RACGP

RACGP Response to the National Stakeholders Statement: Quality Use of Medicines to Optimise Ageing in Older Australians

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The Royal Australian College of General Practitioners

Introduction

The RACGP is pleased to provide comment on the National Stakeholders' Statement for the Quality use of medicines for older Australians (the Statement). This consultation process facilitates important discussion between government, the health profession and consumers on ways to reduce the number of unnecessary and potentially harmful medicines typically prescribed to older Australians.

The RACGP recognises the need for a comprehensive approach to improve quality use of medicines for older Australians, in particular on avoiding the harms of polypharmacy. However, we consider a 50% reduction in harmful or unnecessary medication use by older Australians over the next five years may be an unattainable target.

We also believe there are certain domains that need to be addressed in order to effectively reduce medication prescribing to older Australians.

Our detailed comments and recommendations to the National Stakeholder's Statement are below.

Gaps in the National Stakeholders' Statement

1. Provide explicit guidance on polypharmacy and deprescribing

Multimorbidity, the presence of multiple chronic conditions in a single individual, is common in older patients and increasingly the norm in general practice[1]. In these patients, treatment and management of one disease can often contribute to poorer outcomes of a co-existing disease.

Single-disease guidelines are commonly used in the elderly and tend toward polypharmacy (defined in the Statement as more than 5 different medications). Although multiple medications are often necessary and can constitute best care for individuals, it is usually regarded as an inconvenience for patients on complex medicine regimes and may lead to adverse outcomes.

To assist health professionals at the point of care, evidence-based guidance and information addressing the challenges of multimorbidity, including adverse outcomes related to polypharmacy and de-prescribing, are needed. Guidance should encourage users to explore evidence-based non-pharmacological methods of treatment as a first option. It should also encourage understanding of patient needs from a biopsychosocial perspective to enable improved care collaboration (for more information, see section 3 below).

Recommendation 1:

- Develop guidance that help health professionals address multimorbidity, polypharmacy and de-prescribing.

2. Raising consumer awareness of polypharmacy and deprescribing

Health information is more readily available than ever before due to the increased access to communication technology through mobile phones, the internet and electronic media. As a result, many individuals approach healthcare as informed consumers. Although communication technology has become an integral part of everyday use for many people, they are underutilised by older Australians.[2]

The draft Statement describes that more than 90% of older Australians surveyed would like to stop one of their medicines if their doctor said it was possible. Whilst encouraging, this number does not reflect the experience of many GPs working in this area, who report older adults usually show a high level of resistance towards the withdrawal of long-term medication.

Furthermore, it is not uncommon for carers and families to perceive de-prescribing as a withdrawal of active treatment. This may result in a failed collaboration between the health professional and significant others, which in turn negatively impacts the health and wellbeing of the older person. Consequently, the task of educating and motivating individuals and their support networks about the benefits of de-prescribing may be slower than anticipated.

In order to facilitate change it is important that health professionals consider family members and significant others involved in the care of older people. Educating both patients and the support network around the risks of polypharmacy is crucial to the partnership of care and assists health professionals in their efforts of improving patient literacy around de-prescribing. The Statement does not clearly communicate the pull and push factors that stimulate health consumers and professionals to consider de-prescribing.

In addition, increasing processes-of-care by incentivising more medication reviews is unlikely to achieve de-prescribing targets. Communicating the health benefits, convenience and costs savings for individual and the community is more likely to motivate older Australians and those involved in their care to adopt change.

Recommendation 2:

- Develop information and resources to help health professionals communicate the potential harm of polypharmacy to older patients and their support networks.
- Statement to carefully consider appropriate incentives for individuals and health professionals to actively engage in de-prescribing.

3. Multidisciplinary patient-centred care

The discrepancies between what the older person takes, what the pharmacist dispenses, the GP medication list, the national eHealth record medication list (MyHealth Record), and the specialist/hospital medication lists are considerable. This is particularly dangerous during transitions in care between health care sectors. For example, it is not uncommon for non-adherent patients to suddenly receive all their prescribed medications on entry to a nursing home without going through a proper medication reconciliation first.

Continuity of care becomes increasingly important for patients as they age, develop multiple conditions or complex problems, or become socially or psychologically vulnerable. Quality use of medicines is strongly related to continuity in medication management, and health care professionals have a responsibility to participate in all aspects of medication management in partnership with consumers and their carers.

The RACGP supports the medical home model, under which a personal doctor and their practice tends to a person's health care needs throughout their life journey. Under this model, a GP and their practice team is trusted and known by the older person and vice-versa, making the identification and discussion of patient values and priorities easier. Identifying patient values and priorities is key to choosing what can be de-prescribed when there is equivocal evidence for use of a medication.

Recommendation 3:

- Support GPs in leading the continuous medication reconciliation process.
- Promote good practice guidelines to health professionals involved in the care of older people. The RACGP Silver Book (4th ed) encourages collaboration between health professionals and provides suggestions for implementing systematic care involving residents, their general practitioners, residential aged care facility staff, family and other cares. A review of the Silver Book is scheduled to commence in late 2015 and a link to the existing guideline is provided below. [3]

4. Education and tools for healthcare practitioners

The Statement appears to focus on the big picture, and only alludes to education and training in point 5. As described above, GPs need access to evidence-based clinical resources and education to address polypharmacy and support de-prescribing. Detecting drug-drug and disease-drug interactions presents a challenge for GPs, which is further compounded by a lack of drug interaction programs to assist GPs evaluate possible adverse effects.

It is often difficult to determine the treatment horizon. However, there are circumstances where new treatment is unlikely to benefit such as statins for secondary prevention in nursing home residents with limited life expectancy.

Information, education and tools to assist healthcare practitioners evaluate possible side-effects are needed as part of a larger appropriate prescribing process.

Recommendation 4:

- Evidence-based guidance related to addressing polypharmacy and appropriate prescribing processes must be supported by education
- Support GPs in conducting medication reviews. While this has tended to be delegated to pharmacists, the evidence of benefit of the latter is mixed. A clinician medication review should cover:
    - indications
    - contraindications
    - dosage
    - appropriateness
    - current self medications
    - alcohol intake
    - any previous medication intolerance
    - likely benefit of the medication
    - patient understanding of mode, timing, frequency, monitoring and adverse effects
    - possible interactions: drug-drug and drug-illness
    - treatment duration
    - monitoring of impact, therapeutic 'level' and adverse effects
    - renal function
    - adherence.

Conclusion

The RACGP recognises the need for a comprehensive approach to improve quality use of medicines for older Australians, in particular on avoiding the harms of polypharmacy. However, a 50% reduction in harmful or unnecessary medication use by older Australians over the next five years may be an unattainable target.

Building push and pull factors is important to encourage de-prescribing across the community and health professionals to increase levels of confidence around the reduction of polypharmacy.

The success of the strategy is also dependent on supporting health professionals in communicating the potential harm of polypharmacy to older patients and their support networks. A strong patient-GP partnership of care can help build older people's confidence to engage in medication reviews, which will potentially lead to a reduction in the number of medications taken on an ongoing basis. Health professional guidance and education in relation to appropriate prescribing processes, including de-prescribing, is a key element to support achieve the strategy outcomes in the long-term.

Most importantly, the promotion of good practice guidelines that emphasise systematic care is the cornerstone for the successful implementation of the strategy.

References

[1] RACGP. June 2014. General practice plays the lead role in the management of patients with multimorbidity. Retrieved from: http://www.racgp.org.au/download/Documents/Policies/Health%20systems/ppi_multimorbidity_position-statement.pdf [9 October 2015]

[2] Australian population & migration research centre. August 2013. Older people's use of new communication technologies. Retrieved from: https://www.adelaide.edu.au/apmrc/pubs/policy-briefs/APMRC_Policy_Brief_Vol_1_8_2013.pdf [9 October 2015]

[3] RACGP.April 2006. Medical care of older person in residential aged care facilities – silver book (4th ed.). Retrieved from: http://www.racgp.org.au/download/documents/Guidelines/silverbook.pdf [9 October 2015]