UKMi North West

NICE Bites

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A summary of prescribing recommendations from NICE guidance

Multimorbidity: clinical assessment and management

NICE NG56;2016

This guideline covers optimising care for adults with multimorbidity, by reducing treatment burden (polypharmacy and multiple appointments) and unplanned care.

General principles

- Be aware that multimorbidity refers to the presence of ≥2 long-term health conditions, which can include:
  - defined physical and mental health conditions such as diabetes or schizophrenia,
  - ongoing conditions such as learning disability,
  - symptom complexes such as frailty or chronic pain,
  - sensory impairment such as sight or hearing loss,
  - alcohol and substance misuse.
- Be aware that for people with multimorbidity:
  - management of risk factors for future disease can be a major treatment burden and should be carefully considered when optimising care,
  - evidence for recommendations in NICE guidance on single health conditions is regularly drawn from people without multimorbidity and taking fewer prescribed regular medicines.
- Think carefully about risks and benefits of individual treatments recommended in guidance for single health conditions.
- Discuss this with the patient alongside their preferences for care and treatment.

How to plan care that takes account of multimorbidity

- Consider an approach to care that takes account of multimorbidity if the person requests it or if any of the following apply. They:
  - find it difficult to manage their treatments or day-to-day activities,
  - receive care and support from multiple services and need additional services,
  - have both long-term physical and mental health conditions,
  - have frailty or falls, See NICE pathway; falls in older people.
  - frequently seek unplanned or emergency care,
  - are prescribed multiple regular medicines.
- Using the criteria above identify adults:
  - opportunistically during routine care,
  - pro-actively using electronic health records.
- Consider using a validated tool such as eFI, PEONY or QAdmissions, if available in primary care electronic health records, to identify adults with multimorbidity who are at risk of adverse events such as unplanned hospital admission or admission to care homes.
- Consider using primary care electronic health records to identify markers of increased treatment burden such as number of regular prescribed medicines.
- Use an approach to care that takes account of multimorbidity for adults of any age prescribed ≥15 regular medicines, because they are likely to be at higher risk of adverse events and drug interactions.
- Consider an approach to care that takes account of multimorbidity for adults of any age who are prescribed:
  - 10 to 14 regular medicines,
  - <10 regular medicines but are at particular risk of adverse events.

Assessing frailty

- Consider assessing frailty in people with multimorbidity.
- Be cautious about assessing frailty in a person who is acutely unwell.
- **Do NOT** use a physical performance tool to assess frailty in a person who is acutely unwell.
- **Primary and community care settings,** consider using one of the following:
  - an informal assessment of gait speed e.g. time taken to answer the door, time taken to walk from the waiting room,
  - self-reported health status; that is, 'how would you rate your health status on a scale from 0 to 10?', with scores of ≤6 indicating frailty*,
  - a formal assessment of gait speed, with >5 seconds to walk 4 metres indicating frailty*,
  - the PRISMA-7 questionnaire, with scores of ≥3 indicating frailty*.

  * these assessments can be used in any setting.
- **Hospital outpatient settings**, consider using one of the above tests suitable in any setting* **OR** one of the following:
  - the 'Timed Up and Go' test, with times of >12 seconds indicating frailty,
  - self-reported physical activity, with frailty indicated by scores of ≤56 for men and ≤59 for women using the Physical Activity Scale for the Elderly.
- See NICE pathway: dementia, disability and frailty in later life: mid-life approaches to delay or prevent onset.

Principles and steps to follow

- When offering an approach to care that takes account of multimorbidity, focus on:
  - how the person's health conditions and their treatments interact and how this affects quality of life,
  - the person's individual needs, preferences for treatments, health priorities, lifestyle and goals,
  - the benefits and risks of following recommendations from guidance on single health conditions,
  - improving quality of life by reducing treatment burden, adverse events, and unplanned care,
  - improving coordination of care across services.
- Follow the recommendations in NICE pathway; patient experience in adult NHS services, which provides guidance on knowing the patient as an individual, tailoring healthcare services for each patient, continuity of care and relationships, and enabling patients to actively participate in their care.
- NICE has written information for the public explaining its guidance on multimorbidity. See: Improving care for people with more than 1 long-term health problem.

Recommendations – wording used such as 'offer' and 'consider' denote the strength of the recommendation.

Drug recommendations – the guideline assumes that prescribers will use a drug's Summary of Product Characteristics (SPC) to inform treatment decisions.

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Multimorbidity; clinical assessment and management

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Steps to follow

Step 1: discuss the purpose of an approach to care that takes account of multimorbidity.

Step 2: establish disease and treatment burden.

Step 3: establish patient goals, values and priorities.

Step 4: review medicines and other treatments taking into account evidence of likely benefits and harms for the individual patient and outcomes important to the person.

Step 5: agree an individualised management plan.

Step 1 – Discussing approach to care

- Discuss that the purpose of this approach to care is to improve quality of life. This might include reducing treatment burden and optimising care and support by identifying:
  - ways of maximising benefit from existing treatments,
  - treatments that could be stopped because of limited benefit,
  - treatments and follow-up arrangements with a high burden,
  - medicines with a higher risk of adverse events e.g. falls, gastrointestinal bleeding, acute kidney injury,
  - non-pharmacological treatments as possible alternatives to some medicines,
  - alternative arrangements for follow-up to co-ordinate or optimise the number of appointments.

Step 2 – Establish disease and treatment burden

- Establish disease burden by talking to people about how their health problems affect day-to-day life. Include discussion of:
  - mental health,
  - how disease burden affects their wellbeing,
  - how their health problems interact and how this affects quality of life.
- Establish treatment burden by talking to people about how treatments for their health problems affect day-to-day life. Include in the discussion:
  - the number and type of healthcare appointments a person has and where these take place,
  - the number and type of medicines a person is taking and how often,
  - any harms from medicines,
  - non-pharmacological treatments such as diets, exercise programmes and psychological treatments,
  - any effects of treatment on their mental health or wellbeing.
- Be alert to the possibility of:
  - depression and anxiety. See NICE pathway; Common mental health disorders in primary care,
  - chronic pain, the need to assess this and adequacy of pain management.

Step 3 – Establish patient goals, values and priorities

- Clarify with the patient whether and how they would like their partner/family members/carers to be involved in key decisions about management of their conditions. Review this regularly. If the patient agrees, share information with their partner/family members/carers.
- Encourage people with multimorbidity to clarify what is important to them, including personal goals, values and priorities. These may include:
  - maintaining independence,
  - undertaking paid or voluntary work, taking part in social activities and playing an active part in family life,
  - preventing specific adverse outcomes e.g. stroke,
  - reducing harms from medicines,
  - reducing treatment burden,
  - lengthening life.
- Explore the person's attitudes to their treatments and potential benefits and harms of those treatments. Follow recommendations in NICE pathway; Medicines optimisation.

Step 4

- When reviewing medicines and other treatments, use the database of treatment effects to find information on the:
  - effectiveness of treatments,
  - duration of treatment trials,
  - populations included in treatment trials.
- Consider using a screening tool e.g. the **STOPP/START** tool in older people, to identify medicine-related safety concerns and medicines the person might benefit from but is not currently taking.
- When optimising treatment, think about any medicines or non-pharmacological treatments that might be started as well as those that might be stopped.
- Ask the person if treatments intended to relieve symptoms are providing benefits or causing harms. If the person is unsure of benefit or is experiencing harms:
  - discuss reducing or stopping the treatment,
  - plan a review to monitor effects of any changes made and decide whether any further changes to treatments are needed (including restarting a treatment).
- Take into account the possibility of lower overall benefit of continuing preventive treatments that aim to offer prognostic benefit, particularly in people with limited life expectancy or frailty.
- Discuss with people whether they wish to continue treatments which may offer them limited overall benefit.
- Discuss any changes to treatments that aim to offer prognostic benefit with the person, taking into account:
  - their views on the likely benefits and harms from individual treatments,
  - what is important to them in terms of personal goals, values and priorities,
- Tell a person taking a bisphosphonate for osteoporosis for at least 3 years that there is no consistent evidence of:
  - further benefit from continuing bisphosphonate for another 3 years,
  - harms from stopping bisphosphonate after 3 years of treatment.
- Discuss stopping bisphosphonate after 3 years and include patient choice, fracture risk and life expectancy in the discussion.

Step 5

- Agree an individualised management plan with the person. Agree what will be recorded and what actions will be taken. These could include:
  - starting, stopping or changing medicines and non-pharmacological treatments,
  - prioritising healthcare appointments,
  - anticipating possible changes to health and wellbeing,
  - assigning responsibility for coordination of care and ensuring this is communicated to other healthcare professionals and services,
  - other areas the person considers important to them,
  - arranging a follow-up and review of decisions made,
  - timing of follow-up and how to access urgent care.
- Share copies of the management plan in an accessible format with the person and (with the person's permission) other people involved in care (including healthcare professionals, a partner/family members/carers).
- See NICE pathway; Social care for older people with multiple long-term conditions