Problematic Polypharmacy: why Deprescribing is important, but not enough

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Warwick Primary Care
Co-creating education and research solutions to Primary Care problems

A LADYBIRD NHS CRISIS DISCOVERY BOOK
FIVE SHARE A HOSPITAL BED

A Liverpool tale…

Think**differently**

What we did

- Register
- Visit for care assessment
- Implement changes (inc. record keeping)
- Follow on

What we found

- Patients (and practitioners) liked it
- Reduced prescribing
- Clinically significant change in approach to care for 2 /3 of patients
- More questions than answers…

Sharing what we learnt…

Primary Health Care Research & Development page 1 of 8
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DEVELOPMENT

Generalist solutions to overprescribing: a joint challenge for clinical and academic primary care

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Polypharmacy is a phenomenon of modern health care that can offer benefits in terms of patient outcomes. Known risks associated with so-called inappropriate polypharmacy can be reduced through good medicine management and appropriate use of clinical guidelines. However, we now see a growing literature highlighting additional risks to individual well-being and social functioning not recognised within these existing

Managing multi-morbidity in practice... what lessons can be learnt from the care of people with COPD and co-morbidities?

Case study 1:

Vauxhall Primary Health Care, Liverpool

Vauxhall Primary Health Care (VPHC) is an urban practice in Liverpool with a list size of 6,000 patients and a team including GPs, practice nurses and a health care assistant.

A quality improvement project has been running here for three to four years since the practice obtained funding from neighbourhood cluster efficiency savings for 1.5 days/week of GP time to address the question:

"How can we improve the care of housebound patients with complex needs registered at VPHC?"

What do they do?
First of all the practice established a register identifying patients at need, targeting first those who were housebound with more than one Quality & Outcomes Framework (QoF)-registered disease, multiple medications and unplanned admissions in the last year.

Patients were contacted by letter. All visits were carried out by GPs who completed an assessment, involving a review of the notes - including tidying up problem lists; medication review; care assessment (where possible involving carers themselves); assessment of level of need (low, medium or high) and a documented plan of care.

What did they achieve?
Recorded data was audited and experiences of staff, patients and carers reviewed. Results from initial data available indicated a lack of impact on admissions but a reduction in prescribing. Data showed that inappropriate medication was stopped in 54 patients out of 101 patients, due to a long-term view being taken about safety. Informal feedback was generally positive, especially from staff and carers (see table 2

"The consultation was an expert generalist needs assessment, based on the principle of a person-centred assessment of what was wrong and what intervention was needed. In practice, much of the decision making related to domedicalisation... reducing the burden of care."

What are the challenges?
With the next stages of this work being planned, the following challenges have been identified:
- Who are the next most important target groups? Care home residents? New patients with multimorbidity? Patients with acute complex needs?
- Limits to funding due to competing priorities.
- With limited time available, the team will need to be clear about how best to use community matrons and GPs, for example focusing GP effort on the less straightforward cases such as those where diagnostic issues are dominant.

Key learning points
- Identify your key 'at-risk' group that is most likely to benefit.
- Bear in mind the importance of holistic care - **63% of patients were found to have needs not met by existing chronic disease management or medication review processes** and identifying these needs was difficult from routine collected data alone. Assessment by an experienced GP with an 'off-protocol' patient-centered approach was found to be more useful.
- Make use of your community teams.
- Work through how much clinical time is required and how you will find or fund it.

We are starting to make greater use of community matrons and also community pharmacy. Reserving GPs for the less straightforward cases...what we are still struggling with is how to predict who those are. But often it is where the DIAGNOSTIC issues are dominant.

Dr Joanne Reeve, Vauxhall Primary Health Care

Table 2: Feedback Summary

Patients/carers	For some, surprise/suspicion/concern that doctor has visited for review, unsolicited by patient. From family/carers, support for opportunity for time for full assessment/discussion especially re medication.
Staff at care homes	Positive impact of proactive review of patients, including tidying up/rationalising medication.
Staff at VPHC	Useful impact of reviewing the patient's list of problems, medication reviews etc; protected time for visits for complex patients valuable.

7

Warwick Primary Care

Defining De-prescribing

Deprescribing: process of supervised withdrawal of inappropriate medicines to improve outcomes

- “inappropriate medicines”?
- “improved outcomes”?
- the process - how to do it?

Reeve E et al Br J Clin Pharmacol 2015; 80: 1254

Scott's 5 steps for deprescribing

CLARITY OF GOAL

- Review what medicines and why
- Assess overall risk of drug…
- …and eligibility of each medicine to continue
- Prioritise which to stop

DEFENDABLE DECISION

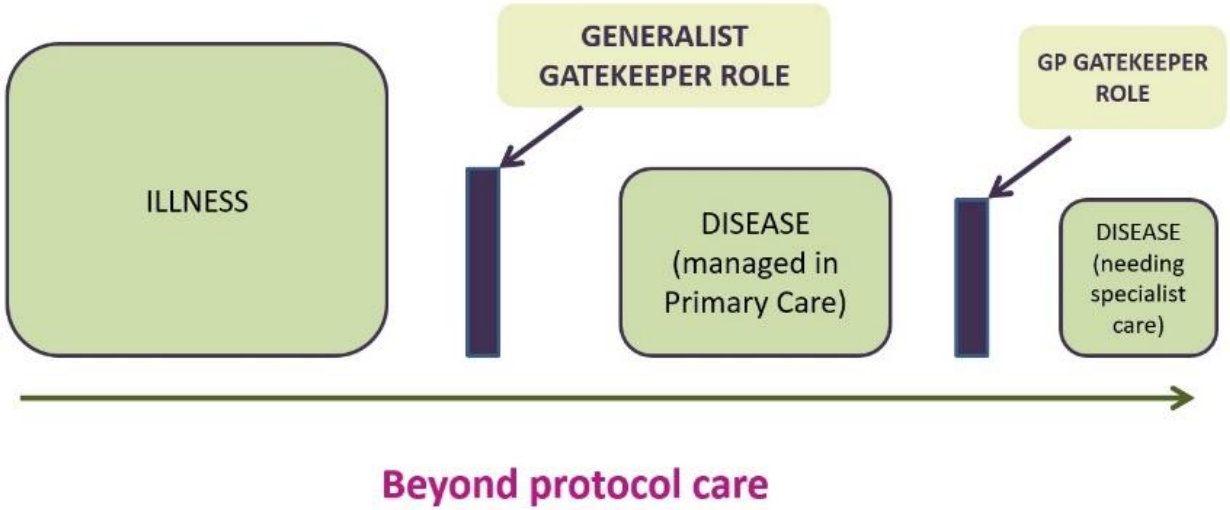
- Implement action plan and monitor

Scott et al JAMA 2015; 175: 827-834

Clarity of Goal

Clarifying the Generalist goal

Deciding, from a whole person perspective, whether to medicalise this illness experience



(after Heath 2011.
Divided we fail. The Harveian Oration)

Defendable decisions: rethinking the Consultation

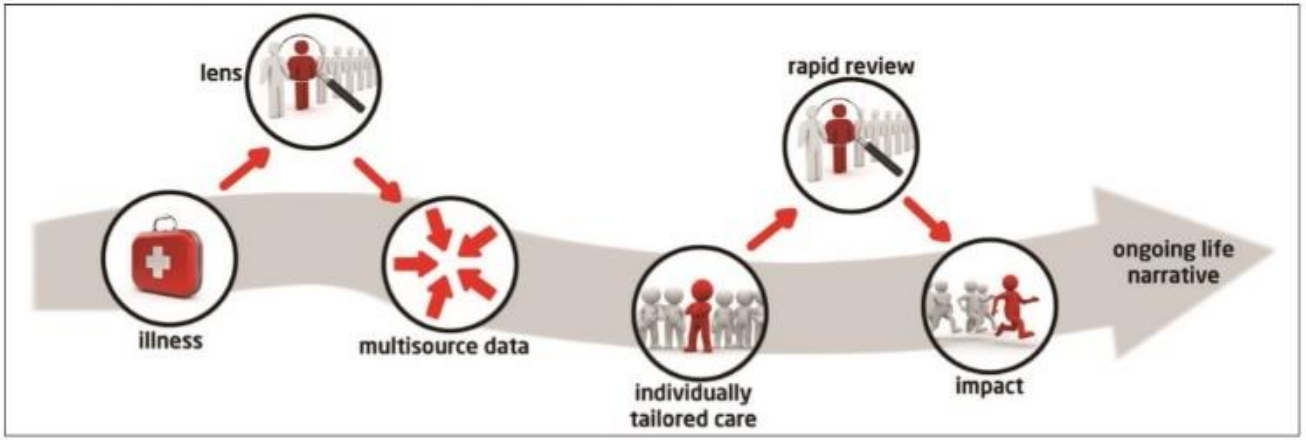
1. Connecting
2. Summarising
3. Handing Over
4. Safety Netting
5. Housekeeping

(Roger Neighbour 1987)

Generalist decision making

The SAGE consultation model

Figure 1. The SAGE consultation model. © J Reeve 2015. Reproduced with permission.



Reeve J. 2015. BJGP; 35:207-208.

SAGE: Defendable decisions

Data collection	Did I collect an appropriate range of data?
Interpretive process	Did I use the data to make a shared decision?
Explanation offered	Did my decision support/address improving health as a resource for living?
Generalisability	Would I have made the same decision for others?
Evaluate validity	Did my decision making make a difference for this individual?

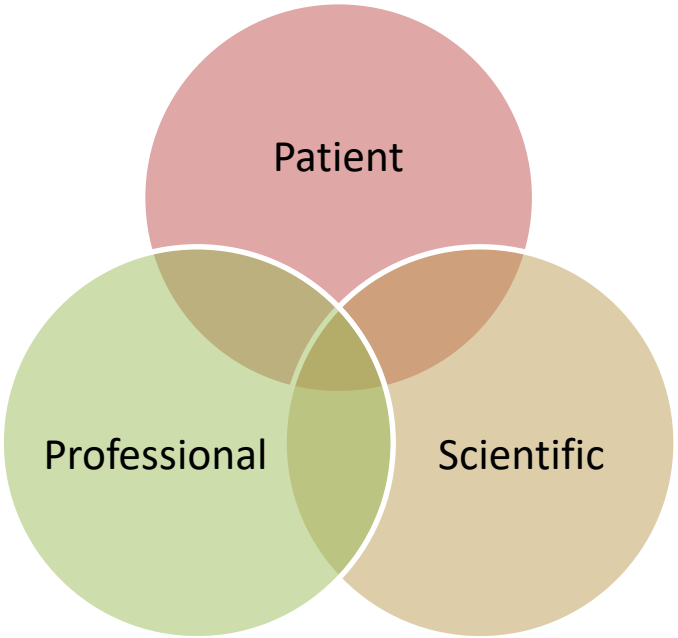
Reeve OPS 2011, Reeve BJGP 2015

Case study: Elsie

A defendable decision?

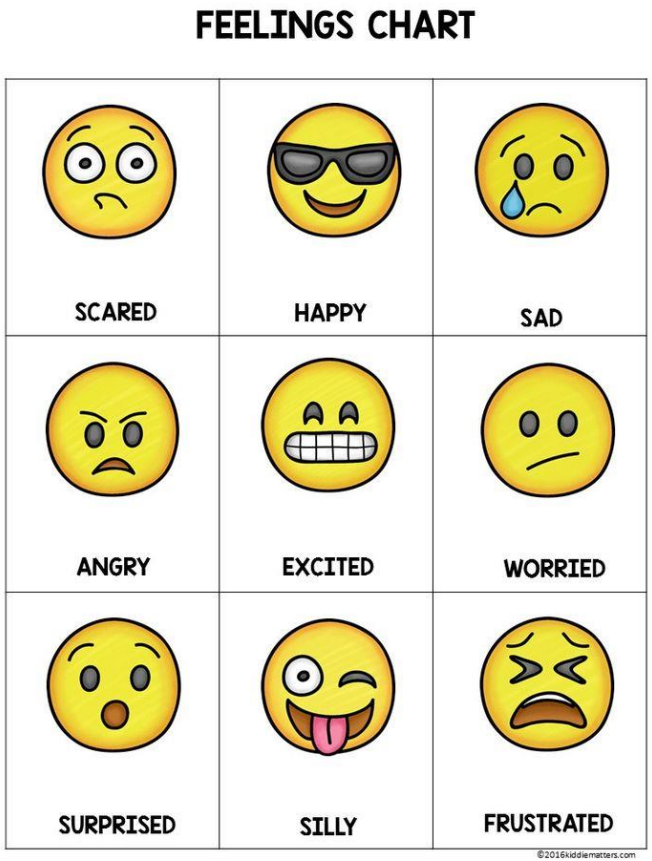
Data collection	Data from Elsie and carers, examination (targeted). Looked up case notes and amiodarone benefit/risks. Could have checked with MM guidance, cardiology?
Interpretive process	Several visits, slow withdrawal of amiodarone and checking
Explanation offered	Goal was to improve BP, falls risk, cognitive impairment and mood
Generalisability	Same decision if family present, not dementia?
Impact	Subsequently BP up – and very high (180/90) – needed to start an antihypertensive. And that took some doing. So resource use (repeat visits) became not insignificant Elsie became less flat and more engaged, but actually grumpier/agitated – others increased AD with limited effect

Step 2 - multisource data



Scottish polypharmacy guidelines 2015

CEREBROVASCULAR/ CARDIOVASCULAR DISEASE							
17 **Warfarin** (target INR 2 - 3)	Aspirin 75mg daily	Age > 75yrs with AF	1st occurrence of fatal or non fatal disabling stroke (ischaemic or haemorrhagic), other intracranial haemorrhage or	2.7 years (mean follow-up)	**20**	**54**	Mean age of patients prescribed warfarin was 81.5 years [14] 73% of patients had a CHADS2 score of 1-2 67% of patients on warfarin remained on this treatment for the complete duration of the trial
18 **Aspirin**	Placebo or no treatment	**Primary prevention of CVD** Individuals without history of occlusive disease	Serious vascular event (Defined as MI, stroke or vascular death)	5.8 years (mean follow-up)	**246**	**1428**	Age range in trials was 19-94yrs [15] Patients had hypertension or coronary risk factors without overt disease
19 **Aspirin or other antiplatelet**	Placebo or no treatment	**Secondary prevention of CVD in patients with history of stroke or TIA (outwith acute period)**	Serious vascular event (Defined as non-fatal MI, non-fatal stroke or vascular death)	29-31 months	**28-40**	**68 – 94**	Antiplatelets include aspirin (most widely studied), clopidogrel, dipyridamole, and other antiplatelets not commonly used in UK practice [16 17]



Changing Practice

- What we're trying to do
- How we make decisions
- How we organise care

Barriers to providing individually tailored care

Research

The Royal Society of Medicine

Journal of the Royal Society of Medicine
Short Reports; 4(12) 1–9
DOI: 10.1177/2042533313510155

Examining the practice of generalist expertise: a qualitative study identifying constraints and solutions

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- Clinical skills
- Organisational context

Survey Methods

RESEARCH QUESTION: what factors enable or limit hcp in delivering individually tailored prescribing in everyday care

DESIGN: Normalisation Process Theory informed on-line survey examining +/- within 4 domains of work - S.E.A.M

SAMPLE: UK prescribers identified through professional networks

Survey Methods (2)

DESCRIBED ITP as requiring 3 tasks

- Assessing individual burden of illness and care
- Identifying health-related modifiable points of change
- Designing & implementing IT plan for medicines use

SURVEY TOOL: 18 questions derived from NPT toolkit, Nomad, Reeve et al 2013

ANALYSIS: Descriptive statistics, constant comparison analysis of free text responses

Results: sample (n=444)

Profession	53% nurse prescribers, 20% pharmacists, 22% GPs
Career stage	18% early career, 30% middle, 52% 16+ years experience
Gender	72% female
ITP practice	1/3 already offering ITP; GPs least likely to recognise self as ITP

Reeve et al. Submitted to BMC HSR

Key themes: Sense making

Enablers and barriers	Implications for practice
INTEGRAL part of professional practice but LACKS UNIVERSAL understanding	Need work to raise UNDERSTANDING of Individually Tailored Prescribing

"patients need to understand not prescribing as important as prescribing" (pharmacist)

"recognition from the powers that be that this is a good thing" (GP)

Reeve et al. Submitted to BMC HSR

Key themes: engagement

Enablers and barriers	Implications for practice
Professionals lack the time, energy and head space	Need to PRIORITISE ITP within the range of work

"limited by time, caseload and so lack of mental capacity" (GP)

Reeve et al. Submitted to BMC HSR

Key themes: action

Enablers and barriers	Implications for practice
EXPERIENTIAL (42.5%) over formal (18%) learning Particular concerns in making/recording DEFENDABLE DECISIONS	Need training and support for INTERPRETIVE PRACTICE

"experience gained intuition" (GP)

"a fear of making a mistake and the potential consequences"(NP)

Reeve et al. Submitted to BMC HSR

Key themes: monitoring

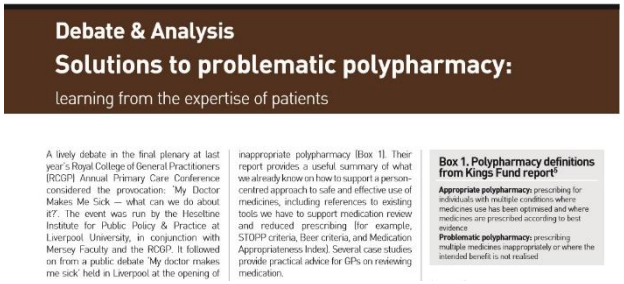
Enablers and barriers	Implications for practice
Lack of formal feedback Peer and patient feedback vital	Need to support informal feedback and monitoring through peer reflection; and consider the impact of formal monitoring on care

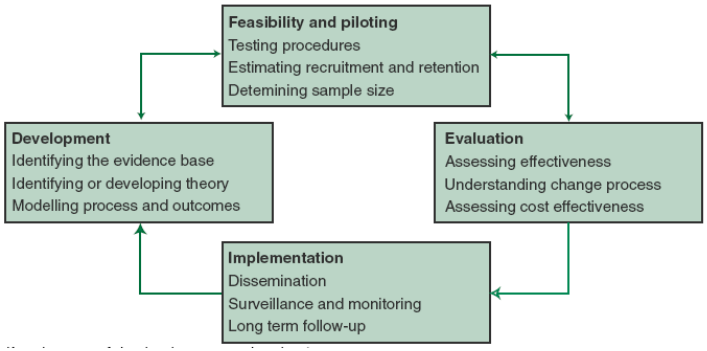
"pressure to prescribe to guideline is great" (GP)

"each time I see a positive effect, I'm motivated to do more" (NP)

Reeve et al. Submitted to BMC HSR

Tackling problematic polypharmacy: FLIPMeds



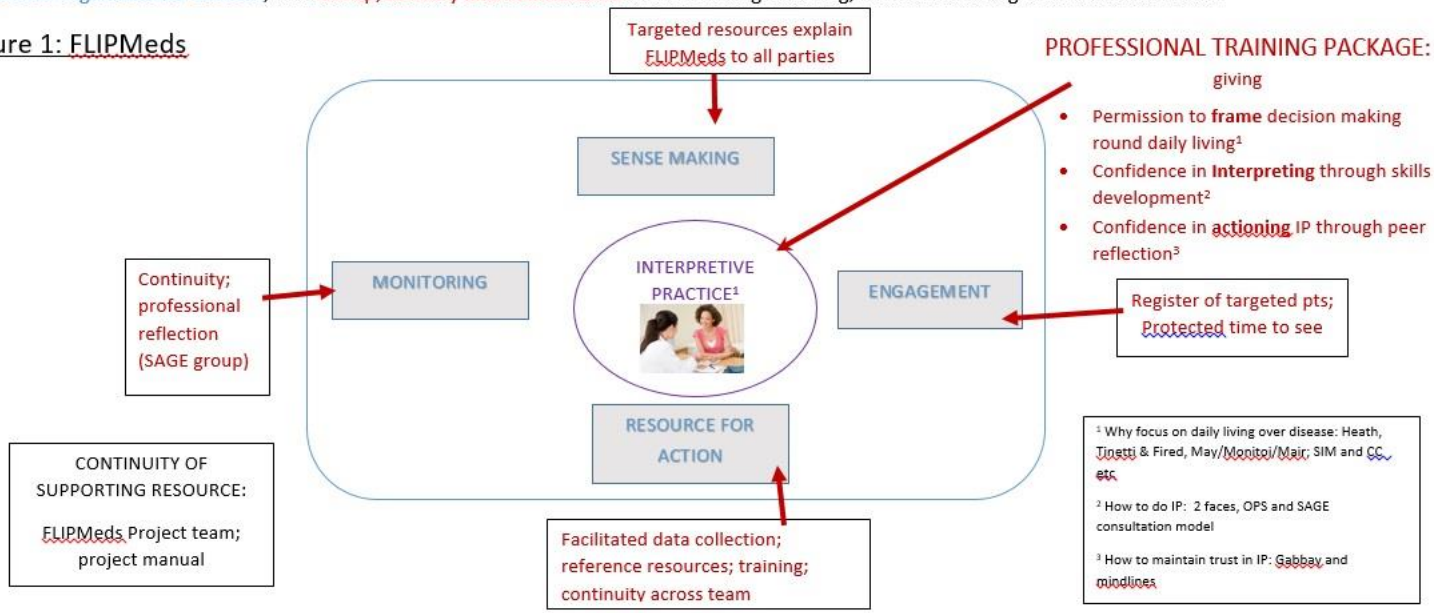


FlipMEDS: Facilitating daily Living through Individualised Prescribing of MEDicineS

Describing FLIPMEds

The FLIPMeds intervention incorporates the clinical component (Interpretive Practice supporting Individually Tailored Prescribing) embedded within a supportive organisational context, with set up, delivery and maintenance of both through training, a manual and organisational facilitation.

Figure 1: FLIPMeds



[1]INTERPRETIVE PRACTICE - the critical, thoughtful, professional use of an appropriate range of knowledge in the dynamic, shared exploration and interpretation of individual illness experience, in order to support the creative capacity of individuals in maintaining their daily lives (REEVE OPS).[1]

PROPOSED MECHANISM OF ACTION of FLIPMEDS

FAILURE TO REALISE INTENDED BENEFIT OF CARE ON DAY TO DAY LIFE [kf]

- Arises from an imbalance of health related resources* and demands** [reeve sim]
- Resulting in disruption to daily living [reeve & cooper]
- Which is perceived (by patient and/or physician) as contributing to illness [ound, demain,r&c]

Individually Tailored needs assessment and plan of (medical) care
{tinetti & fried, reeve, byng}

RESOURCES:
Narrative of self-agency/health as resource for living/control in care decisions; mental wellbeing; health related QOL, resilience; time and energy for daily living (reduction resource spent on medical things); improved physical and mental health/function

DEMANDS:
End of inappropriate medication, surveillance and monitoring (both by medical profession and by self – see narrative above

ANTICIPATED OUTCOMES
REBALANCING of health related demands/resources with enhanced: Health as Resource for Daily Living; Reduced prescribing, surveillance/screening. Increased self/community mmt of disruption

Finishing the story or writing the sequels…?

Deprescribing – Less is More?

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