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Multimorbidity: perspective from a General Practitioner

Professor Chris Salisbury

Professor of Primary Health Care

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Who attends general practice?
The challenges for patients
The challenges for GPs
What do we need to change?
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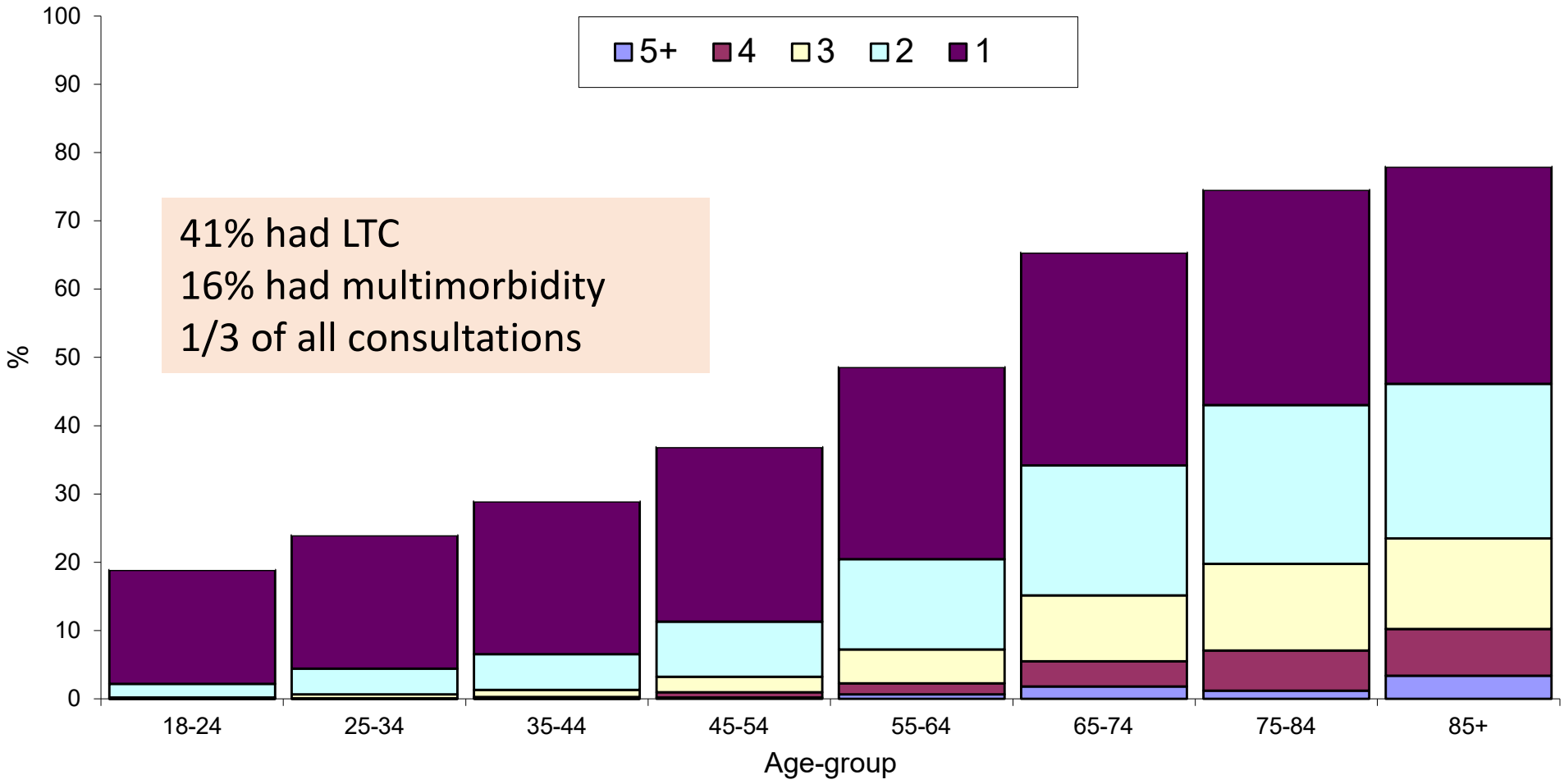
The patients who attend

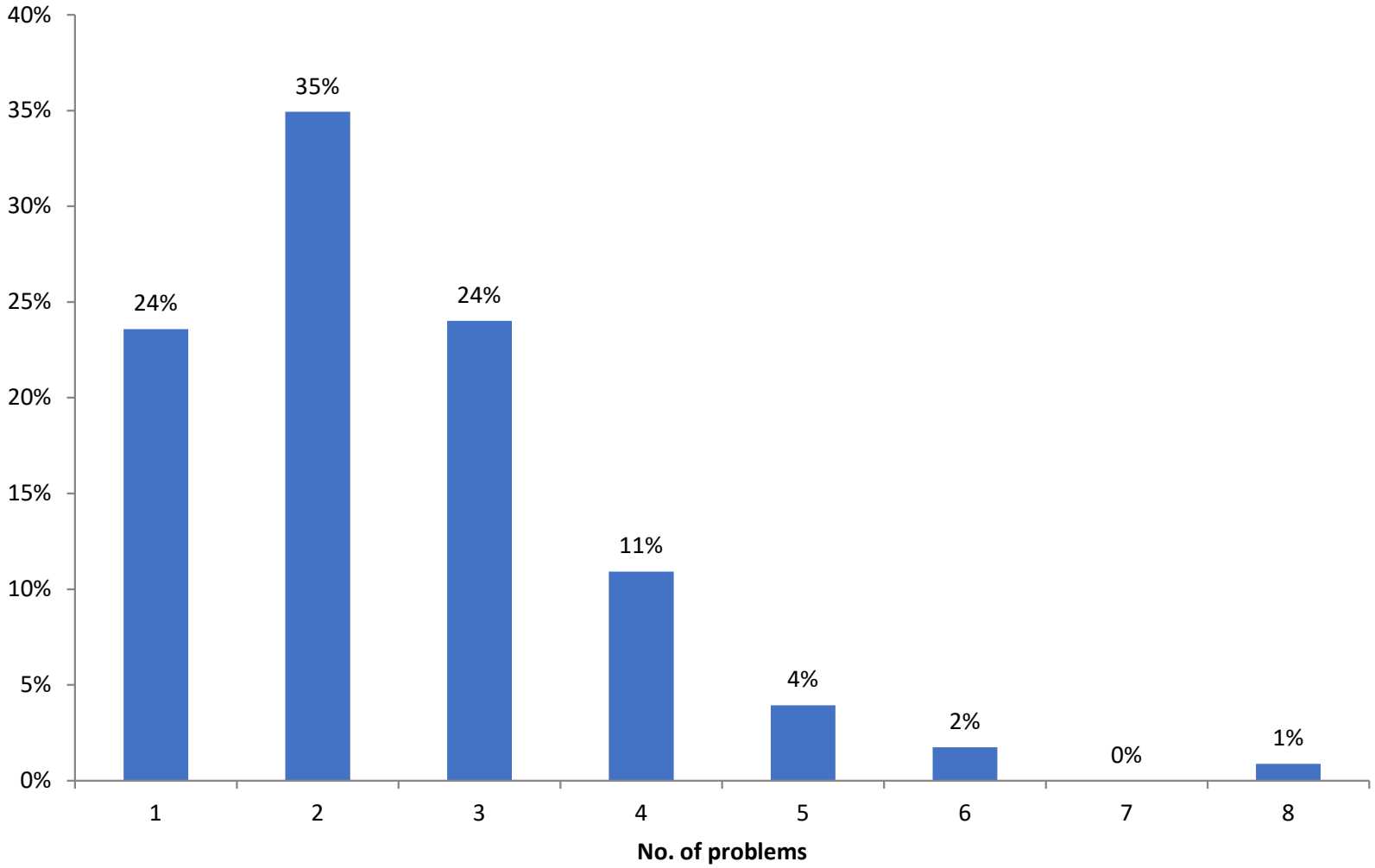
The patients who attend

Number of QoF conditions, per patient, by age group



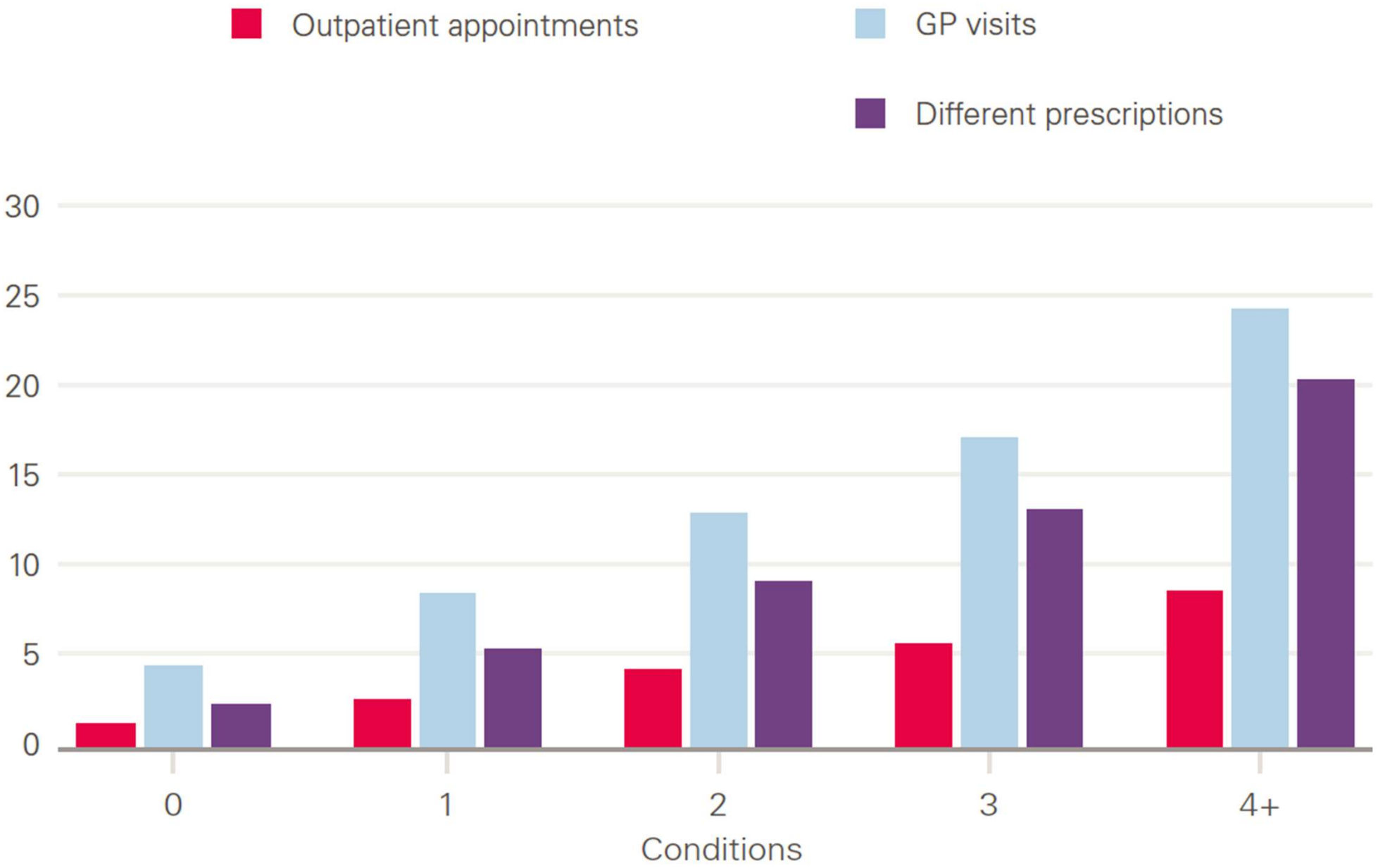
Salisbury C, Johnson LR, Purdy S, Valderas JM, Montgomery AA. Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. Br J Gen Pract. 2011;61(582):e12-e21.

Number of problems discussed in GP consultations



Salisbury C, Procter S, Stewart K, Bowen L, Purdy S, Ridd M, et al. The content of general practice consultations: cross-sectional study based on video recordings. Br J Gen Pract. 2013;63(616):e751-9.

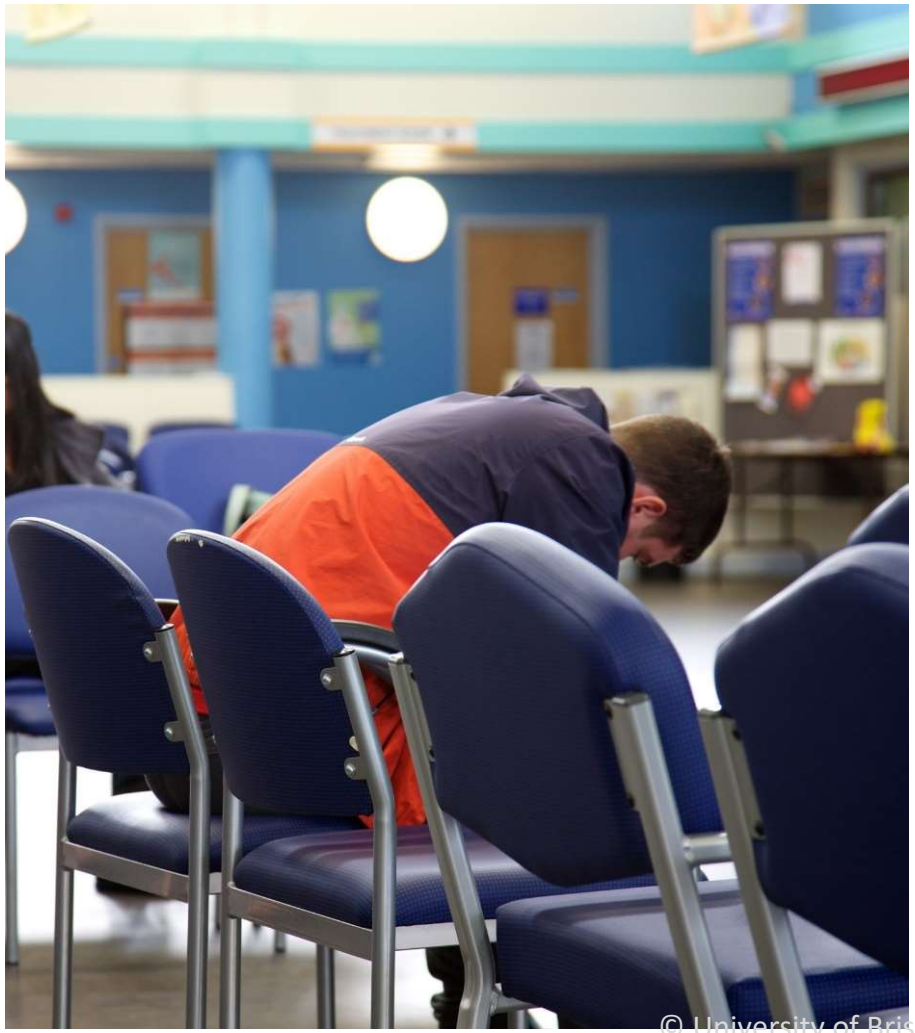
Figure 5: Outpatient and primary care interactions by number of conditions



Understanding the health care needs of people with multiple health conditions. © The Health Foundation

Multimorbidity

- Poor quality of life
- Poor mental health
- High mortality



THE LANCET

Subm

ARTICLES | VOLUME 392, ISSUE 10141, P41-50, JULY 07, 2018

Management of multimorbidity using a patient-centred care model: a pragmatic cluster-randomised trial of the 3D approach

Prof Chris Salisbury, MD • Mei-See Man, PhD • Prof Peter Bower, PhD • Prof Bruce Guthrie, PhD • Katherine Chaplin, PhD • Daisy M Gaunt, MSc • et al. Show all authors

Open Access • Published: June 28, 2018 • DOI: https://doi.org/10.1016/S0140-6736(18)31308-4 •

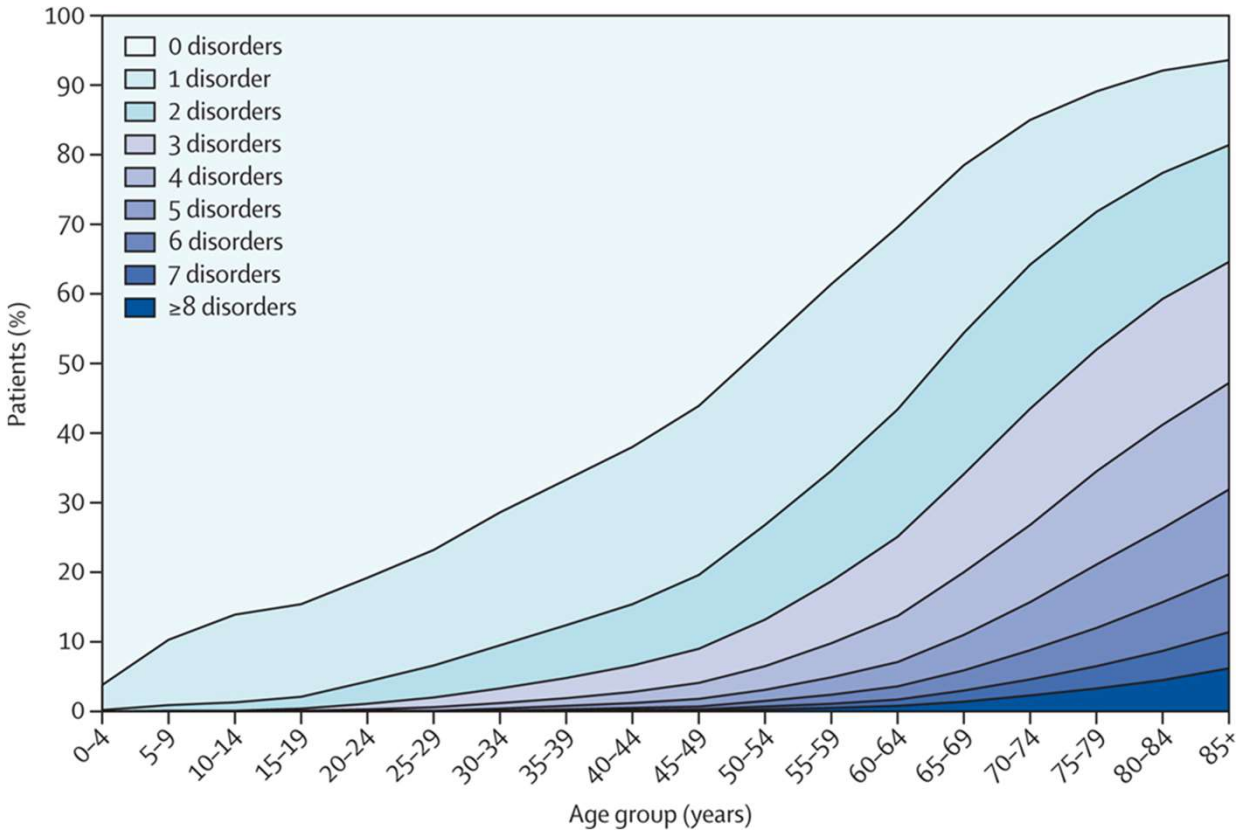
Check for updates

3D trial: usual care

- 2/3 had ‘fair’ or ‘poor’ health
- 1/3 had anxiety or depression
- Continuity of care low
- 90% of patients didn’t have a care plan
- 23% of patients said their care was ‘rarely or never’ joined up.
- 35% hadn’t discussed their most important problems

Prevalence of multiple long term conditions

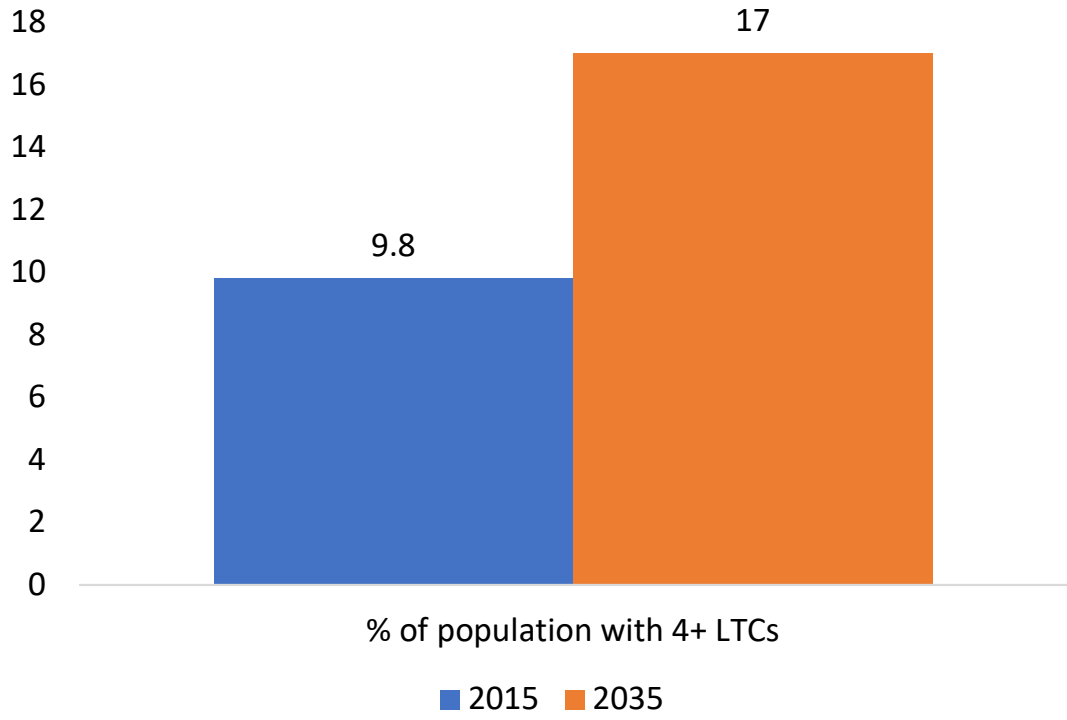
- ¼ of adults in England have 2+ long-term conditions
- Prevalence of multiple long term conditions rises with age
- Half of those aged 65+, and two thirds of those aged 85+ have 2+ long term conditions



The Lancet 2012 38037-43DOI: (10.1016/S0140-6736(12)60240-2)

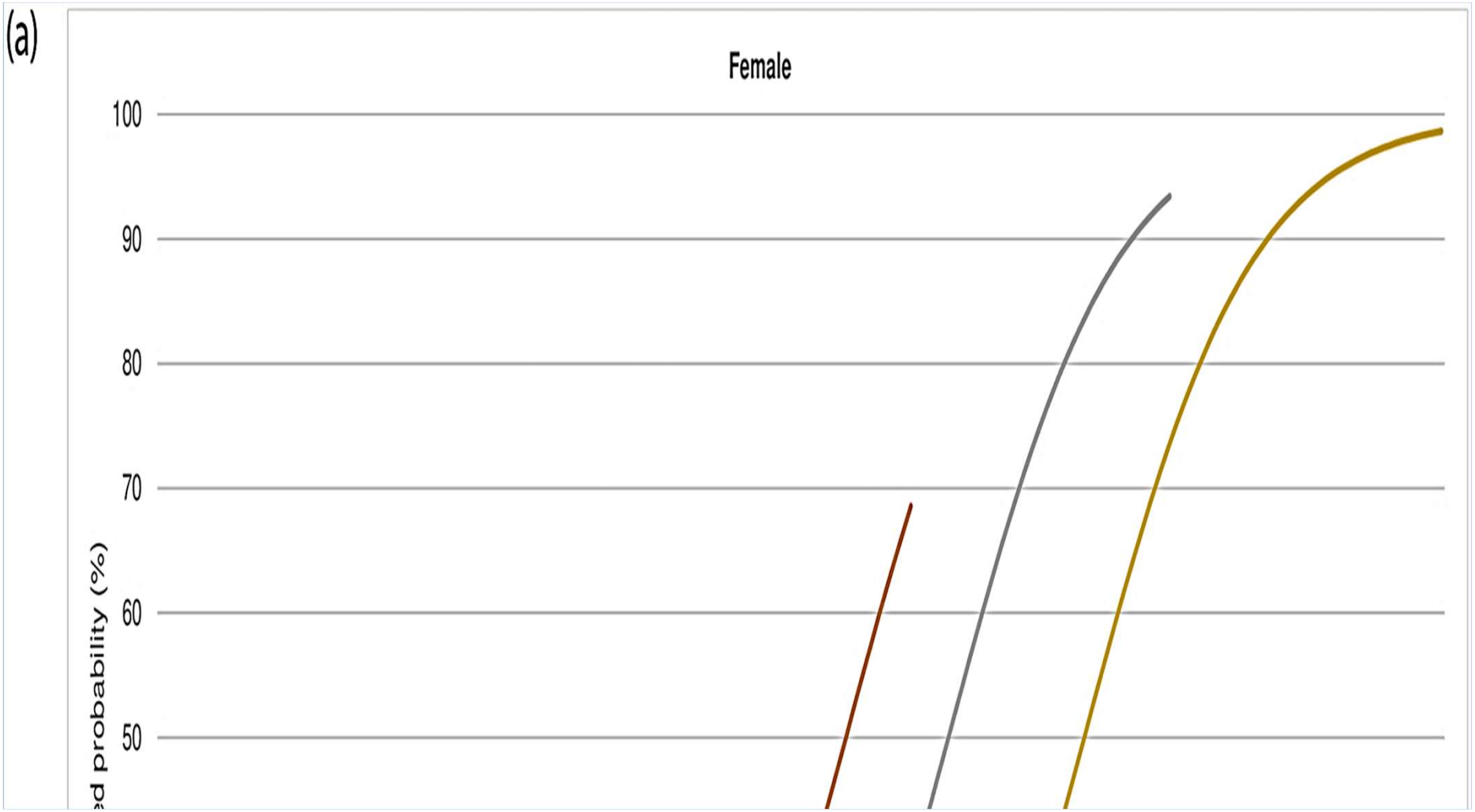
Projections

- Number of people aged over 85+ will double in next 20 years
- By 2035:
  - % of population aged 65+ with **4+ conditions** will almost double
  - 34.1% of those with 4+ conditions will have mental health problems or dementia
- More people with MLTC under the age of 65 than over



Kingston A et al *Age and Ageing*, Volume 47, Issue 3, May 2018, Pages 374–380

Projections by age group



Vos R, Boesten J, van den Akker M (2022) Fifteen-year trajectories of multimorbidity and polypharmacy in Dutch primary care—A longitudinal analysis of age and sex patterns. PLOS ONE 17(2): e0264343.

GP Payments

QOF
(Quality and Outcomes Framework)

Version V2.0 - 29th June 2022

NHS England

Primary Care Support England

"The good news is that you have my favourite disease."

Specialisation in primary care

Tension

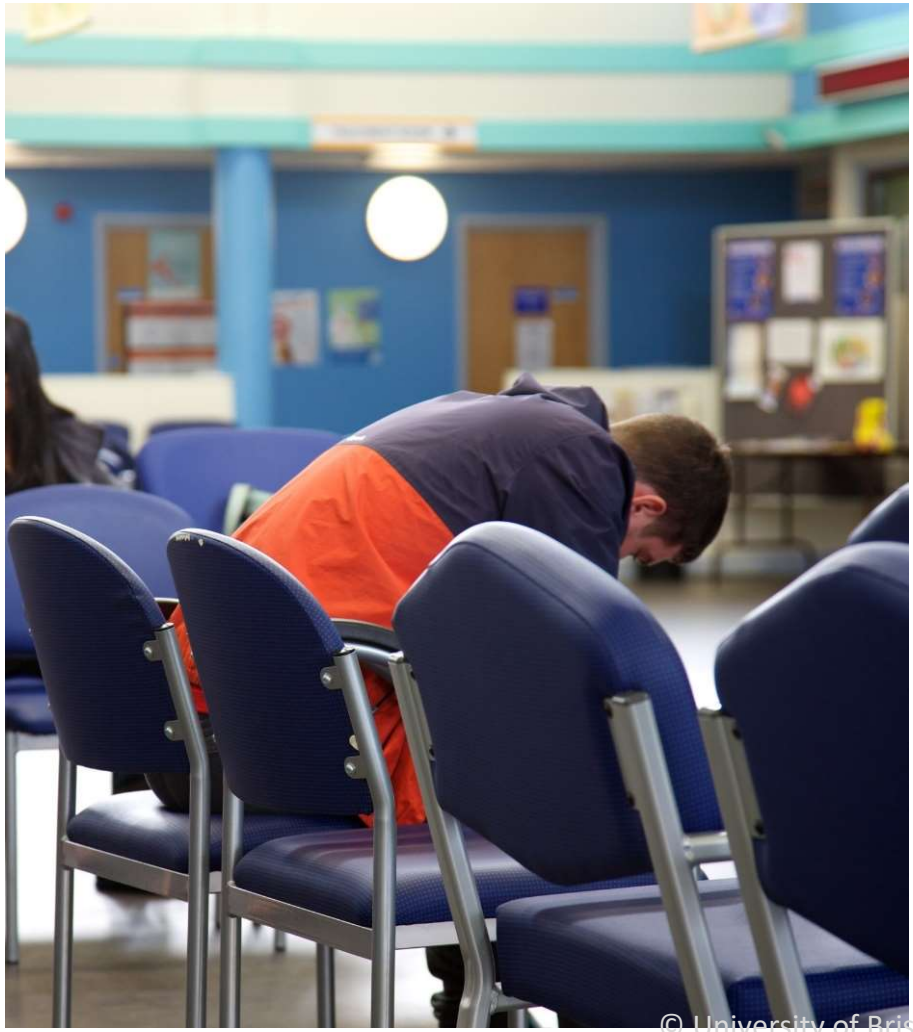
Patients who use primary care have multiple diseases

Primary care focus on single diseases

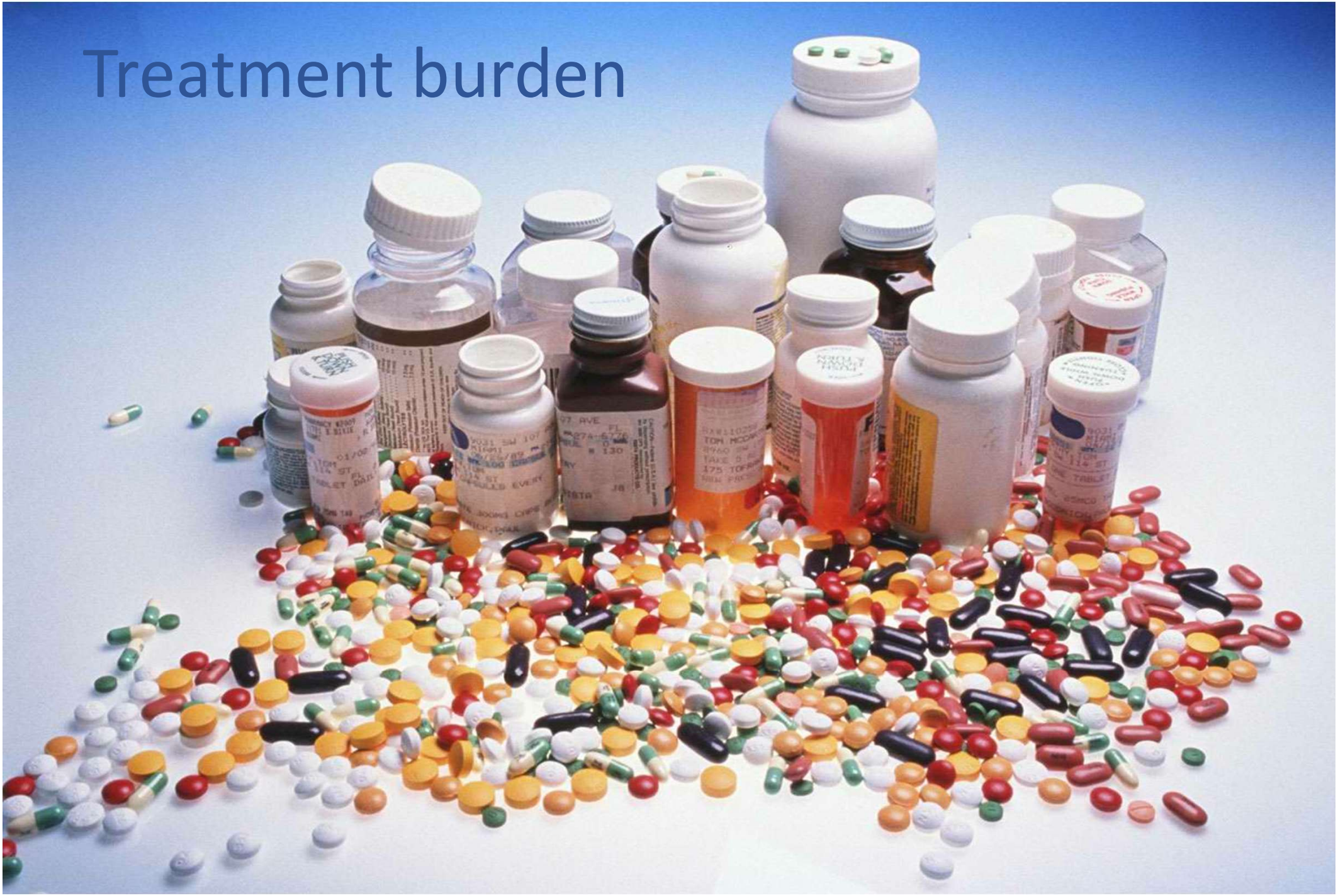
Multimorbidity

- Poor quality of life
- Poor mental health
- High mortality

Illness burden



Treatment burden



BMJ Open

Danish validation of the Multimorbidity Treatment Burden Questionnaire (MTBQ) and findings from a population health survey: a mixed-methods study

Marie Hauge Pedersen [1], Polly Duncan [2], Mathias Lasgaard,[1] Karina Friis,[1] Chris Salisbury [2], Finn Breinholt Larsen [1]

To cite: Pedersen MH, Duncan P, Lasgaard M, *et al*. Danish validation of the Multimorbidity Treatment Burden Questionnaire (MTBQ) and findings from a population health survey: a mixed-methods study. *BMJ Open* 2022;**12**:e055276. doi:10.1136/bmjopen-2021-055276

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2021-055276).

Received 07 July 2021
Accepted 28 October 2021

ABSTRACT

Objective To validate the Danish Multimorbidity Treatment Burden Questionnaire (MTBQ) and obtain a population-based evaluation of treatment burden.

Design Mixed-methods.

Setting Danish population-based survey.

Participants Translation by professional translators and an expert group. The scale was tested by 13 407 participants (aged ≥25 years) in treatment.

Measures The 10-item MTBQ was translated into Danish using forward-backward translation and used in a large population health survey. A global MTBQ score was calculated and factor analysis and Cronbach's alpha assessed dimensional structure and internal consistency reliability, respectively. Spearman's rank correlations between global MTBQ scores and scores of self-rated health, health-related quality of life and the number of long-term conditions, respectively, assessed construct validity. MTBQ scores were grouped into four categories (no, low, medium, high burden) to assess interpretability

Strengths and limitations of this study

- ► Using data from a large population health survey, we examined the validity of the Multimorbidity Treatment Burden Questionnaire (MTBQ) as a measure of treatment burden for identifying high-risk groups at the demographic level and guiding policy decisions and clinical practice.
- ► The response rate was high (64%), and weights were constructed to increase the generalisability of the analyses to the general population.
- ► A thorough process including forward-backward translation was undertaken to translate the MTBQ from English into Danish and to ensure the usability of the measure in a large population health survey.
- ► Establishment of content validity was out of scope for this paper and convergent validity was not established as the MTBQ was included in a comprehensive large-scale population survey, which precluded a comparative treatment burden measure

BMJ Open: first published as 10.1136/bmjopen-2021-055276 on 3 January 2022. Downloaded from http

Impact on the GP


Goede Tijden
Slechte Tijden

Impact on the GP

- Not the main problem
- Disease-by-disease checklists
- Care pathways by disease
- Trade-offs and competing risk
- Patient preference

What do people with multiple long term conditions want from primary care?

- access to care when they need it
- continuity of care
  - someone who knows them as a person
  - knows about all of their relevant conditions
  - takes their concerns seriously
  - having someone to count on
- Someone with knowledge of local support services
- Better co-ordination of care

A multimorbidity manifesto

- The norm not the exception
- A generic model of care
- Individualised, personalised care
- Whole person care
- Continuity of care
- Co-ordinated care
- Simplify medication
- Support for self-management

The 3D trial

Management of multimorbidity using a patient-centred care model: a pragmatic cluster-randomised trial of the 3D approach

Chris Salisbury, Mei-See Man, Peter Bower, Bruce Guthrie, Katherine Chaplin, Daisy M Gaunt, Sara Brookes, Bridie Fitzpatrick, Caroline Gardner, Sandra Hollinghurst, Victoria Lee, John McLeod, Cindy Mann, Keith R Moffat, Stewart W Mercer

Summary

Background The management of people with multiple chronic conditions challenges health-care systems designed around single conditions. There is international consensus that care for multimorbidity should be patient-centred, focus on quality of life, and promote self-management towards agreed goals. However, there is little evidence about the effectiveness of this approach. Our hypothesis was that the patient-centred, so-called 3D approach (based on dimensions of health, depression, and drugs) for patients with multimorbidity would improve their health-related quality of life, which is the ultimate aim of the 3D intervention.

Methods We did this pragmatic cluster-randomised trial in general practices in England and Scotland. Practices were randomly allocated to continue usual care (17 practices) or to provide 6-monthly comprehensive 3D reviews, incorporating patient-centred strategies that reflected international consensus on best care (16 practices). Randomisation was computer-generated, stratified by area, and minimised by practice deprivation and list size. Adults with three or more chronic conditions were recruited. The primary outcome was quality of life (assessed with EQ-5D-5L) after 15 months' follow-up. Participants were not masked to group assignment, but analysis of outcomes was blinded. We analysed the primary outcome in the intention-to-treat population, with missing data being multiply imputed. This trial is registered as an International Standard Randomised Controlled Trial, number ISRCTN06180958.

Findings Between May 20, 2015, and Dec 31, 2015, we recruited 1546 patients from 33 practices and randomly assigned them to receive the intervention (n=797) or usual care (n=749). In our intention-to-treat analysis, there was no

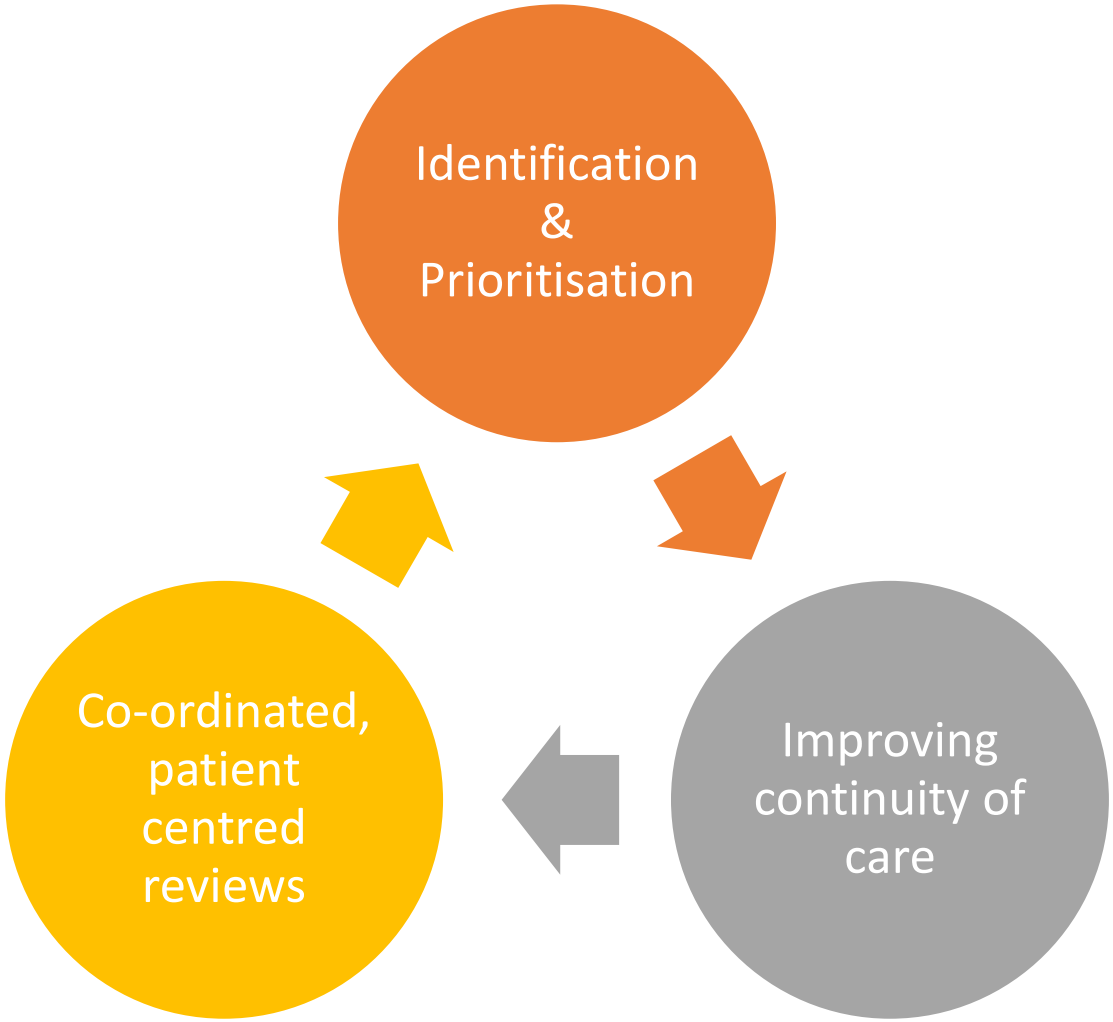
Lancet 2018; 392: 41–50

Published Online June 28, 2018 http://dx.doi.org/10.1016/S0140-6736(18)31308-4

See Comment page 4

Centre for Academic Primary Care, NIHR School for Primary Care Research (Prof C Salisbury MD, M-S Man PhD, K Chaplin PhD, S Hollinghurst PhD, C Mann MSc) **and Bristol Randomised Trials Collaboration** (D M Gaunt MSc, S Brookes PhD), **Population Health Sciences, Bristol Medical School, University of Bristol, Bristol, UK; NIHR School for Primary Care Research, Centre for Primary Care, Division of Population of Health, Health Services Research and Primary**

The 3D intervention

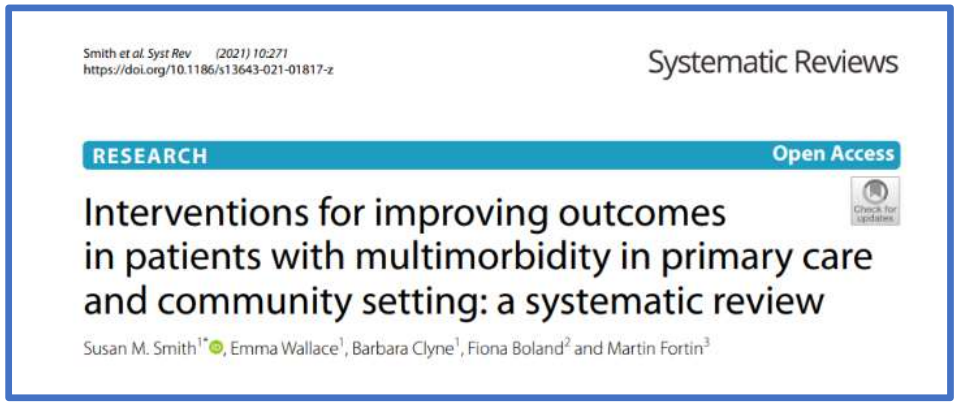


3D Trial
Results on primary outcome EQ5D

	Control (N=749)		Intervention (N=797)				
15 months	**Mean (SE* or SD)**	**n**	**Mean (SD)**	**n**	**Adjusted difference in means (95% CI)[1]**	**P-value**	**ICC (95% CI)**
1. Primary analysis	0.504 (0.012*)	749	0.533 (0.012*)	797	0.00 (-0.02, 0.02)	0.825	0.00 (0.00, 0.00)
[1]Adjusted by baseline EQ-5D-5L, site, GP practice deprivation score and list size, GP practice as random effect							

- Improvements in patient's experience of care
- No significant different in cost

Systematic Review of interventions



Smith et al. Syst Rev (2021) 10:271
https://doi.org/10.1186/s13643-021-01817-z

Systematic Reviews

RESEARCH Open Access

Interventions for improving outcomes in patients with multimorbidity in primary care and community setting: a systematic review

Susan M. Smith[1*], Emma Wallace[1], Barbara Clyne[1], Fiona Boland[2] and Martin Fortin[3]

- **16 RCTs**
- Little/no evidence of effect on primary outcomes of health related QoL or mental health
- Little or no effect, or mixed results, on:
  - clinical outcomes
  - psychosocial outcomes
  - function and activity
  - patient health behaviours
  - healthcare utilisation
  - patient satisfaction with services
- care coordination *may* improve patient experience of care
- self-management support *may* improve patient health behaviours.
- Overall, certainty of evidence low due to significant variation in study participants and interventions.

Problems in research on interventions to improve care for multimorbidity

Whole system change

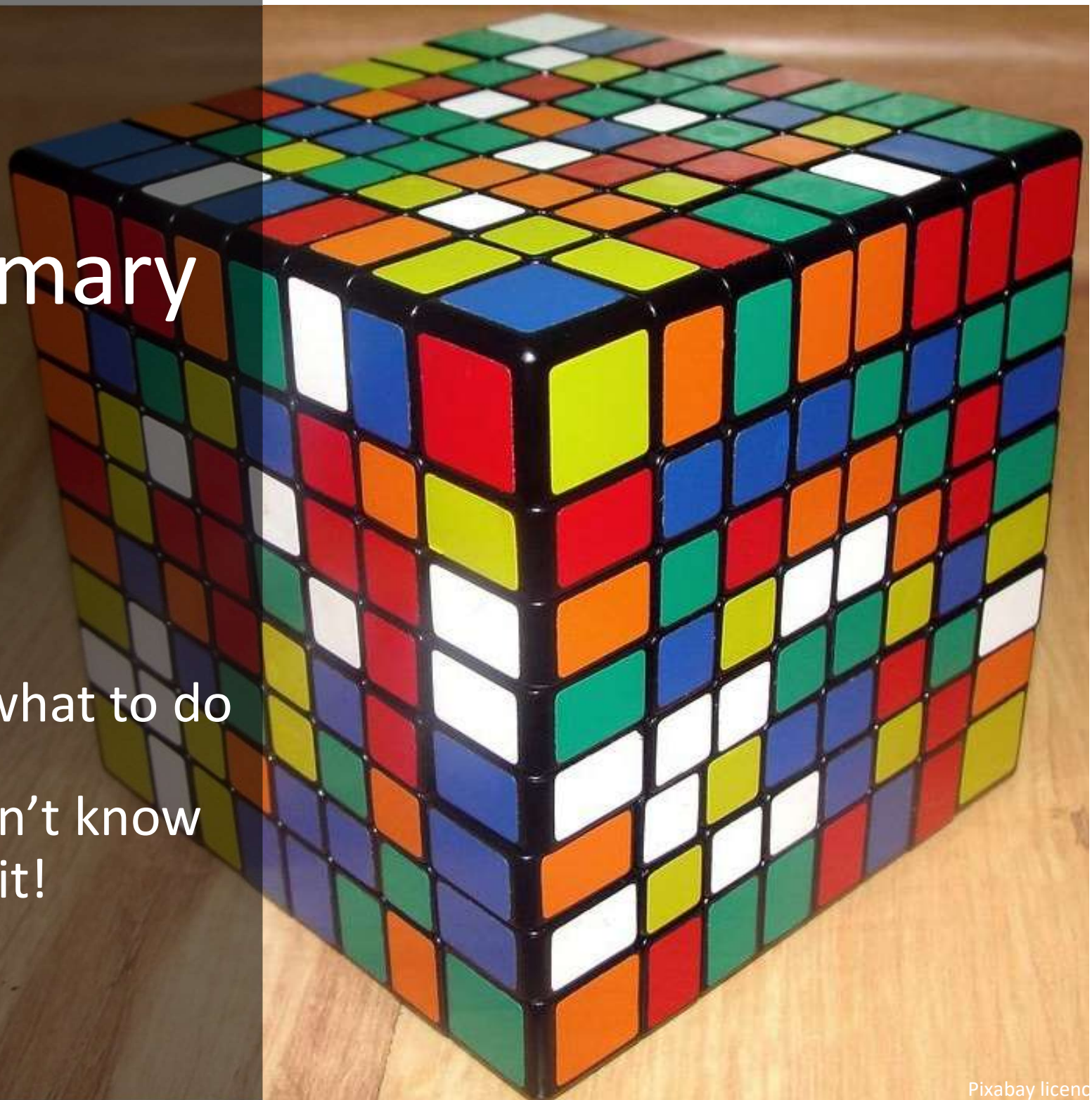
- Model of care in general practice
- IT systems
- Referral to secondary care
- Clinician training

Research problems

- Research different from real life
- Insensitive, generic outcomes
- Individualised outcomes
- Change takes time

In summary

- We know what to do
- We just don’t know how to do it!



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