

## **An ideal model of care for multimorbidity – the search continues**

J Treadwell MBBS, MRCP, DCH, DRCOG, DTB Associate Editor

Imagine you are one of the 65% of adults in the UK with multimorbidity. You will have several long-term conditions, including depression, and may be taking five or more medicines. There will be many visits to your GP surgery each year: twice for the diabetes clinic with appointments for blood tests beforehand and another for retinal screening; appointments with the nurse for a COPD review, a blood pressure check and 'flu vaccination; and a handful of consultations with the GP to address depression and osteoarthritis. Most of these will be dealing with one problem at a time, following single-condition guidelines that may be based on evidence of limited applicability to you.<sup>1</sup> You will make regular trips to the community pharmacy and may be offered an annual Medicines Use Review with the pharmacist. Being on the receiving end of all this care can feel like quite a burden, and despite all this medical contact, the issues you really want to address may be sidelined by well-intentioned professionally-driven tick-box protocols.<sup>2</sup>

Imagine if instead, every six months you received an invitation from your practice to review all your health problems. You first see a practice nurse who asks what conditions are the most important to you and how they affect your life. You're asked screening questions for depression and dementia, and your social and care needs are considered. Then there are the usual routine checks as well as focused questions about your particular long-term conditions. You get up-to-date with your vaccinations and are given tailored health advice. At the end, a printed summary includes an agenda to discuss at your GP consultation. Meanwhile, a

pharmacist has been reviewing your medical record, identifying drug interactions, missing treatments and those that could be optimised or stopped. Finally, you see your GP who reviews what's happened, agrees priorities and goals with you, makes a joint management plan all wrapped up with a printed summary and planned follow-up.

This ambitious model, entitled the 3-D approach (referring to the dimensions of health, depression and drugs), has been assessed in a National Institute for Health Research funded trial published in the *Lancet*.<sup>3</sup> Against a context of national guidance on multimorbidity recommending such an integrated approach, but with a paucity of direct evidence to support it, this was the first substantial study of its kind.<sup>4,5</sup> This well-designed pragmatic cluster randomised trial compared usual care with the 3-D approach and involved 33 practices and 1546 patients in Bristol, Greater Manchester and Ayrshire.<sup>3</sup> Inclusion criteria were chosen to create a trial population representative of the general population; practices were well matched for deprivation; and patients well matched for demographics and morbidities. The pre-specified primary outcome was health-related quality-of-life measured by the EQ-5D-5L tool; outcome assessment and analysis were blinded.

Although a noble researcher will celebrate the completion of good quality research whatever the finding, one can't help imagining there must have been more than a little heartache when, at 18 months follow-up, the 3-D approach showed no difference in the primary outcome. Despite the beautifully designed intervention that included staff training, monthly feedback and a modest financial incentive, backed by the enthusiasm and resources of a clinical trial, improving the quality of life for patients with three or more long term conditions

remained an elusive goal. There were some positives however, with improvements in multiple measures of patient satisfaction with care - in itself a valuable outcome.

This disappointing result may have a number of explanations. Perhaps, despite all its current challenges, “usual” British primary care is still good at delivering important interventions to the population it serves. It is also well-recognised that the health-related problems which matter most people, like chronic pain and mental health problems, are often those most challenging to treat; whereas successfully managing people’s asymptomatic risk factors does not improve people’s quality-of-life (except those few who avoid adverse outcomes).

There is further news to come from this study, with qualitative findings yet to be published, which may reveal some valuable lessons. Meanwhile it seems we are still lacking a better model of care for this large and important population.

1.Steel N et al. A review of clinical practice guidelines found that they were often based on evidence of uncertain relevance to primary care patients. *Journal of Clinical Epidemiology* 2014; 67: 1251-57.

2.May, C., V.M. Montori, and F.S. Mair, We need minimally disruptive medicine. *BMJ*, 2009. 339: b2803.

3.Salisbury C et al. Management of multimorbidity using a patient-centred care model: a pragmatic cluster-randomised trial of the 3D approach. *Lancet* 2018; 392: 41-50.

4.National Institute for Health and Care Excellence, 2016. *Multimorbidity: clinical assessment and management (NG56)* [online]. Available: <https://www.nice.org.uk/guidance/ng56> [Accessed 7 September 2018].

5.Smith SM et al. Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. *Cochrane Database Syst Rev* 2016; 3: 10.1002/14651858.CD006560.pub3.