The Art of the Edit:

Collaborative De-prescribing and Symptom Management in Long-Term Care

Megan Dunay MD, MPH; Julie Brown PharmD; Lenny Jensen MSN-FNP-C

Introduction – Redefining Care Goals

The Core Message: Moving from "cure at all costs" to "comfort as the priority."

- **The Challenge:** Residents in SNFs/ALFs often have 5+ chronic conditions and take an average of 9–12 medications daily.
- **The Opportunity:** Integrating Palliative and Hospice care isn't about "giving up"; it’s about **tailoring care** to the patient’s actual life goals.
- **The Setting:** How these services bridge the gap between facility staff, families, and outside specialists.

Palliative Care – The "Extra Layer" of Support

The Core Message: Specialized medical care for people living with a serious illness, available at any stage.

- **Symptom Management:** Focuses on pain, shortness of breath, fatigue, and nausea.
- **Concurrent Care:** Unlike hospice, residents can still pursue curative treatments (e.g., physical therapy or specific surgeries).
- **Medication Review:** The palliative team acts as a "pharmacological filter," identifying drugs that no longer serve the resident's quality of life.
- **Benefit to Facility:** Reduces unnecessary hospital readmissions (ER transfers) by managing crises in-house.

Hospice Care – Quality at the End of Life

The Core Message: Compassionate care for those with a prognosis of 6 months or less.

- **The Holistic Pivot:** Shifts focus entirely to comfort, dignity, and family support.
- **Regulatory Support:** Hospice providers bring extra eyes (RNs, aides, social workers) into the SNF/ALF, easing the burden on facility staff.
- **Grief & Spiritual Support:** Extends care to the family and facility staff, who often form deep bonds with long-term residents.

Medication & "Med Burden" Management

The Core Message: De-prescribing is a clinical intervention, not a withdrawal of care.

- **The Burden of Polypharmacy:** High pill counts lead to falls, cognitive impairment, and decreased appetite.
- **Strategic De-prescribing:**
  - Discontinuing "preventative" meds that take years to show benefit (e.g., statins or aggressive tight glucose control in the elderly).
  - Prioritizing medications that offer **immediate** comfort.
- **Alternative Routes:** Moving from pills to patches, liquids, or concentrated drops to help those with swallowing difficulties (dysphagia).

Implementation & Quality Outcomes

The Core Message: Better care leads to better data and happier families.

- **Shared Decision Making:** Using Palliative/Hospice experts to facilitate "The Talk" regarding DNR/DNI orders.
- **Facility Benefits:**
  - Improved **Quality Measures** (Pain management scores).
  - Decreased medication waste and lower pharmacy costs.
  - Higher family satisfaction ratings.
- **Conclusion:** By reducing the "chemical fog" of over-medication, we allow residents to be more present with their loved ones.

How to make it happen: Prognostication

The Core Message: De-prescribing requires prognostication.

- **Understand mortality risk:** lifespan
- **Understand morbidity risk:** healthspan, functional status
- **Tools:**
  - **eprognosis.ucsf.edu**
  - Prognostic tools perform better than clinicians
  - Tools must be appropriate for clinical setting, e.g. SNF vs. home
- **Conclusion:** Time horizon to benefit should drive de-prescribing choices

How to make it happen: understand indications

The Core Message: All medications must have a clinical indication.

- **Understand what each medication is treating:**
  - Ensure diagnoses are still accurate and relevant
  - Understand the difference between treating symptoms and preventing disease progression
  - Use prescribing guidelines
- **Understand which conditions require medications:**
  - Not all clinical conditions require medication
  - Connect time horizon to benefit to patient’s prognosis
- **Conclusion:** De-prescribe medications if not indicated

How to make it happen: understand risks

The Core Message: Honor risks as legitimate and contextualize risks in prognosis.

- **Medication intolerance:**
  - Discomfort can be caused or exacerbated by medications
  - Consider allergies and sensitivities
  - The route of administration must be realistic e.g. crushed in dysphagia
- **Adverse outcomes:**
  - Falls, falls with injuries
  - Bleeding
  - Delirium
- **Conclusion:** Time horizon to harm should drive de-prescribing choices

How to make it happen: STOPP-Frail

The Core Message: this is a validated instrument for making prudent de-prescribing choices

- STOPP-Frail comprises 27 criteria for potentially inappropriate medications in frail older adults with limited life expectancy.
- STOPPFrail may serve to assist physicians in deprescribing medications in a structured fashion in this group.
- STOPPFrail can be applied in frail older adults with limited life expectancy in any healthcare setting.

Reference: Authors : Hanora Lavan, A., Gallagher, P., Parsons, C., & O'Mahony, D. (2017);

Our typical geriatric patient: Where do we even start…

- Clopidogrel 75 mg
- Atorvastatin 40 mg
- Apixaban 5 mg
- Glimepiride 2mg
- Metformin 1000 mg
- Amlodipine 5 mg
- Bupropion SR 100mg
- Amiodarone 200 mg
- Zolpidem 10 mg
- Famotidine 40 mg
- Fentanyl 75 mcg
- Gabapentin 600 mg
- Hydrocodone/APAP 10/325 mg
- Ipratropium/Albuterol
- Isosorbide ER 30 mg
- Loperamide 2 mg
- Nitro Tabs 0.4 mg
- Mexiletine 150 mg
- Tiotropium 18 mcg
- Tamsulosin 0.4 mg
- Omeprazole 20 mg
- Trazodone 50 mg
- Lidocaine patch 4%
- Preservision
- Vitamin D
- Multivitamin
- Hair Skin and Nails
- Vitamin E
- Ginkgo
- Tylenol
- Loratadine
- Cinnamon
- NAC
- Albuterol
- Fiber capsule
- Melatonin
- Glucose monitoring kit

➔ JD is a 78 year old male new admit

➔ COPD, Post MI, Chronic Pain, HTN, Depression, GERD, IBS, Urinary Frequency, Insomnia, Diabetes

➔ They arrive to community with duffle bag of medication they have partially been taking at home, expired, and mixed bottles

It is systematic and proactive in approach: de-prescribing

The Core Message: Polypharmacy and Potentially Inappropriate Medications (PIMs) account for the majority of preventable adverse drug events (ADE)

- **Polypharmacy:**
  - Concurrent use of > 5 medication
  - Higher risk of falls, cognitive impairment, hospitalisation and all cause death
- **Potentially Inappropriate Medications (PIMs):**
  - Identifying gaps in prescribing approach (4 in 5 patient in nursing homes)
  - Comorbidities, Renal impairment, Multiple Prescribers, Geriatric age, medication interactions
  - Medication with higher potential risk than benefits
- **Evaluation:**
  - Upon admission- signed med list
  - Yearly- minimum

Conclusion: Patient should be assessed by collaborative approach for medication de-prescribing in a proactive manor.

Tools to narrowing approach: Highest risk patients

The Core Message: Systematic approach is needed for both prescribing and de-prescribing

- **Tools for assessment:**
  - START (screening tool to alert right treatment)
  - STOPP (Screening tool of older people's prescriptions)
  - Beers Criteria
  - Medication Appropriateness Index
  - Pharmacist medication utilization review
- **Financial Burden:**
  - Over The Counter (OTC)
  - High copays
  - Brand name medications
  - Excessive medication, multi-daily dosing

Conclusion: There are multiple ways all care modalities can intervene and be good steward of de-prescribing

Pharmacist’s Applied Approach: Plan

The Core Message: Simple changes can make a large impact on patient care

- **What medication should we consider stopping first?**
  - Drug without indication
  - Medication that are ineffective -Do not add too
  - Drugs to treat drugs
  - Short-term use
  - High risk medications
  - Medication that do not increase quality of life
- **Chronic Care Management: Multidisciplinary**
  - Utilized a provider that provides a collaborative practice approach to de-prescribing
  - Follow through with recommendations

Conclusion: Come up with a medication target for your community then; plan, utilize, follow up

Go to Medications: Let’s not miss these!

The Core Message: Understand medication commonalities

- **High risk medications:**
  - Anticholinergic
  - Benzodiazepines
  - Chronic PPI Usage
  - Over the Counters
  - Anticoagulants
  - Antipsychotic
  - Antihistamines
  - Multiple PRN with same indication
  - non-use in the last 6 months
  - Subtherapeutic doses
  - Other

Conclusion: Understand the key medications in de-prescribing can make us an advocate for our patients.

Individualized de-prescribing: What does the data support

The Core Message: Risk and benefit will change as patient ages, de-prescribing is a ongoing process

- **Medications without data in patients over 75 years of age**
  - Outcomes data is limited
  - Fall vs intended effect
  - OTCs
- **Prescribing Cascade:**
  - Treating the side effect… Not the disease state
- **Drug-Drug escalation:**
  - Increase medication= Increase medication (Carbidopa/Levo and Antipsychotics)
- **Use your pharmacy team!!**

Conclusion: The hamster wheel.. Follow up, follow up, follow up