SharedCare
Partners for Patients

Polypharmacy Risk Reduction (PPhRR) Community Visioning Session

Summary Report

April 26, 2018

Overview

The Shared Care Polypharmacy Risk Reduction (PPhRR) initiative aims to reduce risks of polypharmacy in the elderly by providing physicians with tools and strategies to reduce medications for improved safety and quality of life. With experience in developing approaches and resources to support physicians in residential and acute care, the purpose of this day is to explore opportunities to support approaches in community settings to align with Patient Medical Homes and Primary Care Networks as they're being developed.

Participants

The participants in the day included, General Practitioners, Specialists, Pharmacists, Patient Representatives, Ministry of Health, and Health Authority Representatives.

The Day

Dr. Keith White, PPhRR Physician Lead, and Dr. Chris Rauscher, Clinical Lead for PPhRR, started the day by reviewing the opportunities and objectives for the day's discussion.

The 5 hour working session was designed to:

1. Identify where opportunities exist to introduce PPhRR into community practice
2. Determine how prescribers can become aware of opportunities and identify what support is needed
3. Identify where and how to focus our efforts and who should be involved

Presentations

Three presentations then set the context for the day's discussions:

1. Katie Hill (Director of the Shared Care) spoke to the opportunity to integrate PPhRR in Patient Medical Homes, Primary Care Networks, and with Specialist Physicians
2. Jamie Yuen, (Pharmacist from the UBC program) presented on the opportunities for primary care pharmacist involvement in PPhRR
3. Dr Jack Kliman, (Family Physician in Richmond) talked about the value of doing meaningful medication reviews in-practice

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What's Working and What's Not

Attendees were prompted to discuss in small group discussions, what's working in the current system, what's not, and opportunities ahead. Participants then chose to be part of one of the following focused conversations:

1. What PPhRR means for GPs in their office
2. How PPhRR relates to specialists in their office & the Specialist-GP relationship
3. What it means to work as a network in pursuit of community PPhRR
4. Dr Tracy Monk, (Health Data Coalition) talked about how to leverage EMR data
5. Dr Bruce Hobson, presented "Bob's story" a collective competence case study related to medication prescribing and common care plans

Each discussion group reported out on key issues, ideas and suggestions; these were captured and themed on the wall for all to see. (See Appendix B)

Participants were then invited to vote on the topics they wished to discuss further in the afternoon session.

After lunch, two speakers helped to set further context regarding community PPhRR before returning to the discussion.

The topics that received the greatest number of votes were:

1. Transitions – how do we improve transitions in care through collaborative team approach i.e. communication re drugs between team members, patient and family? How do we develop teams that have effective relationships that have providers working effectively and/or efficiently?
2. How do we link practices with dedicated pharmacists?
3. How do we bring specialty functions from the acute setting out into the community?
4. Where do we start prototyping?
5. How do we raise awareness about prescriptions that are causing problems e.g. the top adverse drug interactions?
6. Patient Education - how can we educate patients and family caregivers on Polypharmacy Risk Reduction?

Common Themes

These different discussions produced some common themes that repeated across groups – specifically around the necessity of

1) clear and timely communication;
2) the need to define roles and responsibilities
3) how to best engage patients and family members.

There were also some suggestions of in-practice actions that physicians could take that could be a first foray into community PPhRR prototyping. The complete notes from the discussions are in Appendix B.

Next steps

To close the day, participants discussed the next steps that individuals and the PPhRR committee could take to move this work forward. Some suggestions included:

- Promoting the importance of family involvement and information gathering
- Explore improving health literacy of patient and family - and translating information into a meaningful care plan and communicating it.
- Ensuring there are tools, and resources available for patients and families
- Providing information to patients and providers about drugs with most common adverse reactions
- Begin by focusing efforts and work on patients with a frailty score of 4/5
- Promoting what primary care pharmacists have to offer and dedicating time to communicating effectively. Long term we need to share information through EMRs.
- Leveraging existing relationships with pharmacists and taking advantage of that relationship to start the communication
- Communicating follow-up information and long-term changes (eg. Post discharge) between

SP and GP. Encourage patient to bring all meds to appointment and explore where there could be electronic record/notification

- Encouraging greater uptake of Best Possible Medication History

Suggestions for moving the work forward will be shared with the PPhRR Working Group to inform discussion and help identify where to tackle PPhRR issues in the community, building on the learnings from previous PPhRR work in acute and residential care settings.

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Appendix A

Participant List

Name	Organization	Role
Alix Adams	Ministry of Health	Manager, Special Populations
Lori Blain	Fraser Health Authority	Pharmacist
Rudy Chow	Providence Health Services	Geriatric Cardiologist
Dana Cole	Northern Health Authority	Regional Director of Pharmacy Services
Kathy Copeman-Stewart	Rural & Remote Division of Family Practice	Executive Director
Janet Currie	Canadian Deprescribing Network & Psychiatric Medication Awareness Group	PhD Student
Doug Danforth	West End Medicine Centre	Pharmacist
Danielle Edwards	Abbotsford Division of Family Practice	Programs Lead
Margaret English	Shared Care	Initiatives Lead
Edward Fang	UBC Medical School	Pharmacist
Delrae Fawcett	Doctors of BC	Project Manager
Brynn Fominoff	Surrey Memorial Hospital Fraser Health Authority	Manager, Acute Medicine Program
Colleen Fuller	REACH Community Clinic	Public Member
Camille Gagnon	Canadian Deprescribing Network	Assistant Director
Gina Gaspard	First Nations Health Authority	Clinical Nurse Specialist
Leslie Gaudette	Council of Senior Citizens' Organizations of British Columbia	Board Director
Barbara Gobis	UBC Faculty of Pharmaceutical Sciences	Director
Katie Hill	Shared Care Committee	Director
Gordon Hoag	Polypharmacy Risk Reduction Steering Committee	Pathologist
Bruce Hobson	Powell River	Family Physician
Catherine Jenkins	Polypharmacy Risk Reduction Steering Committee	Geriatrician
Wendy Johnstone	Family Caregivers of BC	Provincial Program Consultant
Jack Kliman	Richmond	Family Physician
Robyn Kuropatwa	RKL Health Informatics Ltd.	
Steve Larigakis	White Rock South Surry	Family Physician
Hugh (Hiu-Wah) Li	Burnaby Hospital	Hospitalist
Iain Mackie	Vancouver	Internal Medicine
Stephanie Mah	UBC	4th Year Pharm.D. Student
Cathy McGuinness	Health Data Coalition	Program Manager

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Tracy Monk	Health Data Coalition	Physician
Jessica Nadler	Shared Care	Project Coordinator
Lisa Needoba	South Okanagan Similkameen DoFP	Project Lead
Terryn Naumann	Provincial Academic Detailing Service	B.Sc.(Pharm.), Pharm.D.
Cindy Preston	First Nations Health Authority	Health Benefits Pharmacist Lead
Chris Rauscher	Polypharmacy Risk Reduction	Clinical Lead
Ian Schokking	Polypharmacy Risk Reduction Steering Committee	Family Physician
John Sherber	Victoria	Patient Representative
Nikita Soares	Doctors of BC	Primary Care Network Liaison
Johanna Trimble	Patients for Patient Safety Canada	Patient Champion
Susan Troesch	MidMain Community Health Centre	Community Pharmacist
Sanjeev Vohra	Surrey Memorial Hospital	Geriatric Medicine
Shannon Walker	Polypharmacy Risk Reduction Steering Committee	Respirologist
Keith White	Polypharmacy Risk Reduction	Physician Lead
Adriaan Windt	Abbotsford	Family Physician
Jamie Yuen	UBC	Pharmacist

Appendix B (summarized notes from the table discussions)

Patient Education – how can we educate patients and family caregivers on Polypharmacy Risk Reduction?

- Public/patient awareness "campaign"
  - Cost/Benefits/Risk of medications
  - Importance of not seeing multiple providers
  - Importance of using one pharmacy (if possible)
- Put out information on how to access Pharmanet data
- Physicians – importance of family input → link to "Is there a caregiver in your waiting room?"
- Tools and Resources for Patients and families
  - How to raise the questions
  - How to ask for a longer appointment
  - Tools and resources
  - Culturally sensitive
  - Link info from disease orgs

Raising Awareness -- What are the top prescriptions that are causing problems and how can we improve recognition of Adverse Drug Reactions?

- HDC can provide top 10 ATC classes or top drugs as a measure for GPs
- De-prescribing drugs that
  - decrease blood pressure because physicians may not have enough education
  - decrease blood sugar
  - Sleeping pills
  - Benzodiazepines, hypnotics, opioids
- Ashton protocol – tapering for benzo's, good evidence although it takes time
- Prescription cascade – how to combat this?
- Patient Education
  - Patients have very little understanding of drugs and adverse drug events and they need help and education
  - ADR's – best way to inform patients is via package insert, can this be standardized by gov't vs drugstore and more written in more digestible/understandable way
  - Deprescribing is developing ADR site for practitioners to highlight common ADRs to communicate to patients (hopefully in one year)

Where do we start prototyping?

- Suggestion polypharmacy with frailty (4= vulnerable, 5 = slightly frail, 6 = moderately frail, 7 = almost residential)
- Step 1 Identify Patients
  - Start high benefit, low risk on groups of patients
  - Start with 4&5 on frailty scales
  - Embed frailty scales so there is common language

    - Record in EMR
    - Physicians complete frailty with allied health (from Alberta)
    - Use med risk assessment questionnaire
        - Subjective and patient-centered
        - Best used when pharmacist on the team
    - Start with people who have had an adverse event
- Geriatrician – approach to med reconciliation
    - Steps of risk assessment a) frailty look at 4&5 of frailty scale b) use #3 of meds because greater than 4 cause exponential increase in risk; c) psychotropic review d) meds that increase falls (antihypertensive + diuretics)
    - Consider dosing as well as med type
    - FNW/FHC D/C assessment tool for referring to decrease risk of re-admission
    - Pharmacist opportunity to see 4/5 frailty patients
- Transition
    - Health literacy for patient and family → translate info into meaningful care plan and communicate
    - FHA addresses this H.L> & transitions
    - Look at communication of meds when in transition highlighting changed/deleted meds
    - Med Rec for D/C form → fax to GP

How do we link practices with dedicated pharmacists?

- Need to understand what primary care pharmacists have to offer
- Need dedicated practice communication
    - pharm needs consultation notes faxed over
    - Maybe having remote access to the EMR in the future
- Have to leverage existing relationships with pharmacists: take advantage of that relationship and start that communication
- Effectiveness of discharge or outpatient consult, reason for increase, decrease or change in meds
- Efficiency and timeliness of communication
- Spread to GP/Clinic; SP; hospital chart; primary care pharmacist; patient; caregivers; residential care
- Opportunity to let EMR help us to the above
- Follow up and Long-Term Changes (eg. Post discharge)
    - Encourage patient to bring all meds to appointment
    - Review with primary care pharmacist
    - Team management in the community
    - Electronic record/notification

How do we bring specialty functions from the acute setting out into the community?

- Building relations → GP, SP through shared care; patients; pharmacists
    - Roles and responsibilities
    - Opportunity to maximize those roles and responsibilities and relationships in a community care setting and continuity of care
    - Role for engagement and education for stakeholders

- Promotion of "Geriatric Care" – the *Frail Reality*
    - Tools
    - Education needs to start in med school
- Communication
- Follow up and Long-Term Changes (eg. Post discharge)
    - Encourage patient to bring all meds to appointment
    - Review with primary care pharmacist
    - Team management in the community
    - Electronic record/notification

Transitions – how do we improve transitions in care through collaborative team approach i.e. communication re drugs between team members, patient and family? How do we develop teams that have effective relationships that have providers working effectively and/or efficiently?

- Define transitions → lots of opportunity to drop the ball
    - Community ←→ hospital
    - Respite ←→ hospital
    - GP ←→ GP
    - Community ←→ specialist
    - Rural ←→ Urban
    - Lab ←→ community
    - Health status transition e.g frailty
- Is there a pattern to transitions? No. Foundation is communication
- What is transitioning?
    - Goals of care
    - Patient perspective
    - BPMH
    - Change in clinical status
    - One EMR to another
    - Care plan
    - Functional status
    - Social relationships
- How?
    - Repeated discussion?
    - Redefine Goals of Care
        - Client/patient is keeper of information and yet are vulnerable
        - What exists in this community? Community specific, part of PMH, PCN planning
        - Family are an integral link, help continuity of care → BIG responsibility but not all patients have this support
        - Patient information and tools → need to incorporate goals of care
- Best Possible Med History (BPMH)

  - Accurate med list
  - Now an accreditation standard
  - Patient should have this
  - GP should review this
    - Could go into pharmanet to indicate that drug has been stopped
  - Patients may have old meds in home
  - Meaningful med review
    - Different pharmacists involved e.g. community, emerg, acute/HA, PCN
  - When do we do these? Transitions in care, annually, when something changes
    - Kamloops prototype is looking at transition acute ←→ GP
  - EMR issue – ehealth owned by patient
- Communication
  - EMR – Fee for notification to GP
  - Cell phone number to connect
  - Quality of communication and timeliness
  - GP & Pharmacist both need the info
  - Still based on/influenced by relationship
  - Need role clarity
  - Challenge of too much information and need to know what to pay attention to
  - What does a good team medication review look like? Care conference – need context!

Other topics from the morning conversations that were not chosen for small group discussions:

- How do we educate people (clinicians and patient/family) enough to have the conversation with the patient? (- a collaborative conversation that is facilitated by an EMR)
- How can clinical decision support be provided at the right time and in the right place
- How do we leverage what's out there to share information across systems
- Provide guideline – cheat sheets for providers to engage/empower patients and families to feel comfortable asking questions (cultural humility/ awareness)
- Templates to support complete information/ sharing among providers
- How do we start and keep it simple? Focus on # of drugs or specific drugs?
- Ensure that UBC CPD incorporates information on medication management in IMG program
- How do we balance off short term risk reduction and long term risk reduction? Will need a different approach: educational awareness
- Med review "clinics": where patients would be able to ask about their medication