Problematic Polypharmacy: why Deprescribing is important, but not enough

Dr Joanne Reeve FRCGP PhD
FIVE SHARE A HOSPITAL BED
A Liverpool tale...
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...
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 guidelines.

Sharing what we learnt...

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

Case study 1:

Vauxhall Primary Health Care, Liverpool

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

We are starting to make greater use of community services and also community pharmacy. Prescribing GPs for the less straightforward cases... what we are still struggling with is how to predict who those are. But when it is where this TMC/CHCPC scores an advantage...
Defining De-prescribing

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

• “inappropriate medicines”?
• “improved outcomes”?
• the process - how to do it?
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
- Implement action plan and monitor

Scott et al JAMA 2015; 175: 827-834
Clarity of Goal

Medical generalism
Why expertise in whole person medicine matters

Warwick Primary Care
Clarifying the Generalist goal

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

Beyond protocol care

(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.

## SAGE: Defendable decisions

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

Reeve OPS 2011, Reeve BJGP 2015
Case study: Elsie
### A defendable decision?

<table>
<thead>
<tr>
<th>Data collection</th>
<th>Data from Elsie and carers, examination (targeted). Looked up case notes and amiodarone benefit/risks. Could have checked with MM guidance, cardiology?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpretive process</td>
<td>Several visits, slow withdrawal of amiodarone and checking</td>
</tr>
<tr>
<td>Explanation offered</td>
<td>Goal was to improve BP, falls risk, cognitive impairment and mood</td>
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<tr>
<td>Generalisability</td>
<td>Same decision if family present, not dementia?</td>
</tr>
<tr>
<td>Impact</td>
<td>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</td>
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</table>
Step 2 - multisource data
<p>| | | | | |</p>
<table>
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<tbody>
<tr>
<td>17</td>
<td>Warfarin (target INR 2 - 3)</td>
<td>Aspirin 75mg daily</td>
<td>Age &gt; 75yrs with AF</td>
<td>1st occurrence of fatal or non-fatal disabling stroke (ischaemic or haemorrhagic), other intracranial haemorrhage or</td>
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<td>2.7 years (mean follow-up)</td>
<td>20</td>
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<td>Mean age of patients prescribed warfarin was 81.5 years</td>
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<td>73% of patients had a CHADS2 score of 1-2</td>
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<td>67% of patients on warfarin remained on this treatment for the complete duration of the trial</td>
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<tr>
<td>18</td>
<td>Aspirin</td>
<td>Placebo or no treatment</td>
<td>Primary prevention of CVD Individuals without history of occlusive disease</td>
<td>Serious vascular event (Defined as MI, stroke or vascular death)</td>
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<td>5.8 years (mean follow-up)</td>
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<td>246</td>
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<td>Age range in trials was 19-94yrs</td>
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<td></td>
<td>Patients had hypertension or coronary risk factors without overt disease</td>
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<tr>
<td>19</td>
<td>Aspirin or other antiplatelet</td>
<td>Placebo or no treatment</td>
<td>Secondary prevention of CVD in patients with history of stroke or TIA (out with acute period)</td>
<td>Serious vascular event (Defined as non-fatal MI, non-fatal stroke or vascular death)</td>
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<td>29-31 months</td>
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<td>28-40</td>
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<tr>
<td></td>
<td>Antiplatelets include aspirin (most widely studied), clopidogrel, dipyridamole, and other antiplatelets not commonly used in UK practice</td>
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</table>
Changing Practice

- What we’re trying to do
- How we make decisions
- How we organise care
Barriers to providing individually tailored care

- 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 online 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)

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profession</td>
<td>53% nurse prescribers, 20% pharmacists, 22% GPs</td>
</tr>
<tr>
<td>Career stage</td>
<td>18% early career, 30% middle, 52% 16+ years experience</td>
</tr>
<tr>
<td>Gender</td>
<td>72% female</td>
</tr>
<tr>
<td>ITP practice</td>
<td>1/3 already offering ITP; GPs least likely to recognise self as ITP</td>
</tr>
</tbody>
</table>
Key themes: Sense making

<table>
<thead>
<tr>
<th>Enablers and barriers</th>
<th>Implications for practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTEGRAL part of professional practice but LACKS UNIVERSAL understanding</td>
<td>Need work to raise UNDERSTANDING of Individually Tailored Prescribing</td>
</tr>
</tbody>
</table>

“patients need to understand not prescribing as important as prescribing” (pharmacist)

“recognition from the powers that be that this is a good thing” (GP)
## Key themes: engagement

<table>
<thead>
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<th>Enablers and barriers</th>
<th>Implications for practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals lack the time, energy and head space</td>
<td>Need to PRIORITISE ITP within the range of work</td>
</tr>
</tbody>
</table>

“limited by time, caseload and so lack of mental capacity” (GP)
### Key themes: action

<table>
<thead>
<tr>
<th>Enablers and barriers</th>
<th>Implications for practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPERIENTIAL (42.5%) over formal (18%) learning</td>
<td>Need training and support for INTERPRETIVE PRACTICE</td>
</tr>
<tr>
<td>Particular concerns in making/recording DEFENDABLE DECISIONS</td>
<td></td>
</tr>
</tbody>
</table>

“experience gained intuition” (GP)

“a fear of making a mistake and the potential consequences” (NP)
## Key themes: monitoring

<table>
<thead>
<tr>
<th>Enablers and barriers</th>
<th>Implications for practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of formal feedback</td>
<td>Need to support informal feedback and monitoring through peer reflection; and consider the impact of formal monitoring on care</td>
</tr>
<tr>
<td>Peer and patient feedback vital</td>
<td></td>
</tr>
</tbody>
</table>

“pressure to prescribe to guideline is great” (GP)

“each time I see a positive effect, I’m motivated to do more” (NP)
Tackling problematic polypharmacy: FLIPMeds
FlipM Edwards: 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

- **Continuity of professional reflection (SAGE group)**
- **RESOURCE FOR ACTION**
  - Facilitated data collection; reference resources; training; continuity across team
- **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).

**PROFESSIONAL TRAINING PACKAGE:**
- Permission to frame decision making round daily living
- Confidence in interpreting through skills development
- Confidence in acting through peer reflection

- **SENSE MAKING**
- **ACTIONING**
  - Register of targeted pts; protected time to see

- **MONITORING**
- **ENGAGEMENT**
- Targeted resources explain FLIPMeds to all parties

**CONTINUITY OF SUPPORTING RESOURCE:**
- FLIPMeds Project team; project manual

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Warwick Primary Care
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

PROPOSED MECHANISM OF ACTION of FLIPMEDS

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?