Section 5

Update on the implementation of recommendations from:

Managing PharmaCare: Slow Progress Toward Cost-Effective Drug Use and a Sustainable Program (2nd follow-up)

March 2006

October 2009

804171

Ms. Norma Glendinning
Assistant Auditor General
Office of the Auditor General of British Columbia
8 Bastion Square
Victoria BC V8V 1X4

Dear Ms. Glendinning:

John Dyble, Deputy Minister, Ministry of Health Services has asked me to respond to your letter of September 9, 2009, in which you request an update on the Ministry's progress in implementing recommendations contained in your report *Managing PharmaCare: Slow Progress Toward Cost-Effective Drug Use and a Sustainable Program.*

I appreciate the opportunity to provide an update on the significant progress that has been made on the outstanding recommendations, and attach hereto the completed documents as requested.

I look forward to your semi-annual follow-up report.

Sincerely,

Bob Nakagawa, B.Sc. (Pharm.), ACPR, FCSHP
Assistant Deputy Minister
Pharmaceutical Services

Enclosure(s)

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PROGRESS IN IMPLEMENTING RECOMMENDATIONS FROM

Managing PharmaCare: Slow Progress Toward Cost-Effective Drug Use and a Sustainable Program

As at July 31, 2009

General comments

In March 2006, the Office of the Auditor General released a report reviewing how well the Ministry of Health Services manages the PharmaCare program in order to achieve its goal of operating a sustainable, evidence-based, prescription drug insurance program that improves the health of British Columbians.

The Pharmaceutical Services Division (PSD) of the Ministry of Health Services appeared before the Select Standing Committee on Public Accounts on February 2, 2007, to address the points raised by the report.

The division is pleased to report that since the Public Accounts Committee last discussed the report on February 2, 2007, PSD has fully or substantially implemented all fifteen of the Auditor General's recommendations. The new divisional structure, human resource capacity, and planning and reporting activities have supported this progress.

Specifically, with regard to Recommendation #5 ("Work with the College of Pharmacists and others to move custodianship of PharmaNet information to the ministry, and provide timely access"), PSD is proud to inform the Office of the Auditor General that the Ministry of Health Services has now assumed responsibility as the data steward for PharmaNet.

With regard to Recommendation #8 ("Put in place a process to systematically assess the cost-effectiveness of existing drugs in the formulary"), PSD is also pleased to report that considerable effort has gone into developing a multi-faceted systematic process that addresses the recommendation. As per our commitment in PSD's 2009/10 Divisional Plan, PSD has developed a plan to systematically assess the cost-effectiveness of existing drugs in the formulary. While the plan will be fully implemented by fiscal year 2010/11, to date several key components have either been fully or substantially completed.

We are pleased with the progress we have made since the Public Accounts Committee last discussed the report. We are also committed to ensuring that our goals and objectives, as outlined in our Divisional Plan, are achieved in support of the division's vision of pharmaceutical excellence for better health.

Status

F or **S** – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
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Progress by recommendation

For each recommendation, provide your assessment of implementation status as per the legend at the bottom of the page, and information on actions taken and results to support the status reported. Also include a work plan schedule for any recommendations not yet implemented.

Self-Assessed Status	Actions Taken Since Report Issued	Results of Actions and/or Actions Planned (with information on implementation, including dates)
Recommendation 5: Work with the College of Pharmacists and others to move custodianship of PharmaNet information to the ministry, and provide timely access		
S	As a result of implementation of the *Pharmacy Operations and Drug Scheduling Act*, the Ministry of Health Services has assumed data stewardship responsibility for PharmaNet effective April 1, 2009. The pre-existing PharmaNet Committee of the College of Pharmacists has been reconstituted as the PharmaNet Stewardship Committee, supported by the Data Stewardship Secretariat under the Office of the Chief Data Steward (Status: Fully Complete). Approval of requests for PharmaNet data generally takes between 30 and 90 days from submission, depending on the effort required to prepare the application for review and the meeting schedule of the committee. (Status: Substantially Complete). Approval of requests involving linkage to data outside PharmaNet depend on the timelines for review by other data stewards, the complexity and state of preparedness of the request when submitted. The ministry is committed to improving the timeliness of access to all data and is working to provide coordinated application and review processes under the Office of the Chief Data Steward. Progress will be influenced by available resources, but is a high priority (Status: Partially Complete).	Custodianship of PharmaNet information is now with the Ministry of Health Services. The mandate of the PharmaNet Stewardship Committee is: • Consider and make decisions regarding disclosure of information in the PharmaNet database for scientific, health services, drug use, or health policy research, planning, or evaluation, in compliance with applicable legislation. Support functions for the PharmaNet Stewardship Committee are in transition from the College of Pharmacists to the Data Stewardship Secretariat. The formal process is expected to take until the end of 2009, with up to an additional 9 months required for staff to become fully conversant with the technical and other expertise required to provide the level of support previously available from the College of Pharmacists.

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Self-Assessed Status	Actions Taken Since Report Issued	Results of Actions and/or Actions Planned (with information on implementation, including dates)
Recommendation 8: Put in place a process to systematically assess the cost-effectiveness of existing drugs in the formulary.		
S	**Background:** To understand Pharmaceutical Services Division's (PSD) approach to this recommendation, it is important to understand that PharmaCare covers a large number of drugs (approximately 1,000 drugs) and the task of determining the cost-effectiveness of a drug (or group of related drugs) may be a very involved process. The latter consideration relates to complexity in determining the "effectiveness" component of cost-effectiveness, which may involve validation and research of actual patient outcomes from data systems outside of our division. In addition, because drugs (or group of related drugs) have different utilization issues, several strategies are needed to improve the overall cost-effective use of medications. **Process to Systematically Assess Cost Effectiveness of Existing Drugs:** PSD has developed a multi-faceted systematic process that involves the following four key steps: (I) Screening – screening for potential cost-effective drug targets; (II) Validation / Characterization – validating or characterization of targets from the screening step as required; (III) Implementation – take necessary action to address cost-effectiveness findings; and (IV) Monitoring – ongoing monitoring and surveillance of targets and implementation steps. For each of these components, we describe the objective and general strategy developed.	PSD feels that it has substantially implemented various identified strategies, as described below:

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	I. Screening Key objective(s): screening for potential cost-effective drug targets A. Build branch-specific infrastructure and screening tools to identify potential targets	**I. Screening:** A. Build branch-specific infrastructure and screening tools to identify potential targets: PSD has four branches involved with assessing cost-effectiveness of existing drugs. The implementation status (Status) is also indicated. (i) Policy, Outcomes Evaluation and Research (POER) Branch: • POER has built an Economics unit consisting of 8 FTEs to support the evaluation of cost-effectiveness of both drugs being considered for listing in the formulary, as well as existing drugs in the formulary (Status: Fully Complete March 2008). • POER entered into a three year contract with the University of British Columbia to build tools for the ongoing evaluation of the cost-effectiveness of new drugs as well as existing therapies in the formulary (Status: Substantially Complete. Expect to complete implementation by August 2010). (ii) Drug Use Optimization (DUO) Branch: • DUO has built an Evaluation unit consisting of 2 FTEs to provide evaluation data support for the branch's mandate (Status: Fully Complete October 2008). • DUO has created several screening tools to prioritize drug targets. More screening tools are under development (Status: Substantially Complete March 2009). (iii) Drug Intelligence (DI) Branch: • DI has focused on the approximately 125 drugs designated as Limited Coverage drugs, which are available through the Special Authority (SA) program. Drugs covered by this

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		program are those funded with specific use criteria for certain patient populations. PSD elected to focus on these drugs as many are expensive and generally considered less cost-effective than other available PharmaCare benefit drugs. • DI has contracted external consultants to develop a Quality Assurance (QA) program to monitor existing SA drugs (Status: Complete May 2009). • DI has prioritized the implementation of the QA program to monitor existing SA drugs, and will take an active role in identifying potential targets for further cost-effectiveness analyses (Status: Substantially Complete; Expect to complete implementation by December 2009). • As part of the QA program, DI has planned to create a framework that will allow for division-wide discussion and prioritization of targets, with the intent to plan for change implementation as necessary through the mechanism identified in point B below. (iv) Business Management, Supplier Relations and Systems (BMSRS) Branch: • BMSRS includes a unit of 6 FTEs with a mandate that includes the identification of opportunities to optimize the cost-effectiveness of existing drugs through price negotiations or other commercial strategies. • For example, BMSRS has conducted an initial review of drugs subject to the Low Cost Alternative Program and Reference Drug Program and has identified several targets for cost savings. (Status: Opportunity identification complete June 2009. Implementation planning under way).
	B. Build divisional operational mechanism to discuss and prioritize targets and implement findings	B. Build divisional operational mechanism to discuss and prioritize targets and implement findings • Division has formed a designated team called the Pharmaceutical

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		Services Formulary Team (PSFT) to review identified drug targets and develop implementation plans as required. PSFT meets weekl and includes participants from POER, DUO, DI and BMSRS (Statu Completed Feb 2009).
	II. Validation / Characterization: Key objective(s): Not all drug targets identified from the screening step require validation and thus can proceed directly to implementation. However, some may require further validation or characterization to inform what implementation steps may be required to address the findings. A. Build the necessary internal divisional resources or external resources (or linkages) necessary to validate or further characterize a potential drug target.	**II. Validation / Characterization:** Build the necessary (a) internal or arms length divisional resources or (external resources (or linkages) necessary to validate or further characterize a potential drug target. Validation or further characterizati make take the form of a clinical evidence review for a specific drug or group of related drugs (therapeutic review), pharmacoeconomic review pharmacoepidemiologic study, utilization review, expert clinician consultation, and/or a combination of these. (a) Internal Resources (PSD or arms length): • The evaluation unit of DUO and economics unit of POER also have the ability to validate or characterize targets (Status: Completed August 2009). • DUO also utilizes its evaluation unit to systematically identify topics for its Provincial Academic Detailing (PAD) service. • The DI branch built a Clinical Decision Support unit to identif and coordinate therapeutic drug class reviews (Status: Comple September 2009). • Complete a request for proposal (RFP) for clinical evidence reviews or pharmacoeconomic reviews (Status: substantially complete; RFPs completed Aug 2009; expect to be finalized b Dec 2009). • Complete contract with Faculty of Medicine, University of British Columbia, to obtain services for clinical expert review, clinical evidence review, and pharmacosurveillance or pharmacoepidemiologic studies (Status: Substantially complet expect to complete by Nov/09).

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		• The position of Director of Research and Evidence Development in the POER branch is now shared by two half-time academic researchers: Dr. Malcolm Maclure, a pharmacoepidemiologist who is BC Chair in Patient Safety and Professor in the Dept of Anesthesiology, Pharmacology and Therapeutics, and Dr. Rebecca Warburton, a health economist, who is Associate Professor of Public Administration at University of Victoria. Dr. Warburton is principal investigator of an inter-provincial project evaluating the policy of Coverage with Evidence Development. Dr. Maclure is co-investigator on several pharmacoepidemiology projects evaluating safety, effectiveness and cost-effectiveness of drugs (Status: Complete August 2009). (b) External Resources (provincial, national, other): • CADTH: PSD is an active participant in the Canadian Agency for Drugs and Technologies in Health (CADTH) for its three directorates: Canadian Optimal Medication Prescribing and Utilization Service (COMPUS), Common Drug Review (CDR), and HTA (Health Technology Assessment). COMPUS identifies and promotes optimal drug therapy through the use of strategies, tools, and services to encourage the use of evidence-based clinical and cost-effectiveness information in decision making among health care providers and consumers (Status: Complete). • Drug Effectiveness Review Project (DERP): Managed by the Centre for Evidence-Based Policy located at the Oregon Health and Science University, DERP provides a series of comprehensive, updated, and unbiased systematic reviews, in addition to 3 evidence-based practice centres. These allow for increased use of drug class reviews in the formulary process. CADTH distributes DERP reports to members of the Advisory Committee on Pharmaceuticals (ACP). PSD is connected to DERP through direct participation on ACP. (Status: Complete). • Drug Safety and Effectiveness Network (DSEN): PSD has a representative on the National Advisory Committee for this

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		initiative, chaired jointly by Health Canada and the Canadian Institute for Health Information. POER's Director of Research and Evidence Development is a co-investigator with PEG on the Canadian Drug Safety and Effectiveness Research Network funded by Canadian Institutes for Health Research. PSD is collaborating with planning a BC node for the national Drug Safety and Effectiveness Network. • Collaborations and/or support of academic research groups working on or proposing health outcomes and cost-effectiveness projects (e.g., UBC eHealth Strategy Office, Centre for Outcomes Research and Evaluation (CORE)) (Status: Substantially complete September 2009). • Co-researcher on CIHR-funded priority setting methods study with BC Cancer Research Centre and BC Cancer Agency (Status: Complete July 2009).
	III. Implementation: Key objective(s): To take necessary action to address cost-effectiveness findings. Compared to the appropriate PharmaCare comparator, the identified drug target(s) will be determined to be less cost-effective, equally cost-effective, or more cost-effective. A. Build divisional operational mechanism to prioritize and implement findings B. Build the necessary internal resources and processes required to implement the desired implementation action.	**III. Implementation:** A. Build divisional operational mechanism to prioritize and implement findings • PSFT (See I-B above) B. Build the necessary internal resources and processes required to implement the desired implementation action. • Implementation will depend on the findings (i.e., less cost-effective, equally cost-effective, or more cost-effective) and should be informed by the cost-effectiveness or utilization issue. • There are several implementation options available to

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	IV. Monitoring: Key objective(s): To monitor implementation steps taken. A. The infrastructure and tools used for Screening (see Step I) are also used for this step.	include: a) Drug Coverage Policy Change – Reconsider a previous drug listing (e.g., for targets found to be less effective, options could include delisting or imposing more restrictive drug access criteria). Most drug coverage policy changes would be vetted through the Ministry's drug review process which includes the Ministry's independent Drug Benefit Council (Status: enhanced drug review process substantially complete: expect to be completed by December 2009). b) Education of Health Professionals and/or Public – The DUO branch leads various initiatives to optimize the cost-effective use of medications such as the Provincial Academic Detailing (PAD) service to educate health professionals; and outreach through the PharmaCare website, community health fairs, public libraries and schools to educate the public. (Status of Provincial Academic Detailing (PAD) service: Substantially complete Sept 2009; Status of public outreach initiatives Complete Mar 2009 and continually evolving). c) Negotiation – The BMSRS branch leads negotiations with brand and generic drug makers to improve the cost-effectiveness of drugs covered by PharmaCare. For the 2009/10 year to date, BMSRS has negotiated agreements for three drugs currently covered on the PharmaCare formulary which are expected to deliver total savings in excess of $2 million per year. **IV. Monitoring:** A. Actions implemented would be monitored through the same infrastructure and tools used for screening (See Section I).

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