Geriatric Clinical Pharmacist Can Improve Care

BY DAMIAN McNAMARA

ORLANDO — Consultation by a geriatric clinical pharmacist prompted medication changes for 50% of older cancer patients in a pilot study of a new clinical geriatric program set to launch at Memorial Sloan-Kettering Cancer Center, New York.

Importantly, 17% of older cancer patients were prescribed a potentially inappropriate medication, according to a second, retrospective review of charts at the same institution.

Results of both studies point to a polypharmacy problem in this population, Dr. Stuart M. Lichtman, the lead author, said at the annual meeting of the American Society of Clinical Oncology.

"Polypharmacy is a complex issue that can lead to nonadherence, adverse drug reactions, drug-drug interactions, and increased emergency room visits, hospitalizations, and nursing home admissions," warned Dr. Lichtman, chair of the 65+ Clinical Geriatric Group, a part of the Cancer and Aging Program at Memorial-Sloan Kettering.

"This incidence of potentially inappropriate mediations is too high," commented Dr. Jerome Yates of the American Cancer Society, Atlanta, who was invited to discuss the study. "We certainly need to have better approaches" to address adverse drug reactions, drug-drug interactions, and noncompliance issues, he said.

The prospective study assessed 154 patient consultations from April 2007 to December 2008 in an ambulatory oncology care clinic. In collaboration with the patient's oncologist, the geriatric clinical pharmacist took these actions:

- ▶ Recommended additional medication (42% of patients).
- ▶ Identified medication adherence problems (37% of patients).
- ▶ Discontinued an agent (35% of patients).
- ▶ Suggested an alternative agent (20% of patients).
- ▶ Adjusted or recommended pain management (18% of patients).
- ▶ Identified cost as a barrier to treatment (12% of patients).
- ▶ Changed medication dose (11% of patients).
- ▶ Identified drug-drug interactions (10% of patients).

Some patients had more than one intervention. The median age was 74 years (range 65-91 years); 59% were women, and 47% reported that this was their first consultation with a pharmacist. Part of the new 65+ Clinical Geriatrics Program includes patient education about optimal drug use and safety.

The five leading reasons for consultations were pain management, osteoporosis management, dementia screening, gastrointestinal toxicity (constipation or diarrhea), and anticoagulation management. "Overall, the clinical pharmacist plays a very active role in providing disease and supportive care management," Dr. Lichtman said. Also, the drug-specific interventions improved medication management, he added.

Dr. Lichtman and his colleague Manpreet K. Boparai, Pharm.D., also reviewed the charts of 100 consecutive cancer patients older than 65 years seen from July 2007 to November 2007 at a regional site for Memorial Sloan-Kettering in Commack, N.Y. The patients were equally distributed by gender and were prescribed a median of 8 medications (range 0-23). The patients were most likely to be prescribed or to report taking antihypertensive medications (52%), vitamins/herbals (46%), proton-pump inhibitors (32%), and lipid-lowering agents (29%).

Diphenhydramine (when taken as a sleep aid), meprobamate, high-dose benzodiazepines, cyclobenzaprine, meperidine, propoxyphene, metaxalone (Skelaxin), and dipyridamole were the potentially inappropriate medications identified using Beer's criteria (Arch. Intern. Med. 2003;163:2716-24).

A meeting attendee prompted a discussion by asking Dr. Lichtman how hospital administrators could be convinced to hire an additional pharmacist when the resulting savings would go to Medicare and insurance companies, rather than the hospital.

"You're absolutely right," Dr. Lichtman replied. "Part of this is to justify [the pharmacist's] work, and it's another aspect of high-quality cancer care."

Dr. Yates noted that "geriatric clinical pharmacists are a luxury that the present system does not support in most environments." These programs must be shown to save money as well as improve care. "That is really all administrators understand. The outcome is dollars."

Dr. Harvey Jay Cohen, session moderator, added that "administrators are very sensitive now to rates of rehospitalizations, rates of overutilization, and length of stay."

"If we can demonstrate we can modify those outcomes, hospital administrators will be jumping up and down to hire people to do it," said Dr. Cohen, director of the Center for Study of Aging and Human Health at Duke University Medical Center in Durham, N.C.

Dr. Lichtman and Dr. Yates had no relevant disclosures. ■

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