Tackling polypharmacy in BC—The Shared Care approach

Polypharmacy is frequently in the news as concern continues to grow about the risks of taking multiple medications, especially for our elderly and frail elderly populations. Studies show that taking multiple medications puts a person at risk of serious adverse events, including confusion and falls, with risk rising exponentially with each added medication. The negative impact on the safety and quality of life of our patients and on our health care system, with increased emergency department admissions and transfers to acute care, cannot be underestimated, especially as our elderly population continues to grow.

In 2012, recognizing the severity of the issue, the Shared Care Committee introduced its Polypharmacy Risk Reduction (PRR) initiative to collaboratively and systematically tackle the problem. The Shared Care Committee is a joint collaborative committee of Doctors of BC and the Ministry of Health.

Since then, the PRR—with significant support from the Divisions of Family Practice—has been engaging physicians to raise awareness of the issue of polypharmacy and to offer funding and support to address PRR in their own care settings.

The initiative is being rolled out across the province in three phases:

- Phase 1: Residential care facilities
- Phase 2: Acute care and transitions (underway)
- Phase 3: Community-based/primary care (2015/2016)

Phase 1: Residential care facilities

The initiative was first prototyped in residential care facilities in eight BC communities, with each customizing the approach to suit their own care facility. This approach includes the following:

- Medication reviews with the circle of care: A multidisciplinary approach involving physicians, pharmacists, care facility staff, the resident, and family members collaborating to design processes and implement strategies for polypharmacy risk reduction for each resident. Residents' family members play an important role when it comes to identifying adverse drug events and reporting improvements.
- Workshops: Through a series of local workshops, physicians receive information and tools to facilitate polypharmacy risk reduction in their own care settings.
- Clinical resources materials: Materials previously reviewed by an expert clinical advisory group provide the best evidence-based information to inform the medication review process and decision making. The materials are continually modified and improved in response to feedback from the field.

The PRR initiative uses the Plan-Do-Study-Act approach to test, implement, and sustain process improvements.

Reports from the eight prototyped sites have generated a clearer understanding of the key factors for success in each community. Initial results and feedback are encouraging:

- Enhanced medication reviews followed by close monitoring supported the safe discontinuation of medications. For example, in a Chilliwack site, 194 medications were successfully discontinued for 90 residents.
- A key learning was the necessity of involving residential care staff, pharmacists, residents, and families in the process from the outset.
- The clinical resource materials were reported to be beneficial in medication decision making.
- Care providers reported benefits with increased knowledge and strategies on how to optimize medication for their patients.
- The multidisciplinary approach helped foster positive interpersonal relationships among care facility staff, physicians, pharmacists, and family members.

Ongoing strategies include:

- Developing faculty to sustain the process at the local level.
- Providing education and support for residents and family members to inform medication-related decisions.
- Supporting local strategies for data collection to monitor impact and assess sustainability.
- A train-the-mentor program has been developed and will be expanded across the province to foster physician to physician mentoring in PRR.

Phase 2: Acute care and transitions

Phase 2 prototyping in acute care is in the early stage of development on medical units at four hospital sites. In addition, prototyping is starting on hip fracture surgical units at four other hospital sites through a partnership with the provincial Hip Fracture Redesign Project (funded by the Specialist Services Committee).

The PRR initiative is also involved in other provincial medication-related projects such as Call for Less Antipsychotics in Residential Care, Medication Reconciliation, and Hospital Care for Seniors: 48/6 (all supported through the BC Patient Safety and Quality Council).

If you would like further infor-

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mation on how to bring the PRR initiative to your area, please contact us at shared_care@doctorsofbc.ca, or e-mail Dr White at kjwhitedoc@gmail.com.

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Continued from page 508

MU5 enables community collaboration. With quality data at their fingertips, family physicians and specialists can more readily share care. As other systems mature, physicians will be able to collaborate with multidisciplinary teams, hospitals, and allied community care. Aggregated practice data can support the work of Divisions of Family Practice in their communities as well as provincial initiatives like A GP for Me.

The 31 March 2015 deadline for BC physicians to achieve MU3 is not an end in itself. Physicians who put MU3 to work in real time will see the greatest return on their investment of time, with improved practice efficiencies and patient care in the years to come.

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Reference

1. Hobson B. EMR use in BC: The future is now (part 1). BCMJ 2013;55:415.

billing tips

Audit tip: The 5-year audit period

Many physicians are not aware of the 5-year audit period; almost none are aware of extrapolation and what that means.

While there will be a specific trigger for your onsite audit, did you know that when the audit is conducted on your practice the medical inspector will look at all entries in the medical records? Did you know that the total errors identified during the audit are extrapolated over the entire 5-year audit period?

During an audit, a statistically representative random sample of services billed is established and the medical records reviewed by the medical inspector. If the medical record does not support the fee billed or supports a lesser fee, then that service will be adjudicated by the medical inspector as an error. An error rate for the sample is then established, and that error rate is extrapolated to all the services billed during the 5-year audit period. What this means from a practical perspective is that errors found during the audit may result in a request for recovery. Audit recoveries can be substantial. To put this in perspective, we will use the following example of an audit that was triggered by high counseling visits.

Dr A, a busy urban physician, has MSP billings over the 5-year audit period of $1 800 970.54. Dr A has been inappropriately billing counseling visits when the documentation only supports an office visit. He also has multiple missing records. After giving Dr A credit for the office visits, Dr A's total error rate based on dollars is 18%. The error rate is then extrapolated, using statistical tools, to all the billings over the audit period. The result will be a quantification of approximately $320 000.

This is why it is important to make sure you are billing correctly and documenting what you do. Could you afford to pay this amount of money back? Do not assume that because you have been paid for the services you have billed that you have billed them correctly. If you are unsure of what to bill, call Doctors of BC.

—Keith White, MD, Chair, Patterns of Practice Committee

This article is the opinion of the Patterns of Practice Committee and has not been peer reviewed by the BCMJ *Editorial Board. For further information contact Juanita Grant, audit and billing advisor, Physician and External Affairs, at 604 638-2829 or jgrant@doctorsofbc.ca.*