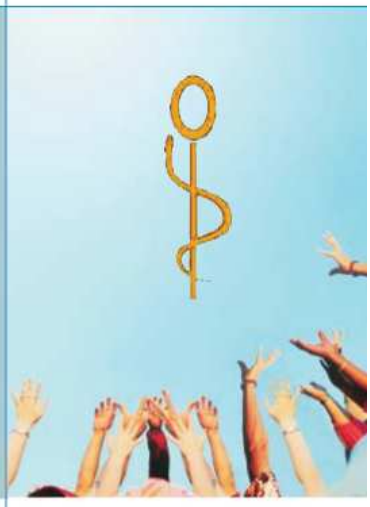
The IMS & FIP Community Pharmacy Section Prize 2003 - 2004

A prestigious Prize to reward study on

How can pharmacists be fully engaged in patient oriented healthcare ?

Aspects of management, change strategy and training.



WINNERS' EXECUTIVE SUMMARY 2005

In collaboration with EAPLE,
the European Association for Pharmaceutical Law & Economics

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- First prize:

Geovanni Vargas Solano, Costa Rica:

"Pharmacy Service Plan of the William Allen Hospital, Turrialba."

Executive Summary

The present project is the outcome of the combined work of all the pharmacists of the William Allen Hospital of Turrialba (Costa Rica), since 1995 and has aimed itself at improving the quality of life of all patients that utilize the social security facilities in and of that hospital. With the development of a novel concept in pharmaceutical work, this project has claimed to improve the institutional vision, thus breaking though, the binding barriers that past ideas have induced in pharmaceutical functionality. Paradigms are thus broken and new ones formed.

The priority, the patient, interacts as a consequence of this project with the institution, his habitat, job and family life all together. The concept that has been proposed and espoused has been one of a multi variable application at the pharmaceutical praxis or work effect. Its principal components are the team work as a unified functional concept, the emphasis being upon an active hospital and health stance in the community, the diversity of its components, the degree of social participation and their integration and the quantification of all pharmaceutical interventions. The model is both holistic as well as integrative.

It is both social as well as individual.
Three different priorities have been selected and already carried forth.
These respond to Indian communities; terminal patients and chronic patients that denote difficult level of pharmaceutical control.

The pharmacists of the Turrialba Hospital Social Security Hospital of Costa Rica have created and directed a program of interdisciplinary work. This program is characterized by the formation of interdisciplinary work teams that were not only highly efficient but also became involved in the problems of patient healthcare service in a more complete manner than hospital systems usually demand.

The job, one might say the very work of the pharmacist, has been able to transcend the walls of the pharmacy.
The patients become the main priority of the professional in pharmacy. Thus, the patient, his or her health conditions, education, family, relationships and the complete social as well as economical contour that surrounds and also

defines that life. Thanks to the help of both the pharmacists and the technicians of the William Allen Hospital, the author of this work was able to secure greater funding on behalf of the Security Institutions of Costa Rica.

The latter is particularly true in the case of the Indian Cabecar population, one of the neediest and impoverished populations of Costa Rica.

The home attention and visit program in both therapy and follow up has improved the drug therapeutic effects as well as the greater constancy of their utilization.

I believe that the program presently in operation has permitted a change in both the practice and the vision of the pharmacist. Both hospital and community practice have improved significantly. The author was able to strongly stimulate the level of information flow and communication though this program with other professionals in the health area. It is thus believed that this present program has proved not only innovative, but also highly successful in promoting a more humane approach to the health condition of low income patients in more rural setting.

- Two Second prizes:

Jean-Marc Krähenbuhl, Switzerland:

"Development and Evaluation of a Medication Review Service in Community Pharmacies."

Executive Summary

A Medication Review (MR) is a global structured retrospective analysis of patient's medication records. Proposals for therapies optimisation can result from the analysis, especially in order to increase treatments efficiency, improve patient safety and reach the therapeutic objectives. Many studies have demonstrated that a MR service could add clinical benefits to the patients and decrease costs.

The objectives of this study are to answer the following questions:
Is there any interest for the healthcare system (drugs' efficacy, safety, efficiency) in developing such a service in Switzerland?

Which should be the methodology (resources, process) to implement this service in Swiss community pharmacies?

In which context (types of patients, drugs and conditions) does the service give the maximum added value?

Which are the barriers of the implementation of the MR service in the community pharmacy practice?

Which could be the arguments to negotiate a remuneration based on Federal Health Law with health insurers?

The main identified barriers to the implementation of a MR service came from the healthcare partners (patients, insurances, practitioners and pharmacists):
- Doubts from insurers and pharmacists on profitability of the service and on a win-win situation for both partners.
- Fears from physicians on an increased role of the pharmacists
- Difficulty of pharmacists to change their practice
- Lack of knowledge of patients about the potential benefit of such a pharmacy service.

This study showed important savings for the insurances (about 600 CHF / patient / year). On the other hand, resources and time spent by the pharmacist (90 minutes per review) should be taken into account in order to define a remuneration fee (250 to 300 CHF / MR was estimated as adequate).

The developed method allowed to easily identify patients for whom the MR service has an interesting potential for rationalisation.
This study permitted to estimate the clinical and economical benefits from a structured Medication Review service in community pharmacies. It also determined arguments and barriers to take into account for a reimbursement negotiation. Further experiments will have to explore the acceptance of patients, general practitioners and health insurers.

Olanike Adedeji & Ukamaka Okafor, Nigeria:

”How can Pharmacists be fully engaged in Patient-Oriented Healthcare?”

Executive Summary

Pharmaceutical Care is a patient-centred, outcomes-oriented pharmacy practice that requires the pharmacist to work in concert with the patient and the patient's other health care providers to promote health, to prevent disease, and to assess, monitor, initiate, and modify medication use. The goal of Pharmaceutical Care is to optimize the patient's health-related quality of life, and achieve positive clinical outcomes, within realistic economic expenditures.

Recent literature has suggested that the primary obstruction to the wide spread implementation of Pharmaceutical care is a lack of standards for pharmacists to conform to in daily practise.

Pharmacist care services include reporting of specific drug/patient problems, identification of patients within therapeutic categories who will benefit from intensive drug therapy management, monitoring of patient progress, and the analyzing resultant outcomes of care.

This study was multidimensional in nature and necessitated the adoption of a two-stage research approach. The qualitative stage provided validation of non-definitive information such as motivation, attitudes, expectation and perception.

In the quantitative stage, the self-completed, fully structured questionnaire technique was adopted.

A week after collection of the questionnaires administered on community pharmacists, exit polls were used on the selected premises to administer questionnaires on 3 to 5 members of the public/patients exiting from the premises to determine their satisfaction with the services in the pharmacy as well as to determine their perception of ideal services from Pharmacists.

The effective response rate among the pharmacists was 97.1% and 56.5% among the patients and/or members of the public.

<u>Recommendations:</u>

It is suggested that intervention strategies for the areas mentioned below be designed and implemented to fully engage the community Pharmacists in patient-oriented health care. These recommendations are based on the outcomes of questionnaires to community pharmacists, the public and focus group discussions (FGDs), in addition to our personal experiences having being exposed to a cumulative of over 20 years of community practice, policy and administrative pharmacy.

- ***Training***
- *Change in Practice Methods*
- *Standards of Practice*
- *Confidentiality of Information*
- *Health Promotion / Health Education*
- *Co-operation among members of the health team*
- *Counselling*
- *Policy Change*
- Patient Monitoring and follow-up
- *Skills Acquisition / Capacity Building*
- *Documentation*
- *Pharmacy Layout*
- *First Aid Services*
- *Legal and Ethical Requirements*
- *Drug Procurement*
- *Public Enlightenment*

<u>Practical Suggestions for Initiating Pharmaceutical Practice in The Community Pharmacy:</u>

1. The community pharmacist should get over any physician communication phobia he might possess and present ideas that clearly indicate a desire to help the physician render quality care to the patients, in a non-judgmental and gentle approach.
2. Start by offering services that meet real needs in areas of health education/promotion e.g. tips on irrational drug use, HIV/AIDS etc
Design practical cost effective programs that address specific problems e.g. initiating a D.O.T (Directly Observed Therapy) programme for tuberculosis patients.
Design a pharmaceutical chart or adopt an already existing one if it suits your environment.
Develop a therapeutic and social relationship with the patients.
Design a questionnaire (probably verbal, then document) that will help you assess the patients for compliances.
Follow up the patient from time to time.

- First Special Award:

Ross Tsuyuki & Theresa Schindel, Centre for Community Pharmacy Research and Interdisciplinary Strategies, University of Alberta, Canada:

"Leading Change in Pharmacy Practice: Fully Engaging Pharmacists in Patient-Oriented Healthcare."

Executive Summary

In asking the question, *how can pharmacists be fully engaged in patient oriented healthcare,* FIP and IMS draw attention to the critical point our profession has reached with respect to contributing to patient care and evidence-based outcomes. In this submission, we have drawn from the change management and leadership disciplines to understand the complexity of achieving the vision of engaging pharmacists in patient-oriented healthcare. We outline eight critical steps, offered by John Kotter, a leading expert in organizational change, in achieving practice change in pharmacy. The work required to achieve the vision of pharmacists working in patient-oriented healthcare represents a transformational change in the evolution of the profession. We have not created a new pharmacy practice model. Instead, we tell the story of our experiences with patients, in our role as educators, pharmacy practice researchers and practitioners, and our discussions with pharmacy leaders, policy makers, industry partners, and other pharmacy practice researchers to illustrate the complexity of practice change and the leadership required for this next step in the evolution of our profession. At the conclusion of this submission, we offer 10 strategies to follow in leading the change to patient oriented practice. Patient oriented healthcare means keeping the patient at the centre of these changes. While it is tempting to frame all of these changes in terms of pharmacists and pharmacy practice - it's not about us; it's about the patients and what we can do for them.

Recommendations:

The following recommendations encompass the necessary steps towards engaging pharmacists in patient oriented healthcare. Ideally, a global organization such as FIP should act upon these recommendations, leading national, local, and individual pharmacists towards practice change.

1. Establish a sense of urgency for change by communicating unmet patient needs to pharmacists, payors and healthcare policymakers, and the general public.

2. Further drive this sense of urgency by announcing that traditional dispensing roles for pharmacists are no longer viable.

3. Form a coalition of all pharmacy organizations. Pharmacy organizations are united by the desire to show the value of pharmacists in patient care, and a

global organization such as FIP has the strength to bond these groups together in a common cause. This coalition should also include pharmacy practice-based research centres to continue to create the evidence, and to share results and methodological skills.

4. Use this coalition to develop a clear, easily communicated vision for the profession.

5. The vision statement should be communicated widely through FIP and the coalition members.

6. Begin addressing the major obstacles to the vision: pharmacists' mental models, education/training, and health-system obstacles.

7. Communicate the short-term wins that we already have.

8. Use these wins to tackle more obstacles and keep the change effort moving forward.

9. Make patient-oriented healthcare part of the new culture for pharmacy by showing pharmacists the benefits of practice change, raising expectations, and instilling the new values into our trainees.

10. Encourage continued research to build the evidence base for the efficacy of patient-oriented care by pharmacists. As funding for such research is scarce, FIP could bring together various stakeholders to raise money for a research grant program.

Patient oriented healthcare means keeping the patient at the centre of these changes. While it is tempting to frame all of these changes in terms of pharmacists and pharmacy practice – it's not about us, it's about the patients and what we can do for them.

- Second Special Award:

Martin Schulz, Centre for Drug Information & Pharmacy Practice, ABDA, Germany:

"Community Pharmacy-based Asthma Services - From Controlled Trial to Remunerated Pharmaceutical Care."

Executive Summary

The first nation-wide contract concerning the provision of pharmaceutical care including remuneration was closed between the German Pharmacists Association (DAV), representing the interests of the community pharmacy owners and responsible for contracts, and the largest country-wide operating health insurance fund (BARMER Ersatzkasse, approximately 7.5 million policy holders). This so called family pharmacy contract was signed on 4th of November 2003 in Berlin after approximately 10 months of negotiation. Two state-wide contracts with regional health insurers had preceded this nation-wide contract.
The agreed family/domiciliary pharmacy concept includes remuneration for advanced services i.e., pharmaceutical care (drug profiles, medication reviews, counselling and medication reports), starting with asthma/COPD services as the first indication.

In Germany, the government sets the framework of pharmaceutical legislation, like laws and ordinances. As far as the overall reimbursement of community pharmacies is concerned, the government just recently decided on dispensing fees instead of margins depending on the drug price, which came into effect 1st January 2004. So far, nothing is regulated regarding the remuneration of additional cognitive services. The dispensing fees neither include nor particularly exclude additional services. The contractual framework where negotiating takes place with the aim to achieve remuneration of pharmacists for provision of pharmaceutical care is between the partners of self-administration, which are the insurance companies and the associations of pharmacists.

Another change in legislation was of great importance for the development of these contracts: The introduction of Disease Management Programmes (DMP) in 2001/2002 with financial benefits for health insurance funds, for each patient participating in these programmes. So far, asthma/COPD, coronary heart disease/angina, diabetes, and breast cancer have been defined as diseases for which these programmes can be offered. Although pharmacists are not explicitly mentioned as partners in the Disease Management Programmes, these programmes still offer a new option for community pharmacies.

Family (or domiciliary) pharmacies are community pharmacies focussing on case management for major disease states. Under this programme or contract, the patients choose their family pharmacy from a list of participating community pharmacies. They sign up to this pharmacy for a set term, usually at least one year. This means that all medicines both, prescription-only and pharmacy-only/over the counter drugs, supplements and devices are delivered by this pharmacy. All personal and medication data is recorded and processed in the pharmacy's computer only. In addition to "normal" services, these pharmacies offer medication reviews, possibly including cost analysis in a further step, and home delivery, mainly for prescribed medications, as an attractive alternative to mail-order services, among others. To qualify for this programme, pharmacists have to complete a certified education programme.

To support the implementation of these programmes, the ABDA has developed quality management programmes, protocols, and manuals for each disease state. Certified continuing education programmes in accordance with physicians' associations are offered by the 17 state chambers of pharmacists. Quality circles on pharmaceutical care have been established. Software companies have developed pharmaceutical care software. These services are an important tool for negotiations with health insurers.

To successfully negotiate and close family pharmacy contracts, it is important to effectively meet the (3rd party) payer's perspective and to know their main driving forces. Health insurers look for additional benefits for their customers, like price reductions, home deliveries, check-up services, etc., in order to prevent them from changing to another (cheaper) insurance company. Cost containment is another driving force.

By November 2004, more than 70 % of the community pharmacies entered the training programme and more than 60 % applied for joining the contract.

INFORMATION DOCUMENT

IMS Health: Operating in more than 100 countries and with nearly 50 years of experience, IMS is the world's leading provider of information solutions to the pharmaceutical and healthcare industries.
http://www.imshealth.com

FIP CPS: The Community Pharmacy Section of FIP supports community based pharmacist in providing professional development within pharmaceutical care, pharmacotherapy, health promotion, communication, and documentation -- offering a platform for professionals and leaders, and increasing the focus from product to services.
http://www.fip.org

IMS Health & **FIP CPS** have joined forces, with the scientific cooperation and support of the European Association for Pharmaceutical Law & Economics (EAPLE) to organise the:

IMS & FIP CPS Prize 2003 - 2004,
a prestigious Prize to reward study on

How can pharmacists be fully engaged in patient oriented healthcare?

Aspects of management, change strategy and training

The IMS & FIP CPS Prize will apply to any paper submitted by any entrant, who fulfils the conditions as defined below. Papers will have to be submitted in one of the four following languages:
English, French, German or Spanish

Conditions to be fulfilled by entrants:
Entrants may be of any nationality and may by either students, researchers or health care professionals belonging to private or public organisations.
No entries will be accepted from IMS Health or its associated companies, nor from the Boards and / or Executive Committees of FIP or EAPLE.

Submission of papers:
The candidate's dossier should contain: proof of identity, CV and the paper itself (50-100 pages / paper copy + electronic format) and a signed declaration that the paper has not previously been published. Each paper should include, IN ENGLISH : a summary (maximum 5 pages), the Table of Contents, an introduction and conclusion.

Any original paper that addresses the theme of the Prize will be welcomed. Special attention will be paid to the following criteria:
Originality of thought (of primary importance), methodology, analysis of the environment, and constructive recommendations for the future.
In order to encourage a wide variety of contributions, only unpublished works and University theses will be accepted. No papers will be accepted that have previously been awarded a Prize.
By submitting a paper, entrants agree to its publication by IMS, FIP CPS & EAPLE, if selected for the Prize.
No copies will be returned to entrants.
For each of the four languages, IMS and FIP CPS will appoint coordinators – all members of FIP or EAPLE - as well as a Selection Committee composed of community pharmacists from FIP, Academics from EAPLE, a representative from IMS, as well as representatives from International institutions.
Each of the four Committees will select two papers to be put forward for 1st Prize, on the basis of a common evaluation system.
The four Committees will select the winner of the 1st Prize together, and then each Committee will allocate 2nd Prizes and Special Awards, if appropriate.
Should papers be of insufficient merit in their view, the Committees reserve the right to withhold any of the Prizes.

The winners of the IMS & FIP CPS Prize will be announced during the 2nd Quarter of 2005.

Procedure:
Entrants should submit their paper and electronic copy by **31st December 2004** to the Secretariat of FIP Community Pharmacy Section, for the attention of:
Mrs. Bente Frokjaer , Secretary, FIP CPS
c/o Danish College of Pharmacy Practice
Milnersvej 43, DK 3400 Hillerød, Denmark
Email: **cps@fip.org**