Streamlining Medication Use during COVID-19

This guideline is applicable to all care settings, though all medication changes should be person-centered and based on individualized assessment of clinical circumstances, including therapeutic indication, past medical history, goals of care, and health region or provincial drug formulary.

Purpose:

- Consider streamlining medication use in order to reduce repeated contact with care providers, thereby preserving PPE, reducing risk of viral transmission and creating efficiencies in caregiver workload.
- Please consult and collaborate with site or team pharmacists to implement the strategies below.
- If individuals are receiving nutritional supplements with their medications, please adjust this therapy, as appropriate, based on the new medication regimen selected.

Approach:

- Accurate and timely communication at transitions of care is essential to ensuring patient/client/resident safety. Where applicable, all changes from home medication regimens must be communicated on transfer and discharge medication reconciliation forms/prescriptions. Clearly document care plans for all medication changes that require re-evaluation and/or ongoing monitoring by the next care provider.
- Prioritize medication changes that are:
    - Essential for infection control (especially measures to reduce duration/frequency/risk of medication administration among people with known or suspected COVID-19)
    - Low risk, easy to evaluate, and can be done immediately. Avoid changes that are riskier, time consuming or necessitate increased monitoring.
- Streamline medication use by:

Strategy	Description (please see Appendix for specific examples)
Deprescribing/ stopping unnecessary medications See https://deprescribing.org/ and https://medstopper.com for specific deprescribing guidelines	• Reassess all therapies and discontinue or taper medications no longer needed • Reassess and discontinue medications that provide limited clinical benefit • Discontinue medications no longer aligned with goals of care • Reassess and temporarily discontinue select medications where interruption will not result in a clinically significant impact during the COVID pandemic
Simplifying medication regimens	• Use standard administration times and minimize doses that are not aligned with standard times ○ Exceptions: medications that require precise dosing times (antibiotics, chemotherapy, antiparkinsonian medications, medications that must be given with meals e.g. short acting insulin, medications that have significant drug interactions with one another or with food)

	• Use medications with the lowest frequency of dosing where there are multiple equally effective Formulary medications available • Change from short acting to long acting formulations, as clinically appropriate
Reducing the frequency of medication- associated monitoring	• Minimize monitoring in stable patients • For new therapy select medications that minimize monitoring, where possible • Bundle medication monitoring with other labs, when possible

Appendix: Specific Examples for Streamlining Medication Use during COVID-19

Strategy	Description	Specific Examples (note: not an extensive list)[1]
Deprescribing/ stopping unnecessary medications See https://deprescribing.org/ and https://medstopper.com for specific deprescribing guidelines	Reassess all therapies and discontinue or taper medications no longer needed	• proton pump inhibitors (PPIs) • benzodiazepines, antipsychotics • antihyperglycemics in adults greater than 65 years of age with Type 2 diabetes[2] • cholinesterase inhibitors • high dose opioids for chronic non-cancer pain[2-3] • PRN nasal sprays; lubricating eye drops
	Reassess and discontinue medications that provide limited clinical benefit	• docusate sodium, docusate calcium[4] • multivitamins • herbal products (e.g. glucosamine, cranberry)
	Discontinue medications no longer aligned with goals of care	• statins in patients with comfort-oriented goals[5-7]
	Reassess and temporarily discontinue medications during the COVID pandemic	• calcium, magnesium, vitamin B12, vitamin D (consult a registered dietitian if applicable) • bisphosphonates (alendronate, risedronate)
Simplifying medication regimens	Use standard administration times and minimize doses that are not aligned with standard times*	• consider changing all dosing to BID instead of q12h (or vice versa) • levothyroxine: give with other medications or with food and adjust dose as required • warfarin: give with either supper, or HS medications • furosemide BID: give once daily (low dose) or give with meals AM and noon or AM and supper (as clinically appropriate)

Strategy	Description	Specific Examples (note: not an extensive list)[1]	
Simplifying medication regimens		• bisphosphonates: change from daily to once weekly dosing; give weekly on same day for all patients • select agents as appropriate that can be bundled with hemodialysis (e.g. cefazolin instead of ceftriaxone for uncomplicated SSTIs) ***Exceptions**: medications that require precise dosing times (antibiotics, chemotherapy, antiparkinsonian medications, medications that must be given with meals e.g. short acting insulin, medications that have significant drug interactions with one another or with food)	
	Use medications with the lowest frequency of dosing where there are equally effective Formulary medications available	**Consider:**	**Instead of:**
		bisoprolol once daily	metoprolol BID
		amoxicillin-clavulanate 875/125 mg BID	amoxicillin-clavulanate 500/125 mg TID
		rivaroxaban once daily (new start)	apixaban or dabigatran BID
		azithromycin once daily	clarithromycin BID (except for *H pylori*)
		ceftriaxone q24h	cefazolin q8h (where clinically appropriate)
		low molecular weight heparin once daily (e.g. dalteparin) for VTE prophylaxis	heparin BID
	Other strategies	**Consider:**	**Instead of:**
		combination eye drops (e.g. Cosopt, Combigan)	single agent eye drops (where possible)
		nitroglycerin patch 12 hrs on/12 hrs off	isosorbide TID
		once daily PPI	ranitidine BID or TID; PPI BID
	Other strategies	cetirizine once daily	diphenhydramine q4-6h
		naproxen BID or celecoxib once daily	ibuprofen TID or QID
		vitamin D 10,000 units weekly	vitamin D 1,000 units daily
		potassium chloride (KCl) oral once daily	KCl BID-QID (for daily doses less than 25 mEq)
		hand-held inhalers (with spacer if possible)	nebulizers
		gliclazide MR: give total daily dose once daily	gliclazide MR daily dose split BID or TID
		tiotropium once daily[8]	ipratropium QID
		Breo Ellipta once daily[8]	Advair or Symbicort BID
		Alvesco or Arnuity Ellipta once daily[8]	Flovent or Pulmicort BID

Strategy	Description	Specific Examples (note: not an extensive list)[1]	
		using single pill combinations (e.g., for antihypertensive drugs)	
		step down from IV to oral antibiotics as soon as clinically appropriate	
	Change from short acting to long acting formulations as clinically appropriate	**Consider:**	**Instead of:**
		phenytoin extended release once daily (max 400mg/dose)	phenytoin same daily dose split BID or TID
		metoprolol SR once daily	metoprolol BID
		long-acting basal insulin (e.g. glargine) daily	Intermediate acting basal insulin (e.g. NPH) BID
		bupropion XL once daily	bupropion SR
		MacroBID BID	nitrofurantoin QID
		Opioids: change to long acting formulations when tapering and discontinuing therapy is not possible; this also allows for consolidating with laxative regimens	
Reducing the frequency of medication-associated monitoring	Minimize monitoring in stable patients	Oral diabetes medications: reduce blood glucose monitoring in inpatient settings	
	For new therapy, select medications that minimize monitoring where possible	Choose antibiotics not known to interact with warfarin in patients not otherwise needing frequent INR monitoring	
	Bundle medication monitoring with other labs when possible	Draw drug levels on days patients already have other lab work scheduled	

1. For more strategies, please see: https://www.pharmacy.umaryland.edu/centers/lamy/optimizing-medication-management-during-covid19-pandemic/
2. Centre for Effective Practice Management of Chronic Non-Cancer Pain https://cep.health/clinical-products/chronic-non-cancer-pain/
3. Centre for Effective Practice Opioid Tapering Template https://cep.health/clinical-products/opioid-tapering-template/
4. CADTH: https://www.cadth.ca/dioctyl-sulfosuccinate-or-docusate-calcium-or-sodium-prevention-or-management-constipation-review
5. Shared Care BC – You Decide Statins in the Older Adult http://www.sharedcarebc.ca/sites/default/files/SC-PP-Statin%20You%20Decide-V-2017-01-07_0.pdf
6. A Guide to Deprescribing Statins (Australia) https://www.primaryhealthtas.com.au/wp-content/uploads/2018/09/A-Guide-to-Deprescribing-Statins.pdf
7. Statins in the Elderly (College of Physicians and Surgeons Alberta) http://www.cpsa.ca/statins-in-the-elderly/
8. For more examples of once daily regimes for stable patients see:
   Asthma: https://cts-sct.ca/wp-content/uploads/2020/04/FINAL-April-13_CTS-re-Asthma-Salbutamol-Shortage.pdf;
   COPD: https://cts-sct.ca/wp-content/uploads/2020/04/FINAL_April-13-CTS-re-COPD-Salbutamol-Shortage.pdf