Polypharmacy: prevention and management

We have followed the CMAJ series of case-based practice articles on polypharmacy with great interest and we commend the authors1,2 for drawing attention to this issue. As the population of older Canadians with multiple chronic conditions grows, the challenge of managing medications in these patients becomes more pressing.

Farrell and colleagues1,2 have presented two instructive cases of senior patients with multiple chronic conditions, complex medication regimens and multiple prescribers. We wish to emphasize the essential role of the interprofessional team in making sense of the complexities inherent to such cases. In both the cases1,2 the patients benefited greatly from referral to a local geriatric day hospital. Unfortunately, current demand for such specialized services far outstrips supply. Consequently, much of the management of complex medication regimens is performed in primary care. This is a time-consuming process, as Frank3 has indicated, and is not well suited to the usual 10- to 15-minute family-physician visit.

Necessity being the mother of invention, we developed a new primary care model designed specifically for older patients with complex health and medication needs. The IMPACT clinic4 features an extended 90-minute visit, during which an interprofessional team conducts a comprehensive 360-degree assessment and co-creates, with the patient and family, a plan of care that is time-consuming, as Frank3 has indicated, and is not well suited to the usual 10- to 15-minute family-physician visit.

We agree that more tools are needed to support primary care physicians in their work with seniors. Not all physicians have access to a specialized interprofessional team is not available. We recognize that this is a work in progress.

The authors respond

We thank Tracy and colleagues for their supportive letter2 in response to our series of case-based practice articles on polypharmacy.2,3 Their letter accentuates the challenges of complex, ever-changing medication regimens, numerous comorbidities, multiple prescribers and time constraints in the effort to effect positive medication change. We applaud Tracy and colleagues for their initiative.

Given the high frequency of change in complex regimens, which are often driven by visits to multiple prescribers, we believe that primary care is the appropriate setting for ongoing medication management in complex patients. The series by Farrell and colleagues1,2 also underscores the importance of applied research to develop, implement and evaluate management tools for complex medication regimens.

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CMAJ 2014. DOI:10.1503/cmaj.114-0083

Dental profession fails to meet needs of disabled Canadians

Kelsall and O’Keefe1 emphasize the poor health implications for seniors caused by their inability to pay for necessary dental treatment, but disabled Canadians are also seriously affected by inequitable access to dental care.

Provincial-government dental plans for the disabled have stagnated for years even as dental fees have increased annually. Some government plans now pay only 50%–60% of typi-