Demystifying the Complex Patient

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Disclosures

• Jay Reaume
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  – No conflicts of interest to disclose
Session Outline

• Defining Patient “Complexity”
• Case 1 – James
• Case 2 – Mona
• Summary & Discussion
What Makes a Patient “Complex”? 

Whose Perspective?  

Nature of Complexity?  

Patient Attributes?
Understanding Patient Complexity

• Consider:
  • Barriers / limited supports to achieving optimal health outcomes
  • Inappropriate / excess access to health resources
  • Competing health priorities
  • Clinical uncertainty
Navigating Patient Complexity:
Questions to Ask Yourself

1. What makes this patient complex to you?
2. What is your assessment of the patient’s health goals? What are the pharmacotherapeutic priorities?
3. Are you able to address the patient’s complexity within your scope of practice?
4. What supports would you need to help you best manage this patient’s needs?
5. What supports might be available to your patient to empower patient advocacy & self-management?
Case 1 – James

• 71 year-old male

• He approaches the pharmacy counter with his wife, Debbie, who expresses concern about her husband’s numerous medications.
Case 1 – James

• James’ wife is specifically concerned that he seems to have declined cognitively and wonders if this is a consequence of his recent heart attack.

• She also notes that he seems to be bruising excessively; James shows you his legs and arms where numerous bruises are visible. Debbie knows he is taking a blood thinner and states “The blood thinner is too much. Should I stop giving it to him?”.
James – Past Medical History

1. Diabetic neuropathy (Mar. 2015)
2. Depression (Mar. 2015)
3. ACS with implantation of bare metal stent (Jan. 2015)
4. Atrial fibrillation (Mar. 2014)
5. Mild cognitive impairment (Nov. 2012)
6. COPD (Apr. 2010)
7. Type 2 diabetes (Aug. 2008)
James – Recent Labs

• 3 days ago…
  – A1C = 5.8%
  – eGFR = 68 mL/min
  – LDL = 2.76 mmol/L
  – INR = 2.7

• Home BP readings from the past 2 weeks
  – 155/85, 147/80, 150/87, 134/79, 142/76, 152/81, 138/87
  – Average: 145/82 mmHg
James – Current Medications

1. ASA 81 mg po daily
2. Plavix 75 mg po daily
3. Warfarin 3 mg po daily (adjusted for INR 2.0-3.0)
4. Metoprolol 50 mg po BID
5. Coversyl 4 mg po daily
6. Hydrochlorothiazide 25 mg po daily
7. Crestor 5 mg po HS
8. Metformin 500 mg po 2 tabs QAM, 1 tab lunch, 2 tabs QPM
9. Trajenta 5 mg po daily
10. Gliclazide MR 60 mg po daily

11. Spiriva 18 mcg daily
12. Onbrez 75 mcg daily
13. Ventolin 100 mcg 1-2 puffs QID prn
14. Elavil 50 mg po HS
15. Pantoprazole 40 mg po daily
16. Soflax 100 mg po BID
17. Nitrolingual 0.4 mg SL prn chest pain
18. Multivitamin po daily
19. Vitamin E 400 IU po daily
20. Vitamin C 500 mg po daily
21. Vitamin D 1000 IU po daily

*No Known Drug Allergies*
James – Additional History

Psychosocial History
• Retired school teacher
• 3 grown children

Substance Use
• Tobacco – quit 10 years ago, 40 pack year history
• Alcohol – rarely
Is James “Complex”?

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What Makes James “Complex” To You?

- Elderly
- Cognitively impaired
- Presents with a serious issue – bruising/bleeding
- Multiple comorbidities
- Multiple medications
- Multiple identifiable drug therapy problems
Where to begin?

• Prioritize:
  1. Safety
  2. Efficacy
  3. Simplification

• Always need to balance the patient’s priorities with your own therapeutic concerns
  – Addressing the patient’s concerns will garner buy-in for other necessary changes
Safety First!

• Pharmacists, as medication experts, are ideally positioned to identify and help resolve medication issues that could present harm to patients

• As our population gets older and polypharmacy becomes the norm, we must pay attention to the risks of complex medication regimens
James – Current Medications

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*No Known Drug Allergies*
Consider for James…

• “Triple Therapy” (ASA + Plavix + warfarin) poses a significant risk of bleeding
  – The patient’s wife is obviously concerned about bleeding. Are you?
  – Would you recommend discontinuing one or more of these medications? If so, which one(s)?

• His cognitive decline could be a result of Elavil use
  – Continue it? Stop it? Taper it?
  – Are there safer alternatives than Elavil for his depression and diabetic neuropathy?
Make Sure It’s Working!

• How many times have you encountered a patient that is taking a medication that does little or nothing for them, yet the patient continues to take it?

• As medication experts, pharmacists need to advocate for EFFECTIVE use of medications NOT just medication for medication’s sake
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• Home BP readings from the past 2 weeks
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Consider for James…

- Despite 7-year history of type 2 diabetes and recent ACS, not all of his modifiable risk factors are controlled
  - What is his risk of a CV event? Framingham Risk Calculator
  - BP above target of 130/80 mmHg and LDL above target of 2.0 mmol/L
- What can be done to improve the efficacy of his antihypertensive and dyslipidemia therapy? What other factors should be considered (e.g. vascular protective doses)?
Keep It Simple!

- Pharmacists’ knowledge of available drug products can be useful in simplifying a patient’s medication regimen
  - Decreasing the complexity of a medication regimen will increase adherence and improve QoL

- Medication reviews are an ideal way of identifying duplicate therapies or medications that may be counteracting each other
  - This provides another opportunity to eliminate potentially unnecessary medications
Consider for James…

• Combining medications to reduce pill burden
  – For example, metformin + Trajenta = Jentadueto

• Eliminating medications that may be unnecessary for safety and efficacy reasons
  – Consider decreasing dose or discontinuing gliclazide MR to reduce the risk of hypoglycemia given that A1C is well below target
  – At this point, are the benefits of his numerous vitamin supplements worth the added complication of taking them?

• Changing complex medications to those that might be easier to handle
  – Consider switching warfarin to NOAC to eliminate the need for INR monitoring and managing fluctuating warfarin doses
Consider for James…

• Take on the problems one at a time
• Utilize your full scope to address what you can
  – When you need the counsel/expertise of another health care provider…COLLABORATE!
• Engage the patient in the changes
  – Explain rationale for decision-making
  – Encourage them to discuss your concerns with their health care team
Case 2 – Mona

- 48 year-old female
- Picking up her 12 year-old son’s refill prescription for methylphenidate
- “Can we talk about medical marijuana? I want to get an expert opinion whether this might be right for me and you know more than my doctor.”
Mona – Past Medical History

2. Chronic pain
3. Fibromyalgia
4. Depression
5. Migraines
Mona – Allergies/Intolerances

1. Codeine: GI upset, abdominal cramps
2. Morphine: sweats, shaking, vomiting
3. Nortriptyline: “blank affect”
4. Duloxetine: “out of it”
5. Pregabalin: dizziness, nausea, vomiting, pins & needles sensation
6. Mirtazapine: excessive daytime grogginess
7. Paroxetine: weight gain
8. Bupropion: felt hyper and agitated
Mona – Current Medications

1. Fentanyl 25mcg patch – 1 patch topically q3days
2. Tramacet (acetaminophen 325mg + tramadol 37.5mg) – 1-2 tablets po TID PRN
3. Citalopram 20mg po QD
4. Lorazepam 1-2mg po QHS
5. Cyclobenzaprine 10mg po TID PRN
6. Zolmitriptan 2.5mg po PRN migraines
7. Naproxen 220mg po BID PRN
8. PEG-3350 17 grams po QD-BID PRN
Mona – Additional History

Psychosocial History
- On long-term disability post-MVA
- Common law relationship
- 1 child
  - Concern around behavioral issues at school
- Financial pressures

Substance Use
- Tobacco – nil
- Alcohol – rarely
- Marijuana
  - Tried a few times when she felt her fentanyl patch was wearing off
  - “Took the edge off”
Is Mona “Complex”?

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What Makes Mona “Complex” To You?

- Chronic non-cancer pain – multiple etiologies
- Subjectivity of pain assessment
- High-potency opioid use
- Medical marijuana query
- Multiple sensitivities
- Is there any pharmacological option left?

- Disability-psychosocial situation
- Screening for aberrant drug behavior
- Multiple targeted substances in the home
- Serotonergic drug interactions
- What can I do in my scope of practice?
- Access to records / family doctor
What is Your Assessment of Mona’s Health Goals & Pharmacotherapeutic Priorities?

- Multiple chronic conditions - control, not cure
- Managing patient expectations
  - Anticipated efficacy of analgesia
  - Risk and risk perception of medications and marijuana
- Financial barriers / need for supports
- Psychosocial need for supports
Are you able to address Mona’s complexity within your scope of practice?

- Some, but not all, and not all in one visit!
- Conversations around medication use, risk and benefit
- Framing expectations
- Screening for aberrant drug behaviors
What supports would you need to help best manage Mona’s needs?

- Continuing education around chronic pain / medical marijuana
- Practice with screening for aberrant behaviors
- Consultation with family doctor
- Communication techniques around managing patient expectations
What supports might be available to Mona to empower patient advocacy & self-management?

• How well is Mona able to navigate the health system and be her own health advocate?

• Access to / consultation with other team members – e.g. social worker, school guidance counselor, etc.

• Non-pharmacological supports – e.g. tai chi etc.
When presented with a “complex” patient...

- **Assess** – Use your drug & therapeutic knowledge to identify a patient’s drug therapy problems.

- **Consider** – Evaluate other factors besides medications (e.g. psychosocial issues) that could have an impact on your treatment plan.

- **Prioritize** – Always try to address your patient’s concerns, but prioritize issues that affect patient safety.
When presented with a “complex” patient…

• **Communicate** – The best health outcomes are achieved with a team approach. Keep other providers in the loop and consult them as necessary. DON’T FORGET TO FOLLOW-UP!

• **Act** – Don’t let the “complexity” scare you into inaction. Utilize your full scope of practice to address a patient’s medication issues and assist with referral to their primary care provider if needed.
Resources

• **Patient** – Remember it’s all about patient-centered care! Work with patients and empower them to achieve their health goals.

• **Literature/Clinical Practice Guidelines** – Use these resources to guide therapeutic decision-making and develop evidence-based recommendations.
Resources

• **Other Health Care Providers** – Consult the healthcare team when you need information that can assist in making useful recommendations or identify a problem outside of your scope.

• **Continuing Education** – Pharmacy is a profession of life-long learning. The more opportunities you take for continuing education the better your assessment of patients’ drug therapy problems will be.
Questions

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