Identification and De-prescribing of High-Risk Medications for Older Adults in the Community Pharmacy Setting

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Key Findings

- Implementation of a pharmacist-led program for the de-prescribing of high-risk medications can be successful with adequate resources, training, and staffing.
- Patient education on high-risk medications should be incorporated in community pharmacy workflow to encourage the de-prescribing of potentially dangerous medications.
- De-prescribing high-risk medications is a collaborative and ongoing effort between patients and providers, including pharmacists.

Background

- High-risk medications are a serious public health concern with older adults having more risks.
- High-risk medication minimization is a quality measure for CMS.
- Community pharmacists are ideally positioned within the healthcare team to make a difference in prescribing habits.
- The D-PRESCIBE Randomized Clinical Trial demonstrated that patient and provider education is effective at reducing high-risk medication dispensing in Canadian pharmacies.[1]

Methods

Setting: Progressive Iowa independent pharmacy with a proprietary clinical documentation system
Design: Descriptive study
Timeline: October 1st 2019- January 31st 2020
Exclusions: Hospice, non-English speaking
IRB: Quality Improvement

Objectives

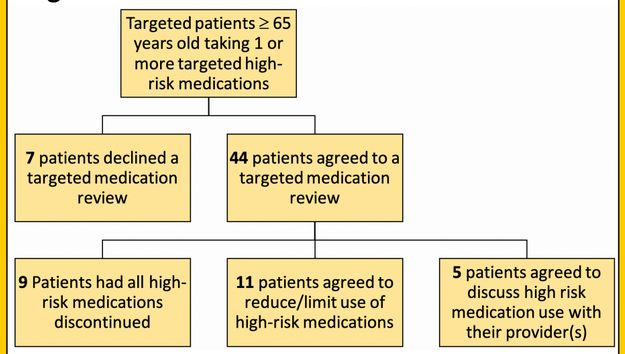
1. Implement a de-prescribing program in a community pharmacy and provide education for patients.
2. Assess integration of a de-prescribing service into workflow in a community pharmacy.
3. Create targeted medication management interventions for older adult patients on high-risk medications to recommend to patient's provider(s).

Implementation

Figure 1: Workflow

1. Counseling note placed in will-call bag of patients identified during DUR
2. Patient presents to the pharmacy and is offered a targeted medication review
3. Patient counseled and education on risks of identified medication and informed of alternatives
4. Recommendation to start alternative sent via fax to provider (if applicable)

Figure 2: Patient inclusion



Results

Table 1: Patient Demographics/Results	
Patient encounters	44
Age, mean	76.39
Female (%)	24 (54.5)
Total Meds, mean	5.8
High-risk medications, mean	1.14
ADRs Confirmed (%)	10 (22.7)
SOAP notes faxed (%)	32 (72.7)
Physician response (%)	14 (43.8)
Time spent with patient, mean	7.8 min
Agreed to talk with provider (%)	10 (22.7)
Agreed to reduce use (%)	16 (36)

Figure 3: Proportion of identified medications

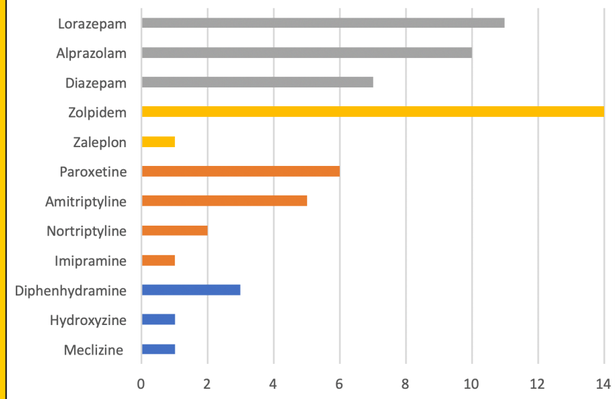


Table 2: HRM results	
Total number of HRMs	50
Scheduled HRMs (%)	17 (34)
HRM discontinued (%)	12 (24)

Discussion

Implementation

- Patients identified during DUR were counseled at point of dispensing and providers were faxed if patient agreed.

Discussion

- Custom-designed clinical software aided in the identification of patients.
- Patients who planned to follow-up with their providers were not followed-up with, allowing doctors to change therapy without being reflected in this study.
- Medications identified have significant risk of sedation, which may contribute to fall risk.
- Ten patients self-reported experiencing 1 or more ADR associated with the HRM.
  - Presence of ADRs did not appear to be associated with successful intervention.
- Most common reasons for a patient to decline intervention was significant other picking up medications and patient being accompanied by family members.

Learnings/Experiences

- Private counseling area preferred, especially for discussing psychiatric medications/conditions.
- Adequate pharmacist staffing necessary to allow for roughly 5 minute educational appointments.
- Identification of patients/medications should be standardized and convenient for pharmacists.

References

1. Martin et al. D-PRESCRIBE Randomized Clinical Trial. *JAMA.* 2018;320(18):1889-98