Addressing multimorbidity in clinical guidelines

Experience from NICE and future plans

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Guidance development

- NICE has now been asked to develop a guideline on ‘management of people with co-morbidities, long term conditions and complex needs’

- Generic interventions?
  - e.g. case management
- Specific clusters of disease?
- Better organisation of existing material?

NICE's clinical guidelines programme

- 149 clinical guidelines published by August 2012
  - First guideline published in 2002
  - Guidelines developed by collaborating centres
  - Methods largely built around the AGREE criteria
  - Increasing integration of cost utility analysis from about 2004
  - Adoption of GRADE from 2009

Selection of topics

- Referral from Department of Health following selection process
  - Process has varied over time
  - Sifted from suggestions made by stakeholders
  - Nearly all single disease topics

What has NICE done so far?

- Whole topics
  - Depression in adults with chronic physical health problems (GG91 Oct 2009)
    - A specific body of evidence does exist around this
  - Psychosis with co-existing substance misuse (CG120 Mar 2011)
    - Interventions that might affect both,
    - Explicit consideration of need to modify existing recommendations for single issue when both co-exist

What has NICE done so far?

- Specific recommendations
  - Treatment decision according to presence of comorbidities
    - *1.5.1 Offer antihypertensive drug treatment to people aged under 80 years with stage 1 hypertension who have one or more of the following:*
      - *target organ damage*
      - *established cardiovascular disease*
      - *renal disease*
      - *diabetes*
      - *a 10-year cardiovascular risk equivalent to 20% or greater*
  - ‘don’t forget about comorbidity’
    - *Take into account comorbidities and current treatment when offering men drug treatment for LUTS*
- Not systematic

The challenges

- Most people with a chronic condition have multimorbidity
  - Evidence is *usually* generated excluding people with multiple morbidity
    - Challenge 1: lack of directly applicable evidence
  - The clinician/patient need to be able to access the content of several guidelines at once
    - Challenge 2: making guidance more accessible
  - Clinician/patient need to make choices about alternative courses of action
    - Challenge 3: providing the right information for decision makers

Challenge 1: lack of directly applicable evidence

- Omega 3 fatty acids in a person age 65 with high risk of CVD, type 2 diabetes
- Cochrane reviews
  - Prevention and treatment of CV disease
    - Some of the trials include some people like this
  - For type 2 diabetes
    - Trials probably include people like this
  - Prevention of cognitive decline and dementia
    - Trials may include people like this

- What would we recommend in a guideline?

Possible solutions in guidelines?

- Often the only choice is to use (very) indirect evidence
  - Note indirectness and think about the assumptions
  - Weak recommendations
  - Modelling?
  - More transparent consensus processes?

- Make research recommendations for specific questions in multimorbid people

- Lobby for
  - clear trial reporting
  - more individual patient data meta-analyses

Challenge 2:
making guidance more accessible

- This isn't a new challenge
  - Systematic reviews and guidelines have got us part of the way

- Need better:
  - searchability to find relevant information
  - cross referencing
  - integration with decision support

Challenge 3: providing the right information

- Can we frame summaries of the evidence in more helpful ways?
  - Absolute rather than relative effects
  - Different estimates for different baseline risks
  - Changes in effects over time
    - short term management of knee pain vs
    - long term management of cardiovascular risk vs
    - treatment of depression

Methodological research

- ‘Better guidelines’ project, Bruce Guthrie et al
  - NIHR funded project 2012-15
    - Summarise evidence of benefit, harm, cost-effectiveness for three common conditions
      - Cross checking for contradictions, reinforcing recommendations
    - Modelling evidence of benefits and harms for people with multimorbidity
      - Building on existing single disease models to explore effects of multimorbidity

Guthrie B, Payne K, Alderson P, McMurdo MET, Mercer SW. *Better guidelines for better care: accounting for multimorbidity in clinical guidelines.* Accepted BMJ Sep 2012.

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