WORKSHOP: MEDICATION CONVERSATIONS TO REDUCE FALLS IN GERIATRIC PATIENTS

2018 Winter Refresher Workshop
Wednesday January 31, 2018
1:30-3:20 pm

1

Medications and Falls

2

MEDICATION CONVERSATIONS
THE PRIMARY CARE PHYSICIANS' PERSPECTIVE AND KEY ROLE FOR PATIENTS ≥ 65 YEARS

This course is a statewide effort among 3 members of the Wisconsin Geriatric Education Center (WGEC) :

- **Aurora Health Care**
- **Medical College of Wisconsin**
- **University of Wisconsin – School of Medicine and Public Health**

This course is Supported in Part by a HRSA Geriatrics Workforce Enhancement Program award to WGEC – Marquette University with a Subcontract to the Medical College of Wisconsin [HRSA Grant # U1QHP28712].

3

Collaborative Effort for PI-CME and/or Part IV MOC Portfolio

Presenting Today

- Edmund Duthie, Jr, MD
- Kathryn Denson, MD
- Deb Simpson, PhD

Managing

- Judy Myers

Support PI-CME/Part IV

- Liz Heimerl-Rolland
  - MCW
- Terry Frederick
  - Aurora Health Care
- Barb Anderson
  - UWSOMPH

4

Disclosures

- Dr. Duthie is a consultant to the American Board of Internal Medicine.
- No other faculty, presenters, planners, or anyone controlling content has any relevant financial relationships to disclose.

WISCONSIN GERIATRIC EDUCATION CENTER

5

Our Objectives Today

1. **Recognize the role primary care physicians** play in the deprescribing of benzodiazepines, non-benzodiazepine hypnotics, and diphenhydramine to geriatric patients.
2. **Link the use of** benzodiazepines, non-benzodiazepine hypnotics, and diphenhydramine to **falls** among geriatric patients.
3. **Identify barriers** and biases related to initiating medication deprescribing discussions in the primary care setting.

6

Our Objectives Today

4. **Cite evidence that brief patient education** on medication and falls can increase patients' willingness to taper/discontinue use of benzodiazepines, non-benzodiazepine hypnotics, and diphenhydramine *
5. **Educate geriatric patients** re: likelihood of benzodiazepines, non-benzodiazepine hypnotics, and diphenhydramine being associated with falls and their consequences as impacting patients' **function and quality of life**. **

* **Markota M, Rummans TA, Bostwick JM, Lapid MI.** Benzodiazepine use in older adults: dangers, management, and alternative therapies. In Mayo Clinic Proceedings 2016 Nov 30 (Vol. 91, No. 11, pp. 1632-1639). Elsevier.

Tinetti ME, McAvay GJ, Fried TR, Allore HG, Salmon JC, Foody JM, Bianco L, Ginter S, Fraenkel L. Health outcome priorities among competing cardiovascular, fall injury, and medication-related symptom outcomes. Journal of the American Geriatrics Society. 2008 Aug 1;56(8):1409-16.

** **For those who are interested and affiliated** with one of co-sponsors, you may launch your Part IV / PI CME activity – the workshop completes "A" or baseline

7

Medication and Falls

8

Today's Session Flow

- Explore Medications and Fall Risks
  - Complete Quiz
  - Debrief Interactively
- Set your Aim *****
- Key Features of Medication Discussion
  - Barriers
  - Initiating a discussion/scripts and practice
- Q&A *or* Part IV or PI-CME Launch
  - Q&A with presenters *or*
  - Meet with respective CME Providers *****

*** For those who are interested and affiliated** with one of co-sponsors, you may launch your Part IV / PI CME activity – the workshop completes "A" or baseline

9

Your Turn – Check Your Understanding: The Role Of PCP in the tapering/ discontinuation of benzodiazepines, non-benzodiazepine hypnotics, and diphenhydramine in patients ≥ 65 years old

Quiz

10

Debrief Quiz Q1-2

1. **One in ____ adults 65 years or older fall each year.**
   a. 12 (8% fall rate)
   b. 10 (10% fall rate)
   c. 6 (17% fall rate)
   d. 4 (25% fall rate)
   e. 3 (33% fall rate)
   f. 2 (50% fall rate)
2. **More than 95% of hip fractures are caused by falling, usually by falling sideways.**
   a. True
   b. Unsure
   c. False

11

Debrief Quiz Q3-4

3. **Up to one-third of patients with a hip fracture die within one year of their fracture.**
   a. True
   b. Unsure
   c. False

4. **A fall can take away what matters most to older adults including independence as 50% of fallers decrease social and physical activity with a 3-10 fold increased risk of ending up in a nursing home.**
   a. True
   b. False

12

Debrief Quiz Q5-6

5. Psychiatrists prescribe the largest absolute number of long-term benzodiazepines.

a. True
b. False

6. Benzodiazepines are associated with a *statistically and clinically significant increase in risk(s)* for falls and fractures.

a. True
b. False

13

Debrief Quiz Q7

7. Barriers to PHYSICIAN deprescribing (Check all that are <u>true</u>)

A. Worry about stopping medication(s) started by others
B. Limited knowledge regarding how to stop medication (taper process)
C. Concern about medication withdrawal effects
D. Lack of resources including limited time and decision to focus on other important medical issues
E. Fear of jeopardizing doctor-patient relationship
F. Unwillingness to question other colleagues' prescription rationales
G. Finding non-pharmacologic approaches to manage symptoms

14

Debrief Quiz Q8

8. Barriers to PATIENT deprescribing associated with falls (Check all that are <u>true</u>)

A. Lack of awareness that deprescribing is possible
B. Lack of understanding why a medication should be discontinued including potential adverse effects
C. Perceptions that falls are inevitable with aging
D. Less than 505 of older adults who fall discuss the fall with their health care provider
E. Lack of perceived support from healthcare provider to deprescribe

15

Barriers: Initiating conversations about falls and benzodiazepines, non-benzodiazepine hypnotics, and diphenhydramine

16

Debrief Quiz Q9-10

9. Over 2 out of 3 older adults believe that medications are necessary to improve health AND would like to reduce their current medication use.

a. True
b. False

10. The most common reasons for physicians to prescribe benzodiazepine to older adults include (check all that are <u>true</u>)

a. Alcohol Dependence
b. Anxiety
c. Behaviors associated with Dementia
d. Depression
e. Insomnia

17

Debrief Quiz Q11-12

11. Convincing a patient to taper/discontinue benzodiazepines is unlikely to succeed.

A. True
B. False

12. Approximately 85% of older adults placed greater importance on reducing the risk of fall injuries and medication symptoms than on reducing the risk of cardiovascular events.

A. True
B. False

18

Debrief Quiz Q13-14

13. Educating patients about the potential risks of long-term benzodiazepine use in a effective first stop in tapering benzodiazepine use.

A. True
B. False

14. Focusing goals of care discussions for older adults on disease specific targets rather than quality of life (improved symptom management and function) positively influences patient's willingness to taper selected medications.

A. True
B. False

19

Debrief Quiz Q15

15. Less than one quarter of older adult patients who received a direct-to-consumer educational leaflet about benzodiazepine cessation will bring the topic up with their clinician.

A. True
B. False

20

Debrief Quiz Q16

- **16. What is your professional discipline?**
- ❑ Nursing (please specify: ❑RN ❑NP ❑CNS ❑LPN ❑DNP ❑PhD ❑Other
- ❑ Social Work
- ❑ Pharmacy
- ❑ Medicine (please specify: ❑Family ❑Internal ❑Geriatrics ❑Psych ❑Rehab ❑Other_____
- ❑ Physician Assistant
- ❑ Rehabilitation Therapy (please specify: ❑PT ❑OT ❑SPA ❑Respiratory ❑Other❑ Other (please specify):

21

Debrief Quiz Q17-18

- **17. Are you a faculty member** (full- or part-time) at any institution of higher education (including medical/health professions) school?
  A. Yes
  B. No

18. Do any of the following describe your employment location? *(Check all that apply)*
A. Primary care setting
B. Medically underserved area
C. Rural area
D. None; not applicable

22

Medications: What your patients are hearing

23

Significance of Falls

- According to the CDC, falls are the leading cause of both fatal and nonfatal unintentional injury among adults aged 65 or older in the US.
- One in three to one in four adults aged 65 or older fall each year.
- Falls account for >95% of hip fractures which can be deadly. Up to one third of patients with a hip fracture die within a year.

24

Medications and Falls in Primary Care

- Primary care physicians prescribe the largest absolute number of long-term benzodiazepines

- Benzodiazepine, non-benzodiazepine hypnotics, and diphenhydramine use tends to increase significantly with age.
  - Insomnia increases with age
  - Anxiety tends to decline with age

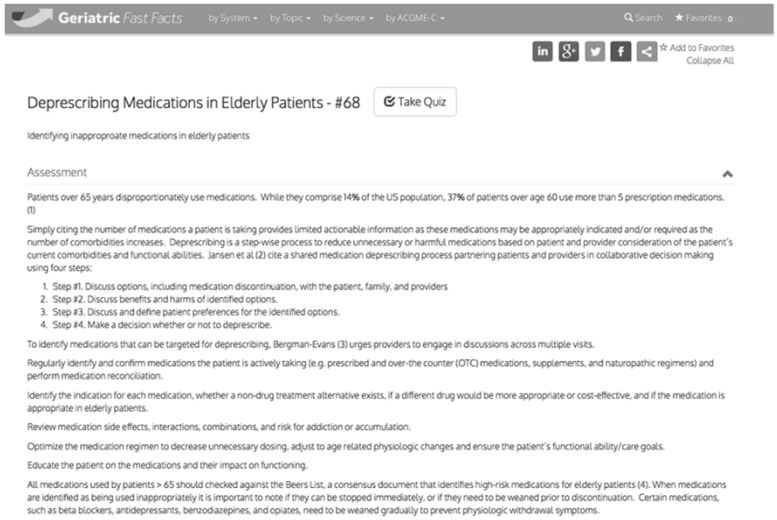
25

Resource – Geriatric Fast Facts

http://www.geriatricfastfacts.com/

26

Deprescribing Medications in Elderly Patients - #68



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Deprescribing Medications in Elderly Patients - #68 Take Quiz

Identifying inappropoate medications in elderly patients

Assessment

Patients over 65 years disproportionately use medications. While they comprise 14% of the US population, 37% of patients over age 60 use more than 5 prescription medications. (1)

Simply citing the number of medications a patient is taking provides limited actionable information as these medications may be appropriately indicated and/or required as the number of comorbidities increases. Deprescribing is a step-wise process to reduce unnecessary or harmful medications based on patient and provider consideration of the patient's current comorbidities and functional abilities. Jansen et al (2) cite a shared medication deprescribing process partnering patients and providers in collaborative decision making using four steps:

1. Step #1. Discuss options, including medication discontinuation, with the patient, family, and providers
2. Step #2. Discuss benefits and harms of identified options.
3. Step #3. Discuss and define patient preferences for the identified options.
4. Step #4. Make a decision whether or not to deprescribe.

To identify medications that can be targeted for deprescribing, Bergman-Evans (3) urges providers to engage in discussions across multiple visits.

Regularly identify and confirm medications the patient is actively taking (e.g. prescribed and over-the counter (OTC) medications, supplements, and naturopathic regimens) and perform medication reconciliation.

Identify the indication for each medication, whether a non-drug treatment alternative exists, if a different drug would be more appropriate or cost-effective, and if the medication is appropriate in elderly patients.

Review medication side effects, interactions, combinations, and risk for addiction or accumulation.

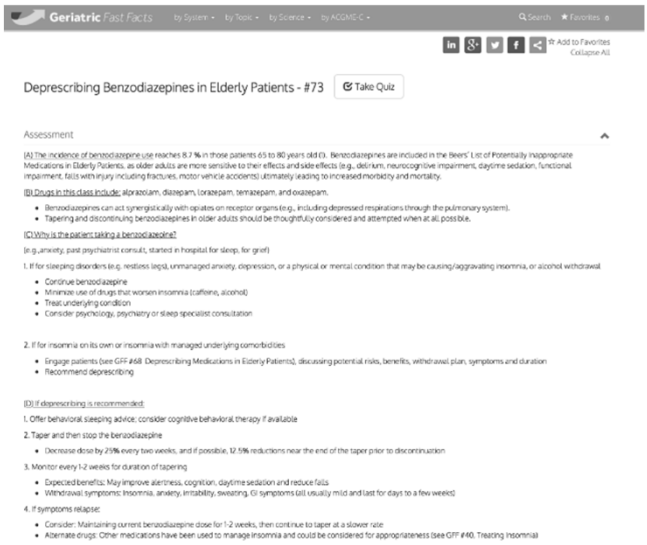
Optimize the medication regimen to decrease unnecessary dosing, adjust to age related physiologic changes and ensure the patient's functional ability/care goals.

Educate the patient on the medications and their impact on functioning.

All medications used by patients > 65 should checked against the Beers List, a consensus document that identifies high-risk medications for elderly patients (4). When medications are identified as being used inappropriately it is important to note if they can be stopped immediately, or if they need to be weaned prior to discontinuation. Certain medications, such as beta blockers, antidepressants, benzodiazepines, and opiates, need to be weaned gradually to prevent physiologic withdrawal symptoms.

27

Deprescribing Benzodiazepines in Elderly Patients - #73



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Deprescribing Benzodiazepines in Elderly Patients - #73 Take Quiz

Assessment

(A) The incidence of benzodiazepine use reaches 8.7 % in those patients 65 to 80 years old (1). Benzodiazepines are included in the Beers' List of Potentially Inappropriate Medications in Elderly Patients, as older adults are more sensitive to their effects and side effects (e.g., delirium, neurocognitive impairment, daytime sedation, functional impairment, falls with injury including fractures, motor-vehicle accidents) ultimately leading to increased morbidity and mortality.

(B) Drugs in this class include: alprazolam, diazepam, lorazepam, temazepam, and oxazepam.

- Benzodiazepines can act synergistically with opiates on receptor organs (e.g., including depressed respirations through the pulmonary system).
- Tapering and discontinuing benzodiazepines in older adults should be thoughtfully considered and attempted when at all possible.

(C) Why is the patient taking a benzodiazepine?

(e.g., anxiety, past psychiatrist consult, started in hospital for sleep, for grief)

1. If for sleeping disorders (e.g. restless legs), unmanaged anxiety, depression, or a physical or mental condition that may be causing/aggravating insomnia, or alcohol withdrawal

- Continue benzodiazepine
- Minimize use of drugs that worsen insomnia (caffeine, alcohol)
- Treat underlying condition
- Consider psychology, psychiatry or sleep specialist consultation

2. If for insomnia on its own or insomnia with managed underlying comorbidities

- Engage patients (see GFF #68 Deprescribing Medications in Elderly Patients), discussing potential risks, benefits, withdrawal plan, symptoms and duration
- Recommend deprescribing

(D) If deprescribing is recommended:

1. Offer behavioral sleeping advice; consider cognitive behavioral therapy if available

2. Taper and then stop the benzodiazepine

- Decrease dose by 25% every two weeks, and if possible, 12.5% reductions near the end of the taper prior to discontinuation

3. Monitor every 1-2 weeks for duration of tapering

- Expected benefits: May improve alertness, cognition, daytime sedation and reduce falls
- Withdrawal symptoms: Insomnia, anxiety, irritability, sweating, GI symptoms (all usually mild and last for days to a few weeks)

4. If symptoms relapse:

- Consider: Maintaining current benzodiazepine dose for 1-2 weeks, then continue to taper at a slower rate
- Alternate drugs: Other medications have been used to manage insomnia and could be considered for appropriateness (see GFF #40, Treating Insomnia)

28

Your own care management data

- In the LAST WEEK, I have initiated approximately _____ discussions with my patients ≥ 65 years old regarding fall risk associated with benzodiazepines, non-benzodiazepine hypnotics, and diphenhydramine.
  - 1-2
  - 3-4
  - 5-6
  - 7-8
  - 9-10
  - 11-12
  - 13-14
  - > 15

29

Initiate a conversation

- **As physicians you already utilize scripts.**
- **Break into small groups to develop a script on how to initiate the conversation.**
- **Share your script.**

30

Debrief

31

Debrief

- Education about the risks of the medications is an effective first step.
- Often minimal interventions are needed to initiate a slow tapering protocol.
- Offering the patient written educational material has been found to be effective.
- Consider cognitive behavioral therapy
- Avoid adding new psychopharmacological agents during the taper

- Markota M, Rummans TA, Bostwick JM, Lapid MI. Benzodiazepine use in older adults: dangers, management, and alternative therapies. Mayo Clinic Proceedings 2016 Nov 30 (Vol. 91, No. 11, pp. 1632-1639).

32

Questions

33

Breaking Apart

PI-CME // Part IV MOC Credits?

If affiliated with:

- Aurora Health Care
  - Terry Frederick
- MCW
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- UWSOMPH
  - Barb Anderson

Winter Refresher CME

- Question and Answers

34