APPENDIX 3 — DR. HENRI MANASSE

RX BLUEPRINT FOR PHARMACY
Designing the Future Together

Presentation and Q&A period at the Blueprint Town Hall, June 2, 2007

Dr. Henri R. Manasse Reaction
Town Hall Meeting for the Blueprint for Pharmacy
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Having heard from the panel of the Task Force members present their views and perspectives on the Blueprint for Pharmacy, Dr. Henri Manasse, CEO and Executive Vice President of the American Society of Health-System Pharmacists was invited to comment.

Dr. Henri Manasse: It is a pleasure to be here today and I wish to commend you all on your great work to date.

I believe that there are four areas that require more dialogue, discussion and thinking: 1) the model of practice, 2) pharmacy as a profession, 3) performance measurement and 4) a continuum of education and credentialing.

First, allow me to discuss the model of practice. Are we prepared to use the adage "every patient every time?" What do I mean by that? It means that for every patient we encounter, we have a responsibility to facilitate and interact with that patient to ensure the appropriate use of medications. In the context of the international parlance, "patients as partners," are we prepared in every single transaction with a patient to be their partners? Are we going to be an independent profession or are we going to be collaborators? I understand that this argument is coming up as we deliberate the notion of pharmacist prescribers. I would submit that a portion of what we do is, and should be, independent. However, we do not operate within a vacuum. I believe that we, as a profession would suffer greatly if we became so independent that we did not have the respect of our colleagues in medicine, nursing, and the other health care professions. All of whom are part of the safety net and hold the patient in their hands. This is a matter that will require further thought and consideration. Later, I will discuss the extent to which we need to have our independence. However, there is also an extent to which we must be held accountable and work in a collaborative fashion. This will ensure proper care of the patient.

What do we mean by the term "accountability?" I will begin by saying "yes we need to have a financially viable profession." The old story about no margin, no mission, has become a real issue. We will have to have a financial underpinning. Particularly in the sense that in Canada, there is a significant amount of accountability to the government. In the United States, we have a dual responsibility to the private sector as well as the government sector. Nonetheless, as pharmacists we must be able to demonstrate value for the services we wish to be reimbursed for. With that said how do we as a profession continue to demonstrate our value to society? I like the wording you are using, namely the two-pronged approach. We have to ensure a safe and effective system of drug distribution, and management of that supply. I believe in the undergirds of the social value of pharmacy and I also believe that this ties together with the adage, "every patient every time." With this in mind, I believe we have a good case for why this profession should exist.

This leads me to then ask the question, is pharmacy a profession? Those who are social scientists and have followed the sociology literature on this question know that this matter continues to be an argument. If you look at how sociologists define professions, we have been called a "marginal" profession; and also called a profession in transition. We, as a profession must come to a decision and assist sociologists in making up their minds. We need to take a careful look at what makes a profession, the criteria and characteristics. I believe we need to elaborate on these criteria in order to ensure that we continue to remain a profession.

What I did not see in the Blueprint was a focus of taking care. We all have a custodial responsibility for this profession, and its future. As a former educator, I have always believed that it is my duty as a teacher to carry on certain traditions and fields of knowledge so that others may carry on to do the same. It would be of value to have further discussion on what we need to do as an organization, and as multiple organizations across the country in addressing this matter. However, before this can take place, we will also need to respond to some questions. Specifically, what are our intrinsic values about this profession? What do we really believe about this profession?

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This also raises another important question, and a matter I am extremely concerned about; namely, what is the autonomy of our practice? To what extent are we as pharmacists able to apply our knowledge and clinical judgement in making decisions for the patient? Allow me to clarify. I am not saying we should not follow the rules of procedure in the pharmacy, nor am I saying that we should not listen to our superiors, or review policies and procedures. However, if we are to truly live up to the adage, every patient, each and every single time, this will require autonomous judgement. Each patient is different and the circumstances that surround each patient will also be different. It will require our freedom and degree of independence if we wish to manage our patients. This issue of autonomy is just one key characteristic of a profession that needs to be valued and expanded upon.

The third area I have identified that will require further dialogue is performance measurement. As we experience chaos in our respective health care systems, there is immense pressure to begin to measure performance. This pressure is not only to measure what we are getting for our money, but also to measure more specifically what is happening to patients, health care systems and hospitals. There is a saying in quality theory that says "if you cannot measure it, it does not happen." While I am unsure if I fully agree with this theory, the measurement of systems is definitely an important aspect in the process of quality control.

Health care has been quite care-free about performance measurement. There are many advocates within the health care quality movement who are beginning to focus on performance measures, holding organizations, institutions and practitioners accountable for specific performance measures. In the Part D benefit of Medicare in the United States, we now have a Pharmacy Quality Alliance that is responsible for developing performance indicators for particular drug therapies. This will provide pharmacy with an opportunity to begin to demonstrate to government that both the services and medications need to be reimbursed. This will also aid to demonstrate that a quality dimension is present in medication use.

The final area for discussion is the issue of the continuum of education. This leads me to ponder about the human genome and what it means in terms of our future science and its application? I think about the role of emerging technology in terms of drug delivery and drug delivery systems. Both of these areas have the potential to dramatically change drug therapy. I believe we truly need to get a grip on what is happening in the scientific world which is driving new drug development and innovation. We must consider what implications this will ultimately have. Not only in terms of our knowledge base, but also for our patients. This is an extremely complicated matter.

We then ask the question, what sort of implications will this have on curricula? What are the advances in clinical therapeutics and patient care management? We are not speaking about trivial matters. Medication therapy management is not a trivial activity. Chronic disease is complicated; multiple chronic diseases are even more complicated. When combined with patient characteristics, matters become even further complicated. What does it mean in terms of life-long learning in order that we may be at the peak of our practice? What about areas such as informatics, safety, systems thinking and integration? All of which are evolving and developing fields which will also be required to be incorporated into the pharmacy curriculum. Several of the faculties of pharmacy here in Canada are struggling with matters the significant majority believe should be incorporated into the curriculum. These same faculties are also striving to find ways to ensure all of these subject matters are included into the curriculum without over-pressuring students.

I hope I have provided you all with some food for thought. Thank you David for the opportunity to be the reactor to today's panel discussion. It is my hope to have stimulated some thoughts in all of you in order that we may have a robust discussion. Thank you.

Q&A
Comments and Responses from the floor:

Comment: Two things are missing from the Blueprint document: *Leadership and quality*.
Comment: We need to define what the determinants of a quality pharmacy service are.
Comment: If we promote, through the blueprint, the pharmacist as the drug therapy management expert, along with a commitment to quality, that the pharmacist is a champion of quality, I think those two strategies combined will automatically result in a pharmacist being accepted on a health care team.

Question to the panel: How are you going to get the province to cough up the money so that we can do the kind of work we are supposed to do? And for, coming from Ontario, the new Ontario legislation has meant that pharmacies are bringing in less money. They're cutting pharmacists and technicians.

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Answer: CSHP a couple of years ago created an advocacy committee. This is part of the new strategic plan and we have committed money in terms of recruiting professional assistance from communication experts and public relations experts to assist in messaging the importance of pharmacists within the healthcare system. I think where we can easily demonstrate and convince based on lots of evidence that pharmacists are increasing safety and reducing health care costs by their involvement in patient care teams. There is more and more evidence accumulating out there that pharmacists make the most difference. So we have to develop the skills and bring it to the right key stakeholders, bureaucrats, politicians, CEOs of hospitals. It starts from CSHP and the support of our members and hospital pharmacists in getting the message out there and repeating the message over and over again with these stakeholders.

Comment: Two things are missing: majority of pharmacists are not ready to change and the patient's desire. We have to engage the patient or whatever we do will fall flat on its face. So I think that is one thing that is missing – there doesn't appear to be a whole lot of patient engagement and what the patient is looking for.

Comment: I was very concerned about the Blueprint because you talk about the safety, security and integrity of the drug distribution system will continue to be protected through the enhanced role of the regulated pharmacy technicians. But you don't really say in your vision if you think pharmacists are still ultimately responsible for the drug distribution system and its safety. I think there has to be some statement within the vision that talks about the safe and reliable drug distribution system and whether or not you expect pharmacists to be ultimately responsible. Not really doing the technical aspects but ultimately responsible because it's not there.

Comment: You don't have a lot of definitions in here. In Alberta, we now have 9 different types of health professionals who can prescribe drugs and more are on the way. We have quite a few different health professionals who can also dispense and compound. What does dispense mean? Is it simply repackaging? Or is it ensuring that that's the right product for that patient? The same thing with compounding. Is it just following a recipe? Or does it mean the knowledge to change that recipe? Collaboration was another word that's been tossed around. Again, you talk about it quite a bit in this document but you don't have a definition. Is it a dependent scenario or is it a communication type scenario? That makes a big difference.

Comment: With looking at some of the technical aspects with pharmacy technicians and impacting and everything, one thing that I know had been discussed 15–20 years ago was re-distribution of patient ready pharmaceuticals so you didn't have to count, lick and stick and stuff like that. I don't know if it's time to look at that again so that there isn't the need for more human resources.

Comment: With the pharmacy technician programs that I hear being talked about, especially with the three year programs if not longer, are these people after 5 years in practice going to want to prescribe and counsel as well?

Follow-up comment by Henri Manasse

The way that I would define autonomy is the capacity to use one's knowledge and the capacities for judgements to make decisions for and with a patient in the best interest of rational therapeutics. It says nothing about having to talk to someone else to do that. One of the things I am concerned about, speaking as a patient going to a pharmacy, the pharmacists are so wrapped up in the processes of getting those prescriptions filled that the practice model doesn't allow for that autonomy and saying to me, a patient who has diabetes and cardiac problems, these are the things that you have to deal with. I have, in 25 years of diabetes, never been spoken to by a pharmacist. And I spend a lot of money in the pharmacy. This stuff is not cheap. If I had wanted it, I could have banged on the counter. But I look at what those pharmacists are doing, and they're doing what the pharmacy process requires them to do. You have to hug the counter. There's something wrong there. I think about that autonomy when I have that cognition and I have that capacity to make judgement. I've got to be there with that patient regardless of what that process is all about. The process is less important at that point in time than what I do with and for that patient.

Comment: I heard some whispers about public awareness campaigns and maybe some marketing about what pharmacists can do for patients. I think it comes back to the quality and the evaluation that we're going to do to be able to show that this improves patient outcomes because why do patient go to doctors, because that will help them. We want to be able to show how pharmacists can improve patient outcomes. It is really onerous to gather research data. It should be built into the process. But it will require time up front to figure out how, what those variables should be and how to collect them.

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Questions: How you are going to communicate to other stakeholders? I'll give you two examples — the PHAC released their strategic and health human resource plan and they have 6 professions who are going to be major contributors and 26 who are going to be other contributors and pharmacy is not on there at all. So we haven't communicated very effectively. The second issue is that CIHR has announced clinician-scientist awards and they are available to physicians, dentists and not pharmacists. And we know that pharmacy has been successful in getting funding in the NIH. So there are just a couple of areas.

Answer: As far as our consultation process, we have just rolled it out to the pharmacy community. We have had a lot of discussions with Health Canada and we are fairly confident that we are going to get a grant approved from them that we can go out and consult with other health care professionals on this. CPhA is moving on the PHAC strategic and health human resource plan because that was very discouraging. Specifically with the blueprint, we do need to go out and communicate within the pharmacy community and also with other health professionals and with that we also hope to get at the RHAs and governments. One of the challenges is that we do have a draft communication plan that addresses a lot of the things that are being talked about here: the need to communicate widely, the public communication, engagement. It costs a lot of money to do that. Right now the blueprint has very minimal funding to move any of this forward, that is a challenge for the CEOs and Presidents of all the pharmacy organizations in this country. It will also fall to the Blueprint Task Force on how we are actually going to get the funds to do the communication piece and the consultation. We do have to leverage other opportunities that we all have when we're out there talking. Henri's point is pretty clear, as a diabetic, if he doesn't have a pharmacist asking him anything about his care and his health care needs, then all the other things that we say in our associations, really don't count for a lot if that's not what patients are experiencing when they walk into a pharmacy.

Comment: It's really important that we address experiential education as we go forward with blueprint. The future vision that you have for the profession is going to call on that need for clinical judgement and that confidence for the pharmacist to say to Henri "how are your blood glucose levels today or how have the been lately?" And not be concerned about the possibility of not being able to help him. It's really important that our students are in a practice setting with a pharmacist, so that they can learn clinical judgement and learn to work in that uncertainty. How can you help support that opportunity for a pharmacist to be a preceptor and for our students to be able to work with those wonderful pharmacists as we go ahead with the vision?

Comment: One comment addressing medication use challenges. We constantly continue to read about medication misadventures, adverse problems. It's kind of almost embarrassing and I keep thinking where have we been and what are we doing as pharmacists because these keep occurring. So what is preventing us from actually halting or re-directing some of these issues for patients? The fundamental thing that keeps coming back to me is model of practice. I would be interested, from the panellist's perspective and at the working group level, if there has been discussion, around what each of them and their organizations expect out of a model of care. I know working in the hospital sector it is different than working in the community sector. From a student's perspective, what do they think that the model of care? From the educators and how they teach the model of care. Because if they don't align then there's going to be expectations not being met from a new graduate going to their first job and it doesn't mesh with their environment. They're expecting this model of care, they're expecting this environment and it's just not standing up. So I'm hoping that students become stronger in expecting that from their employer, expecting that level of care they were taught, that they move on to another employer that actually embraces that. Hopefully that will be the catalyst for change. I would really like to see something around the model of care and sketching out the ideal and there may be several from different settings. What do those look like? And I think if we're not on the same page, we're going to have some issues.

Answer 1: There is a lot of work happening in the profession right now looking at models of care: $1.5M invested by the federal government in pharmacy human resources. CPhA is working with Marketview Research and they have Barb Wells and Jim Blackburn as their subject matter experts exploring and defining innovative and more unique pharmacy practice models. They are also looking at why they started it in the first place, what were the challenges, and what were the drivers for them as individual pharmacists.

We have just gone out to field with the RFP for a big piece of research ($250,000) that will look at pharmacists, pharmacy students, and new practitioners. Not just issues and challenges in recruitment and retention, but

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really trying to get at some of the drivers behind what we need to do to change as a profession.

Answer 2: Models of care and when we look at information and knowledge that new grads are coming out faculties with, you're right — the expectations do not meet the reality. We had an opportunity within CACDS to meet with Association of Deans of Faculties of Pharmacy, and this is exactly one of the messages that we were delivering, that we want to work collaboratively with the faculties, with the deans, towards decreasing that gap in terms of reality and expectations. And when we're looking at things such as entry level PharmD programs this is something that is of concern particularly to pharmacy retailers because it is exactly that — the expectations of the grads coming out of programs they don't match the reality and the business model does not support that type of model of care and that's one of the reasons why we are very eager to start work and start exploring different avenues, different models of not only reimbursement, but models of practice. And I think change is already occurring. We've got the changes going on in places like Alberta that are starting to recognize the cognitive role that pharmacists can play, Ontario with the MedsCheck program is starting to recognize the role that pharmacists are playing and are actually putting money behind that. The question is, is that going to be sustainable in its own right? And I think we do need a lot more work, a lot more thought. We need to test not only the implementation but ultimately whether or not these are cost-effective and sustainable models. I think it is going to be a very active topic of discussion amongst the BPTF.

I'd like to say that I'm really sorry to hear that you've never been asked what your blood sugars are at the till. I am a practicing pharmacist in a one-man pharmacy. And as I'm bringing the person through the till, I ask them what their blood sugars are and while I'm taking their credit card, I give them some counselling on things they can do, have they done some exercise that day and so on. Or, I look at their basket, and sometimes I had them a sheet that tells them what the lower-sugar products are. But I think where a lot of this has to start is actually with the practicing pharmacist. We have to model it. And you know what? We can. I often ask my patients as they're going through the till "what's your blood pressure? Have you checked it? There is a machine there, I have a card that will give you a print out. Do you want it?" We need to take some impetus. Now how we're going to motivate those pharmacists — that is something that we on the task force have spent a lot of time talking about. And we start with small steps. As the practicing pharmacists start this and start asking, it can become longer conversations and then the techs will start taking up their part and we may gradually progress into that. How all of that is going to work, I don't know. But we have to start somewhere and we have to motivate, those of us who are on the front lines, to do simple steps.

I wanted to speak to the inertia, but really it has to do with what you've all been talking about as well. Why, when I was working mainly in a community pharmacy, why didn't I ask anyone about their blood sugars? I think for me, and maybe for a lot of other community pharmacists, it was because I didn't know what I would do with the answer. And that's pretty sad. But the person who was talking about education was talking about that too. That if we aren't prepared either with knowledge or skills or time to be able to help that patient when we ask them a clinical type question about monitoring, then it's very difficult to get a pharmacist to change what they're doing because there's an element of fear there that they're not going to admit that's the reason why because they don't want to admit that they're not smart. I think what you're doing though with this task force is working on the infrastructure for change. I know that you'll be thinking about education and quality assurance as to how pharmacists can feel prepared to talk to patients and help patients more. And you'll be working on infrastructure in terms of who's doing the work in the pharmacy. If you're actually, somebody from your task force, knows what it is like to be in a pharmacy, and what the workflow is and how it could be different so that the pharmacist is interacting with the patient most of the time. But that inertia, I think it goes back to a certain amount of fear and that has to do with the clinical skills and professionalism and judgement of the pharmacists that are there now. And the students that are coming through, trying to learn this, you know their preceptors that they are learning from, some of them will be modeling this model of care that we're hoping for and some of them won't be because they just haven't go to that point yet. But I think you're providing the groundwork and the infrastructure for this change that can allow the pharmacist to make these changes at the ground level and I thank you for that.

I just wanted to say quickly Erica, but I'm sorry that I totally disagree with you. We are way past the baby steps. We must take bigger steps. We have been doing the same thing for many many years and I haven't seen us inch further along so I think that the time has come for pharmacist to set more ambitious targets than just the baby steps and they have to get ready to run.

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