Best Practices for Polypharmacy and Deprescription

**Purpose:** Provide PALTC providers with practical and evidence-based resources on deprescription to address polypharmacy.

**Definition:**
- Deprescription is the process of intentionally stopping a medication or reducing its dose.
- Deprescription is appropriate when the drug may be causing harm, is no longer providing benefit, or is no longer appropriate for the situation.

**Steps:**
1. Create medication list for patient through process of medication reconciliation.
2. Align medications with proper indications.
3. Clarify expectations and outcomes for each medication with patient and family caregiver.
4. Identify issues related to medicines such as effectiveness, adherence, side effects and cost.
5. Identify medications that need to be deprescribed and then prioritize for deprescription based on the following factors: patient preferences, potential benefits, potential harms, interaction with other medicines/disease state.
6. Develop deprescription strategy. It can be gradual weaning or abrupt discontinuation depending upon medication class and disease state.
7. Communicate deprescription plan to patient and family caregiver and implement plan based on shared decision making.
8. Develop contingency plan in case symptoms emerge or recur.
9. Continue to monitor patient for adverse effects, recurrence of symptoms, and withdrawal symptoms.
10. Make follow up plans to ensure any concerns are addressed timely.

**Practical Tips for Successful Deprescribing:**
1. Possible categories of medications to discontinue:
   a. Medications that are often unnecessary, provide no to minimal clinical benefit.
   b. Medications often discordant with goals of care and potential time to benefit.
   c. Medicines that are no longer indicated.
2. Deprescription does not always mean discontinuing and can include following strategy:
   a. Reduce frequency of dosing.
   b. Changing from short acting to long acting/extended release formulation if appropriate.
3. Monitor symptoms: Communicate with interdisciplinary team to monitor for certain symptoms and to offer non-pharmacological solutions and alternate (safer) pharmacological solutions if needed.

4. Develop plan to restart medication in a low dose if symptoms re-emerge and are not able to be managed with nonpharmacologic measures or alternative (safer) medications.

5. Communicate with health care team:
   a. If you are not the primary provider, any deprescription intervention should be communicated with primary care provider.
   b. Communicate with provider who initially prescribed medications to discuss concerns regarding medication use and to discuss deprescription strategy. For example:
      c. Communicate with patient's cardiologist to discuss possible risk of antiarrhythmics in frail older patient and develop mutually agreeable alternative solution to offer patient in place of antiarrhythmic.

6. Toolbox
   a. Beers Criteria
   b. Screening Tool of Older Persons Prescription (STOPP) and Screening Tool to Alert Doctors to Right Treatment (START) criteria
   c. STOPP FRAIL and STOPP for US Nursing Homes
   d. Anticholinergic Burden Scale (ACB)

References:

- Amanda Hanora Lavan, Paul Gallagher, Carole Parsons, Denis O'Mahony; STOPPFrail (Screening Tool of Older Persons Prescriptions in Frail adults with limited life expectancy): consensus validation, Age and Ageing, Volume 46, Issue 4, 1 July 2017, Pages 600–607, [https://doi.org/10.1093/ageing/afx005](https://doi.org/10.1093/ageing/afx005)
- [https://deprescribing.org/](https://deprescribing.org/)