

HCCIntelligence™ present
Medication Management: The Art of De-Prescribing

Q) Can you define what multi complexity is?

A: The National Quality Forum defines multi complexity as two or more chronic conditions collected and that have an adverse effect on the health status of the patient. In terms of function, or the quality of life that requires complex health care management, coordination, or decision management.

Q) Deprescribing guidance for patients who have been on ppi long term without associated diagnosis:

A: Formal guidelines, there are a lot of expert options on deprescribing, as you can imagine doing formal studies are very difficult. What we have learned from doing the research is that if you cannot find a clinical indication why a patient is on a proton pump inhibitor (ppi), you can reduce the patient's current ppi by ½ every 7-10 days until they get to the lowest possible dose, and if they continue to do well, to discontinue. It is important to make one change medication at a time and give some advice in terms of anticipatory guidance type questions – what they may experience and how they can reach out to you in case they experience an adverse deprescribing reaction. Another approach is when the patient is on the lowest dose, take it every other day for a few weeks. The reason for that is the patient can have a hyper-acidic response if you suddenly stop it because you have been suppressing their acid.

Q) How soon do you follow up with a patient after a change in medication?

A: It depends on the medication, the patient's personality and their needs, would like to hear from them if any medication is going to be dose reduced, and changes that are occurring for the patient. It does not need to be a personal visit; a phone call is also sufficient. It is the stop-criteria that has guidance on certain medicines that need to be weened off and the schedules that need to be followed.

Q) How do you deal with the patients and families who seem to have an emotional attachment to medications? Many patients literally fear deprescribing medications.

A: Many patients are attached to their benzodiazepine – that is the one drug that is often very difficult to de-prescribe. It is an ongoing discussion with the patient. Try to not make statements but ask open ended questions. For example: what do you see as a potential problem; what are your concerns; and what are your fears? This allows for follow up questions and keeping the dialogue going so you can find an “entry point” for a compromise. There are some patients that are so attached to XYZ medications that they will not budge, but you can document your interactions about habituation, falls, tolerance, etc. Take time to review their medications, to go over it with them, and to let them know that you are not automatically clicking the refill button without thought. It does not have to be permanent. You try but if symptoms return or worsen, you can always go back up. Be available to answer their questions and concerns so that you can address the appropriately and if needed you can go back. It demonstrates thinking and thoughtfulness in caring for our medically complex patients.

Q) Why are providers reluctant to de-prescribe?

A: There could be several challenges in terms of not wanting to de-prescribe. 1. I don't want to rock the boat, if there is not a problem then I do not want to cause one. 2. Time – de-prescribing as you can imagine talking it over with the patient and so forth takes time. 3. We are guideline people; we like to follow rules of the road. With regards to de-prescribing there is no one set guideline as to how to approach it. We should make patients prove that they need every medicine. Often because patients have multiple hospitalizations, multiple specialists, that prescribe multiple medications, but no one takes ownership and that is what we do in home-based primary care. We usually end up being the provider because often they cannot get to other providers. Another barrier may be communication, language, cogitation, or many of our patients have a history of multiple conditions. An inhaler may have been prescribed by a pulmonologist, heart medication by a cardiologist, vitamins or supplements by a nephrologist, and then the question is who is responsible for taking all these medications and deprescribing.

Q) We know that physician burn out is incredibly common and damaging, but why do you think it remains such a taboo subject?

A: It is not just providers, but also clinicians, NP, RNs, etc. keep going taking care of patients often forgetting to take care of themselves. There is a concern that if you show a burnout state that people might perceive you as weak or it would be reported to the state. It is important to talk to all those involved in the care of patients about sharing their worries and their struggles because while we want to be those who can take care of business. But those who are “injured” or “broken” can often provide better care because they also show a human side and can identify with the struggles that patients have. We also have a webinar on the HCCIntelligence page that can provide supporting information: [CLICK HERE](#)

Q) To follow up on the family/patient desire to remain on medication not necessary, what can you offer for guidance on de-prescribing rivastigmine topical patch in a patient with advanced dementia? It is much easier to reduce oral medications.

A: It is important to talk to the family about what the medication is prescribed for and the efficacy that it is going to be meaningful for the patient. Regarding medications for dementia, the family may believe that stopping the medication for the dementia that the patient will decline rapidly, and we are hastening their death. Ask the patient or family what their concerns are. Patches may come in smaller mg doses that will allow the patient to reduce the medication slowly over time. It is important to help the family and patient understand that these medications are not curative. The medications, whether a pill or patch, will not cure the disease. The margins of benefit are modest at best, and it is not something that will make a dramatic impact in their lives. Ongoing dialogue, bringing the medication down slowly by patch or pill, and don't be afraid to research additional information to help make an educated decision.

Q) What are some strategies that you can recommend or that you have used that you have found to be successful for burnout?

A: There are two approaches. One is a system approach. Look at your workflow and the demand that is placed on you and your staff. What can you do with your health care provider to help lessen the load that is placed on you and your staff? The second is within your office. Within the office, if staff is feeling disempowered, having no voice can contribute to this. Have regular meetings with everyone in the office to voice concerns, to share their ideas, how to improve the office and the care for our patients. There is also a personal level. Keeping a limit on working; take advantage of time at home; make sure you get enough sleep; make sure you exercise; and connect to something that is bigger, something that is more than data entry and meeting the needs of patients and their families. From the management perspective, help everyone to feel empowered and be responsive and supportive to what they are bringing to you. Give time to recognize everyone on the team, recognize the human side of your team, and help to build a positive culture of excellence in caring.

Q) What are the recommendations of de-prescribing antipsychotics?

A: It is recommended to visit the deprescribing.org website to provide your examples when a trial period has been used on a patient. In terms of a protocol, this website will help give insight into how it is done.

Q) Which formula do you use to calculate renal dosing of medications?

A: Often when our metabolic panel comes back, we see the EGFR, and yet when we look up our favourite apps regarding dosing and medications it is reported as creatinine clearance. Two things – the traditional gold standard is creatinine clearance. There is an app where you can put in the patient's height, weight, age and their creatinine and it will give you a creatinine clearance based on the formula. If you look at a medication such as metformin which is used for diabetes it is reported as EGFR. That is because when the drug companies did the studies it looked at EGFR reading versus creatinine clearance. Bottom line use the creatinine clearance as the gold standard but reference your favourite apps to see what dosing is recommended from the manufacturer and if it was done using EGFR or creatinine clearance.