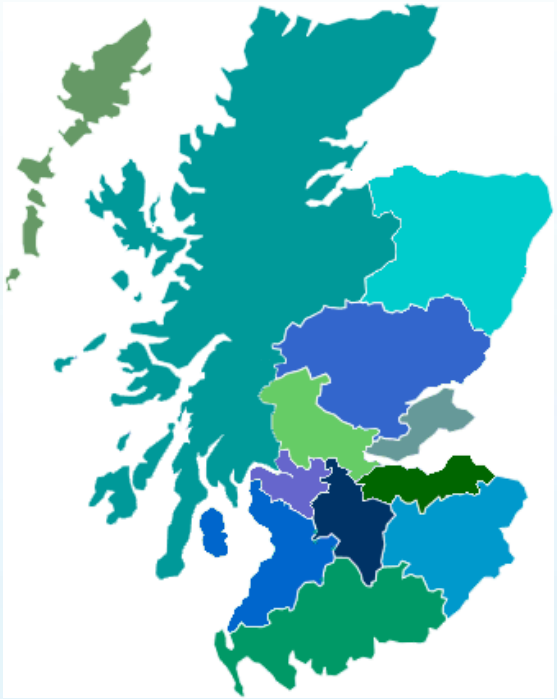
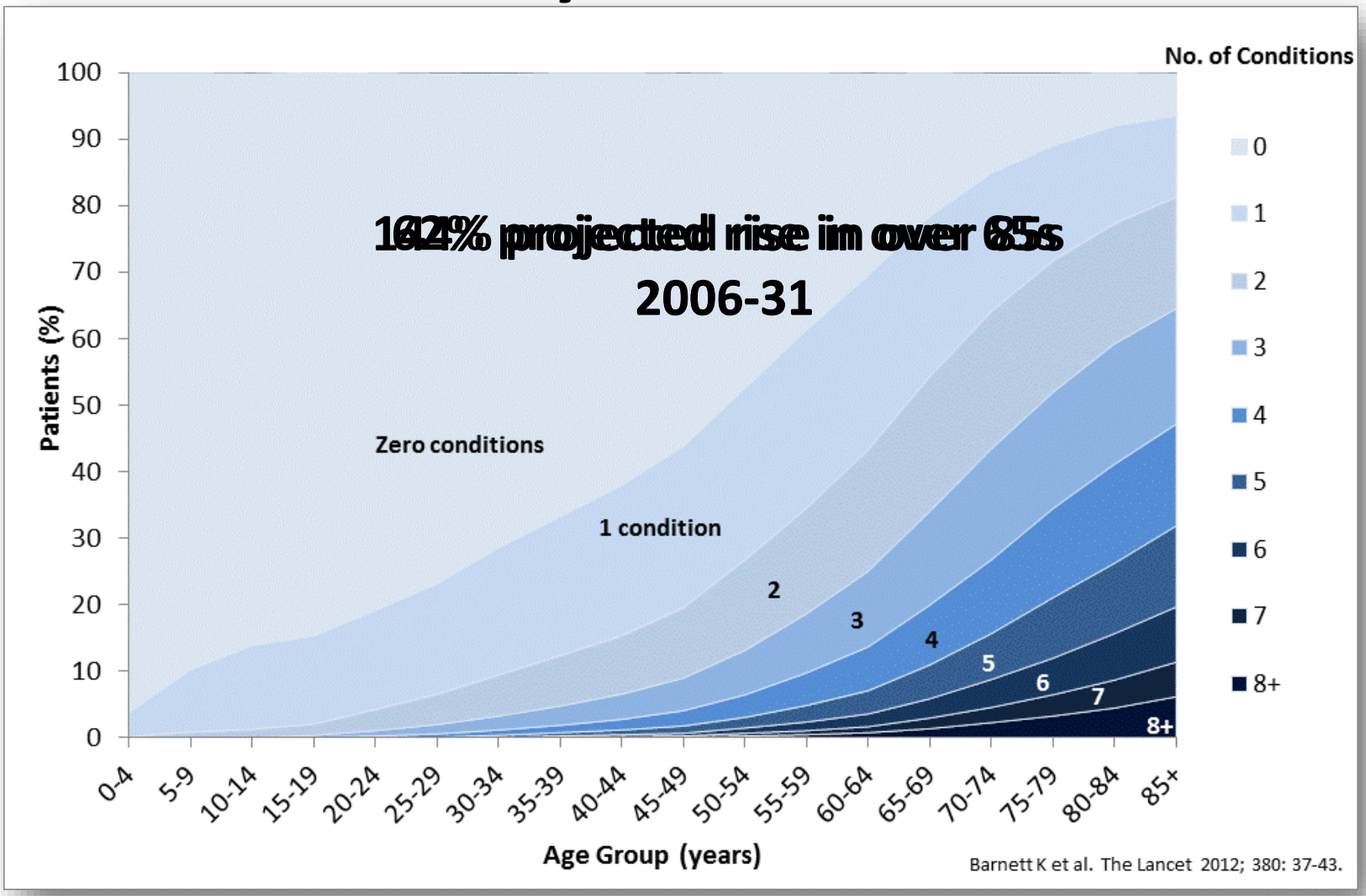


Alpana Mair, Head of Prescribing & Therapeutics Scottish Government
EU Project Coordinator:SIMPATHY, Clinical Pharmacist, Homeless practice
@alpanamair @ SIMPATHYProject

Multimorbidity is common



More people have 2 or more conditions than only have 1

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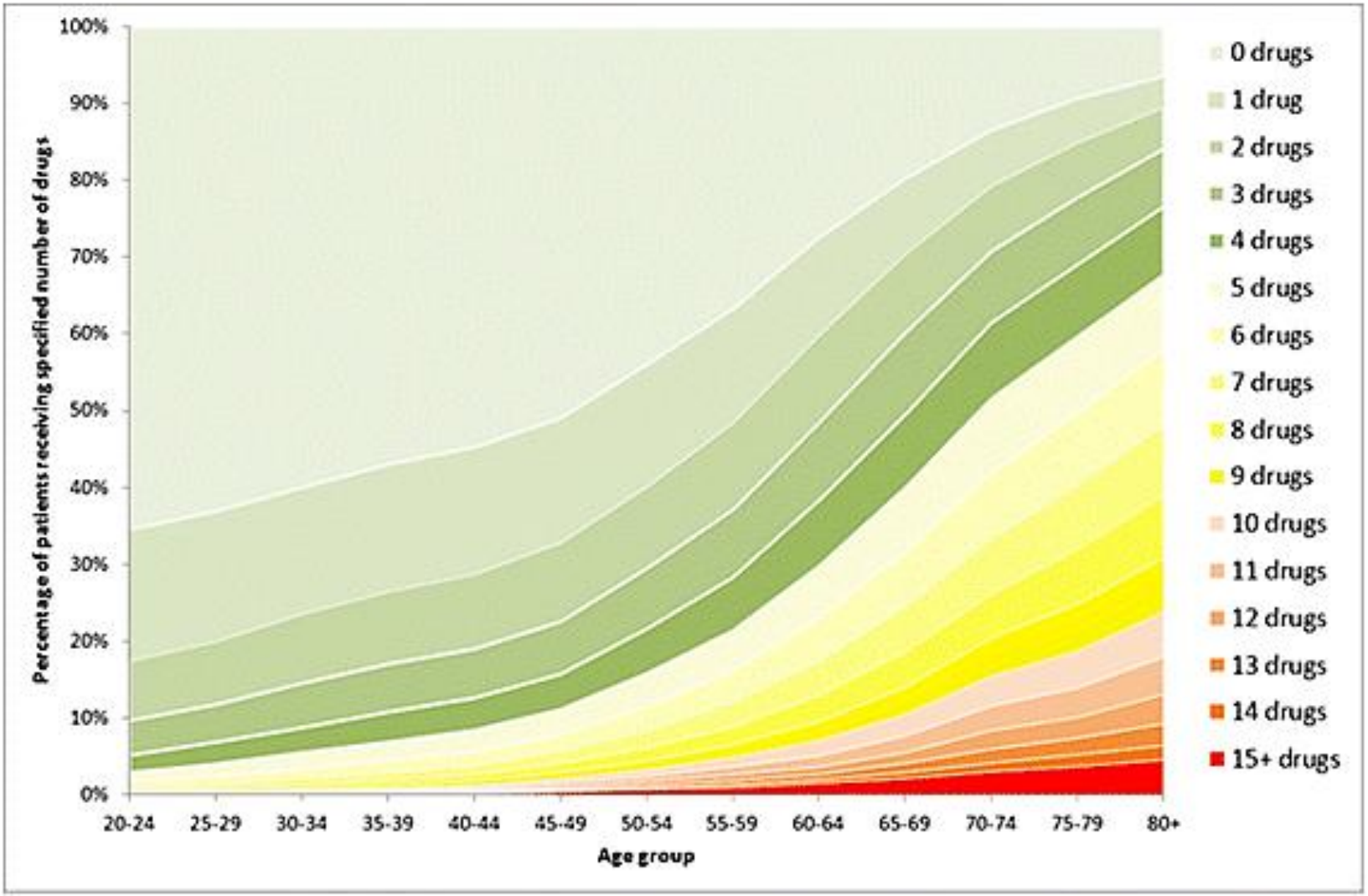
PHARMACOLOGY

Why did you jump off a cliff?

Because the Guideline told me to.

The Scottish Government

2010



The Scottish Government

Guthrie et al

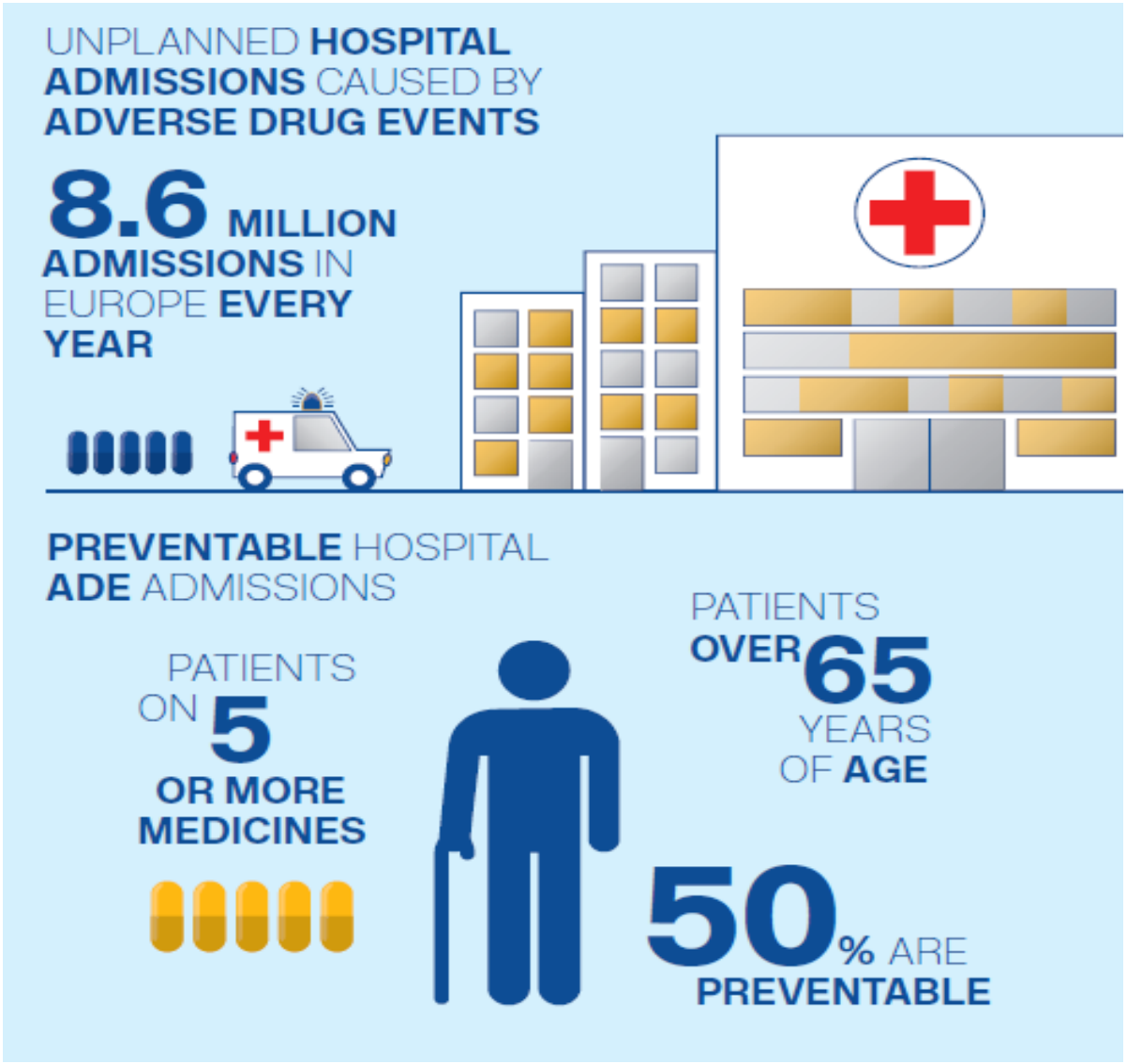
Functional Status v Age : Person centred

A Standard guideline would not differentiate between the two

‘Use clinical judgement’

The Scottish Government

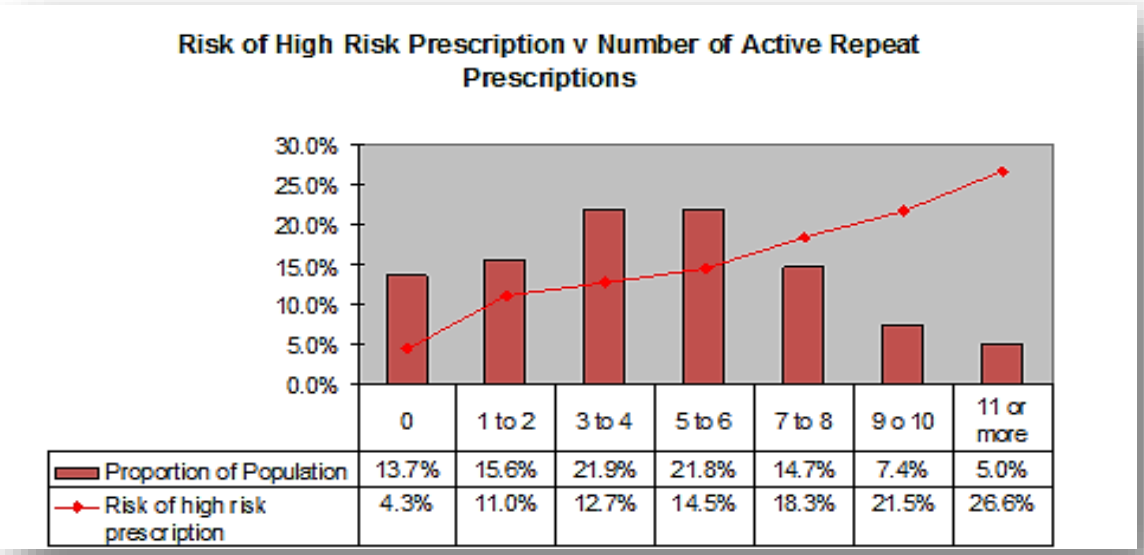
Urgency



"not to put people on drugs they don't need" (GP Senior manager)

The Scottish Government

Urgency:



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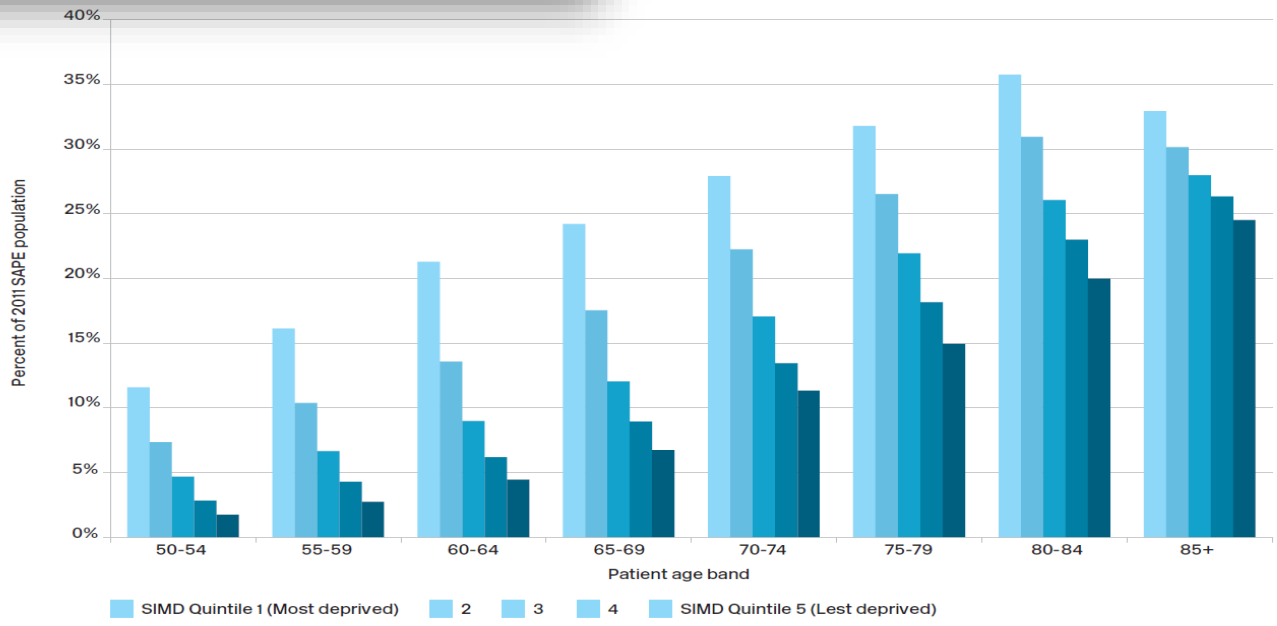
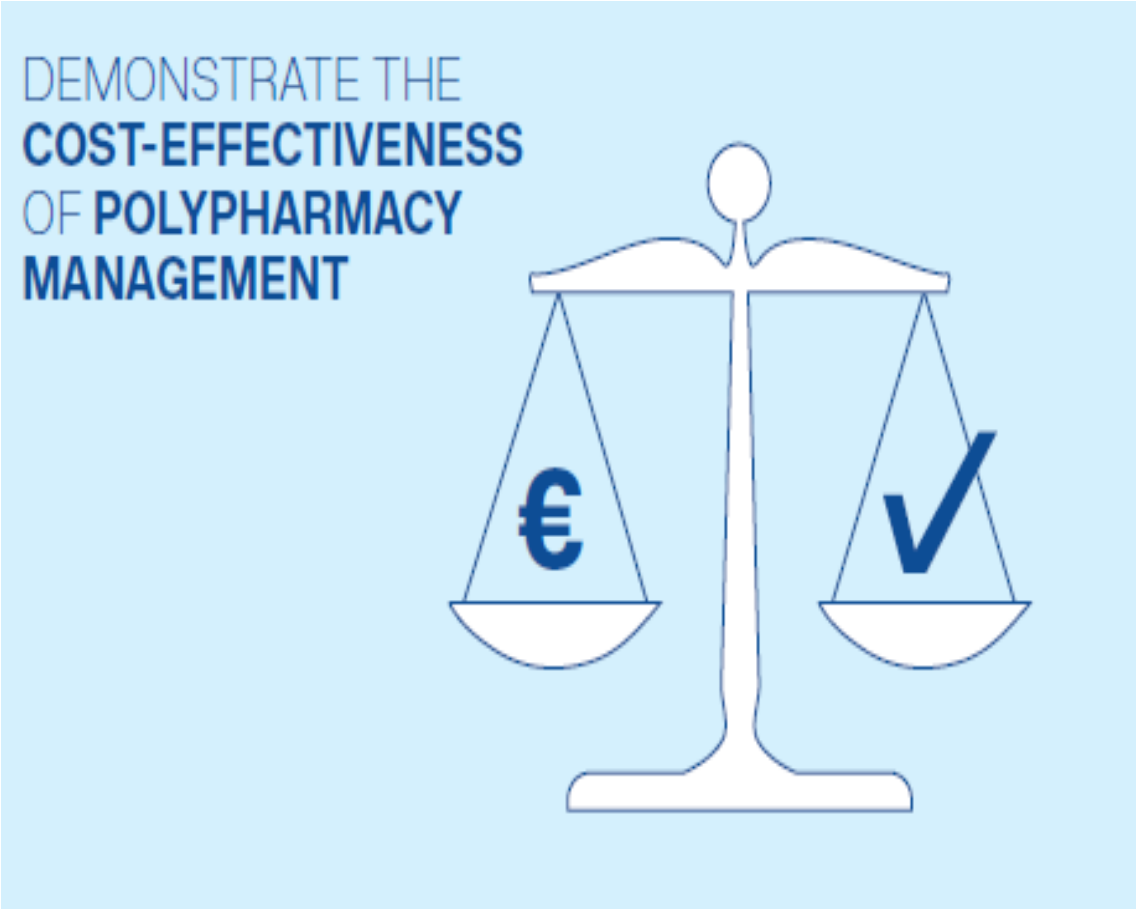


Chart 2. Percentage dispensed 10+ BNF paragraphs + high risk drug
By age group and 2012 SIMD Quintile, Scotland Jul - Dec 2016

NHS SCOTLAND



Convince someone it is cheaper to prescribe well

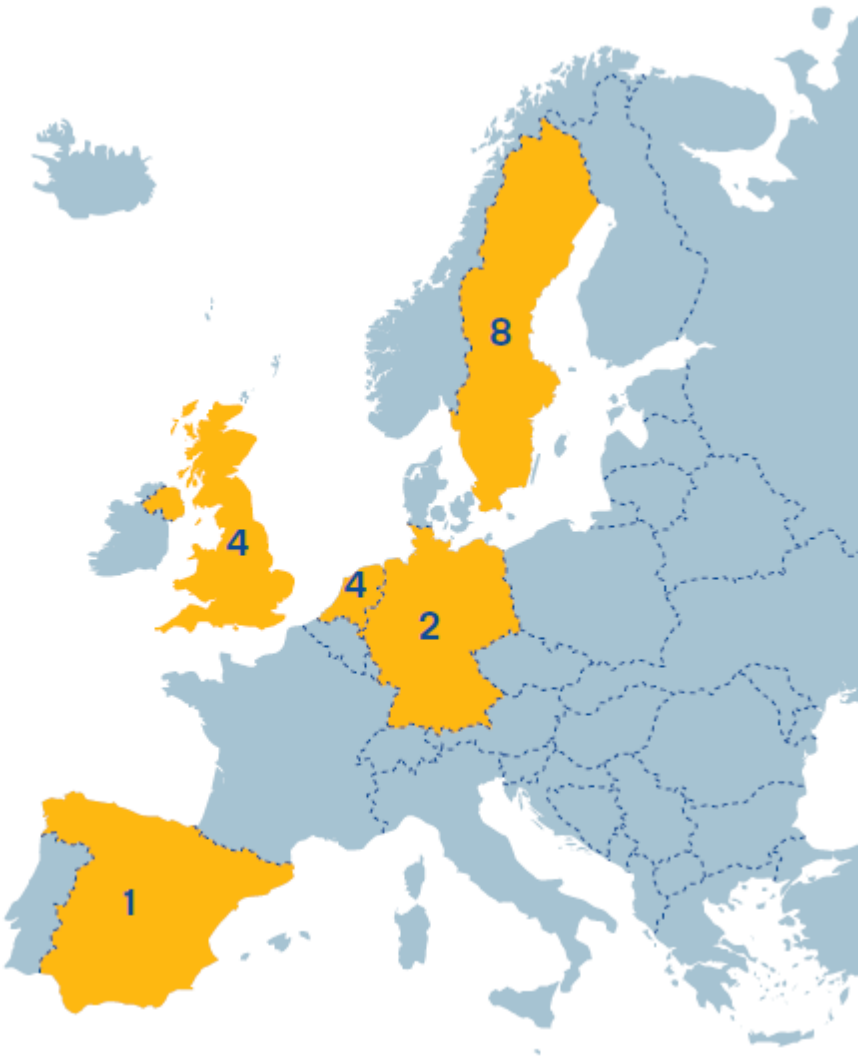
IMS Report *" Advancing responsible use of medicines" & WHO, World Bank Global data set across 186 countries: 4% of total avoidable costs due to polypharmacy. Total of 3% global health expenditure could be saved = $18bn*

The Scottish Government

The Scottish Government

Guidelines

- EU evaluation: 5 countries with guidance- 3 scored highly
- BEERS, STOP START
- Australian- deprescribing



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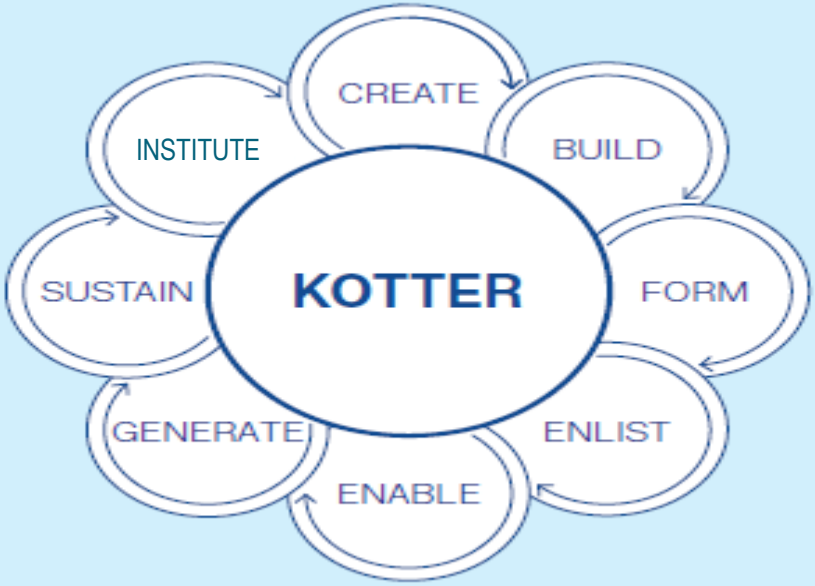
MULTI-DISCIPLINARY HOLISTIC PATIENT REVIEW

USE CHANGE MANAGEMENT



Creating practice models & Initiatives

Polypharmacy national Programme: guidance : consensus 7 steps

Domain	Steps		Process
Aims	1.	What matters to the patient?	**Review diagnoses and identify therapeutic objectives with respect to:** ➢ Identify objectives of drug therapy ➢ Management of existing health problems ➢ Prevention of future health problems
Need	2.	Identify essential medicines	**Identify essential medicines (not to be stopped without specialist advice)** ➢ Medicines that have essential replacement functions (e.g. thyroxine) ➢ Medicines to prevent rapid symptomatic decline (e.g. drugs for Parkinson's disease, heart failure)
	3.	Does the patient take unnecessary medicines?	**What is medication for? (Consider OTCs and traditional medicines.) Review the reason for giving, and the on-going need for, each medication:** ➢ with temporary indications ➢ with higher than usual maintenance doses ➢ with limited benefit/ evidence of its use in general ➢ with limited benefit in the patient under review (see Drug efficacy & applicability (NNT) table)
Effectiveness	4.	Are therapeutic objectives being achieved?	**Identify the need for adding/intensifying drug therapy in order to achieve therapeutic objectives** ➢ to achieve symptom control ➢ to achieve biochemical/clinical targets ➢ to reduce disease progression/exacerbation ➢ Is there a more appropriate medication or strategy that would help achieve goals?
Safety	5.	Is the patient at risk of side effects? Does the patient know what to do in the event of illness?	**Identify patient safety risks by checking** ➢ if the targets set for the individual are appropriate? ➢ drug-disease interactions ➢ drug-drug interactions (see ADR table) ➢ monitoring mechanisms for high-risk drugs ➢ risk of accidental overdose **Identify adverse drug effects by checking** ➢ specific symptoms/laboratory markers (e.g. hypokalaemia) ➢ cumulative adverse drug effects (see ADR table) ➢ medicines that may be used to treat side effects caused by other medicines **If appropriate, discuss and give Sick Day rule card to patient (link)**
Cost-effectiveness	6.	Is therapy cost-effective?	**Identify unnecessarily costly therapy by** ➢ considering more cost-effective alternatives (but balance against effectiveness, safety, convenience)

GP contract & commitment to practice based pharmacists £16.2M Scot) +£31M (England)

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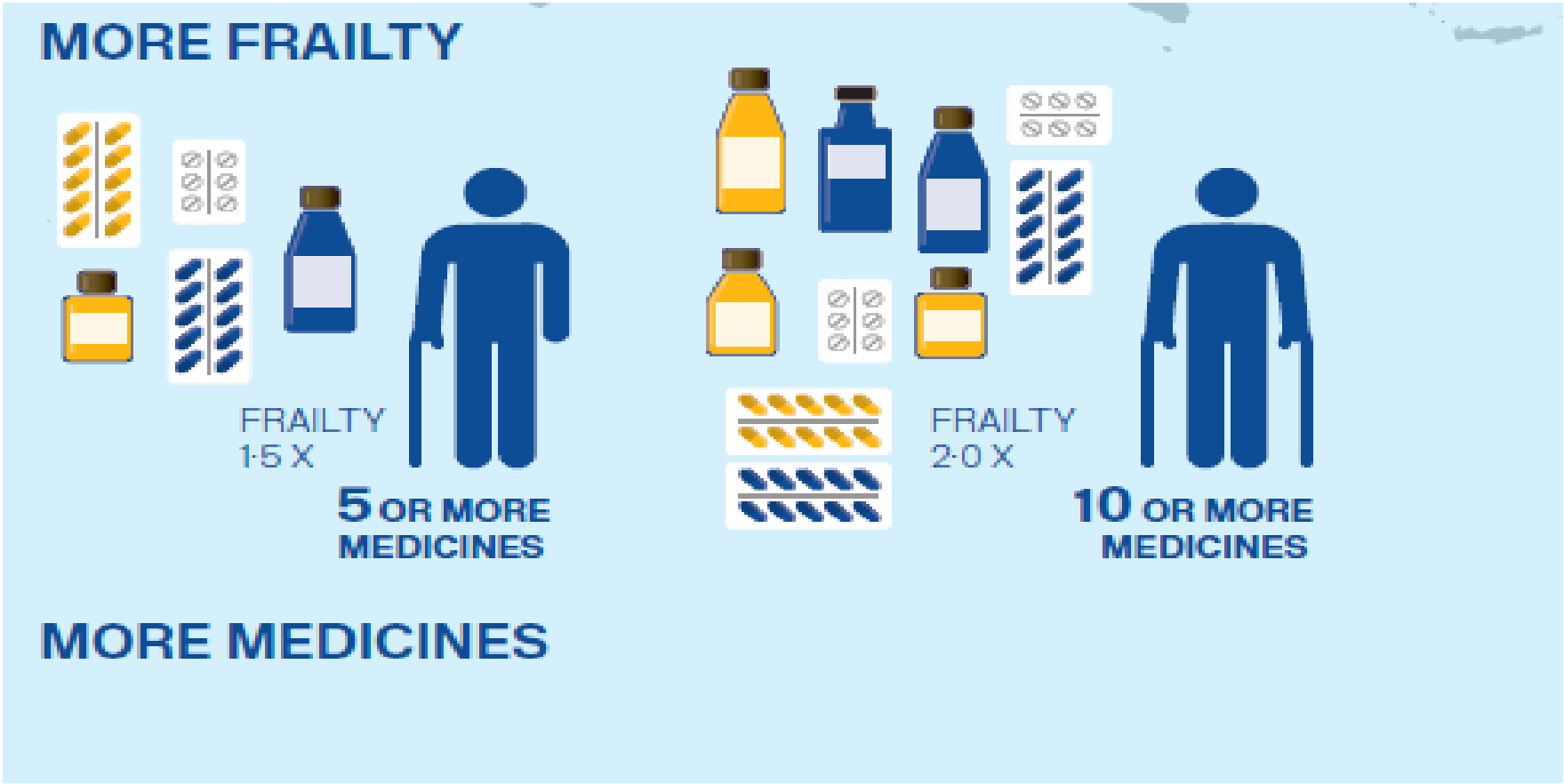
Aims
Need
Effectiveness
Saftey
Cost effective
Patient centeredness
what matters to me?/ the patient



Identifying Patients to target: Risk stratification

- Indicators e.g Swedish
- Tools such as BEERS, STOPP START, Palliative
- High Risk drugs
- 10+ meds

Co-morbidities

Frailty

Care homes

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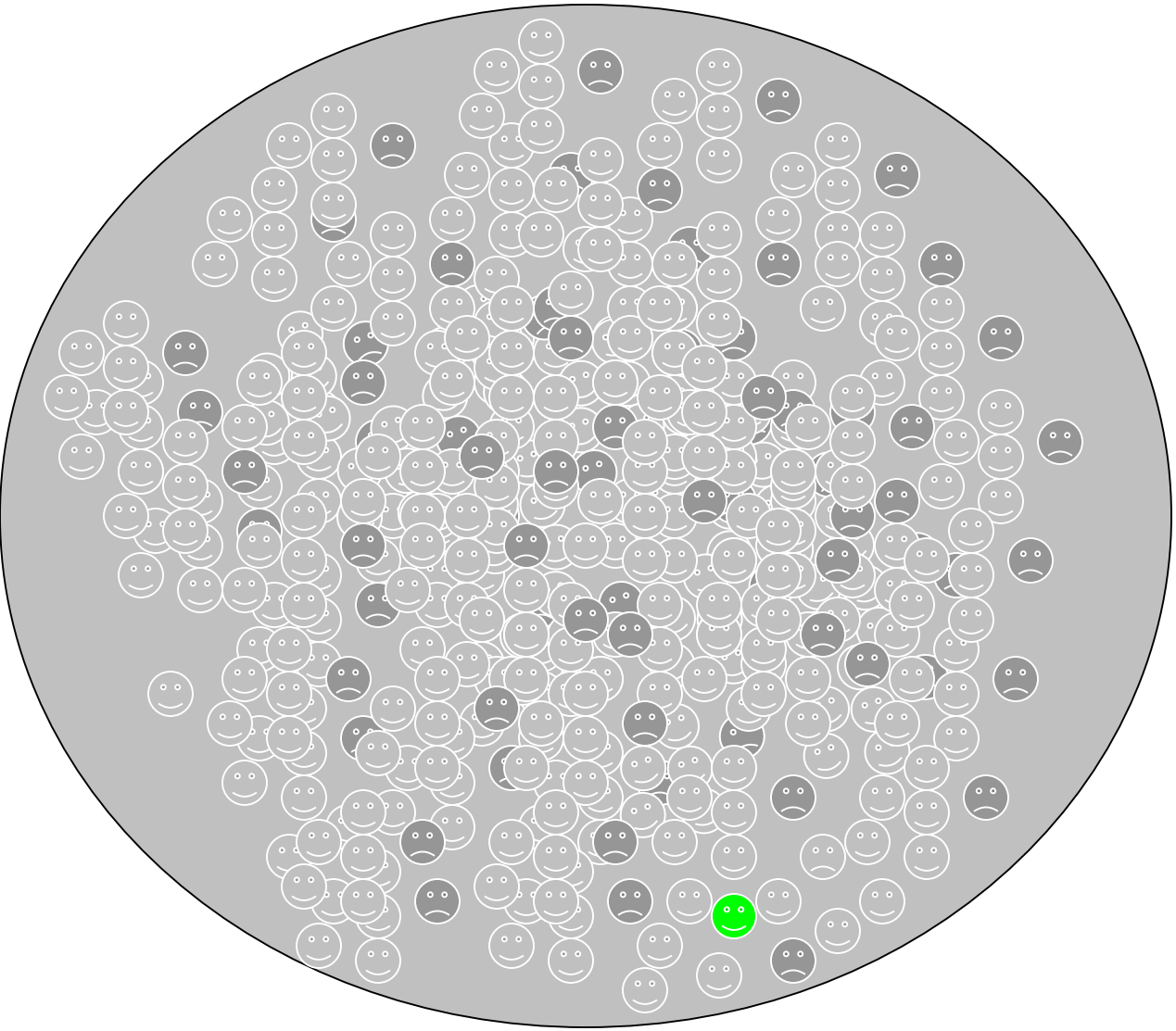

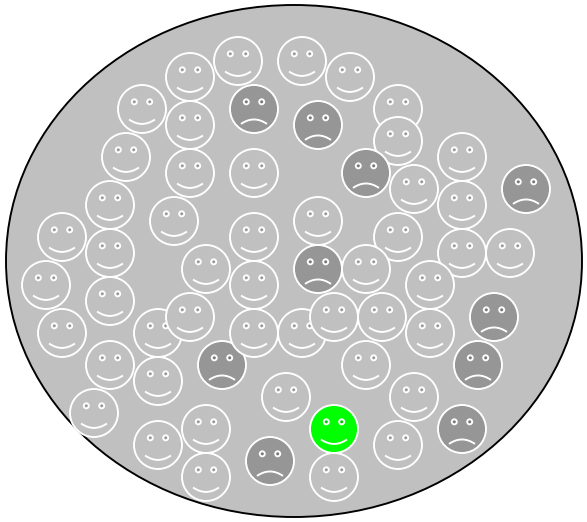

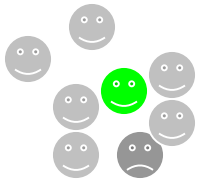

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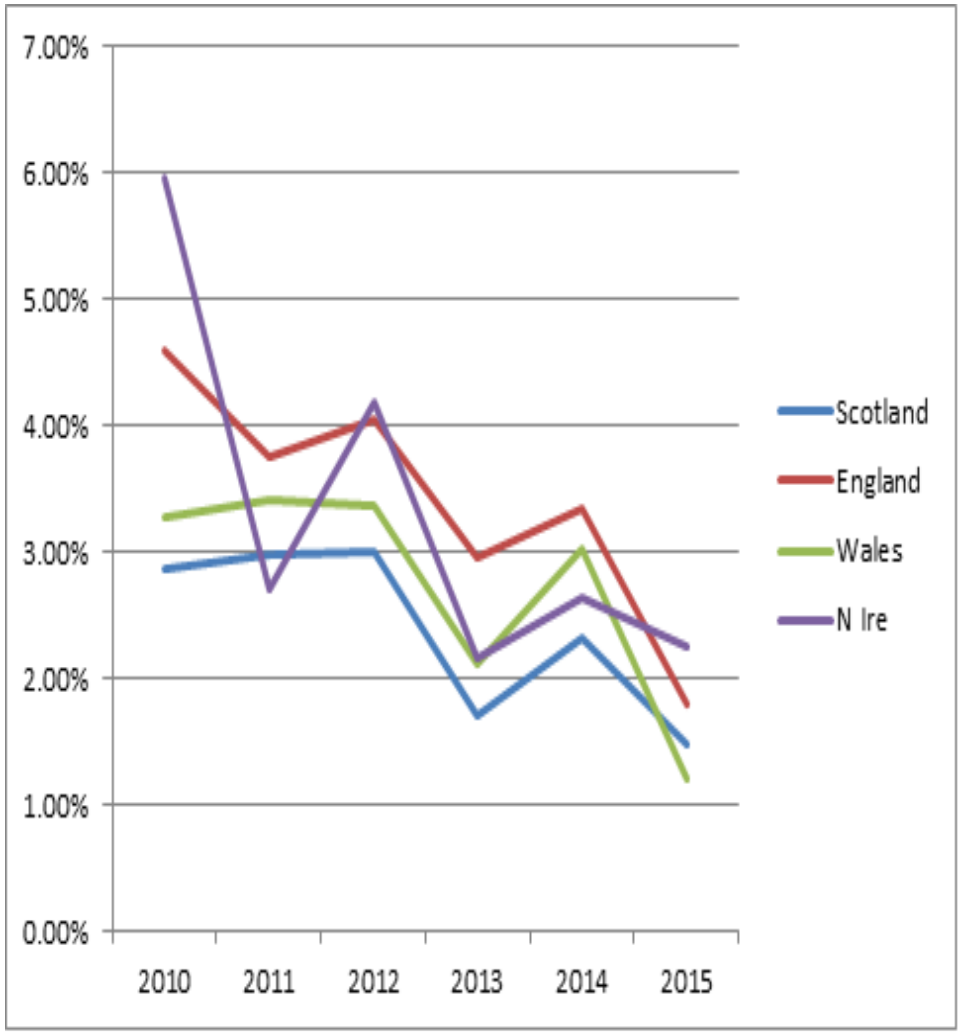
What has been successful?

- DQUIP study
- PINCER study
- USA
- Spanish
- Chinese: National Essential Medicines Scheme
- Australia: deprescribing



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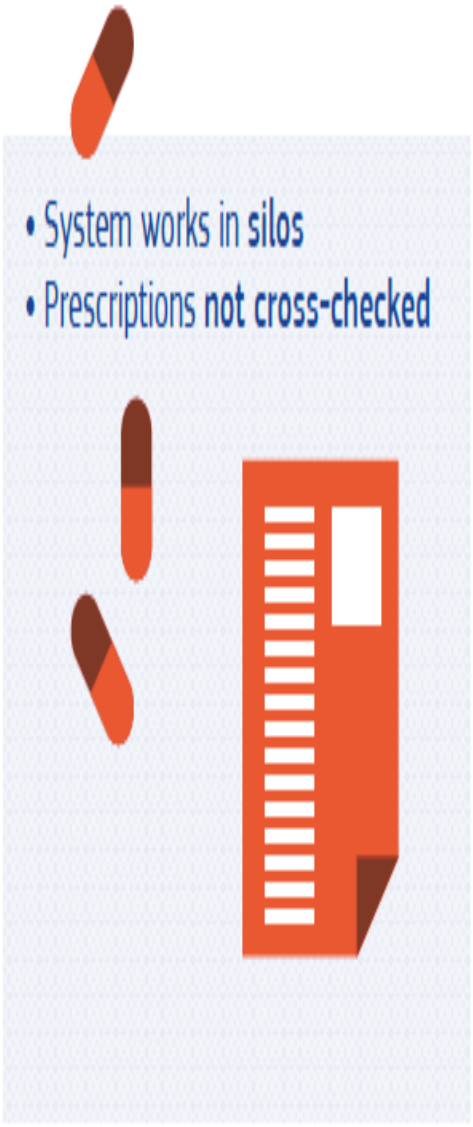
Communicating : Across the care interfaces



Can this be implemented @ Scale?

10 Organisations

www.simpathy.eu

Partners:

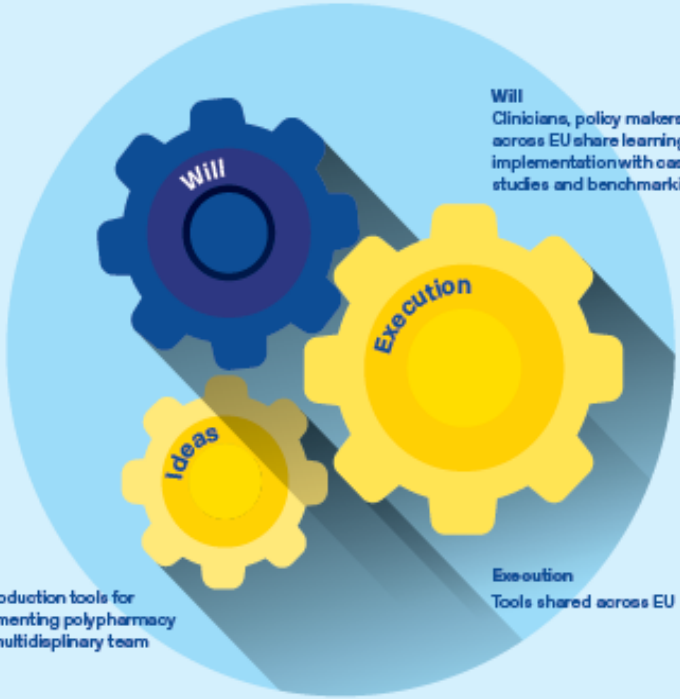
ROBERT GORDON UNIVERSITY ABERDEEN · Northern Health and Social Care Trust · MEDICAL UNIVERSITY OF LODZ · CLÍNIC BARCELONA · Universidade de Coimbra · The Scottish Government · ΠΑΝΕΠΙΣΤΗΜΙΟ ΠΕΛΟΠΟΝΝΗΣΟΥ UNIVERSITY OF PELOPONNESE · AKADEMISKA SJUKHUSET · MHH Hannover Medical School

SIMPATHY Stimulating Innovation Management of Polypharmacy and Adherence in The Elderly

Inappropriate Polypharmacy
A Major Health Issue

50% of the people taking 4 or more medicines don't take them as prescribed.

Changing the approach to multiple prescriptions requires a "collective" and joint effort involving different stakeholders.



Will
Clinicians, policy makers across EU share learning on implementation with case studies and benchmarking

Ideas
Co-production tools for implementing polypharmacy with multidisplinary team

Execution
Tools shared across EU

Co-funded by the Health Programme of the European Union

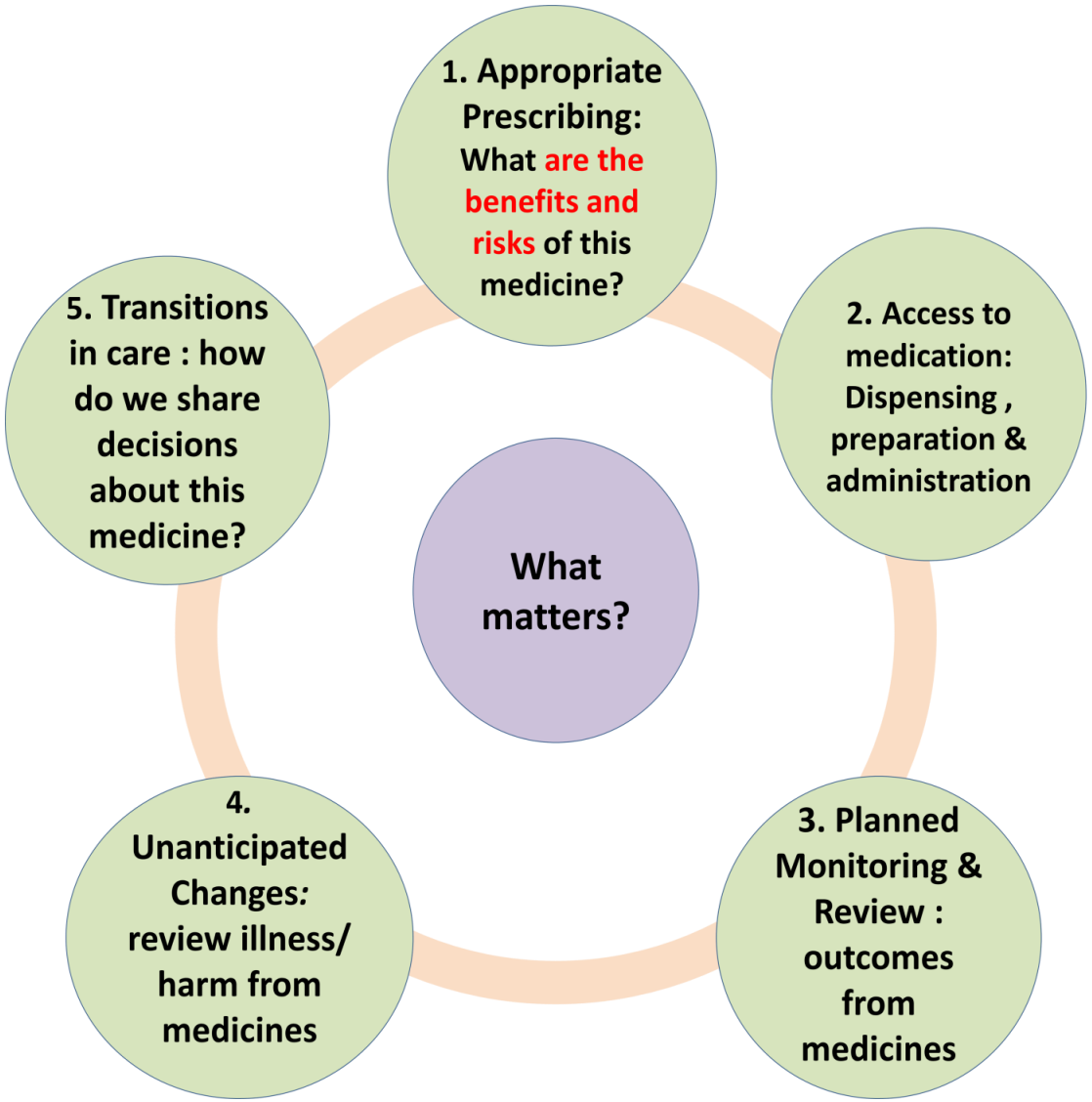
This leaflet is part of the SIMPATHY project (663082), which has received funding from the European Union's Health Programme (2014-2020).

Global Challenge : Health Professionals

Co-production

- Cultural issues: human factors
- Joint education
- Guidance-
- mobile app developed by team + patient for use across interface
- Multi-disciplinary working
- Health professionals engage “what matters to you”

Global Challenge: Systems & Practices



SIX PILLARS:

- Patient held medical records
- Pharmacovigilance systems
- Scientific regulation
- Monitoring for improvement
- Governance
- Patient and community engagement

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Global Challenge: Patients

Medicine Sick Day Rules

NHS Highland

When you are unwell with any of the following:

- Vomiting or diarrhoea (unless only minor)
- Fevers, sweats and shaking

Then STOP taking the medicines listed overleaf

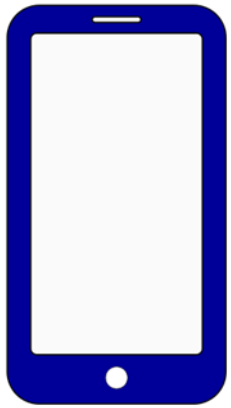
Restart when you are well (after 24-48 hours of eating and drinking normally)

If you are in any doubt, contact your pharmacist, GP or nurse

Medicines to stop on sick days

ACE inhibitors:	medicine names ending in "pril" *eg, lisinopril, perindopril, ramipril*
ARBs:	medicine names ending in "sartan" *eg, losartan, candesartan, valsartan*
NSAIDs:	anti-inflammatory pain killers *eg, ibuprofen, diclofenac, naproxen*
Diuretics:	sometimes called "water pills" *eg, furosemide, spironolactone, indapamide, bendroflumethiazide*
Metformin:	a medicine for diabetes

Produced April 2013. Authorised by: NHS Highland SPSP Primary Care working group



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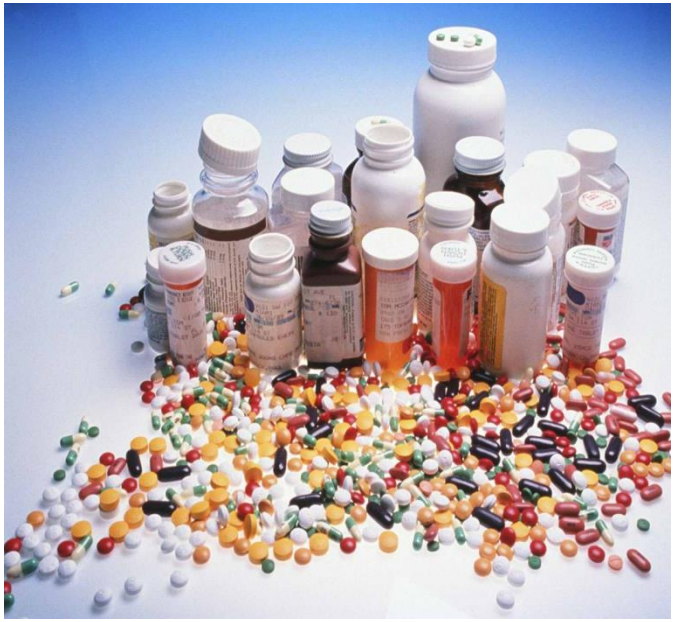
Global Challenge: Medicines & Monitoring & Evaluation

Medicines

- Key messages for patients
- Bar coding
- packaging



Monitoring & Evaluation

- Indicators :
  - GI bleeds
  - AKI
  - Antibiotics- HAI
  - Heart failure
  - Falls
  - Resp- corticosterioids/ excess SABA
  - Anticholinergic burden
  - Vascular events
  - Dependency
  - Constipation

- Data across interface
- Patient passport data

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You don't have
to see the
whole staircase,
just take the
FIRST STEP

@alpanamair

Global Challenge

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