Polypharmacy: prevention and management

We have followed the *CMAJ* series of case-based practice articles on polypharmacy with great interest and we commend the authors[1,2] 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 colleagues[1,2] 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 cases[1,2] 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 Frank[3] 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 clinic[4] 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 mutually agreed upon. Review of medication appropriateness and reconciliation is a vitally important component of the clinic, and all IMPACT patients and their families are provided with an up-to-date, user-friendly medication list.

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 colleagues[1,2] 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:10.1 503/cmaj.114-0082**

The authors respond

We thank Tracy and colleagues for their supportive letter[1] 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.

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 interdisciplinary team, nor are they able to afford a significant block of time to address all the issues at hand. We hope that our case series (a total of eight case reports and two commentaries in *Canadian Family Physician* and the *Canadian Pharmacists Journal*)[4–11] will help physicians to prioritize medication changes and to realize that these changes do not need to happen all at once. In emphasizing the supporting roles of the various health professionals on our team, we hope to assist primary care physicians to determine whether some functions could be carried out by existing team members. Physicians should also be aware of local community supports, such as physiotherapy clinics with fall-prevention programs, when access to a specialized geriatric team is not available. We recognize that this is a work in progress.

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

Dental profession fails to meet needs of disabled Canadians

Kelsall and O'Keefe[1] 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-