British Columbia
Pharmacy Association

A voice for community pharmacy

British Columbia Pharmacy Association (BCPhA)
Response to Ministry of Health *Methadone Maintenance Payment Program Review*
Prepared by Medical Beneficiary and Pharmaceutical Services Division (1/19/2015)

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Executive Summary

The British Columbia Pharmacy Association (BCPhA) is pleased to provide comments on the *Methadone Maintenance Payment Program Review* (the *Review*) dated 1/19/2015.

The Association's comments are predicated on the view that only by considering the Methadone Maintenance Treatment Program (MMTP) in British Columbia in its entire context can the Methadone Maintenance Payment Program (MMPP) be understood. The MMPP is intended to support the goals of the MMTP, which are to promote better health outcomes for individuals battling opioid addiction and other health issues; reduce risks to public health; and minimize the social problems associated with addiction including criminal behaviours.

We appreciate the limits of this review and that of MBPSD jurisdiction extends only to the cost structure associated with the program. However, we are strongly of the view that if costs are looked at in isolation there is a significant risk of undermining the purposes the program is meant to support.

As we have advocated for in the past, we believe any review of program costs for only one portion of the overall program will fall short of achieving any meaningful review of the program as a whole and will not serve patients well.

The Ministry's *Review* has highlighted some concerns that we believe are best resolved collaboratively and we stand ready to do that.

The Importance of Opioid Substitution in the Treatment of Addiction

There is now a substantial body of research supporting the cost-effectiveness and therapeutic effectiveness of Methadone Maintenance Treatment (MMT) and the high individual social costs of lack of treatment. The literature says that because of the importance of access to treatment, the pharmacy-based daily witnessed ingestion program is socially beneficial. Nosyk and Anis (2009) argue that every additional $1 spent on increasing access to treatment yields $76 in discounted lifetime benefits.

The rationale for the MMT program is clear: it is a cost-effective way to reduce the individual and social harm, crime, disease transmission and death that are associated with non-medicinal opioid use.

Issues in the *Review*

There were several statements in the *Review* that we believe need to be challenged. In our view, some inaccurate and/or inappropriate conclusions were drawn that merit a response.

Dispensing Intervals – The *Review* makes two direct allegations that pharmacists, driven by economic gain, are moving patients to daily or short term dispensing regimes:

It suggests *"problematic pharmacy practices, which included pressuring clients to request daily witnessed ingestion even when not prescribed by a physician".*

"The number of additional drugs the methadone maintenance patient population takes creates powerful incentives for pharmacies to put patients on short dispensing intervals."

In our view these are serious and inappropriate allegations that overlook the fundamental fact that pharmacists do not make these decisions. Pharmacists dispense according to physician directions.

Physicians are required to get a special exemption under the *Controlled Drugs and Substances Act* in order to be permitted to prescribe methadone. The decision to initiate carries can only be made by the physician and must be prescribed.

The *Methadone Maintenance Program: Clinical Practice Guidelines* require the physician to take responsibility for ensuring that the patient actually takes the methadone, and that it is not diverted to the black market.

Given the risks of permitting patients to carry, it isn't surprising that 78 per cent of methadone claims in 2013/2014 were for daily witnessed ingestion, demonstrating either that physicians are quite reluctant to prescribe carries, or that few patients actually meet the criteria, or both.

In light of these risks, and of the physicians' sole authority over daily dispensing and the obvious physician reluctance to prescribe carries, we take issue with the suggestion in the *Review* that pharmacists are wrongfully engaging in daily dispensing. We also question whether it is appropriate to expect a large increase in the number of carries that could be prescribed because of the clear risk to patient safety this could present.

We encourage the Ministry to engage with physicians to determine whether they believe there is the opportunity to extend carries to a larger number of patients enrolled in the program.

Recommendations

Recommendation: **Create an Opioid Substitution Treatment Committee to improve the co-ordination of care between physicians and pharmacists in the treatment of patients enrolled in the MMTP.**

The current program would clearly benefit from increased collaboration among the providers and regulators.

We support the recommendation made by experts Parkes and Reist to create a multi-stakeholder oversight group to develop a range of improvements to the MMT system in BC. Specifically, membership would include representation from the College of Physicians and Surgeons of BC, the College of Pharmacists of BC, the Doctors of BC, the BC Pharmacy Association, and Ministry of Health representatives responsible for physician and pharmacist services.

At the outset the proposed Opioid Substitution Treatment Committee should review other MMT programs being offered nationally/globally to determine best practices that have resulted in the development and implementation of successful MMT programs.

The ongoing mandate of the committee would be to create a collaborative care model that ensures the current fragmentation of care between the two primary caregivers for patients with addictions living in the community is overcome. The committee would have the authority to adjust clinical care guidelines and set provider standards for participation in the MMTP.

Recommendation: Create an independent financial oversight group that is charged with looking at physician and pharmacist fee structures to ensure no inadvertent perverse incentives exist that result in compromised care for patients.

The literature and anecdotal information suggests that a small number of physicians and pharmacists are taking undue economic advantage of the current fee provisions. The current siloed budgets within the Ministry do not allow for an integrated review of these speculated situations. In our view such a review is essential.

Recommendation: Work with the College of Pharmacists of BC to evaluate the current training and licensing structure for all pharmacists involved in the delivery of opioid substitution medications.

The BCPhA believes the current pharmacist training program and licensing requirements no longer meet the needs of the growing population of patients with addiction issues.

Much more is now known about the complex nature of this patient group and the important role pharmacists must play in their care. In our view, an online, self-directed training program for pharmacists is simply insufficient.

It also seems reasonable to assume that low standards of training and licensing have created opportunities for pharmacies to operate in ways that fail to meet patient needs and have compromised the public reputation of community pharmacists.

We also believe it is timely to review the training and licensing requirement for physicians enrolled in the MMTP. It is well past time to raise the bar in terms of what is required from the two primary care health providers involved in community based care of patients challenged with addiction issues.

Recommendation: Restructure the current MMPP to a payment program that provides a patient-focused plan with a single payment for all clinical and dispensing services received by patients on methadone.

PharmaCare would create a unique billing fee for patients enrolled in the opioid substitution program. Regardless of the number of medications prescribed to a patient in the MMTP, only a single fee could be charged by the pharmacist for caring for that patient.

The MMTP would continue to leverage the opportunity to maximize patient care with the majority of patients continuing to rely on their pharmacist as daily point of care.

- Revise the Methadone Maintenance Policy into an Opioid Substitution Treatment Policy (OSTP) that would include both methadone and Suboxone.
- Restructure this OSTP from a fee-for-service model to a single payment model
- Frequency of Dispensing (FOD) provisions would not apply for any patient prescribed an opioid substitution medication. We know that the Ministry is reviewing the FOD program as a separate project.
- Recognize a “Refusal to Fill” (“special service”) as an integral component of the OSTP.
- Include two bi-annual OSTP-specific Medication Reviews as a required component of the OSTP.
- Include completion of mandatory education (to be developed in consultation with the College of Pharmacists of BC) as a prerequisite to participate in the OSTP.

Recommendation: Pursue a stepped approach to patient attachment to primary care physicians and community pharmacists for patients eligible for the newly-defined OSTP.

The client population utilizing MMT is very diverse, highly complex, and variable. No single health-care provider can address all the needs of this heterogeneous population alone. The Ministry should develop resources of all available programs with guidelines for prescribers and allied health-care professionals on how to refer patients between the various levels of care (low threshold, primary care, intensive treatment).

As the Ministry completes its review of the success of the *GP for Me* initiative, it is an ideal time to explore whether the attachment initiative could be extended to this complex and high needs population.

A. Introduction

The BC Pharmacy Association (BCPhA) is pleased to provide comments on the *Methadone Maintenance Payment Program Review* (the *Review*) dated 1/19/2015.

We thank Medical Beneficiary and Pharmaceutical Services Division (MBPSD) staff for the candid discussion we had at the stakeholders' meeting on May 5, 2015. It is clear that there are many areas of agreement between us, including that the most important issue is that the Methadone Maintenance Treatment Program (MMTP) deliver optimum outcomes for patient health.

Our comments are predicated on the view that only by considering the MMTP in British Columbia in its entire context can the Methadone Maintenance Payment Program (MMPP) be understood. The MMPP is intended to support the goals of the MMTP, which are to promote better health outcomes for individuals battling opioid addiction and other health issues; reduce risks to public health; and minimize the social problems associated with addiction including criminal behaviours.

We appreciate the limits of this review and that of MBPSD jurisdiction extends only to the cost structure associated with the program. However, we are strongly of the view that if costs are looked at in isolation there is a significant risk of undermining the purposes the program is meant to support.

There are three components of the MMTP: prescribing, dispensing of methadone and the provision of psychosocial supports. The Ministry's current review provides the opportunity to examine all three critical components of the program. As we have advocated for in the past, we believe any review of program costs for only one portion of the overall program will fall short of achieving any meaningful review of the program as a whole and will not serve patients well.

The BCPhA is committed to supporting its members in providing the best possible care to all their patients in a manner that is cost-effective and focused on patient outcomes. The Ministry's *Review* has highlighted some concerns that we believe are best resolved collaboratively and we stand ready to do that.

B. History and Success of Methadone Maintenance Treatment

A brief review of the origins of the MMTP will aid in understanding its current fragmented state. The world's first program was established in Vancouver in 1959, and was formalized in 1965. Methadone administration and regulation was exclusively within federal jurisdiction until jurisdiction over treatment regulation was transferred to the provinces in the 1990s.[1] It wasn't until 1996 that the College of Physicians and Surgeons of BC (CPSBC) was made responsible for administering the Methadone Maintenance Program, and not until 2004 did the College of Pharmacists of BC assume responsibility for setting standards and monitoring dispensing practice by pharmacists within British Columbia. Unfortunately, the regulatory oversight is therefore limited, siloed and fragmented. The lack of a comprehensive, patient-centred approach to MMT has resulted in inadequate controls being exercised over ethical and professional standards and treatment decisions. Meanwhile, payment is the responsibility of PharmaCare, which currently has little control over service standards or delivery.

There is now a substantial body of research supporting the cost-effectiveness and therapeutic effectiveness of MMT and the high individual social costs of lack of treatment.[2] According to Nosyk and Anis (2009), because of the importance of access to treatment, the pharmacy-based daily witnessed ingestion program is socially beneficial.[3] Citing Zarkin et al. (2005), they argue that every additional $1 spent on increasing access to treatment yields $76 in discounted lifetime benefits. Further, it is well-accepted that MMT substantially reduces the individual and social harms associated with non-medicinal opioid use. These harms include criminal activity and the associated costs, transmission of blood-borne pathogens including HIV and Hepatitis C, and premature mortality. Reduction in transmission of HIV/AIDS and Hepatitis C translates directly into improved outcomes for many individuals currently on MMT, broad social health benefits, and a substantial lifetime reduction in the costs of treatment.

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[1] Reist, D. (2010). *Methadone Maintenance Treatment in BC: 1996-2008: Analysis and Recommendations*, Centre for Addictions Research BC.

[2] Reist, citing Barnet, P., & Hui, S. (2000). The cost-effectiveness of methadone maintenance. *Mt. Sinai Journal of Medicine*, 67, 365-74; Zaric, G., Barnett P., and Brandeau, M. (2000). HIV transmission and the cost-effectiveness of methadone maintenance. *American Journal of Public Health*, 90, 1100-11; Zarkin, G., Dunlap, A., Hicks K., and Mamo, D. (2005). Benefits and costs of methadone treatment: results from a lifetime simulation model. *Health Economics*, 14, 1133-50; Connock, et al. (2007). Methadone and buprenorphine for the management of opioid dependence: A systematic review and economic evaluation. *Health Technology Assessment*, 11(9), 1-171, iii-iv; Wall, R., Rehm, J., & Fischer, B. (2001) The social cost of untreated opiate use. *Journal of Urban Health*, 77, 688-722; Nosyk, B., Sun, H., Sizto, S., Marsh, D., & Anis, A. (2009). *An Evaluation of methadone maintenance treatment in British Columbia: 1996-2007.* Vancouver, BC University of British Columbia.

[3] Nosyk, B. and Anis, A. (2009). Medical profiteering: the economics of methadone dispensation. *Canadian Medical Association Journal,* 180(11): 1093–1094.

The rationale for the MMT program is therefore clear: it is a cost-effective way to reduce the individual and social harm, crime, disease transmission and death that are associated with non-medicinal opioid use.

C. The Client Population

As many service providers reported,[4] MMT clients tend to be "challenging and complex patients", "tough to deal with" and "chaotic and unstable."

At the same time the clients are very diverse, highly complex, and variable. For example, the majority of downtown east side (DTES) residents are on income assistance, while in Vancouver Island Health Authority (VIHA), Northern Health and Interior Health regions, the majority are employed.[5] Common in this population are higher rates of mental illness, physical injury and disability, diabetes, and neurocognitive disorders. Trauma, violence, poverty, chronic pain and criminal behaviours also loom large.

The CPSBC *Methadone Maintenance Program: Clinical Practice Guidelines* offer insight into the challenges of treating some members of this population.[6] The *Guidelines* indicate that the comorbidity of substance dependence and mood, thought and anxiety disorders, such as post-traumatic stress disorder is as high as 50 per cent. According to the *Guidelines,* most MMT patients are also dependent on other substances and up to 40 per cent of methadone-maintained populations will meet criteria for problematic alcohol use at any one time.[7] These co-morbidities expose the patients to substantial risks.

D. Methadone Toxicity and Overdose Risk

Many of these patients are at risk for methadone toxicity and fatal overdoses. Those most at risk include those who concurrently use alcohol, sedative-hypnotics (including benzodiazepines), stimulants, or medications that interfere with methadone metabolism.[8] Fatal overdoses most often occur during initiation or dose escalation or result from changes or cessation in prescribed medications. Given these risks, the *Guidelines* recommend, during the initiation phase, lower daily doses for patients known to be using other sedative drugs or alcohol, close monitoring of

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[4] Reist, page 5.

[5] Parkes, T. and Reist, D. (2010). *British Columbia Methadone Maintenance Treatment Program: A Qualitative Systems Review – Summary Report*, page 4.

[6] College of Physicians and Surgeons of British Columbia. (2014). *Methadone Maintenance Program: Clinical Practice Guidelines,* February 2014, revised July 2014. [hereinafter *Guidelines*]. Available at: https://www.cpsbc.ca/files/pdf/MMP-Clinical-Practice-Guideline.pdf.

[7] *Guidelines*, page 11.

[8] *Guidelines,* page 19.

patients during induction, higher levels of supervision and constant communication between treating physicians to ensure that prescribed medication changes are made safely.

The *Guidelines* presume a very high level of contact between the physician and the patient on MMT. Yet it is well known that patients interact more times in a year with their pharmacist than with their physician.

According to the Provincial Health Officer's 2012/2013 BC Opioid Substitution report,[9] methadone patients see their physician for any reason an average of only 23 times per year, while it is well-documented that 78 per cent of the methadone patients currently receive daily dosing of methadone. This already-limited interaction between this vulnerable patient group and their physicians is potentially further compromised by the current fee structure for physicians. Fee item T00039 for methadone and buprenorphine/naloxone treatment notes, "The physician does not necessarily have to have direct face-to-face contact with the patient for these fees (T00039) to be paid." In addition to this fee, a physician can also bill the P15039 fee for GP point-of-care testing of $12.22 up to 26 times per year.

Given the amount of contact that patients have with their pharmacists, it makes sense that pharmacists could be providing more information to the physician about a patient's adherence to their drug regimens and progress throughout treatment. One of the alternatives for ensuring this happens would be to require a pharmacist review of any patient's medications who is enrolled in MMT.

E. Methadone Daily Dispensing

Physicians are required to get a special exemption under the *Controlled Drugs and Substances Act* in order to be permitted to prescribe methadone. The decision to initiate carries can only be made by the physician and must be prescribed.

The *Guidelines* require the physician to take responsibility for ensuring that the patient actually takes the methadone, and that it is not diverted to the black market: "Fatal overdoses of methadone often occur in individuals who have acquired methadone from other individuals for whom it was prescribed. Therefore, it is important for the physician to be aware of the risk of diversion of prescribed methadone and to take responsibility for ensuring that the methadone they prescribe as carries is actually being taken by the patient."

[9] Office of the Provincial Health Officer. (2014). *BC Opioid Substitution Treatment System Performance Measures 2012/2013*, page 9. [hereinafter *Performance Measures 2012/2013]*. Available at: http://www2.gov.bc.ca/gov/topic.page?id=3F5D466AC7B34DB4B1BCD31EE5E5A46B

Given the risks of permitting patients to carry, it isn't surprising that 78 per cent of methadone claims in 2013/2014 were for daily witnessed ingestion, demonstrating either that physicians are quite reluctant to prescribe carries, or that few patients actually meet the criteria, or both.

In light of these risks, and of the physicians' sole authority over daily dispensing, and the obvious physician reluctance to prescribe carries, we take issue with the suggestion in the *Review* that pharmacists are wrongfully engaging in daily dispensing. We also question whether it is appropriate to expect a large increase in the number of carries that could be prescribed because of the clear risk to patient safety this could present.

We encourage the Ministry to engage with physicians to determine whether they believe there is the opportunity to extend carries to a larger number of patients enrolled in the program.

Retention Rates

Addiction is a chronic disease, which in many cases may require lifelong treatment. Client retention is central to ensuring ongoing treatment, which in turn is associated with decreases in illegal activity, better health and lower mortality levels.[10] Other studies show that longer duration in treatment is associated with improved post-treatment outcomes.[11] Discontinuation of MMT is associated with a three-to-four-fold increase in death rates.[12]

In other words, when a patient stops taking their methadone, they run a very serious risk of dying. Yet across B.C., only 37 per cent of new patients are retained in treatment after one year; retention rates in VIHA are 45 per cent while rates in VCHA are 34 per cent.[13] We note that this is substantially below the province's goal for 2015 of 60 per cent.

The reasons for this are complex, but much has to do with the nature of the client population and the unique challenges they confront daily. It has been suggested that effective methadone

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[10] Reist, at page 11, citing Caplehorn, J., Dalton, M., Cluff, M., & Petrenas, A-M. (1994) Retention in methadone maintenance and heroin addict's risk of death. *Addiction*, 89, 203-7.

[11] Reist, at page 11, citing Dolan, Shearer, White, Zhous, Kaldor & Wodak (2005). Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, re-incarceration and hepatitis C infection. *Addiction*, 100, 820-8; Hubbard, R., Craddock, S., & Anderson, J. (2003). Overview of 5-year follow-up outcomes in the drug abuse treatment outcome studies (DATOS). *Substance Abuse Treatment,* 25(3), 125-34; Lowinson, Payte, Salsitz, Joseph, Marion & Dole (1997). Methadone maintenance. In J. Lowinson, J. Payte, J. Salsitz, E. Joseph, H. Marion & I. Dole, (Eds.), *Substance abuse: A comprehensive text.* (3rd ed., pp. 405-15). Baltimore: Williams & Wilkins; Zhand, Friedmann, & Gerstien, (2003). Does retention matter? Treatment duration and improvement in drug use. *Addiction*, 98, 673-84.

[12] Reist, at page 2, citing Bell & Zador (2000). A Risk-Benefit Analysis of Methadone Maintenance Treatment. *Drug Safety*, 22 (3), 179-90.

[13] *Performance Measures 2012/2013.*

treatment is a multidisciplinary effort which includes prescribing, dispensing and psychosocial services or support.

These multiple factors impacting retention are not explored in the *Review*. The *System Performance Measures Report 2011/2012*[14] suggests that there is a significant correlation between dose and retention in treatment. Those patients receiving dosages above 100mg per day have the highest probability of being retained in treatment, while those with doses below 40mg per day have the lowest probability of retention in treatment. Less than 60 per cent of all physicians in B.C. adhered to the minimum effective dose guidelines in 2011/2012; in VCHA the percentage was less than 50 per cent.[15]

One very recent study suggested that the requirement to attend the pharmacy directly for daily witnessed ingestion "constrained their capacity to determine their own schedule and restricted opportunities, such as engaging in formal employment."[16] That same study suggested that pharmacy methadone delivery services (now prohibited) reduced the burdens associated with daily dosing. The extreme poverty of many participants in urban areas limits their ability to travel, because they can't afford bus fare. Further, competing demands, such as medical appointments or court dates, led to missed doses because, as one individual is quoted as saying: *"If I got court dates, I'm not going to go and drink my methadone and risk going to jail [*for late court appearance]…*if I have something important to do, I end up missing my* [HIV] *meds and my methadone* [due to the difficulty of travelling to the pharmacy]."[17] That study concluded that there is a need for greater attention to structural vulnerability of patients when introducing changes to methadone programs and that they should include community consultation.

We believe that further investigation and consultation is needed to better identify the causes of patient withdrawal from the MMTP in order for effective solutions to be properly identified.

One thing is clear: the vast majority of MMT patients have daily contact with their pharmacist. The pharmacist's role involves much more than simply witnessing a person ingesting their methadone. The responsibilities are defined in the Standards of Practice of the College of Pharmacists of BC's Methadone Maintenance Treatment Policy Guide (2013) and include client engagement and assessment, ongoing communication with the client, liaising with the

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[14] Office of the Provincial Health Officer. (2013). *BC Methadone Maintenance System Performance Measures 2011/2012 Report.* [hereinafter *Performance Measures 2011/2012*]. Available at: http://www2.gov.bc.ca/gov/DownloadAsset?assetId=8B6BF96F8416431A8BB1EFEACDE5063A&filename=methadone-2011-12.pdf

[15] *Performance Measures 2011/2012*.

[16] McNeil and Kerr et al., (2015). Negotiating structural vulnerability following regulatory changes to a provincial methadone program in Vancouver, Canada: A qualitative study. *Social Science and Medicine,* 133, 168-176, page 171.

[17] McNeil and Kerr, page 172.

physician, reviewing PharmaNet profiles and updating the database, and reviewing and evaluating prescriptions. Our members report that these additional activities are often time-consuming given the complex and diverse needs of these patients and the rigidity of the MMTP. The fee for these services was developed in 2001 based on an external consultant's report[18] that the cost of providing these services was approximately $7.70 per interaction in various pharmacy settings. Calling this the "witness ingestion fee" has led to substantial underestimation of time and work involved in providing these patient services which go far beyond simply watching a person swallow their methadone.

In many of these cases the pharmacist might be the most regular support for clients in situations where their physician or health-care provider sees them irregularly or does not provide more extensive support. We suggest this frequency of contact between the patient and the care provider could be better leveraged with the objective of affecting retention rates, while simultaneously providing better cost predictability. This could be accomplished by restructuring the MMPP, as discussed in the *Recommendations* section.

F. Frequency of Dispensing

The issues with daily dispensing of methadone must not be conflated with daily dispensing of other medication. Although they are related there are two totally different health care decisions that are required. However, the data seems to suggest that in at least some cases, the decision to prescribe daily dispensing of other medications is made in conjunction with the MMT decision. This is inappropriate because in determining whether daily dispensing of methadone is truly required based on the stability and needs of the patient, the physician is obliged to consider issues specific to MMT; whether or not daily dispensing of other medications is appropriate and actually required is a separate prescribing decision, which is unique to each patient.

We understand the Ministry is concerned about the potential for any abuse of billing practices that could be associated by coupling the two programs together and wants to eliminate any unintended incentives that may exist in the current PharmaCare billing policies. We support this intention and address this in our recommendations.

G. Prescribers and Patients and Pharmacies – The Numbers

Provincial data indicates that in 2012/2013, slightly over 50 per cent (176) of the 344 physicians who prescribed opioid substitution therapy (OST) that year were based in the Vancouver Coastal Health Authority (VCHA) region. The second highest number of prescribers (76 prescribers) were

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[18] Ernst & Young. (2000). *Methadone Project: Final Results. June 1, 2000.* Commissioned by the BC Pharmacy Association.

based in the Fraser Health Authority (FHA) region (up from 64 prescribers in 2007/2008). Of the 4.6 million people living in British Columbia, about 37 per cent of them (1,689,875 people) live in the FHA region. Among clients accessing harm reduction supplies throughout B.C. in 2013, heroin use is highest in the FHA region (54 per cent). Illicit drug-related mortality rates in 2011 were highest in the FHA, and of the over 300 drug overdose deaths in 2013, 90 per cent were determined to be accidental.[19]

Interestingly, in 2007/2008, the number of patients in FHA (3,521) was almost identical to the number of patients in VCHA (3,530), but in 2012/2013 there were 4,722 patients in VCHA, while the number in FHA has shot well past that, to 6,716 in 2012/2013. That's an almost 90 per cent increase in patients engaged in OST in FHA since 2007/2008.[20] These numbers would suggest that in 2012/2013 in FHA, 76 prescribers prescribed OST for 6,716 patients.

Given this huge increase in patients in the FHA, it isn't surprising that there has been growth in the number of pharmacies in that region, too. In 2007/2008 there were 167 pharmacies providing OST; by 2012/2013 that number had risen by 67 percent to 279 pharmacies, which tracks, to a lesser extent, the almost 90 per cent increase in patients in the region over the same period.

Yet despite all this growth in the MMT Program, according to *Performance Measures 2012/2013*, the average per patient annual cost to PharmaCare "has ***not*** increased significantly from 2007/2008 levels….in 2012/2013 the average annual cost of OST per patient was $3268 (approximately the same as 2007/2008). The increase in overall costs may be due to patient population growth and the addition of suboxone as a limited coverage benefit in November 2010."[21]

According to the *Review,* from approximately $20M in 2001/2002, the costs grew to $43.7M in 2013/2014. The total expenditure growth for the MMTP follows a similar trend as the growth in the number of methadone patients each year. <u>The annual increase in expenditure is largely due to the annual increase in the number of methadone patients.</u> As already stated, 78 per cent of methadone claims in 2013/2014 were for daily witnessed ingestion of methadone.

Given that the vast majority of patients in 2013/2014 were prescribed methadone to be dispensed daily, and many of those patients have also been prescribed a surprisingly wide range of other drugs, also to be dispensed daily, it is entirely predictable that approximately 88 per

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[19] All statistics in this paragraph are from: Tanner, Z., Matsukura, M., Ivkov, V., Amlani, A., Buxton, J.A. (2014). *British Columbia Drug Overdose and Alert Partnership Report: BC Drug Use Epidemiology (September 2014).* BCCDC. Available at: http://www.bccdc.ca/NR/rdonlyres/360E0050-F939-4C0E-B627-854F0A7B346D/0/FinalDOAPReport2014.pdf

[20] All figures from *Performance Measures 2012/2013*, page 3.

[21] *Performance Measures 2012/2013*, page 6 [emphasis added].

cent of the total PharmaCare methadone expenditures in 2013/2014 were for professional fees (dispensing fees and witnessed interaction fees).

This suggests that growth in the number of pharmacies is a response to actual need. Given the explosion in need in FHA, we agree that any changes to the number of pharmacies serving this population should be done carefully, with a view to ensuring that the patients are able to continue to receive care.

With respect to the issue of the concentration of MMTP pharmacies in certain urban areas, we suggest that there are a number of practical reasons why this is happening. First, given that the majority of MMPP patients are on PharmaCare's Plan C, it is likely that many live in or near these areas, and have limited means of transportation. Second, it is reasonable to assume that businesses will operate in locations where there is a client base.

While competition is a reality in any marketplace, we support pharmacies competing only in an ethical manner that does not place patient safety or outcomes at risk. We have and continue to support efforts by the Ministry to eliminate unethical business practices. The recently implemented PharmaCare enrollment agreement provides the Ministry with the tools it needs to ensure it is doing business with pharmacies able to meet all their contractual obligations.

Any concerns the Ministry has regarding the individual practice standards of pharmacists or pharmacies involved in the program should rightly be referred to the College of Pharmacists of BC.

We would echo the concerns in the *Review* that where patient volumes increase, patient care could suffer, as could attention to the accuracy of claims submitted to PharmaCare for payments. Accordingly, we suggest that any Ministry steps to reduce the number of providers or otherwise change the delivery system for the MMPP be undertaken very carefully.

H. Fractured Delivery System

Currently there is no overarching or collaborative framework for governance of the MMT program; there is no competency test and no quality assurance mechanism.

Physicians and pharmacists work in separate silos, with separate payment mechanisms that have the potential for setting up perverse incentives for both providers.

Performance Measures 2012/2013 also notes that Medical Services Plan payments for physician fee-for-service claims have increased significantly since 2008/2008 when it was under $6 million,

and the total MSP expenditures for OST in the province in 2012/2013 was $12.8 million.[22] According to Parkes and Reist*,* many stakeholders interviewed reported that MMT in urban regions had become a "cash cow" for physicians who took large numbers of patients "without necessarily providing optimal care".[23] It was the view of many that the current system contained perverse incentives and disincentives.

A lack of clarity and clear protocols around physician billing was evident and described as "very problematic."

In this regard we note that methadone fees for physicians have more than doubled in the last fifteen years, from $10.00 to $22.73 (April 1, 2015). When combined with the point-of-care testing fee this number rises to $34.95. As noted earlier, the Fee Guide issued by the Medical Services Commission says it is not necessary to see the patient to bill for this service, and this fee is payable once per week per patient, regardless of the number of visits per week. We have serious concerns about the acceptable minimum standard of physician care that is permissible when the physician isn't required to see these vulnerable patients but can bill for their care. One reasonably asks how is the physician engaging with their patients if they are not required to see them in person?

Parkes and Reist suggested that MMT funding mechanisms should facilitate integration into primary care and should support the roles of other professionals including nurses, counsellors and social workers. Concerns were also raised about the cost of urine drug screens. Parkes and Reist concluded that current fiscal arrangements were potentially negatively, impacting access, retention, quality, effectiveness and client outcomes. A comprehensive review of all funding arrangements and policy was recommended, with a view to normalizing MMT, maximizing best practices, better incorporating psychosocial services and improving access in rural and remote areas.[24] They said: "The problems that often prevent the system from delivering optimized treatment to those that use its services are also many and diverse. Most importantly, the fragmentation and lack of integration of MMT with other mainstream health and social care supports, is severely limiting the ability of the program to meet the needs of its clients. The lack of a treatment "system", as such, leading to a lack of coherent and comprehensive care/treatment policies and practices across the province, is preventing MMT from achieving its potential for many individuals."

Individual pharmacies cannot be responsible for coordinating the various levels of health services to address the needs of their patients given the current fragmentation of the system. Currently, the system does not support pharmacists in triaging their patients. We believe that it is important to address the current lack of coordination in the system and address the current

[22] *Performance Measures 2012/2013,* page 7.
[23] Parkes and Reist, page 8.
[24] Parkes and Reist, page 9.

gaps related to responsibility and accountability across these many separate components of the MMTP.

We support the creation of a multi-stakeholder Opioid Substitution Treatment Committee to develop a range of improvements to the MMT system in B.C., with membership that includes representation from all agencies, regulatory and professional bodies and other stakeholder groups including patients, families and advocates. This proposed committee should, among other activities described below in *Recommendations*, review other MMT programs in other jurisdictions to determine best practices that have resulted in the optimum patient outcomes.

Any program changes need to take into consideration the impact on service providers throughout the province.

Professional Ethics/Standard Operating Procedures

The vast majority of pharmacies providing services in the MMTP do so in an ethical, appropriate and efficient manner. Unfortunately, there is a small subset of pharmacists who do not. We are in support of the Ministry's recent efforts to address problems identified with these pharmacies through the PharmaCare enrollment process.

PharmaCare's efforts to manage the business relationships of those pharmacies enrolled in the program are an important step. However, it is outside the Ministry's purview to address any professionally unethical practices of these few pharmacists or any short coming in the standards of care provided by pharmacists. This is clearly the responsibility of the College of Pharmacists.

Parkes and Reist observed that many participants were frustrated with the manner in which the College of Pharmacists addressed, or failed to address, concerns about suspected professional misconduct, and the apparent unwillingness of the College to respond to complaints.[25] In addition, numerous unethical practices by physicians were also reported, including holding ownership interests in pharmacies or recovery houses to which they would send clients; restricting clients to particular pharmacies; pressuring patients into MMT and inappropriate prescription practices. The College of Physician and Surgeons of BC has failed to properly enforce their bylaws against such bad actors.

The College of Pharmacists of BC is responsible for the licensing of pharmacists and pharmacies in B.C. and ensuring that all licensed pharmacists and pharmacies operating in B.C. meet their ethical and legal requirements. If it becomes evident that patient care is suffering in any pharmacy, it is the responsibility of the College to effectively deal with the concerns. The College has many options at its disposal that would have the effect of improving quality of service and enforcing standards, including from simply undertaking new communications strategies, to

[25] Parkes and Reist, page 10.

improving the training and qualification requirements, imposing supervision or consulting requirements and stepping up investigations into complaints.

The actions of the small subset of pharmacies has caused our profession as a whole to be subjected to serious reputational harm, and has resulted in the government having to utilize contractual means to address abuse of the MMTP.

As the organization that represents community pharmacists in the province, the BCPhA believes the evidence shows that current pharmacist training and licensing standards need to be enhanced together with higher levels of oversight. This would lead to optimal delivery of higher quality patient care.

These practice standards were developed a number of years ago, with a view to supporting the goal of rapidly expanding the MMTP across the province to promote access to care. This approach was extremely successful, as the data establishes that the growth rate in the number of pharmacies dispensing methadone tracks the growth in the number of patients in the MMTP. However, it is clear that what was an appropriate level of training, certification and licensing many years ago, is no longer appropriate.

The BCPhA believes that the self-directed and self-certified online training program that currently is in place has inadvertently created an easy entry into the program for those pharmacists looking to maximize revenue at the expense of patient care. If practice standards were put in place that required training that is more rigorous, time-intensive and with better supervision, we believe issues related to ethical practice and deficient care standards would be greatly reduced.

We have long said that the Ontario methadone training and licensing model, with some minor modification, provides an example of one route that could easily be implemented here in B.C. to good effect. We recommend working with the College of Pharmacists of BC to implement a training program that ensures the best patient care is delivered by all pharmacists enrolled in the program.

Among the proposals for solutions set out below is an outline for a similar program that could be developed and delivered to pharmacists across the province by the BCPhA. Having now trained more than 3,000 pharmacists through our injection training sessions and conducted nearly a dozen “Regulatory Compliance Bootcamps” on PharmaCare audit compliance, the BCPhA is accepted as the organization that can train pharmacists in the optimal delivery of high quality patient care. We are positioned and ready to deliver the proposed program.

I. Proposals for Solutions – Summary of Recommendations

Recommendation: **Create an Opioid Substitution Treatment Committee to improve the co-ordination of care between physicians and pharmacists in the treatment of patients enrolled in the MMTP.**

The current program would clearly benefit from increased collaboration among the providers and regulators.

We support the recommendation of Parkes and Reist to create a multi-stakeholder oversight group to develop a range of improvements to the MMT system in B.C. Specifically, membership would include representation from the College of Physicians and Surgeons of BC, the College of Pharmacists of BC, the Doctors of BC, the BC Pharmacy Association, and Ministry of Health representatives responsible for physician and pharmacist services.

At the outset the proposed Opioid Substitution Treatment Committee should review other MMT programs being offered nationally/globally to determine best practices that have resulted in the development and implementation of successful MMT programs.

The ongoing mandate of the committee would be to create a collaborative care model that ensures the current fragmentation of care between the two primary care givers for patients with addictions living in the community is overcome. The committee would have the authority to adjust clinical care guidelines and set provider standards for participation in the MMTP.

Recommendation: Create an independent financial oversight group that is charged with looking at physician and pharmacist fee structures to ensure no inadvertent perverse incentives exist that result in compromised care for patients.

The literature and anecdotal information suggests that a small number of physicians and pharmacists are taking undue economic advantage of the current fee provisions. The current siloed budgets within the Ministry do not allow for an integrated review of these speculated situations. In our view such a review is essential.

Recommendation: Work with the College of Pharmacists of BC to evaluate the current training and licensing structure for all pharmacists involved in the delivery of opioid substitution medications.

As noted earlier in this document, the BCPhA believes the current pharmacist training program and licensing requirements no longer meet the needs of the growing population of patients with addiction issues.

Much more is now known about the complex nature of this patient group and the important role pharmacists must play in their care. In our view, an online, self-directed training program for pharmacists is simply insufficient.

It also seems reasonable to assume that low standards of training and licensing have created opportunities for pharmacies to operate in ways that fail to meet patient needs and have compromised the public reputation of community pharmacists.

We also believe it is timely to review the training and licensing requirement for physicians enrolled in the MMTP. It is well past time to raise the bar in terms of what is required from the two primary care health providers involved in community based care of patients challenged with addiction issues.

Recommendation: Restructure the current MMPP to a payment program that provides a patient focused plan with a single payment for all clinical and dispensing services received by patients on methadone.

PharmaCare would create a unique billing fee for patients enrolled in the opioid substitution program. Regardless of the number of medications prescribed to a patient in the MMTP, only a single fee could be charged by the pharmacist for caring for that patient.

The MMTP would continue to leverage the opportunity to maximize patient care with the majority of patients continuing to rely on their pharmacist as daily point of care.

- Revise the Methadone Maintenance Policy into an Opioid Substitution Treatment Policy (OSTP) that would include both methadone and Suboxone.
- Restructure this OSTP from a fee-for-service model to a single payment model.
- Frequency of Dispensing (FOD) provisions would not apply for any patient prescribed an opioid substitution medication. We know that the Ministry is reviewing the FOD program as a separate project.
- Recognize a “Refusal to Fill” (“special service”) as an integral component of the OSTP
- Include two bi-annual OSTP-specific Medication Reviews as a required component of the OSTP.
- Include completion of mandatory education (to be developed in consultation with the College of Pharmacists of BC) as a prerequisite to participate in the OSTP.

Recommendation: Pursue a stepped approach to patient attachment to primary care physicians and community pharmacists for patients eligible for the newly defined OSTP.

The client population utilizing MMT is very diverse, highly complex, and variable. No single health-care provider can address all the needs of this heterogeneous population alone. The Ministry should develop resources of all available programs with guidelines for prescribers and allied health-care professionals on how to refer patients between the various levels of care (low threshold, primary care, intensive treatment).

As the Ministry completes its review of the success of the *GP for Me* initiative, it is an ideal time to explore whether the attachment initiative could be extended to this complex and high needs population.