.

☐ I will consider adding an SSRI or SNRI at the next visit if required.

Note: These medications are also associated with falls in the elderly, but are preferred over benzodiazepines, non-benzodiazepine hypnotics and trazodone because of their lower risk profile. Beware: substitution with trazodone or any of the 2-drug hypnotics is not recommended.

☐ Implement and follow the 16-week tapering schedule for this patient (see next page).

☐ Please cease current prescription and switch to:

Medication: ______________________

Dose: ______________________

Refills: ______________________

☐ No change to current prescription

I certify that:

- This prescription is an original prescription
- The identified pharmacist prescribed the sole recipient
- The original will not be re-used

Physician: ______________________

No of license: ______________________

Date (dd/mm/yy): ______________________

Clinical guidelines:

- Older adults are at an increased risk for cognitive impairment.
- Sedatives-hypnotics increase the risk of falls by 50%.
- Fractures may be increased 2-fold even with FRN use and especially if other CNS agents are prescribed.
- Sedatives-hypnotics are also associated with an increased risk of motor vehicle crashes.
- May increase the risk of Alzheimer’s disease by 50%.

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EXPLANATIONS

- Full dose
- Half dose
- Quarter of a dose
- No dose

REFERENCES:

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