

## Long-Term Care Survey Alert

### Quality of Care: Inject These 3 Key Approaches Into Your Medication Review

Find out how these common drugs can trigger the prescribing cascade.

Sidestepping unnecessary medications not only protects residents from adverse drug reactions -- it lowers costs and helps you F329-proof your facility. When you reduce inappropriate polypharmacy, you begin to see less trouble with falls, hospitalizations, and excess mortality, said **Daniel Bluestein, MS, MD, CMD**, in a presentation at the March 2010 American Medical Directors Association meeting.

Strategy No. 1: Start with an accurate medication list. If you don't, "you're starting down the wrong road," stressed **Thomas Lynch, PharmD**, a co-presenter in the AMDA talk. Just by taking this first step, "you can catch more errors and decrease more drugs..."

Go to the source: Actually review with the patient or his family what medications the person is taking, advised Lynch. "It's amazing how many mistakes you'll find just by doing that and looking at the labels" on the patient's pill bottles.

Strategy No. 2: Identify whether each medication on the list has a clear and appropriate indication.

That's especially important to do after the patient's discharge from the hospital, Lynch emphasized. Find out if the physician ordered a medication for a short-term trial or for chronic therapy. For example, Lynch observed that "just about everyone in the hospital gets a proton pump inhibitor (PPI)." So if the patient is taking a PPI, find out when he first started doing so.

Preempt this: Suppose a patient who didn't have gastroesophageal reflux disease (GERD) started taking a PPI for prophylaxis in the hospital. Even people who don't have GERD who stay on the drug for a while will develop rebound GERD when you try to stop the medication, Lynch cautioned.

Danger: Also keep in mind that some PPIs and Plavix (an antiplatelet agent) may be a dangerous combination. Plavix (clopidogrel) is a "prodrug" that has to be metabolized by the CYP2C19 enzyme to become active, Lynch explained. And an important study that came out last year showed people with acute coronary syndrome taking Plavix with a PPI (primarily Prilosec) showed a "huge jump" in the number of hospital readmissions or deaths, Lynch noted. One out of 11 patients on this combination of medications was unnecessarily readmitted to the hospital or died.

"The theory, which is still pretty controversial," is that most, but not all PPIs block CYP2C19, increasing the risk of thrombosis, Lynch said.

Also: As part of your medication reviews, take a close look at the medical necessity for antidepressants. Lynch pointed out that a number of papers looking at clinical trial information show that people with mild-to-moderate depression responded no differently to antidepressants than to placebos. The antidepressant drugs are shown "only to be really effective for severe depression," he said.

Yet if an elderly person seems a little depressed in the hospital, "it's not unusual at all for the psych team" to put the person on an antidepressant, such as Lexapro, Lynch relayed. So try to determine if the person is on an antidepressant as the result of a quick decision, he advised -- or does he have a chronic depression that has responded to that particular antidepressant?

Strategy No. 3: Stay off the prescribing cascade. This occurs when a clinician unwittingly prescribes medications to treat what are really drug-related symptoms, said Lynch and Bluestein. Be on the lookout for these common examples:

- **Nonsteroidal anti-inflammatory agents.** NSAIDs (other than low-dose aspirin) can exacerbate hypertension or heart failure, cautioned Lynch. You can actually precipitate these conditions in individuals who are "right on the edge" for developing them. Yet, if you don't recognize that the NSAIDs are the culprit, then you might start the patient on medications for heart failure or hypertension. For example, Lynch said, a lady may have hurt her shoulder trying to help her spouse out of bed. Her blood pressure is 170/95. "But if you find out she's been taking Aleve twice a day for the last two weeks, you can just stop the Aleve. You'd be surprised how that can cause a pretty significant reduction in blood pressure."
- **Thiazide diuretics.** These can increase uric acid levels and the risk of developing gout. If that happens, the person may get treatment for gout rather than just reducing or stopping the thiazide diuretic, Lynch cautioned.
- **Anticholinergics and cholinesterase inhibitors.** A person can develop urinary incontinence from cholinesterase inhibitors given for dementia, Lynch observed. To counteract the incontinence, the physician then orders an anticholinergic medication, which counteracts the cholinesterase inhibitor. So the person ends up on Namenda (memantine) because his cognition seems to be getting worse. "That's a very real scenario" if the physician doesn't recognize what's going on, Lynch noted.
- **Aripiprazole (Abilify).** Lynch reported seeing an "Abilify craze" in his area. And even though that antipsychotic causes fewer endocrine effects, 25 to 30 percent of people on the drug develop akathisia, which can be misdiagnosed as restless leg syndrome (RLS), Lynch relayed. So the physician orders a Parkinson's drug such as Requip to treat the RLS, which has the exact opposite action of Abilify, which blocks dopamine, he said.