Moving deprescribing forward – what needs to happen so deprescribing becomes a routine part of health care?

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Tuesday, March 27, 2018.

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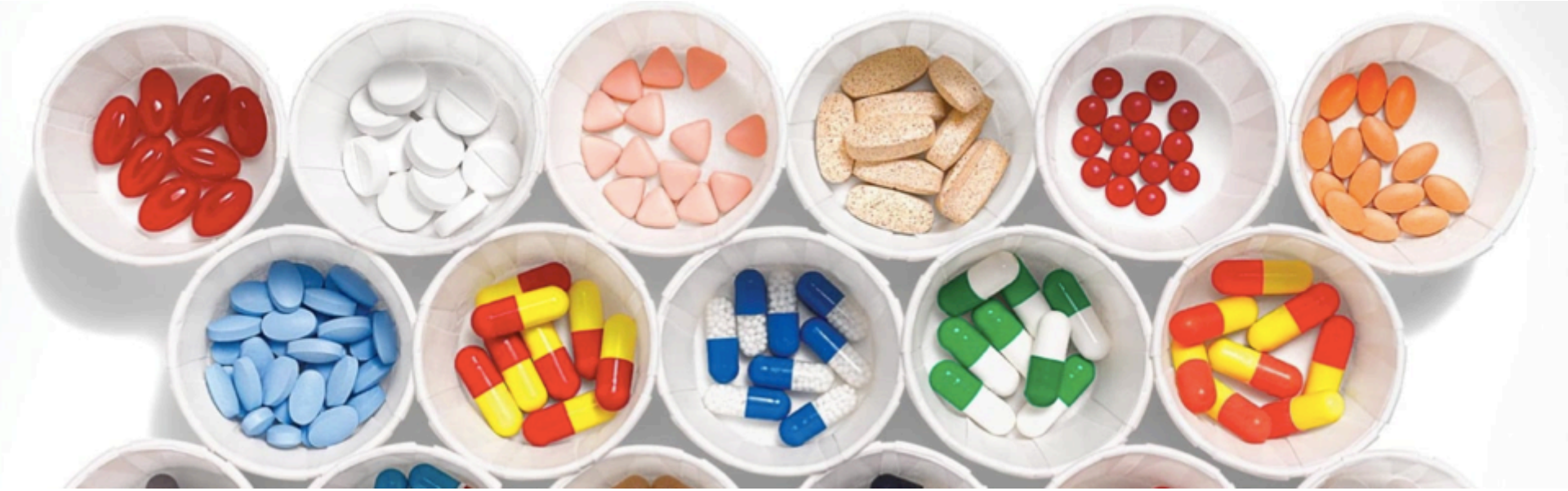
#deRx2018

Disclosures

- Alan Cassels has no conflicts of interest to declare



LEARNING OBJECTIVES….

Participants will be able to:

- Gain a better understanding of the scope of the challenges and where action at multiple levels is needed.
- Understand how important it is to 'make routine' the patient's perspective when attempting deprescribing.
- Understand some key systems-level barriers that continue to stymie our attempts to reduce polypharmacy

My perspective….

I've see polypharmacy viewed through three lenses:

- **As a Journalist**
- **As a Researcher**
- **And, most recently, as a family caregiver**

What have I learned?

- **By documenting and publicizing the problem?**
- **By interviewing clinicians and researching tools for deprescribing?**
- **From my experience with my own mother?**

Johanna Trimble, Vancouver

deprescribing.org

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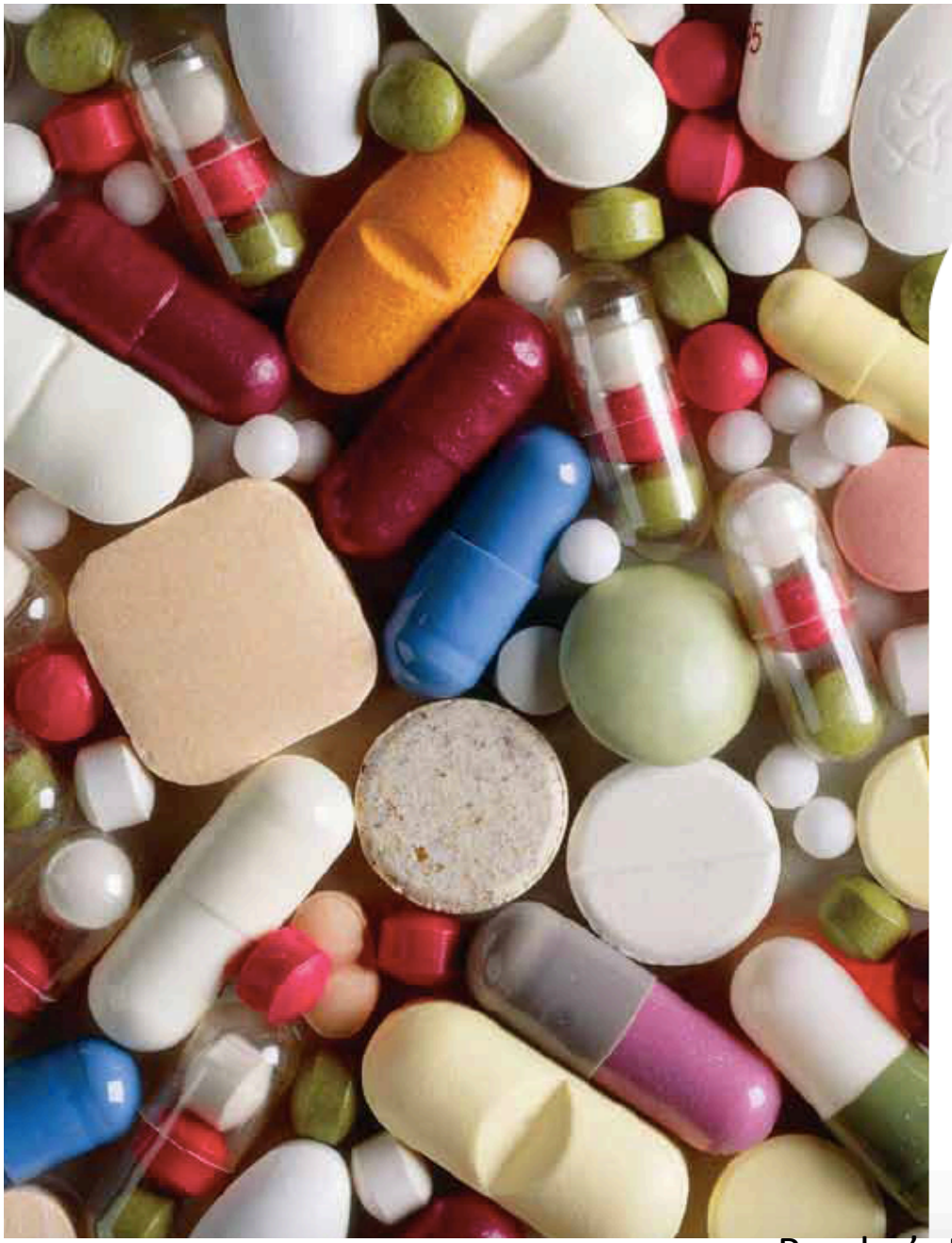

TOO MANY PILLS

Multiple-prescription drug use is on the rise among Canadian seniors. Are doctors too quick to prescribe medications to elderly patients?

BY ALAN CASSELS

Fervid Trimble was a contented, energetic 87-year-old who was enjoying life in a senior's residence in Seattle. With a daughter living nearby, and a son and daughter-in-law in Vancouver, she embraced her independence: She had her own apartment in the residence and was surrounded by her own belongings and a community of friends.

One morning, after waking up dizzy and disoriented, she was admitted to the building's health centre, a sort of in-house hospital, where doctors put her on several new drugs. That's when the real trouble began. Fervid's physical and mental health continued to deteriorate and as her hospitalization lengthened, her doctors added more meds to her regimen—digoxin for her heart, antibiotics for an infection and drugs for pain. Feeling lonely and isolated, she was also prescribed antidepressants and anti-anxiety pills. At one point she was on a total of nine different medications.

PHOTO: DEA/G.GIGOLINI/GETTY

Reader's Digest Canada, March 2011

Deprescribing: what are the clinician's barriers?

Tools?

Time?

Fear?

Understanding of others' prescribing

Complexity?

http://medstopper.com/

Is the drug for symptom relief?
Is the drug for long-term prevention?

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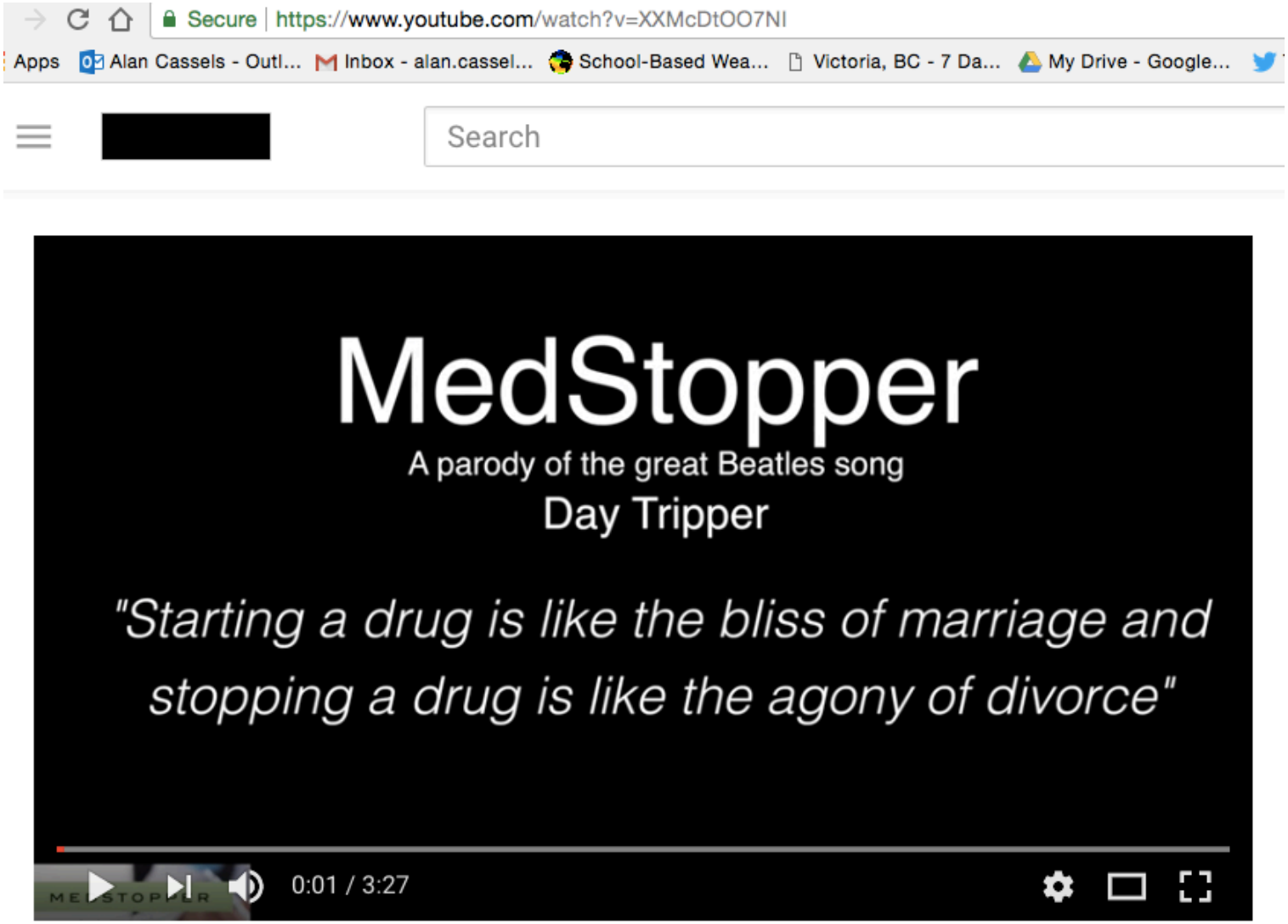

https://www.youtube.com/watch?v=XXMcDtOO7NI

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Cassels A. Eur J Hosp Pharm January 2017 Vol 24 No 1

'Can I stop even one of these pills?' The development of a tool to make deprescribing easier

Alan Cassels

While everyone might recognise the problems inherent in polypharmacy in the elderly, especially due to its many potential harms, there seems to be little consensus on how to reduce the medication burden on our older patients, and few tools to help clinicians initiate deprescribing.

The medical system often supports interventions and shared decision-making in the introduction of evidence-based treatments, yet the literature suggests that without a framework to support polypharmacy risk reduction activities, clinicians do not feel confident about initiating 'deprescribing.'

The prospect of deprescribing is fraught with considerable emotional and psychological stress for both practitioners and their patients. Previous studies[1–3] have shown that many patients believe they are taking too many medications, yet despite the belief, there are barriers to asking their clinician to reduce their number of prescriptions. Patients fear their clinician's response,[3] fear relapsing,[4] fear being

adherence, and improvement in quality of life".[8]

Interestingly, and perhaps more problematically, no comprehensive guidelines to date have been designed specifically to guide deprescribing. Deprescribing takes place in a relatively evidence-free zone. Why? There are no randomised controlled trials of adding or subtracting medications among patients taking multiple medications. Even if meta-analyses of trials prove drugs to be effective among younger, healthier patients, this may not translate into accurate predictions in how those drugs could benefit elderly polypharmacy patients. On the other hand, there is much clinical experience and several randomised trials showing improvements in functioning of polypharmacy patients after reducing the number of drugs they are taking.

While there are a number of resources that help clinicians identify specific medications that may have the potential to be inappropriate (BEERS, Drug Burden Index, Screening Tool of Older Persons' potentially inappropriate Prescriptions),

McCormack, a professor in the Faculty of Pharmaceutical Sciences at the University of British Columbia, was faced with a question by a local general practitioner (GP) whose 90-year-old very frail grandmother, at that time on 23 medications and vitamin supplements, asked: "Can I stop even one of these pills?" The GP did not know how to initiate the needed deprescribing exercise, so asked James' opinion.

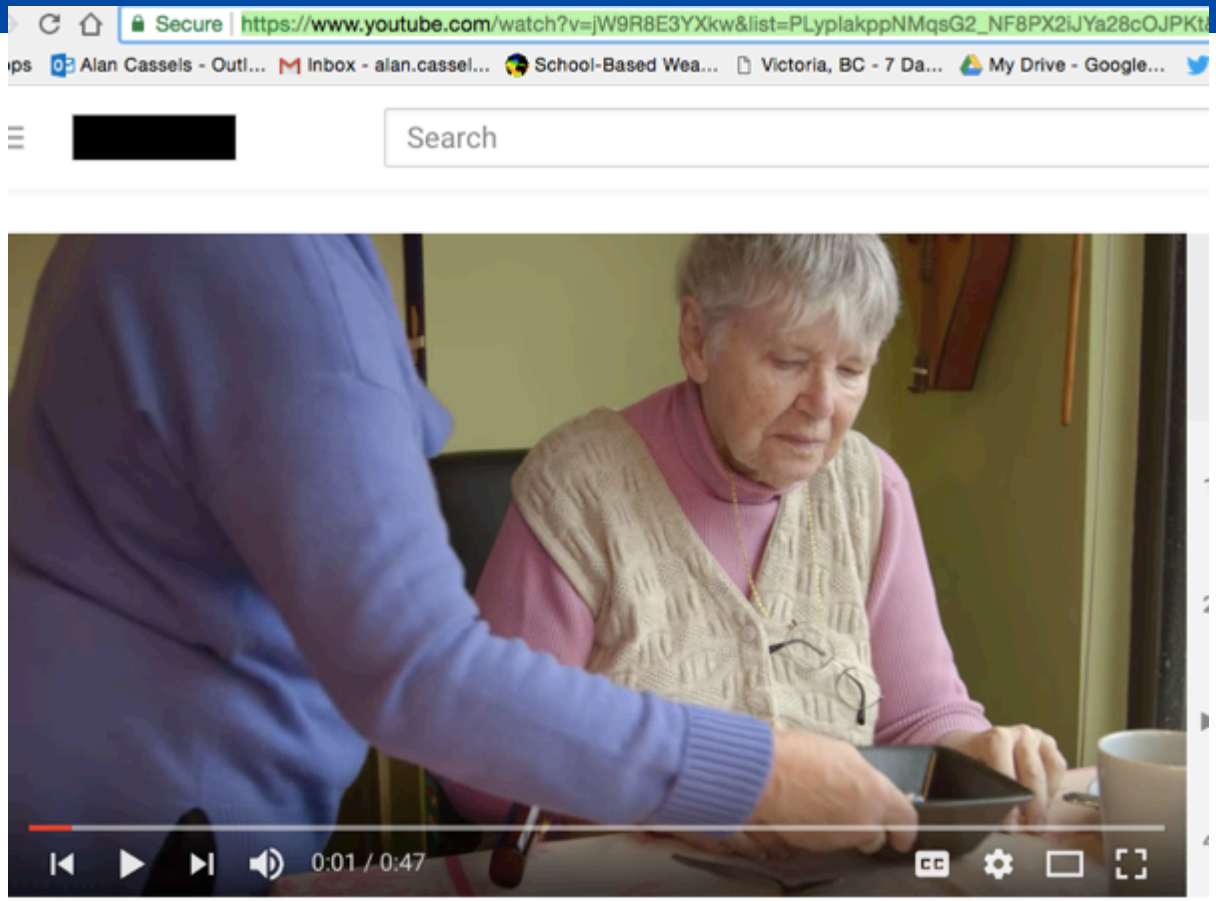
Solving this puzzle became the basis of MedStopper.

James proposed that the basis of MedStopper should be a list of a patient's drug-indication pairs, roughly ranked from potentially most stoppable to potentially least stoppable, with concise displays of the rationale (and evidence if available) for their ranking: a combination of indirect evidence from trials among healthier patients and clinical judgement of experienced deprescribers.

We created a draft MedStopper webpage to demonstrate the functions that we envisioned. The goal was to allow busy users, with a minimum of keystrokes, to select a patient's medications and their indications, and quickly see a visual ranking of the medication-indication pairs based on effectiveness and safety: short-term impacts on symptoms, evidence of long-term improvements in outcomes and potential harms.

The webpage interfaced with a spreadsheet of approximately 400 medications

Public service announcement 1



A bowl of pills PSA 2

https://www.youtube.com/watch?v=jW9R8E3YXkw&list=PLypIakppNMqsG2_NF8PX2iJYa28cOJPKt&index=3

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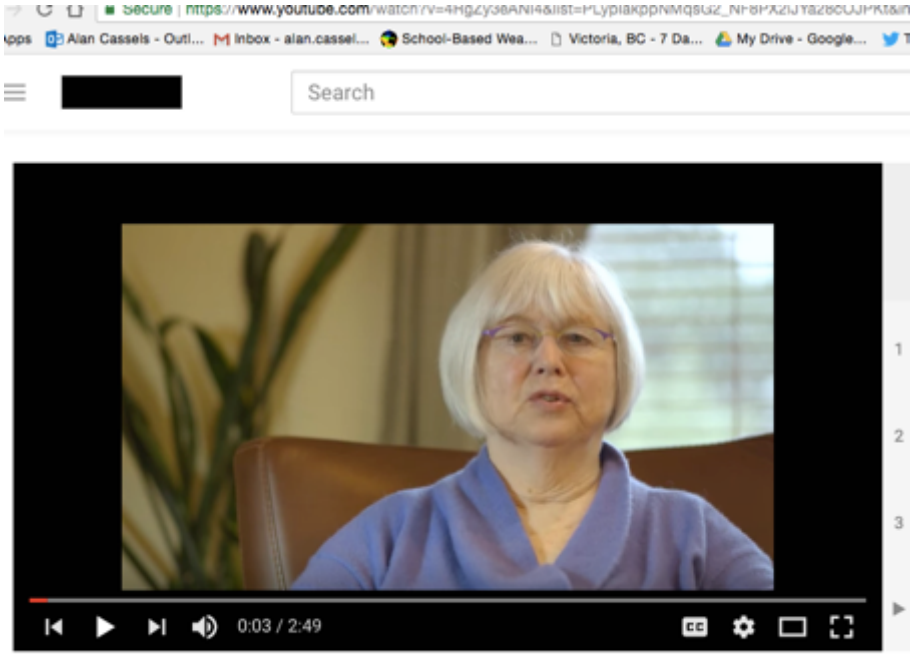
Public service announcement 2



https://www.youtube.com/watch?v=4RgZy3eANI4&list=PLypIakppNMqsG2_NF8PX2iJYa28cOJPKt&index=4

Joey Cassels

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Drugs that I helped her NOT start:

Atorvastatin
Donepezil
Ativan
Zopiclone
Terbinafine

As of Dec 8, 2017, my mom's meds:

1. Atenolol
2. Ramipril
3. Warfarin
4. Synthroid
5. Iron Supplement
6. Pantoprazole
7. Puffers: Atrovent, Salbutemol.

Why might clinicians and caregivers be reluctant to consider deprescribing:

- Don’t know why certain drugs were prescribed in the first place.
- Fear an increased/ unmanageable workload;
- Fear contradicting the order of colleagues or specialists, and;
- Find engaging elderly patients in discussing quality of life/ life expectancy difficult.

What are some system-level barriers to deprescribing:

- Insufficient time in regular primary care visits to stop and ask: Are these pills ultimately helping?
- Patriarchal systems enforcing concepts such as “compliance” or “adherence” / conformity to protocols.
- Medication monitoring systems designed to enforce medication taking.
- Transitions between hospitals and care facilities that almost always result in increased pill burdens or medication uncertainty.
- Pharmacy systems rewarded for filling scripts not reducing them.
- Coverage policies, software and dispensing systems that don’t tolerate trials or hesitancy.

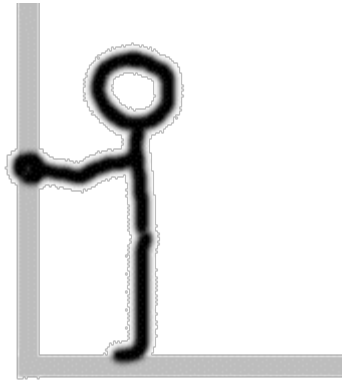
One of the key barriers to deprescribing: FEAR

- Fear of upsetting the status quo: “You mean I can ask to stop taking these drugs?”
- Fear of challenging the authority of prescribers: “What if I make my doctor angry?”
- Fear about questioning the ‘rightness’ of so many drugs: “Surely the doctor knows what she’s doin?”
- Fear of upsetting the specialist: “Surely the specialist knows what he’s doing?”

Ultimately patients are in charge and they need to be:

- **Encouraged to ask questions**
- **Encouraged to say “stop” or “wait” if they feel uncomfortable.**
- **Encouraged to accept that prescribing is a continuum where “drug holidays” are normal.**
- **Accepted if they have the courage to say “no thanks”.**

What I spend most of my time doing….



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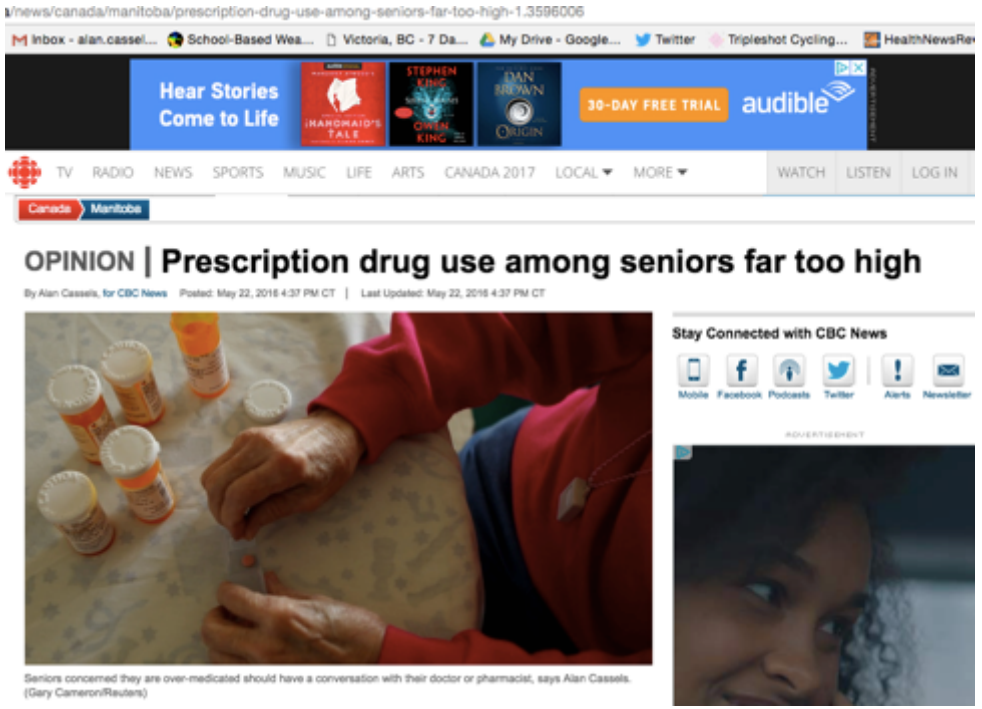

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