

Presentation

To the

Standing Committee on Health Care

Regarding

**The Commission on Medicare Report
“Caring for Medicare – Sustaining a Quality System”**

June 27, 2001

Under authority of The Pharmacy Act, 1996, the Saskatchewan Pharmaceutical Association is the statutory governing body for the profession of pharmacy. In administering the Act, we govern pharmacists, pharmacies and the conditions of sale of drugs. We exist so there will be quality pharmacy care in Saskatchewan. This mission includes:

- Public safety
- Standardized pharmacy services
- A self-regulated profession
- Positive professional image
- Public policy supporting health
- Optimum public use of pharmacy services

Therefore, this submission is presented in the context of our regulatory and public protective role. We will focus our presentation on those recommendations in the Commission on Medicare Report we believe impact the profession and public the most.

Chapter One: Everyday Services

We agree with the recommendations regarding primary care teams, networks and centers in general, and specifically support the recommendations to more effectively integrate the role of the pharmacist within the primary care team. Pharmacists provide important “everyday” services. For example, these include:

- providing prescription drugs and advice to patients on how to use them properly;
- preventing, identifying or resolving drug related problems;
- minimizing drug abuse;
- providing over-the counter drugs and a variety of health care aids along with advice on how to use these products properly in meeting self-care needs of patients; and
- referring patients to other health care providers.

While pharmacists work closely with physicians, we believe Mr. Fyke’s observation that “Pharmacists could work more closely with patients and prescribers to make sure drug therapies work as intended.” can be achieved through closer collaboration with other primary care providers. By contributing products and utilizing drug knowledge and expertise, the pharmacist can play an increasingly responsible role in ensuring positive outcomes of drug therapy in a teamwork environment. The Association will continue to collaborate with government and other regulatory bodies to eliminate regulatory barriers that may exist.

As stated in our media release following public release of the report, *“The report is consistent with Association values and policies. Pharmacists are available, accessible and approachable, so it makes sense to participate in whatever process is established to integrate the pharmacist as a member of the primary health care team. Our ability to improve the outcomes from drug therapy is enhanced when working in collaboration with other health providers.*

We have 854 pharmacists practicing in 362 pharmacies spread over 128 urban and rural communities, with 159 pharmacists practicing in hospitals across the province. This means we should have an adequate distribution of pharmacists to participate in primary care teams anywhere in the province.

We will take a leadership role in advancing the recommendation for an enhanced role for pharmacists, allowing them to apply their knowledge in prescribing decisions. We are anxious to consult with all affected parties to determine how this will work.”

We reiterate this commitment and the availability of pharmacists to become effective members of primary care teams.

The practical application of this concept raises important questions and creates interesting challenges. For example, if this means that pharmacists are to be physically located with other providers, then pharmacists may need to leave the pharmacy to attend the community primary care centers, or relocate their business to that facility. Alternatively, the community pharmacy could become the community primary care center requiring changes to the configuration of community pharmacies to accommodate other members of the team. Relocation of providers may be easier to accomplish in the 94 single pharmacy rural communities where competition with another pharmacy in the community is not a factor. The economic impact of potential losses of other goods and services available from a conventional pharmacy is also an important consideration. Therefore, in either case, pharmacy owners may need regulatory support and government incentives to facilitate these changes.

As an alternative, primary care providers could be gathered together under a “virtual” structure. Technology could be used to connect team members for the purposes of communication and information sharing. Thus, physical relocation may not be needed as team members could be connected with one another through a health information network. We believe that the best chance of integrating all pharmacists from all community pharmacies as a member of the primary care team can occur with implementation of the Saskatchewan Health Information Network. Therefore, we strongly support the recommendations concerning investments in information systems, including the development of an electronic health record under SHIN.

Chapter Four: Getting Results

We believe that the most important recommendations concern establishment of the Quality Council. In our media release we stated *“We continue to believe that optimal use of drugs is the most cost effective therapy. When used properly, drugs can save the system money. Many strategies exist ... with the same goal of proper drug use. To maximize their effectiveness, we have been promoting a drug use management framework that would combine all such strategies under the leadership of one body. This role is compatible with our understanding of the Quality Council.”*

In the section entitled “Improving Quality: The Example of Drugs” the Commission argues in favour of the cost effectiveness of optimal drug use and advances a “solution centered on a major quality improvement plan for the drug sector”. Our discussion paper on a framework for a comprehensive and integrated drug use management strategy (attached) anticipates this “solution”.

A number of drug use management initiatives exist in Saskatchewan. They include:

- Pharmacists conducting drug utilization reviews in hospitals and in community pharmacies (i.e. long term care residents)
- Dial Access Drug Information Service
- SaskADR (i.e. Adverse Drug Reaction) Reporting Program
- academic detailing under Saskatoon District Health’s pilot program
- Triplicate Prescription Program
- Patient profile release from the Drug Plan database
- Saskatchewan Formulary process for determining Saskatchewan Drug Plan benefits
- the Exception Drug Status process for determining Drug Plan benefits under prescribed circumstances and with implicit prescribing guidelines
- Health Canada’s Prescription Monitoring program under the Non-Insured Health Benefits Program, and
- The report from the Health Services Utilization and Research Commission Advisory Panel on Optimal Prescribing

While many organizations cooperate in the delivery of these initiatives, they are fragmented. Duplication exists, for example some health districts maintaining drug information services while similar initiatives exist at the provincial level. Therefore, our discussion paper proposes to integrate the various drug use management strategies and suggests that a governing structure be established to manage, coordinate and integrate these strategies.

To elaborate with examples, the government could establish and fund a drug use management centre governed by the Quality Council. Based on determinants, indicators and measurements established by the Council, the center would use whatever strategies are deemed appropriate to monitor and promote healthy outcomes from drug therapy. With access to drug use databases, such as the Drug Plan, the centre could identify quality of care issues. It could access our existing drug information and continuing education resources to inform and educate providers. Or, it could direct academic detailing where pharmacists provide objective information to physicians on drug therapies of choice. The center could also use the data to develop and evaluate prescribing guidelines based on best practices. This way, the government can be assured of the value of funds spent on drug therapy. Our Association is interested in taking a leadership role in the development and implementation of the framework.

As another solution, Mr. Fyke recommends “*an enhanced role for pharmacists as part of Primary Health Teams, allowing them to apply their knowledge as full participants in prescribing decisions*”. Pharmacists are sufficiently trained to accept this role. For example, we have submitted regulatory amendments to permit the pharmacist to dispense prescription

drugs without a prescription for Emergency Contraception. This would also be permitted in cases where the patient is stabilized on chronic therapy but the prescription is expired and the pharmacist would provide a reasonable quantity of the drug until the next visit with their physician or for the pharmacist to obtain the prescription. We will continue to pursue regulatory changes to permit this in other emergency circumstances, such as when an asthmatic has lost his/her medication and needs it but the prescribing physician is not available.

A second area where we will continue to pursue change is under delegation of authority. In a growing number of situations, pharmacists engage in collaborative drug therapy agreements or protocols where they are allowed to manage the patient's drug therapy without always obtaining the approval of the physician. A new example is community warfarin dosage adjustment programs. Warfarin is an anticoagulant used to thin blood in certain heart conditions and blood levels require careful monitoring so excessive bleeding does not occur. Under these protocols, the pharmacist adjusts the dosage of warfarin based on monitoring regular blood tests. We are proposing regulatory changes to ensure that practices of this nature comply with all aspects of the law.

As the governing body, we will continue to develop and implement programs to ensure the pharmacist maintains competency in current and enhanced roles.

Chapter Five: In Support of Change

Like many other provider groups, we are experiencing a serious shortage of pharmacists. We are collaborating in efforts to examine the nature of the problem and possible solutions. However, we are also interested in measures to ensure that pharmacists are optimally deployed in the system. Therefore, we support earlier recommendations on this principle, and those recommendations to coordinate human resource planning and management on a provincial basis.

A key element of successful drug use management is a strong supportive information system. Health care providers can make better drug therapy decisions when information systems provide them with comprehensive drug use data on patients. Pharmacists in particular can use the data to enhance drug use monitoring activities, prevent duplication or inappropriate therapies and prevent drug abuse. Once again, for this reason, we strongly support the recommendations concerning information systems.

Conclusion

To summarize Mr. Fyke, enhanced health outcomes can occur when optimization of the role of the pharmacist is combined with appropriate drug therapy. As we have publicly stated *“It is a good report and deserves to be supported. While some recommendations are challenging, we see opportunities to enhance health outcomes. What we need now is*

decisive government action that sends a message to all of us to plan for implementation. At the very least, government could implement the Quality Council immediately. Regardless of changes that are implemented, the concept is needed. It could also provide objective information to guide decisions in dealing with Mr. Fyke's recommendations." Through the Standing Committee on Health, we continue to urge government to implement the Commission on Medicare's report. We especially support implementation of the Quality Council, an integrated and comprehensive drug use management strategy, an enhanced role for pharmacists as effective members of primary care teams, and all of which is supported with technology and information systems. We will participate in the implementation plans, and exert a leadership role in drug use management.

Respectfully submitted,
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June 27, 2001



Saskatchewan Pharmaceutical Association

Discussion Paper

A Framework

for a

Comprehensive and Integrated

Drug Use Management Strategy

for

Saskatchewan

June 1999

Introduction

A number of drug use management initiatives exist in Saskatchewan. They include:

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- academic detailing under Saskatoon District Health's Community Drug Utilization Program
- Triplicate Prescription Program
- release of profiles from the Drug Plan database
- Saskatchewan Formulary process for determining Saskatchewan Drug Plan benefits
- the Exception Drug Status process for determining Drug Plan benefits under prescribed circumstances and with implicit prescribing guidelines
- Health Canada's Prescription Monitoring program under the Non-Insured Health Benefits Program, and
- more recently, the report from the HSURC Advisory Panel on Optimal Prescribing

While many organizations cooperate with each other in the delivery of these initiatives, they are mostly uncoordinated. There is also duplication with some health districts offering drug information services and formulary development and maintenance in hospitals, while similar initiatives exist at the provincial level. We understand that research conducted in Manitoba confirms the feasibility of an integrated and comprehensive approach to drug use management. This has resulted in a business plan for a proposed Drug Use Management Centre. The Manitoba Pharmaceutical Association "*Proposal to Demonstrate the Effectiveness and Efficiency of a Manitoba Drug Use Management Centre*" is available from the SPhA to those who are interested. We are uncertain of the status of the business plan.

Because of the duplication and lack of co-ordination of initiatives, and:

- discussions concerning the future of the Triplicate Prescription Program and the proposed network solution to collecting the data,
- the HSURC report on optimal prescribing,
- the probable incorporation of a drug utilization database into the Saskatchewan Health Information Network, and
- discussions concerning a national pharmacare program,

an ideal opportunity exists to consider the broader issue of a framework for a comprehensive and integrated drug use management strategy for this province. Our Council has recently agreed that this Association should at least initially take a leadership role in examining this concept. This discussion paper is our first step.

Drug Use Management Concepts

Drug use management is a broad concept. It includes the provision of drug information, the evaluation of drug use, and the assessment of new drugs entering the marketplace. Drug use management activities:

- endeavour to enhance the benefits and reduce the unnecessary risks and costs of pharmaceutical care;
- recognize the contribution of drug therapy within the health care system;
- are outcome oriented; and
- aim to maintain or improve the health of patients through the careful management of drugs and their use.

Techniques, such as drug use evaluation, have been demonstrated to produce dramatic reductions in health care costs.

In this province, formulary management and product selection of the lowest cost alternative can be considered as drug use management concepts because of their effect on prescribing habits.

Professional Issues

Unfortunately, drug use management techniques are rarely implemented as part of a comprehensive strategy, and tend to be applied separately or in one setting.

There are likely regional disparities on the priority given to drug use management.

Impact on the role of health care professionals in the community is difficult to assess. They often cite lack of time, expertise, resources and support to effectively manage drugs. The problems that result have been shown to adversely affect health and affect other sectors of the health care system. Health care professionals in this province need information for decision-making at the policy and practice levels and an infrastructure that can support solutions to these problems.

Drug Use Management Components

1. Drug Use Evaluation (DUE) or Drug Utilization Review (DUR)

Drug Use Evaluation is used in hospital and community settings to assess the appropriate use of particular drugs, evaluate the clinical effectiveness of drugs, monitor the impact of education and other intervention programs, and compare the costs of two or more drugs that are viewed as potentially interchangeable. The terms DUE and DUR are often used synonymously. The main difference is that DUE is conducted concurrently or on an ongoing basis, while DUR is conducted retrospectively. DUE is a planned, systematic and criteria-based process for identifying, monitoring and evaluating drug therapies.

Part of a DUE program could involve prescribing and dispensing guidelines and evaluating the extent to which they are followed. DUE could also be used as an opportunity for educating health care providers. Combined with pharmacoeconomic research, DUE can be useful in determining cost effective drug therapy.

DUE or DUR can also include monitoring and intervention programs, where patterns of use for targeted drugs are examined, resulting in communications to the provider(s) which are intended to modify behaviour.

2. Drug Information and Education

Evidence exists to confirm that drug information is an essential prerequisite for appropriate drug therapy. The need for credible information has increased with the increasing number of pharmaceutical agents, and the constantly changing body of knowledge on drug therapy.

Information is available from a number of sources, including the literature, references, service providers, professional development programs, or on an individual approach basis such as a pharmaceutical representative. In varying ways, these sources can link information with educational activities. The most common individual approach occurs between pharmacists and physicians, most often when a pharmacist intervenes to solve a drug related problem. Pharmacists also act as information sources for other health care providers. A recent variation on the individual approach is “academic detailing” where objective parties, such as pharmacists, provide information on therapeutic options, rather than pharmaceutical company representatives.

Drug information and education can also be components of monitoring and intervention activities.

3. Pharmacovigilance

This broad concept encompasses many activities including assessment of new drugs, post-marketing surveillance, adverse drug reaction reporting, pharmacoeconomics and pharmacoepidemiology.

Assessment of new drugs, such as occurs with formulary processes, examines the therapeutic usefulness of a drug. Post-marketing surveillance collects information on drug safety and effectiveness. It can include adverse drug reaction reporting where expected or unexpected adverse events are reported. Pharmacoeconomics studies the cost-effectiveness of drug therapy, while pharmacoepidemiology examines health outcomes of drug therapy.

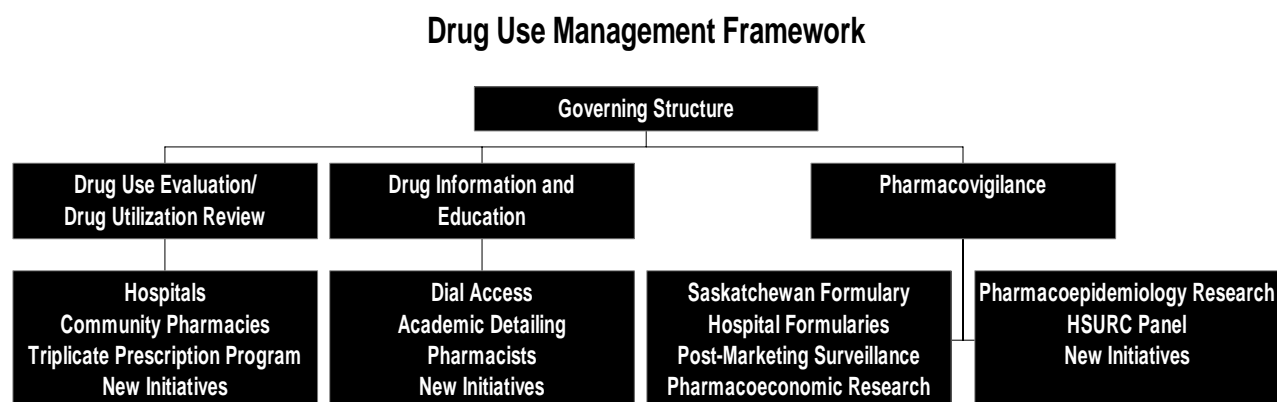
A Framework for Saskatchewan

All of the drug use management activities are, or have occurred to varying degrees in this province. For example:

1. Drug Use Evaluation or Drug Utilization Review occurs:
 - in hospitals under therapeutic monitoring programs;
 - in community pharmacies as part of the contract for pharmacists providing services to special-care home residents;
 - in community pharmacies as part of the third party claims adjudication processes. For example, many systems incorporate messages to pharmacists on possible duplications in therapy; and
 - with the Triplicate Prescription Program.
2. Drug Information and Education
 - Information is the primary mandate of the Dial Access Drug Information Service. Dial Access provides information to health care professionals on a request basis, while the Consumer Drug Information Line responds to consumer inquiries. Dial Access also publishes a bulletin on timely drug information topics.
 - A function of the Saskatoon Health District's Community Drug Utilization Program is "academic detailing" where a pharmacist provides drug information and education to physicians on an individual basis.
3. Pharmacovigilance
 - Assessment of new drugs is part of the function of the Saskatchewan Formulary Committee in determining benefits under the Saskatchewan Prescription Drug Plan. This is also a role of hospital pharmacy and therapeutics committees who use the formulary concept to determine which drugs will be used in the hospital.
 - To some degree, the Saskatchewan Drug Research Institute facilitates post-marketing surveillance, pharmacoeconomic and pharmacoepidemiology studies. Pharmaceutical manufacturers are actively involved in these areas, sometimes in conjunction with research partners at our universities.

- The Saskatchewan Formulary Committee, and other formulary management processes, often use pharmacoeconomic data to support decisions.
- Saskatchewan Health facilitates pharmacoepidemiology research. Research partnerships between industry and universities exist.
- HSURC's Panel on Optimal Prescribing reviewed the literature to support recommendations aimed at improving the prescribing of antibiotics, and in the elderly.
- The SaskADR Reporting Program collects adverse drug reaction reports from health care professionals for analysis and referral to Health Canada. The Program also disseminates relevant information.

A comprehensive framework could be based on a program approach where a governing structure would be established to integrate and co-ordinate the activities of current initiatives, and develop new initiatives as needed. The figure below illustrates this framework.



One option for the governing structure could be a board or advisory committee/council consisting of representatives from stakeholders. They could include provider groups such as prescribers, pharmacists and nurses, and funding sources such as government, industry (pharmaceutical and insurance), professionals, and the public.

Alternatively, the governing structure could be a government department, branch, agency, crown agency or commission.

Thirdly, we could consider partnering with the proposed Manitoba Drug Use Management Centre.

Finally, we should investigate the status of CPhA's proposed model.

Regardless of the option, the main assumption is that the governing structure would contract existing resources involved in drug use management and co-ordinate their activities.

Next Steps

This discussion paper is only intended to introduce the concepts and some options as the basis for determining interest in considering the concept further. It is not an exhaustive discussion of the concept, nor does it analyse its feasibility. Therefore, the proposed next steps are:

1. Consult with stakeholders to determine their interest in the concept and the role they foresee playing. This step could also be used to identify all issues.
2. Consult with the Canadian Pharmacists Association to determine the status of their proposed model.
3. Consult with the Province of Manitoba on the possibility of partnering with their proposed Drug Use Management Centre.
4. Expand this discussion paper to report on the results of the first two steps.
5. Examine the possibility of conducting a feasibility study. If deemed desirable, conduct the study. This could be a project for HSURC.
6. Develop and implement a plan.

Acknowledgements

1. The Manitoba Pharmaceutical Association for providing a copy of their “*Proposal to Demonstrate the Effectiveness and Efficiency of a Manitoba Drug Use Management Centre*”; and,
2. The Canadian Pharmacists Association for providing a copy of the document “*A Canadian Drug Use Management Program – Justification and Proposed Model, Presented to the Standing Committee of Health, November 5, 1998*”.