Clinical assessment and management of multimorbidity:

NICE guideline

INTRODUCTION

The National Institute for Health and Care Excellence (NICE) has published a guideline on the assessment and management of patients with multimorbidity. Multimorbidity is defined as the presence of two or more long-term conditions and is increasingly common as people age. Two-thirds of people aged >65 years will have multimorbidity, which is associated with reduced quality of life and higher mortality. In older people this is associated with higher rates of physical health conditions, polypharmacy, adverse drug events, high treatment burden, and greater use of health services. In younger people and people from less affluent areas, multimorbidity is often due to a combination of physical and mental health conditions. The guideline emphasises that multimorbidity includes conditions such as sensory problems and pain as well as 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; and alcohol and substance misuse.

The aim of this guideline is to support patients and clinicians in optimising care for people with multimorbidity, in particular where there is potential for care to become burdensome or uncoordinated.

THE GUIDANCE

Impact of multimorbidity. Some patients with two or more conditions can manage those conditions and associated treatments in line with single disease guidelines. This guideline suggests that healthcare professionals should consider an approach to care that takes account of multimorbidity, for patients such as those who: find it difficult to manage their treatments for day-to-day activities; are prescribed multiple regular medications; frequently seek unplanned or emergency care; and have frailty (that is, reduction in resilience or biological/physiological reserve).

The guideline suggests that such people might be identified proactively using electronic health records. It is suggested that all patients prescribed >15 medicines should be considered for an approach that takes account of multimorbidity. Patients on <15 medicines may also benefit, particularly where there is likely to be a higher risk of adverse events or drug interactions.

The guideline suggests the use of validated tools to identify patients who might benefit from a multimorbidity approach to care and who may be at risk of unplanned hospital or care home admissions, although it does not recommend any specific interventions to reduce unplanned hospital admissions. QAdmissions (an algorithm to quantify the absolute risk of emergency admission to hospital, which includes established risk factors, and designed to work in primary care) is recommended as a useful tool.

Assessment of frailty. The ‘Fit for Frailty’ British Geriatrics Society campaign, produced in association with the Royal College of General Practitioners (RCGP), suggests that ‘frailty’ is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged >65 years have frailty, rising to between a quarter and a half of those aged >85 years. People living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event that challenges their health, such as an

Box 1. Pragmatic assessments of frailty that can be used by the GP

- An informal assessment of gait speed (for example, 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.
Box 2. Assessing the impact of multimorbidity on the patient

- How health problems affect quality of life or wellbeing.
- How health problems, or treatments, interact.
- The number and type of appointments a patient has for each of their health problems, where they take place, and whether conflicting advice is given by different clinicians.
- Changes in lifestyle needed due to health problems (for example, diet).
- Non-pharmacological treatments such as diets, exercise programmes, and psychological treatments.
- The number and type of medicines a patient is taking, and any side-effects arising from medications.

Box 3. Elements of a management plan for patients with multimorbidity

- Goals and plans for future care (including advance care planning).
- Agreement about who is responsible for coordination of care.
- Planning how the individualised management plan and the responsibility for coordination of care is communicated to all professionals and services involved.
- Agreement of timing of follow-up and how to access urgent care.
- A review of medicines and other treatments, taking into account evidence of likely benefits and harms for the individual patient and outcomes important to the person.

Principles of managing people with multimorbidity. The guideline suggests assessing treatment burden by discussing with people how their health problems and treatments affect their day-to-day life. Box 2 suggests some areas the GP could explore. The guideline also reminds clinicians to consider associated mental health problems and the presence of pain, both of which are common in people with long-term conditions.

Box 3 shows some important elements of such a plan, which should aim to improve quality of life by reducing treatment burden, adverse events, and unplanned or uncoordinated care, and to improve coordination of care across services, particularly if this has become fragmented. An important outcome is how decisions to stop or change treatment are recorded and how such a plan is shared between healthcare professionals.

Of particular importance is the treatment burden of polypharmacy, especially in patients who are frail or who have limited life expectancy. Healthcare professionals are reminded that most recommended treatments are based on guidance derived from trials in which participants have single health conditions and are younger and filter than people with multimorbidity. The trial results may be less relevant to, and treatments may offer limited overall benefit to, patients who have multimorbidity. The guideline offers a database on preventive treatments to enable the practitioner to assess the relevance of treatment effects, including information on the duration of treatment trials and populations included in them. Practitioners are recommended to also review symptomatic treatments to check if people are gaining benefit from these.

A search for evidence on effects of treatment avoidance, including fractures and their prevention, was conducted as part of guideline development but little evidence was found. The guideline considers the importance of patients stopping any other drugs. It is important to note that optimising treatment may include the need to start treatments, particularly in younger people who might otherwise miss out on important preventive treatments because of their multimorbidity.

REFERENCES


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9. Principles of managing people with multimorbidity. The guideline suggests assessing treatment burden by discussing with people how their health problems and treatments affect their day-to-day life. Box 2 suggests some areas the GP could explore. The guideline also reminds clinicians to consider associated mental health problems and the presence of pain, both of which are common in people with long-term conditions.


11. Mair FS, May CR. Thinking about the burden of treatment. BMJ 2014; 349: g6680. DOI: 10.1136/bmj.g6680.


Funding

Norma O’Flynn is employed at the National Guideline Centre, which is funded to develop guidelines for NICE.

Provenance

Freely submitted; externally peer reviewed.

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