Outcome Statement: National Stakeholders' Meeting on Quality Use of Medicines to Optimise Ageing in Older Australians

Executive summary

Australia has a significant opportunity to improve the quality use of medicines by older adults. To progress this opportunity, a National Stakeholders' Meeting was convened on 3 August 2015 for consumers, clinicians, academics and policy makers. The meeting was convened by Sarah Hilmer, Professor of Geriatric Pharmacology, University of Sydney and supported by the NHMRC Cognitive Decline Partnership Centre and NPS MedicineWise.

The goal of the National Stakeholders' Meeting was to set the agenda to improve quality use of medicines for older Australians, with an emphasis on avoiding the harms of polypharmacy (multiple medicines use).

The **three key findings** of the National Stakeholders' Meeting were:

(1) There is a significant prevalence of harmful or unnecessary medicine use in older Australians. This results in negative impacts on health and wellbeing of older Australians, and indirect costs to the community in the order of hundreds of millions of dollars annually. There is increasing evidence that deprescribing (supervised withdrawal) of harmful or unnecessary medicines is safe and benefits the individual and the community. Most Stakeholders agreed that a 50% reduction in harmful or unnecessary medication use by older Australians over five years is a major clinically significant, feasible target.
(2) Addressing polypharmacy in older Australians will require changes in policy, practice, and data collection, analysis and feedback in regards to medication use in older adults.
(3) Harmful or unnecessary medication use can be reduced by a partnership of key stakeholders, focusing on awareness, incentives and tools to optimise quality use of medicines for older Australians.

About this document

This document summarises the outcomes of the National Stakeholders' Meeting and provides a framework for development of a detailed action plan over the next year. Stakeholders participating in the meeting included consumers, consumer representative groups, clinicians, researchers, academics, non-government organisations, aged care industry representatives, professional societies, representatives of expert advisory committees on medicines to the Australian government and observers from the Australian government departments of health and of social services.

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Defining the problem: polypharmacy and the use of harmful or unnecessary medicines

As our population ages there is an associated major increase in people living with multiple chronic diseases, including dementia. There has been a rapid increase in polypharmacy (multiple medicines use) in Australia over the past decade and the prevalence continues to rise, especially in older adults. Medicines use in older people is a complex balance between managing disease and avoiding medicines related problems.

In older Australians, polypharmacy is the norm: two thirds of Australians aged over 75 years take five or more medicines. Depending on the setting and definition used, 20-70% of older people use at least one medicine that is either harmful or unnecessary.

Consequences of polypharmacy include medication errors, adverse drug reactions, falls, confusion, frailty, loss of independence, hospitalisation and mortality. These adverse drug events may be mistaken for disease or ageing itself. For many older adults, taking multiple medicines is a major burden in time, effort and cost. Use of harmful or unnecessary medicines also impacts on the health system through not only the costs of these medicines but also the costs of treating the resultant adverse effects, as well as the opportunity costs of providing low value health care.

There is emerging evidence that supervised withdrawal of harmful or unnecessary medicines (deprescribing) is safe and may improve quality of life in older people. Deprescribing is not about denying effective treatment. Over 90% of older adults surveyed in a range of settings stated that they would like to stop one of their medicines if their doctor said it was possible.

Measuring the problem

Harmful or unnecessary medication use can be measured through a range of medication utilisation measures, patient outcomes, economic outcomes, and process markers.

Medication measures include the prevalence of polypharmacy (use of 5 or more different medicines), hyperpolypharmacy (use of 10 or more different medicines) or specific medicines that are high risk in older people (e.g. anticholinergics, sedatives). Medication measures can be made on routinely collected data in the community, although such data is currently less accessible in the hospital setting.

Patient outcomes include those directly related to adverse drug reactions (e.g. hospitalisation, rehospitalisation or deaths due to adverse drug reactions), global health and functional outcomes (e.g. quality of life, functional independence, falls, frailty), and specific health outcomes related to the condition treated. Outcomes related to adverse drug reactions can be measured in routinely collected data, although the quality of these data is often limited. Measures of global health outcomes and medicines use are available in many epidemiologic studies of older people.

Economic impacts on the individual and the community include costs of medicines and associated health care costs to treat adverse drug events. While no formal estimate of the costs of unnecessary and potentially harmful medicines in older Australians has been made, this is likely to be in the order of

hundreds of millions of dollars annually and could be calculated from routinely collected data. The proportion of the estimated $1.2 billion national annual cost of medication-related hospital admissions that occurs in older Australians exposed to unnecessary medicines could also be calculated.

Process markers that monitor health care factors that may impact on harmful or unnecessary medication use include prevalence of referrals for medication reviews by accredited pharmacists and measures of co-ordination of care (e.g. number of prescribers per patient).

Target for reduction in harmful or unnecessary medicines

A consensus target of a 50% reduction in harmful or unnecessary medicines use over five years was proposed by stakeholders at the meeting. This could be measured on national, routinely collected data using the medication measures described above. For example, most stakeholders agreed with a goal of a 50% reduction in the prevalence of using medicines that are high risk in older adults or a 50% reduction in the prevalence of hyperpolypharmacy. Since risk outweighs benefit for approximately one in five medicines taken by older adults, halving the prevalence of hyperpolypharmacy should be achievable without withdrawing medicines with net clinical value. Based on previous studies of medication use and outcomes, a reduction of this size is likely to have major clinical impact. The target is considered ambitious but feasible.

Strategies to address quality use of medicines in older Australians

(1) Update relevant national policies and regulations to directly address polypharmacy and deprescribing

There is potential to update the Australian National Medicines Policy (1999) and National Strategy for Quality Use of Medicines (2002) to explicitly include the issues of multimorbidity, polypharmacy, medication review and deprescribing. Multimorbidity and polypharmacy have increased significantly over the past 15 years since the policy was developed, with ageing of our population and changes in medication use. There may be opportunities to update other national documents to provide explicit guidance on these issues, such as the Australian Government Guiding Principles for Medication Management in Residential Aged Care Facilities 2012, Guiding Principles for Medication Management in the Community 2006, Guiding Principles to Achieve Continuity in Medication Management 2005 and the National Safety and Quality Health Service (NSQHS) Standards.

There are also opportunities to address polypharmacy and deprescribing within national drug regulation. It was suggested that the Australian Therapeutic Goods Administration consider adding a mandatory heading to the Approved Product Information and Consumer Medicines Information of all medicines entitled, 'Cessation' or 'Deprescribing', providing information on how to safely withdraw or cease the medicine and any known outcomes resulting from this action.

(2) Integrate health care to provide multidisciplinary patient-centered pharmaceutical care

There is a need to integrate health care of older Australians across settings (community, residential aged care, public and private hospitals), practitioners (general practitioners, specialists, pharmacists, nurses, optometrists and other allied health) and funding bodies (Federal and State Governments, private health insurers, aged care providers, individuals). It was proposed that a systems map be developed to better understand the complex pathways older Australians take through health care, followed by work at the policy and practice levels to facilitate multidisciplinary patient-centered care to improve the quality use of medicines.

(3) Collect and use health data to monitor and address polypharmacy

The emergence of eHealth brings opportunities to prompt prescribers and consumers about quality use of medicines. Possible approaches include providing warnings to prescribers in electronic medication management systems about high risk prescribing in their patients, as well as warnings directly to consumers in the personal electronic health record that they should seek advice about their medicines. Prompts for medication review could also be generated according to care setting, such as on admission to hospital or to a residential aged care facility. These strategies rely on the accuracy of the patient's medication list. There is an opportunity to develop systems to maintain accurate up to date medication records for older Australians.

On a community level, prevalence of polypharmacy and high risk medicines use, patient outcomes, economic outcomes, and process markers could each be monitored nationally. While linked data is not available nationally, monitoring and feedback can be provided at a practitioner level within existing programs such as NPS MedicineWise's program, MedicineInsight.

(4) Provide incentives to health care providers for optimising quality use of medicines by older patients

Improving quality use of medicines for older Australians will be enabled by better use of existing MBS items, strategies to provide better access to non-pharmacological therapies and consideration of new incentives.

Submissions could be made to the current review of Medicare to investigate how existing MBS items could be better used and promoted to improve quality use of medicines for older Australians. These include medication review by an accredited pharmacist, which may be more effective with active consumer involvement in the medication action plan, full GP medication review as part of the over 75 year old health assessments, long consultations by GPs specifically to review medicines, and GP led case conferences to review medicines.

Investigation of how to improve access to non-pharmacological therapies is required so that medicines are not used when there is an effective, safer non-pharmacological alternative. This may require increased service provision and funding of non-pharmacological therapies. There may be potential to redirect funds from unnecessary medicines to non-pharmacological therapies.

New incentives could be explored to encourage quality use of medicines, such as more specific quality use of medicines indicators for older Australians in accreditation of Residential Aged Care Facilities and hospitals, and time limited remuneration of specific medicines through the PBS.

(5) Provide health care practitioners with education and tools to optimise Quality Use of Medicines by older patients

The principles of quality use of medicines in old age, geriatric pharmacology and deprescribing should be part of the undergraduate and postgraduate curricula for all health care practitioners involved with medicines management. This could be assessed nationally through prescribing competencies. Multimorbidity, polypharmacy and deprescribing could be addressed within existing single disease guidelines and through specific medication use guidelines for patients with multiple diseases targeting practitioners in community and hospital settings. Practitioner tools and guidelines could be provided through apps and be integrated with existing sources of medicines information (e.g. the Australian Medicines Handbook, RACGP Silver Book) at the point of care. As discussed under policy, information on how to safely withdraw medicines in the product information of each registered drug could support health care practitioners.

(6) Raise consumer awareness of polypharmacy and deprescribing and provide tools to help them discuss the issues with their prescribers

Opportunities to educate consumers (patients and their carers) about the risks of polypharmacy at a public health and a practitioner level should be identified. Empowering consumers to ask their prescribers if they still need all of their medicines may encourage medication review. In many cases, this will require improving health literacy of consumers and changing their expectations of a healthcare consultation. The 'Choosing Wisely Australia' initiative led by NPS Medicinewise and involving consumer organisations could facilitate this. As discussed under policy, information on how to withdraw medicines in the consumer medicine information of each registered drug would help raise awareness.

(7) Develop a national strategic plan for research on polypharmacy and deprescribing

High quality evidence is required on the effects of stopping unnecessary and potentially harmful medicines on the health and wellbeing of older adults. Research is also needed on how to implement deprescribing in Australian clinical practice in a safe, consistent and cost-effective manner. A strategic plan is required to identify evidence gaps, prioritise research questions and identify potential funding sources.

The next steps

This outcomes statement from the National Stakeholders' Meeting on Quality Use of Medicines is the first step in the development of a Strategic and Action Plan by working groups over the next 12 months. This will articulate the approaches required to achieve the goal of a 50% reduction in the prevalence of harmful or unnecessary medication use by older Australians over five years.

Proposed actions arising out of the strategies are indicated below. Small working groups will progress each of these to develop a detailed strategic and action plan by mid 2016.

Action	People Responsible
1(a). Explore opportunities to update the Australian National Medicines Policy (1999), National Strategy for Quality Use of Medicines (2002) and other documents that guide medicines use to explicitly include issues of multimorbidity, polypharmacy and deprescribing	Prof Michael Dooley, President, Society of Hospital Pharmacists Australia and Prof Sarah Hilmer, Cognitive Decline Partnership Centre
1(b). Investigate the inclusion of a mandatory heading to the Approved Product Information and Consumer Medicines Information of all medicines entitled, 'Cessation' or 'Deprescribing'	A/Prof Geoff Herkes, Chair, Advisory Committee on Prescription Medicines and A/Prof Parisa Aslani, President, Australasian Pharmaceutical Science Association
2. Integrate health care to provide multidisciplinary patient-centered pharmaceutical care	Prof Christopher Etherton-Beer, University of Western Australia
3. Collect and use health data to monitor and address polypharmacy at the practitioner, consumer and community levels	A/Prof Simon Bell, Cognitive Decline Partnership Centre
4. Provide incentives to health care providers for optimising quality use of medicines by older patients	A/Prof Ian Scott, University of Queensland
5. Provide health care practitioners with education and tools to optimise quality use of medicines by older patients	Ms Aine Heaney, NPS Medicinewise
6. Raise consumer awareness of polypharmacy and deprescribing and provide tools to help them discuss the issues with their prescribers	Dr Emily Reeve, Cognitive Decline Partnership Centre
7. Develop a national strategic plan for research on polypharmacy and deprescribing	Professor David Le Couteur and Dr Danijela Gnjidic, University of Sydney

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