Editor's Note

AGING AND HEALTH

What Is Needed to Make Deprescribing of High-Risk Medications Routine for Older Adults

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Use of anticholinergic and sedative medications in older adults is associated with multiple harmful outcomes, including delirium, falls, and higher risk of death.[1,2] In *JAMA Internal Medicine*, Fujita et al[3] examined whether pairing electronic medical record display of a single measure of total anticholinergic and sedative medication exposure with pharmacist stewardship could increase deprescribing among hospitalized older adults. The intervention involved displaying the Drug Burden Index, patient-level pharmacist stewardship, and system-level educational materials that encouraged clinicians to consider deprescribing. The authors evaluated the intervention in a stepped-wedge cluster randomized trial across 6 hospitals, comparing deprescribing at discharge during active intervention vs usual care periods. The authors found a modest but statistically significant increase in the number of patients with a deprescribing event during the intervention vs main control period (41.4% vs 38.1%; $P < .05$). However, this result fell below the prespecified 10% difference, and it was not sustained after the patient-level pharmacist stewardship component of the intervention ended.

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A useful feature of this trial is the inclusion of a sustainability period during which the Drug Burden Index tool remained available while the active components of the intervention were withdrawn. Previous deprescribing trials had suggested dedicating resources to patient-level medication review may reduce medication counts.[4] This trial adds to the literature by showing any effects of these relatively intensive interventions may last only as long as they are in place. So what does it take to drive durable change in clinician prescribing behavior? Prior studies suggest it can help to target social norms and professional identity, such as by using peer comparisons.[5] Additionally, active education, such as through academic detailing, is more likely to affect prescribing behavior than the provision of passive materials, such as the leaflets, guide, and online modules used in this trial.[6] In future deprescribing trials, these types of evidence-based prescriber-focused strategies may yield more sustainable results.

Even if active hospital-based interventions can reduce potentially harmful medication use in older adults, it is unclear whether deprescribing in this setting improves long-term clinical outcomes or patient satisfaction. This trial provides limited insight on this point, as it reported only 1 clinical outcome, in-hospital adverse events, which was not impacted by the intervention. Future trials should focus on cogent clinical outcomes, such as delirium, falls, or relevant patient-reported outcomes, such as the Treatment Satisfaction with Medicines Questionnaire (SATMED-Q).[7]

Critically, evaluating these important clinical outcomes will require increasing statistical power. Future deprescribing trials might achieve this through targeted enrollment of high-risk groups. Older adults are a heterogeneous population, and identifying groups at highest risk for medication-related complications will help optimize study design, efficiency, and power. For example, rather than using age as a blunt proxy for risk, studies should consider selecting those with prior delirium or falls or those who have been previously hospitalized for medication-related adverse events, since these groups would be most likely to benefit from these interventions.

This study highlights challenges facing current deprescribing research and points to where the field must go next. Specifically, future trials should explicitly examine whether evidence-based prescriber-facing interventions can affect clinical outcomes that matter most for the high-risk groups most likely to benefit from less medication use.

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