

I. Curricular Change to Improve Quality Prescribing and Deprescribing

Zubin Austin BScPhm MBA MISC PhD FCAHS
Professor and Koffler Chair in Management
Leslie Dan Faculty of Pharmacy
University of Toronto, Canada



Learning Objectives

Upon completion of this session, participants will be able to:

- a) Describe teaching, learning, and assessment methods used to support quality prescribing and deprescribing practices
- b) Evaluate different models and methods used to support quality prescribing and deprescribing practices at the undergraduate, post graduate, and continuing professional development levels
- c) Articulate and justify success indicators for teaching, learning, and assessment of quality prescribing and deprescribing practices
- d) Reflect upon personal and profession-specific strategies that support quality prescribing and deprescribing practices

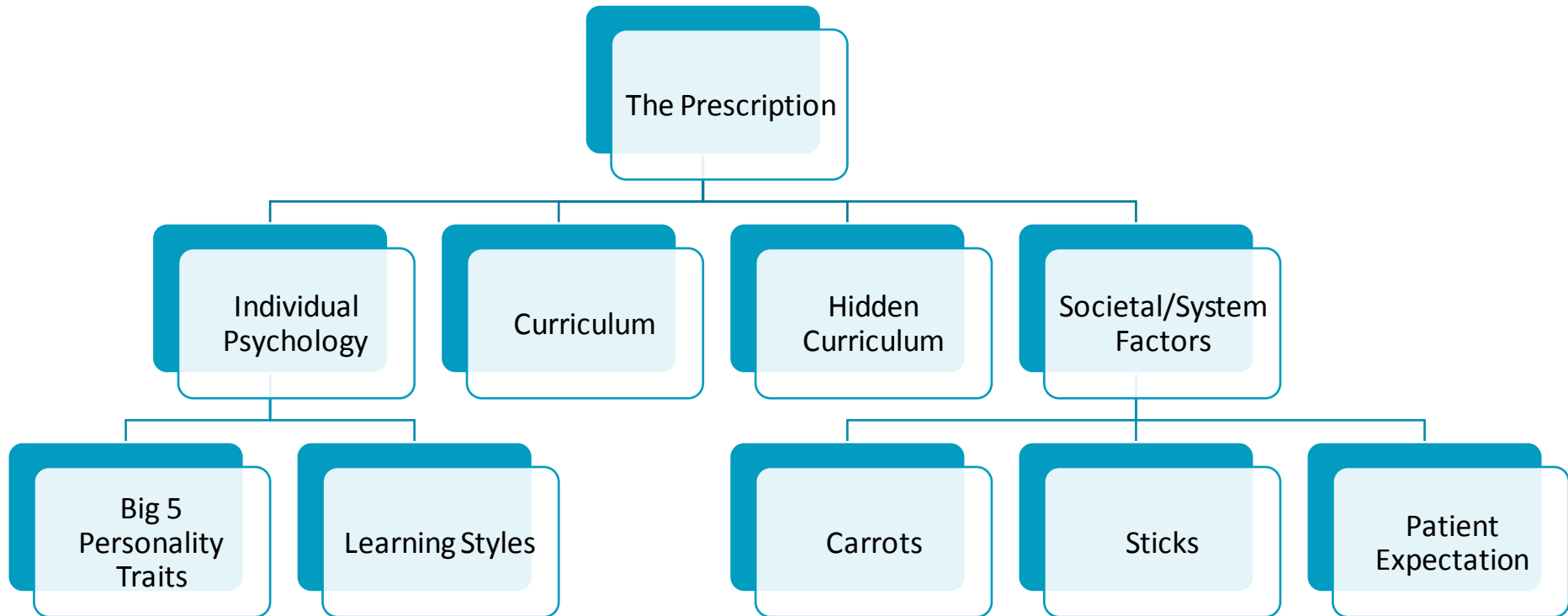


How do clinicians learn to prescribe?

- Medications are integral to effective patient care
- Prescribing is a cognitively complex art built upon a foundation of science
- There has been much speculation about how prescribing is learned, but not a significant body of research or scholarly work



How do clinicians learn to prescribe?



Individual Psychology

Trait Theory:

- Openness to experience
- Conscientiousness
- Extraversion
- Agreeableness
- Neuroticism

Learning Styles Theory:

- Diverger
- Assimilator
- Converger
- Accommodator



The Curriculum

- Building blocks vs Integration
- Theoretical vs Experiential
- School-based vs on-the-job
- Starting vs starting-and-following-through
- Clinical Reasoning
 - First principles
 - Application of Rules
 - Pattern recognition/matching



The Hidden Curriculum

- Social and professional values transmitted through “culture”
- How important – really – are medications?
- What face does one present to a patient? To colleagues? To other health professionals?
- Peer benchmarking
- Intra- and inter-professional hierarchies



Societal and System Factors

- Rewards for good prescribing
- Punishments for poor prescribing
- Patient, general public, and peer experiences and expectations

Small Group Activity #1

In your profession/setting, how is prescribing taught, actually learned, and assessed/evaluated?



Small Group Activity #2

How do professionals learn what **QUALITY prescribing** actually is? How is it taught, actually learned, and how is competence assessed/evaluated?



Quality Prescribing – things that make you go “huh!”

Currie J and Schnell M (2017). Addressing the opioid epidemic: is there a role for physician education?

<https://www.princeton.edu/news/2017/08/15/doctors-trained-lowest-ranked-medical-schools-prescribe-more-opioids>

Rothwell C, Burford B et al. Junior doctors prescribing: enhancing their learning in practice. *B J Clin Pharmacol* 2012;73(2):194-202.

Zhang Y, Baicker K and Newhouse J. Geographic variation in the quality of prescribing. *NEJM* 2010;363:1985-1988



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The quality of GP Prescribing (Kings Fund, UK 2011)

Recommendations for quality indicators:

1. Safety

- a. Systems in place to reduce errors and interactions
- b. Review systems when errors occur
- c. Electronic transmission of prescriptions

2. Patient Centred

- a. Patient's views explored and taken into account
- b. Access to suitable, accredited information for patients
- c. Audits for repeat prescriptions
- d. Coordination between hospitals and GPs
- e. Regular medication review, with pharmacist if possible
- f. Cooperation between GP and community pharmacist



The quality of GP Prescribing (Kings Fund, UK 2011)

3. Information support

- a. Access to high quality drug information/internet access
- b. Multiple systems to keep up to date
- c. Use of preferential drug formularies within practice
- d. Policies governing interactions with the industry
- e. Prescribing advisor networks



The Quality Prescribing Incentive (Australia)

The Quality Prescribing Incentive (QPI) is one of the incentives of the Australian Government's Practice Incentives Program (PIP). It aims to encourage practices to keep up to date with information on the quality use of medicines and medical tests and assists practices with maintaining accreditation standards.



The Quality Prescribing Incentive (Australia)

- Your practice can receive annual financial incentives by completing a minimum number of eligible activities based on the number of full-time equivalent GPs in your practice.
- Payments are calculated at \$1 per Standardised Whole Patient Equivalent (SWPE) per year. The average full-time equivalent (FTE) GP has an SWPE value around 1000 annually, equating to \$1000/annum/FTE GP. The Department of Human Services will advise practices through their Practice Incentives Program quarterly payment advices of the expected number of activities that must be completed by 30 April each year to be eligible for the payment. You can also establish your practice's activity requirements by contacting the Practice Incentives Program on 1800 222 032.
- Payments are made in the May quarter to practices that have met the requirements in the 12 months to 30 April each year.



The role of deprescribing in quality prescribing

- Increasingly discussed but curiously absent from much of the established literature
- Rarely explicitly mentioned or incentivized
- Framed as a component of quality prescribing...but without specific reference to individual, curricular, hidden curricular or societal/system barriers to implementation



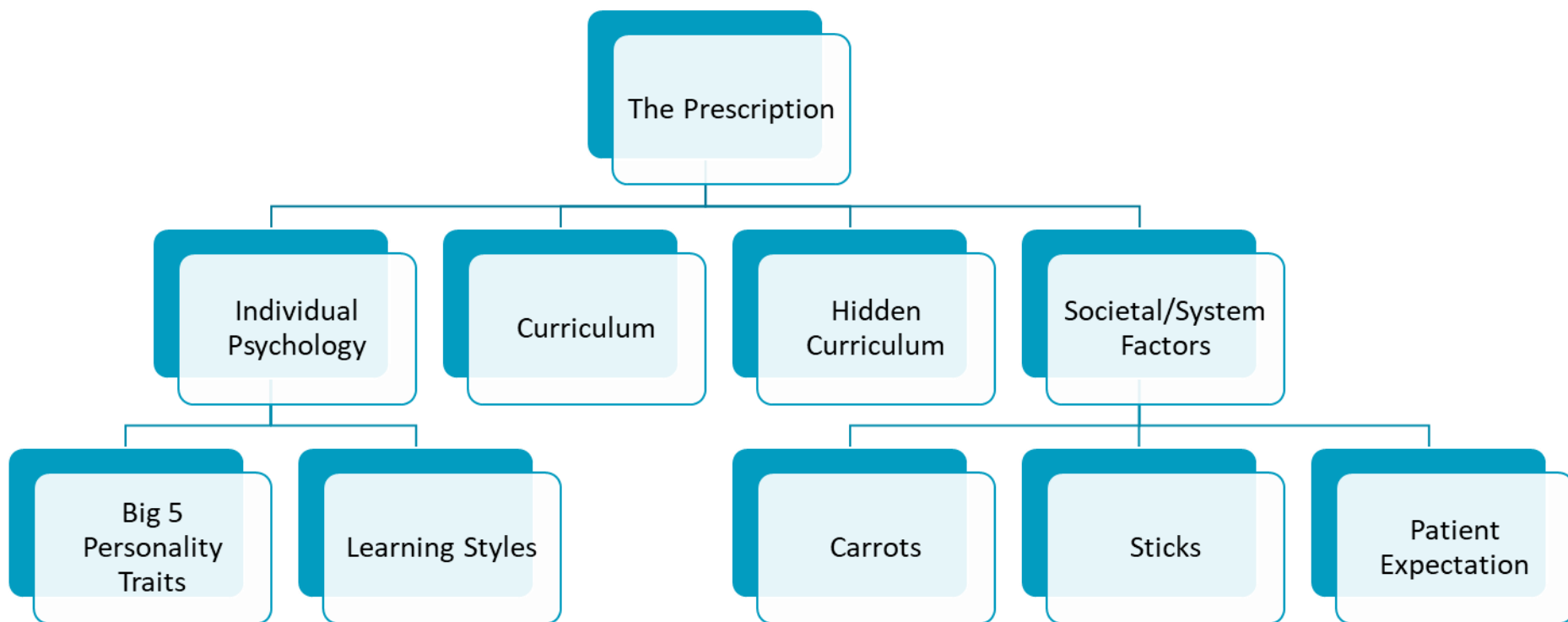
Small group activity #3

What are barriers to adoption of confident, widespread, cost-effective deprescribing in day-to-day practice – and what can be done about them?

- *Individual psychological*
- *Curricular*
- *Hidden curricular*
- *Societal/systemic*



How do clinicians learn to deprescribe?



The sticky problem of heuristics

- An approach to problem solving and clinical reasoning that employs practical methods not guaranteed to be perfect or optimal – but sufficient for immediate goals
- Helps to speed up decision making especially when no perfect solution is possible or actually needed
- “Rules of thumb”, “educated guesses”, “intuitive judgments”, “guesstimates”



Examples of heuristics known to impact prescribing decisions

1. *Anchoring*: over-reliance on first piece of information offered
2. *Availability*: occurs when we make decisions about the probability of an event based on ease with which personally relevant examples come to mind
3. *Familiarity*: especially prevalent during times of high cognitive load, a mental shortcut applied where we assume past behavior still hold true for present situations (i.e. past behaviours can be correctly applied to a new situation)
4. *Loss*: Would rather forgo future gain to avoid present pain



Less well known heuristics

Need to be liked, rather than right: Conflict avoidance subconsciously driving decision making

Certainty: Using 100% certainty (rather than “on-balance”) as criteria for decision making

Risk-balancing: Quantifying potential risks associated with alternative decisions then acting accordingly



The power of heuristics

- Unexamined, they fundamentally shape our behaviours and decisions
- Despite being well-educated and well-intentioned, health care professionals are just as vulnerable to heuristic reasoning as anyone else
- They are “good-enough when good-enough is good-enough” ...how often does this actually apply in health care?



What are the priorities – and what can we actually expect to achieve?

- Quality prescribing and deprescribing practices are crucial for cost-effective and safe healthcare delivery
- Many clinicians lack confidence – or reflective propensity to recognize opportunities for improvement
- What are priorities for:
 - Educators
 - Regulators
 - Professional Associations
 - Employers
 - Payers



Think-Pair-Share Activity

What are the most important next 2-3 practical steps required to support widespread adoption of confident, cost-effective deprescribing?



II. Developing a national approach to quality prescribing and deprescribing



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Learning objective

- a) Identify inclusionary, participative methods for establishing a pan-Canadian interprofessional working group focused on quality prescribing practices including deprescribing

- b) Establish key priorities for a working group in developing a white paper to further guide national, interprofessional discussions and curricular planning at all levels to support quality prescribing practices including deprescribing

- c) Establish parameters (including timelines and development pathways) for defining successful outcomes for a working group in developing a white paper to guide national, interprofessional discussions and curricular planning at all levels to support quality prescribing practices including deprescribing



A White Paper (thanks, Wikipedia!)

- A **white paper** is an authoritative report or guide that informs readers concisely about a complex issue and presents the issuing body's [philosophy](#) on the matter. It is meant to help readers understand an issue, solve a problem, or make a decision.
- The initial British term concerning a type of government-issued document has proliferated, taking a somewhat new meaning in business. In business, a white paper is closer to a form of marketing presentation, a tool meant to persuade customers and partners and promote a product or viewpoint. White papers may be considered [grey literature](#)



All the colours of the rainbow...

White paper: tool for presenting policy-level preferences prior to introduction, a way to test public opinion on controversial issues and help gauge impact

Green paper: usually more open-ended, a consultation document to propose a strategy and to genuinely seek out public opinions and views on a topic

Blue paper: sets out technical specifications for implementation

Yellow paper: document containing research not yet accepted for publication to gauge public response and to subsequently adjust presentation of findings



Styles of White Paper

Backgrounder:

- Describes a new or controversial idea, helps diverse audiences develop common vocabulary and understanding of a situation or idea

Numbered List:

- Presents a series of prescriptive tips/points, or questions about an issue, generally best used to get attention, generate discussion or raise consciousness

Problem/Solution:

- Generally used when dimensions of a problem are well known and accepted and solutions are agreed upon but implementation may be more problematic – used to persuade and inform an audience and to build trust/credibility in the subject



Why a white paper?

- Many different activities related to deprescribing occurring in silos at the current time
- Many clinicians are simply not aware of deprescribing as an activity/objective/role
- Need to advocate for deprescribing across different constituencies, including the general public, funders/payors, governments, administrators, educators, etc
- Need to identify potential pathways to advance deprescribing in clinicians' and patients' consciousness
- Need to showcase promising and best curricular and assessment practices
- Need to support educators in implementing change in training and education programs



Small Group Activity #1

What should the actual focus (or remit) of **this** white paper be?

(so much to choose from: highlight promising teaching practices, describe assessment models, provide curricular tools, outline a pathway for curricular change, advocacy for deprescribing across different constituencies...we can't do it all!)



Small group activity #2

Who should be participating in the drafting of a white paper? What constituencies should be considered and how should representatives be selected/appointed?



Small group activity #3

How do we optimize buy-in and take-up of a white paper?
What kinds of revision and external validation processes
would be useful and important?

Dissemination and scholarship

- Canada is an international leader in the area of quality prescribing and deprescribing
- Important to consider options and opportunities for scholarly work to flow from white papers and other similar projects
- A potentially powerful career-building platform for faculty members that needs to be supported and nurtured



Boyer (1990): Scholarship reconsidered

Discovery: original research that advances knowledge within a field

Integration: synthesis of information across disciplines, across topics within a discipline, or across time

Engagement: application of expertise with results that can be shared and/or evaluated by peers

SOTL: systematic study of teaching and learning processes in a format that allows public sharing and opportunity for application and evaluation by others



Final Thoughts

- This is a multi-step, multi-profession, multi-year, complex undertaking
- Abundant opportunities for involvement at the micro, meso, or macro level
- Commitment and engagement across disciplines, professions, and layers of organizations is needed
- Our ultimate objective: enhance health care outcomes through optimal prescribing practices, including deprescribing

