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Polypharmacy Risk Reduction in British Columbia, Canada- Practical Experience of Moving From Contemplation to Action

Preventing Overdiagnosis 2017-Towards Responsible Global Solutions

Quebec City, Quebec, Canada

Dr. Chris Rauscher, Clinical Lead,

Shared Care Polypharmacy Risk Reduction Initiative

Divisions of Family Practice
A GPSC initiative

BRITISH COLUMBIA

BCMA
BRITISH COLUMBIA MEDICAL ASSOCIATION

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Disclosure of Commercial Support

- **No commercial financial or in-kind support.**
- **No potential conflict of interest.**

Objective: To describe our evolving practical experience of deprescribing in British Columbia, Canada

- Framed at the provincial level through the Ministry of Health and Doctors of BC joint Shared Care Committee
- But developed and tested through physicians and the local inter-disciplinary teams in residential care and in acute care.

Highlights Only- Please come talk to me today or at the cocktail reception this evening or after this conference: rauscherchris50@gmail.com (http://www.sharedcarebc.ca/initiatives/polypharmacy)

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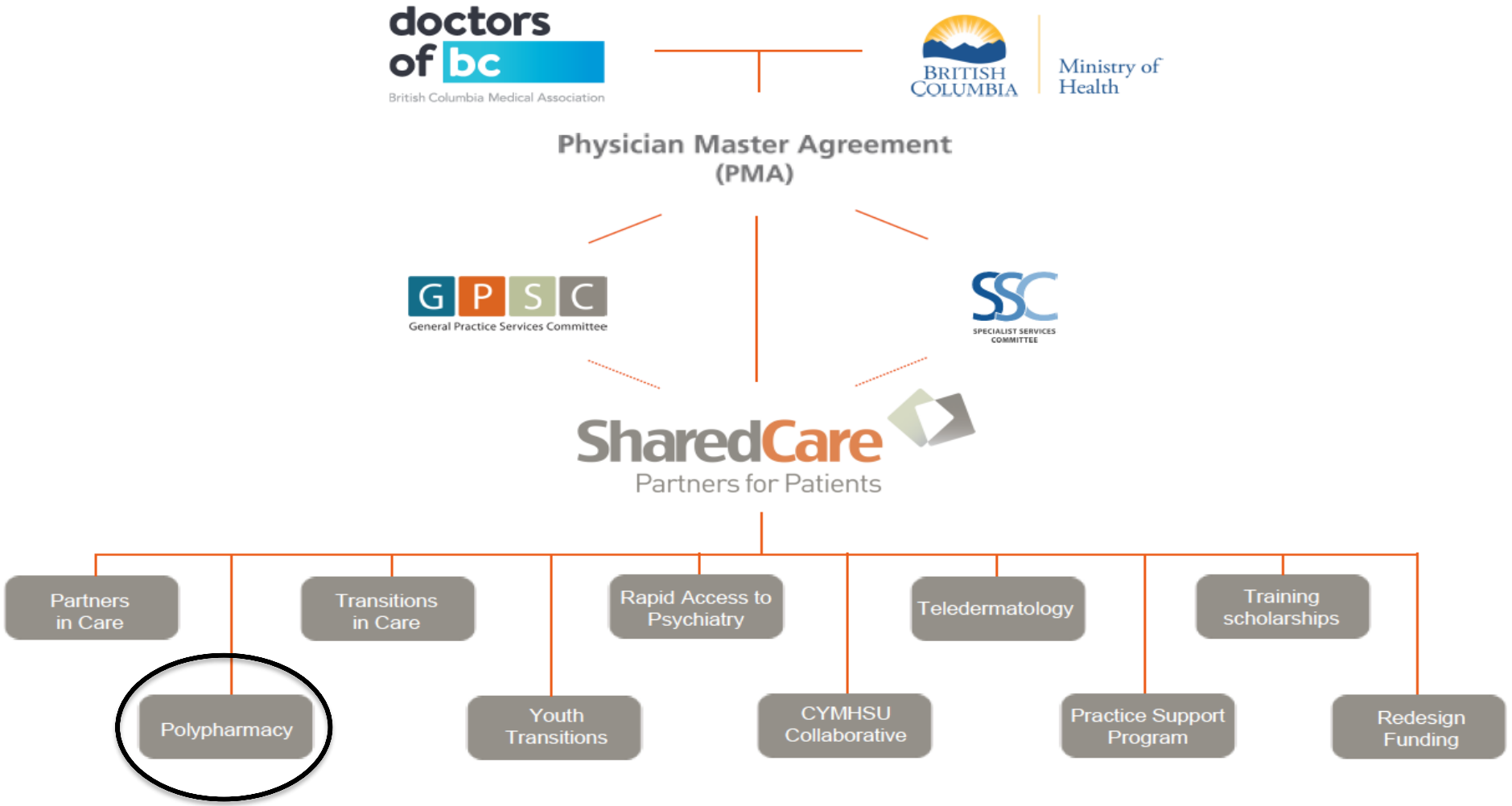
doctors of bc
British Columbia Medical Association
British Columbia
Ministry of Health
Physician Master Agreement (PMA)
GPSC
General Practice Services Committee
SSC
Specialist Services Committee
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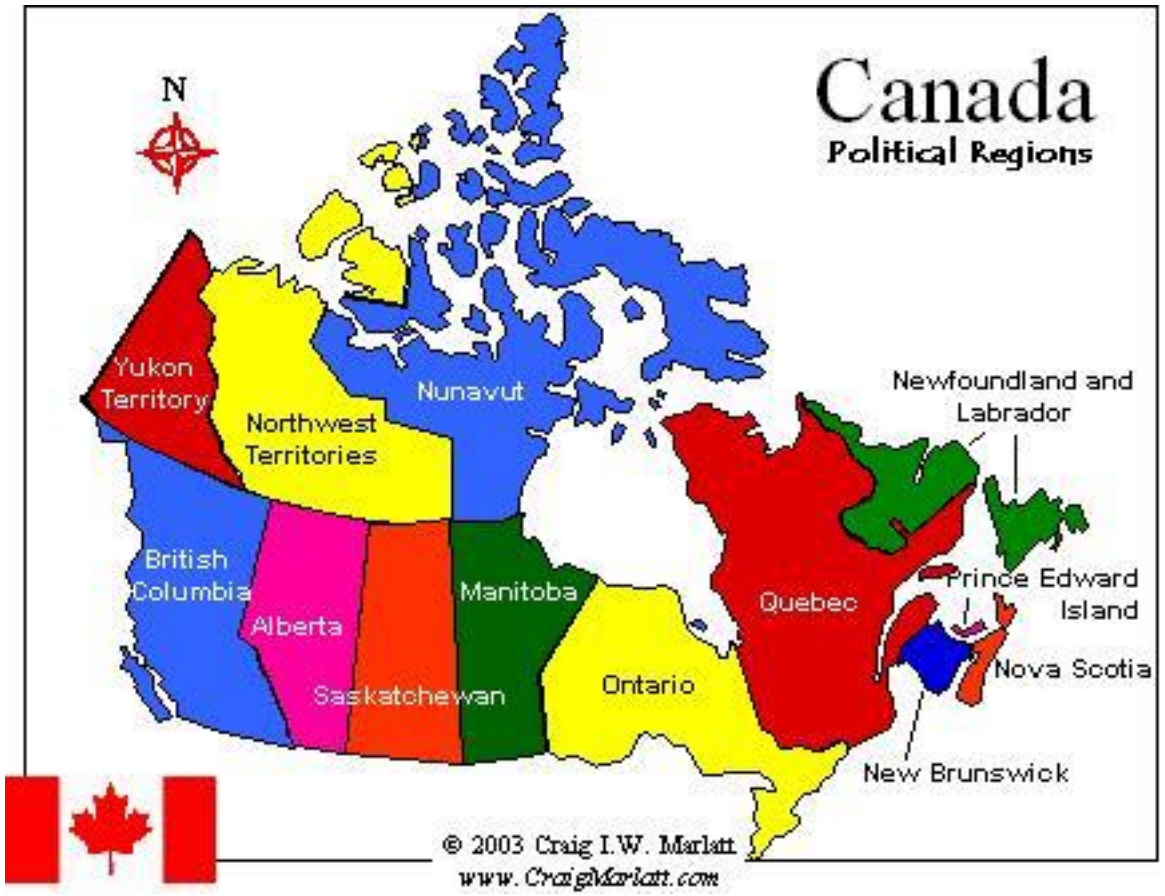
Partners in Care
Polypharmacy
Transitions in Care
Youth Transitions
Rapid Access to Psychiatry
CYMHSU Collaborative
Teledermatology
Practice Support Program
Training scholarships
Redesign Funding

BC 4.6M: Health Regions (5) and Divisions of Family Practice (35)-Communities (230)



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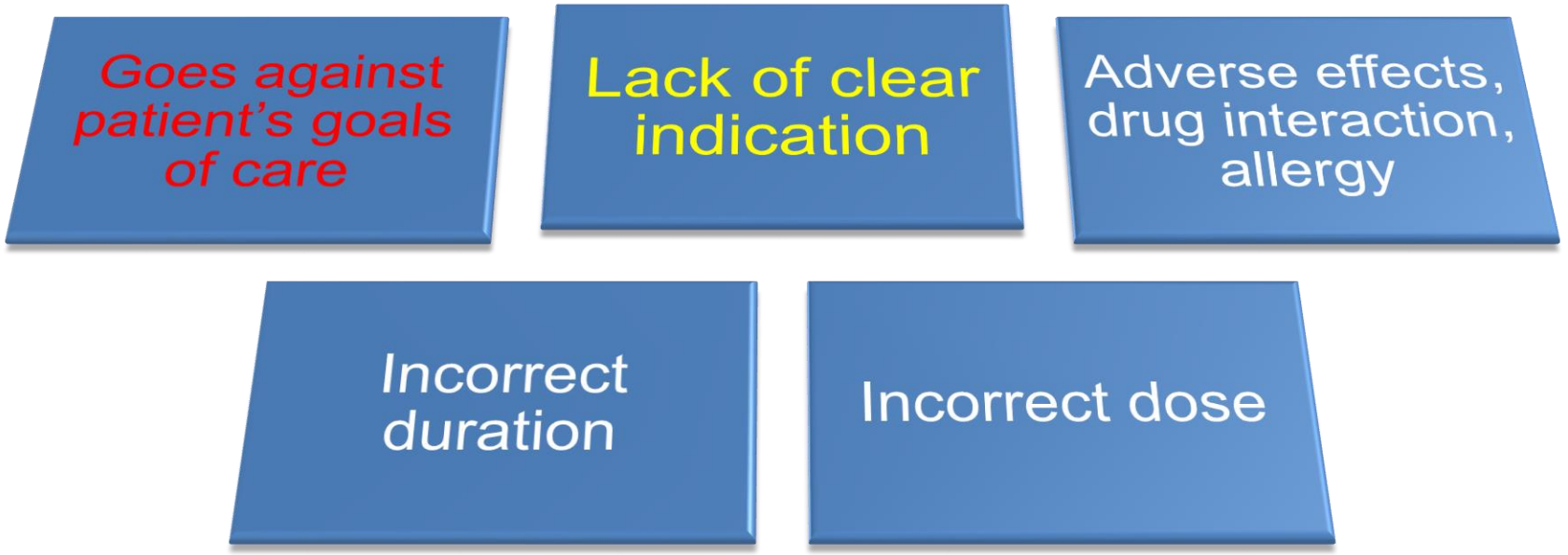
Care Environments-Phased Approach

- Residential Care (2012-Present)
- Acute Care (2014-Present)
- First Nations (2016-Present)
- Community (Not Started)

Polypharmacy: Medications may be inappropriate if:



We treat multiple individual diseases and as a result we give the person an illness:

POLYPHARMACY

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Hospitalisation-Associated Disability

Hospitalization is a sentinel event that often precipitates disability. This results in the subsequent inability to live independently and complete basic activities of daily living (ADLs). This hospitalization-associated disability occurs in approximately one-third of patients older than 70 years of age and may be triggered even when the illness that necessitated the hospitalization is successfully treated.

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What Causes Polypharmacy?

Patient-Centered:

- Multiple comorbidities
- Clinical uncertainty
- The pressure to “Do something”
- Uncertain treatment goals
- Clinical Practice Guidelines
- Drug companies emphasize benefits & downplay the risks
- Multiple prescribers- SPECIALIST consultation (10 years ago?)

System-Related:

- Lack of history
- Lack of communication
- Telephone or fax based medicine
- Transfer back from Acute Care
- Nursing or family reluctance: “Don’t change anything!”
- Treating side effects of another pill
- Free medications

EVIDENCE

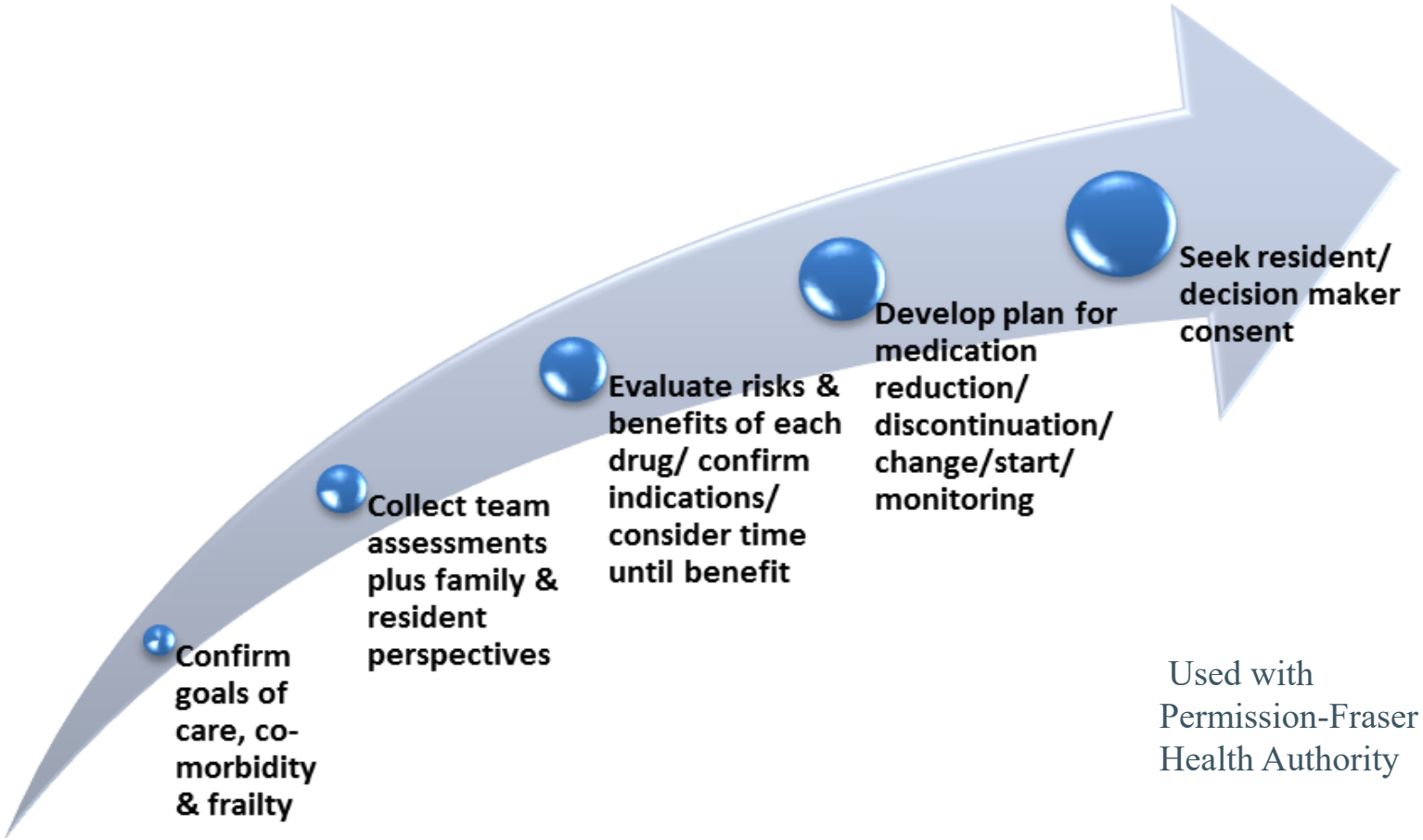
- Garfinkel: Case-control, D/C 3 drugs, re-start 10%, signif dec. hosp and mortality (IMAJ Vol 9, June 2007 pp 430-434)
- Replicated early on in a few residential care homes in BC
- Drug classes rather than Beers or STOPP/START
- Since limited/no evidence in frail elderly looked at general + non-frail elderly
- You Decide Format: Evidence + Practice Points, e.g. Statins:

BENEFITS IN PATIENTS OVER THE AGE OF 65 – data for people over age 80 are minimal

In primary prevention over 3.5 years:
~98% see no benefit
1.2% avoid MI
0.7% avoid stroke

In secondary prevention over 5 years:
~92% see no benefit
2.5% avoid MI
2% avoid stroke
3% avoid death

Approach To Person-Centered Medication Decisions



Used with Permission-Fraser Health Authority

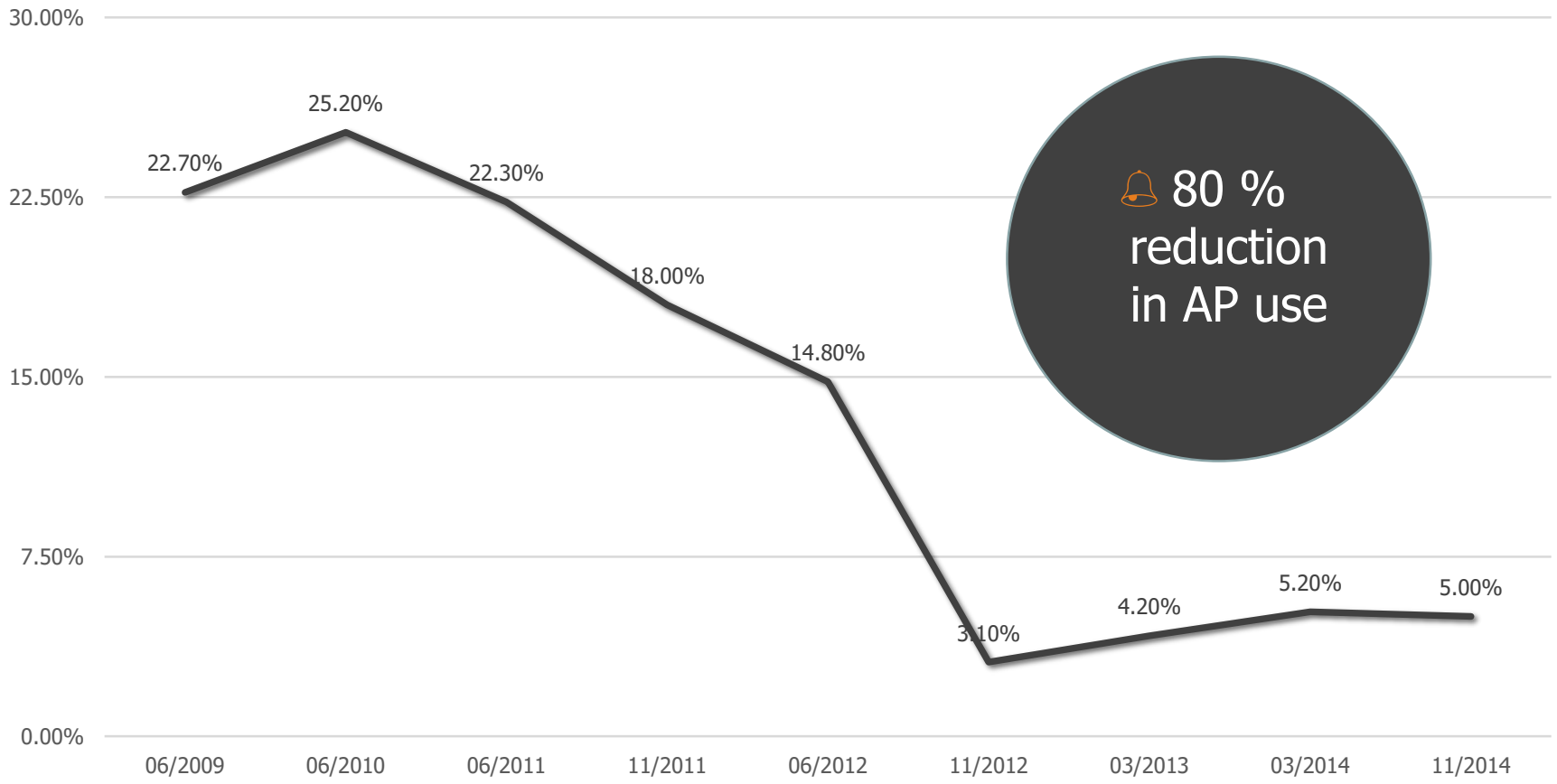
Set the Context in GOC - Symptoms, Function Health Care CG burden

(Adapted from Template of Dr. Ted Rosenberg, Victoria, BC)

Focus on Clinical Issues/Symptoms	Agents/Factors	Actions	Monitoring Plan/Impact of Change

Agassiz-Our Story . . . . Why listen to us?

Because we tried to reduce our use of antipsychotics we failed, we tried again - learning some lessons along the way.



Divisions of Family Practice
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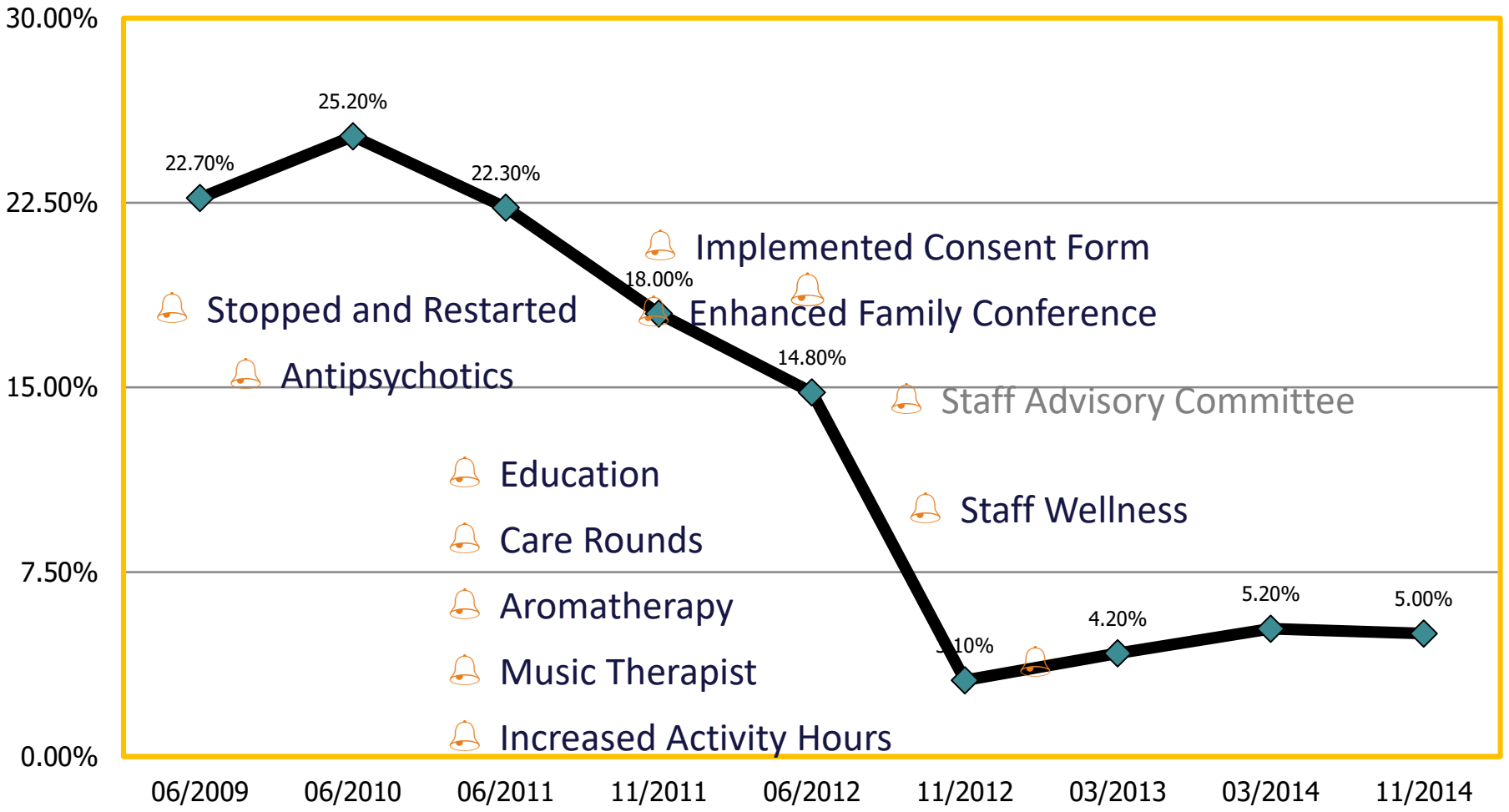
The results - sustained



Rate of antipsychotic use was 6.1 % in May 2016 at Cheam Village. Rate typically varies between 5 and 10%.

Systems Strategy: Residential Care Initiative
GP Services Committee

- *Best Practice Expectations*
  - 24/7 availability and on-site attendance when required
  - Proactive visits to residents
  - Meaningful medication reviews
  - Completed documentation
  - Attendance at case conferences

Engagement so far

- 1900 Physicians who have patients in ResCare
- 30% of docs look after 70% of Residents
- 25 out of the 35 Divisions at various stages of engagement → We have had 600+ ResCare Docs at our sessions!

Acute Care

- Prototyping: Medicine and Surgery (Fractured Hip)
- Challenges: No systematic medication reviews + lack of clinical pharmacy services
- Start with looking at current (mapping), limited and evolving quality improvement approach; champions/working group
- Most focus on discharge phase- med review/reconciliation/communication/ patient education
- Systems strategy: discharge med rec an accreditation standard

First Nations

- Health Authority ←> Individual Communities ←> Primary Care
- Understand First Nations Perspectives: ‘Coyote Story’
- Work With How Services Are Configured: ‘Nursing’
- Physicians Leaders? Pharmacist Involvement?
- Currently Health Authority Focusing on Nursing

Evaluation

- Being Established
- Provincial: Through administrative data sets, potential to look at all over 65 across care environments
- Residential Care-Local: ‘Data Primer”

Lessons Learned/Enablers

- Build a ‘Coalition’ + Leverage ‘Champions”
- ‘Prototype’ When No Established Approach: Developmental (Quality Improvement)- Learned and Adapted As We Went, Local Solutions
- Centre of Goals of Care-Then Can Look at ‘Evidence’/Lack of Evidence
- Understand and Work With Culture (Team), Clinical Approach and Workflow → Develop and Define An Approach, Then
- Identify and Sustain/Spread Through a Systems Strategy/Requirement:
  - BC Residential Care Initiative
  - Acute Care: Discharge Medication Reconciliation

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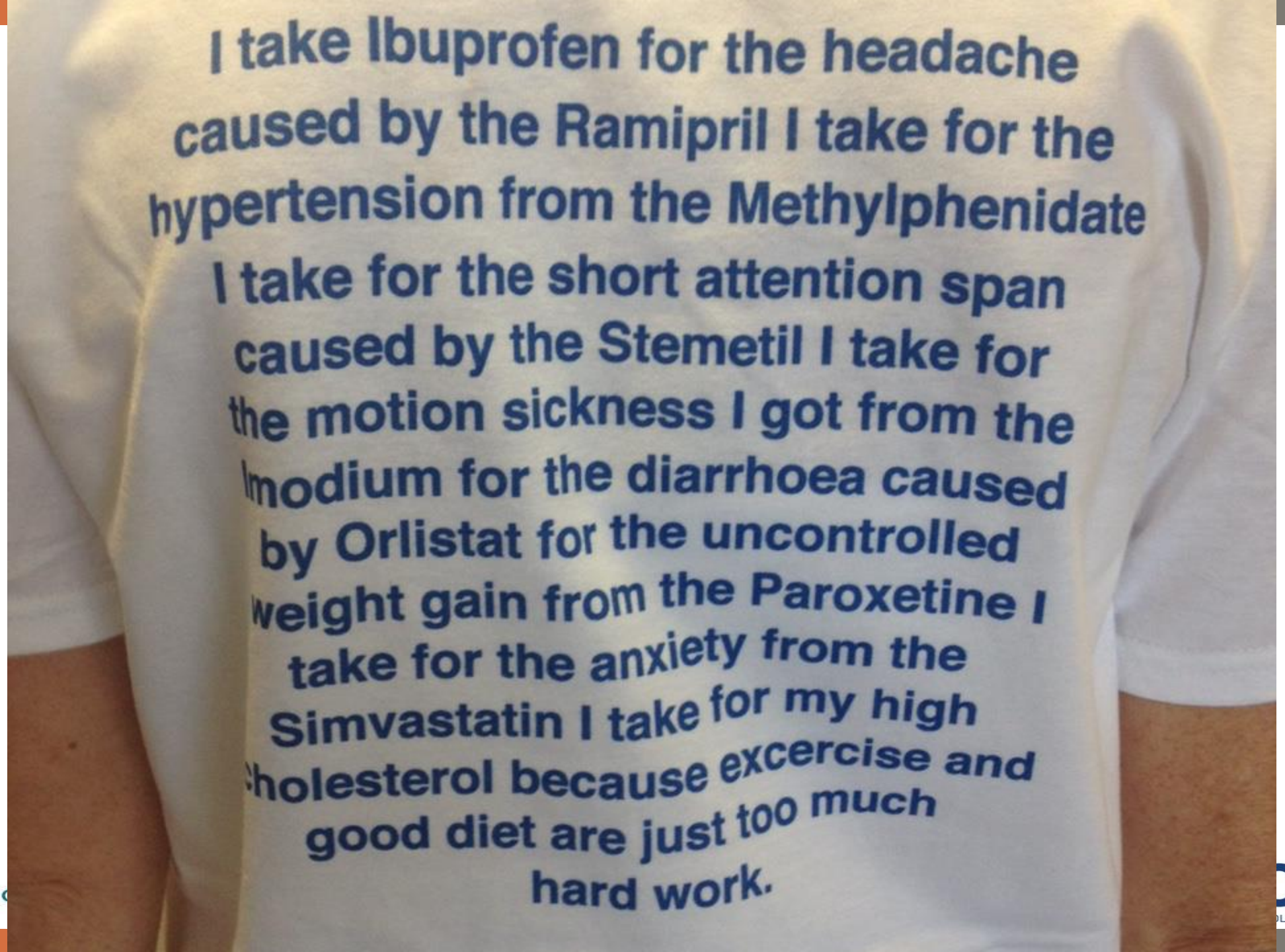
I take Ibuprofen for the headache
caused by the Ramipril I take for the
hypertension from the Methylphenidate
I take for the short attention span
caused by the Stemetil I take for
the motion sickness I got from the
Imodium for the diarrhoea caused
by Orlistat for the uncontrolled
weight gain from the Paroxetine I
take for the anxiety from the
Simvastatin I take for my high
Cholesterol because excercise and
good diet are just too much
hard work.

Residential Care Outcome Measures
St. Joseph Hospital, Comox, BC
115 Chronic Care beds

Time Frame	# Patients on more than 5 medications	# Patients on more than 9 medications
Aug 1-Oct 31 2013	83%	52%
Aug 1-Oct 31 2014	63%	23%
Aug 1- Oct 31 2015	66%	19%
July 1 – Oct 6 2016	50%	21%

Acute Care Outcome measures
St. Joseph Hospital, Comox, BC
120 beds

Time Frame	# Admissions prevented	# Pharmacy Recommendations Accepted	Medication Reduction
June 2014 to May 2015	36	84%	60-77% 4-5 meds
June 2015 to May 2016	41	91%	66 - 83% 5-6 meds

Geriatric pilot project June 2014
Target: high risk elderly patients to reduce inappropriate medications
Saved $88,000 June 2014 to May 2015, $84,000 June 2015 to May 2016