



Birds of a feather

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I recently read an article about a wagtail, who saw himself in a car's side mirror and started fighting with himself. The bird would fight until it was out of breath and then go sit in a nearby tree for a minute or so, only to fly back and continue the fight. Quite comical, isn't it?

Apparently it is a known phenomenon and at times the birds continue fighting until they die of exhaustion.

I also know people who seem to have the same problem! But don't we all do it at times? We see our reflection in other people and feel so threatened that we immediately go on the attack. It is without rhyme and without reason, that we exhaust ourselves fighting and believing we have good reason to continue the fight, will return to it again and again! We even believe that we have grounds to continue fighting and may never realise that we are

fighting our own image! Again it is quite comical (for an observer, not for the poor fool who is fighting or for the victim of the attack).

How do we decide whether we are fighting a real opponent or a real threat and not just our own image?

As always, it is easier said than done! Yet the first step is always to take a step back and calmly assess the situation. Why am I in this situation in the first place? What stops the confrontation from being resolved? Am I attacking the person or do I try to resolve an issue?

If it is about the person, we are missing the point or it might be that egos stand in the way of resolving a conflict. Have we not seen our profession being torn apart by persons with personal interest and clashing egos? Whatever the case, the person should never be of greater importance than the cause, which in our case is the profession.

So – when you sit on your perch in the tree and contemplate taking on the enemy in the mirror, it may be time for a reality check!

Innovations to improve access to and use of medicines for chronic conditions

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This year the SAAHIP Conference workshop introduced delegates to current challenges and innovations related to improving access to and use of medicines for chronic non-communicable diseases (NCDs) in South Africa. This topic is of relevance to pharmacists working in hospitals and institutions in a variety of settings in both the public and private sectors across South Africa.



(l to r) Siraaj Adams, Ricardo Kettle, Margaret von Zeil, Tania Mathys, Hazel Bradley, Richard Laing

1. Introduction

As the global burden of disease shifts from acute to chronic diseases, health systems, including that in South Africa, will have to change to meet the demands of these conditions. Most health systems, especially in the public sector, have a historical focus on children, communicable diseases and emergencies; however patients with NCDs require a different type of service. These 'patients' are often well when they attend facilities, but they require regular monitoring, reliable supplies of medicines and measures to retain them in care, including adherence support, self-care and follow-up of non-attendance:

*"Existing health systems will have to change to accommodate new demands for NCD care, particularly in the public sector"*¹

The increasing burden of NCDs was acknowledged by the convening of the United Nations General Assembly High-level Meeting on the Prevention and Control of NCDs in September 2011.² This was followed by the tasking of the World Health Organization (WHO) to define indicators and targets, one of which was 80% availability of essential medicines and affordable basic technologies required to treat NCDs at all public and private facilities.

In South Africa, despite the challenges posed by increasing numbers of patients with NCDs requiring services at facilities, the recent success of the HIV/AIDS programme in providing long-term treatment demonstrates the possibility of reconfiguring models of care and provides pointers for how programmes for NCDs could be adapted for similar settings. In addition, specific innovations for improving access to medicines have emerged over the past few years and the learnings from these could be shared with stakeholders across the country.

The learning outcomes of the workshop were to:

1. assess key challenges of access to medicines resulting from the increasing burden of chronic diseases in South Africa;
2. identify innovations to improve access and use of medicines for chronic conditions;
3. appraise lessons learned from innovations to improve medicines access and use for HIV/AIDS and NCDs; and
4. reflect on the relevance of innovations to each participant's own setting and other settings in South Africa.

After a brief overview of the emerging problem of NCDs and challenges concerning access to medicines by Prof Richard Laing, the workshop continued with a four short panel presentations in which each presenter described their innovation and highlighted how it improved access to or use of medicines for chronic conditions. The innovations included a private sector initiative using electronic technology to develop a smart phone app, a provincial and a national initiative using public/private partnerships to supply chronic medication to patients, and a ward-level intervention in a private hospital.

2.1 Panel Presentations

2.1 HIV Clinical Guidelines App – Siraaj Adams

The burden of HIV in low- and middle-income countries has increased demand for health services, and this has had a direct impact on the

health workforce, resulting in task shifting, especially in rural settings. The essential support systems within the NIMART (Nurse Initiated Management of Antiretroviral Therapy) process, including training, supervision and referral systems, may not always be in place or functioning well enough. Without strong clinical decision support tools and monitoring, such gaps may compromise quality of care. In response, the HIV Clinical Guidelines App, developed by Metropolitan and other partners, was launched by the Minister of Health in June 2015.

Functionality

The HIV Clinical Guidelines App allows health workers to access the latest national HIV Guidelines via smart phones or tablets, and the guidelines are automatically updated in line with the latest Department of Health policies. The app covers all aspects of HIV care from diagnosis to starting criteria for antiretrovirals to switching treatment regimens. The toxicity and adverse reaction pathology calculator is essential when determining if a patient should remain on a specific treatment or be switched. The paediatric and renal dosage calculator is extremely useful to verify if dosages are appropriately prescribed. A comprehensive HIV drug formulary provides a quick reference to useful information such as contra-indications and pharmacokinetics. In addition a stock-out notification module and adverse drug reaction tool have been added.

App store

The HIV app has been downloaded more than 16 000 times by healthcare providers. The app can be accessed in the App Store or on Google Play and downloaded to an Android or Apple phone or tablet for free. In order to access the app, search for "HIV Clinical Guidelines: National Department of Health" from either source.

2.2 Western Cape Chronic Dispensing Unit (CDU) – Tania Mathys

The CDU is the outsourced, centralised unit that collects prescriptions, and then dispenses and delivers the completed Patient Medicine Parcel to facilities in all districts of the Western Cape Province.

The CDU process can be summarised as follows:

1. the patient is adjudged as stable and requiring chronic care, and enrolled onto CDU;
2. the CDU prescription is submitted to the CDU;
3. the CDU prescription is dispensed according to current Good Pharmacy Practice (GPP) and provincial/national and other legislative requirements;
4. the CDU patient medicine parcels (PMPs) are delivered 3 working days before the patient collection date; and
5. the patient collects the PMP, either at the clinical site or from an alternative collection point.

The CDU service commenced in 2005, and by the end of February 2016 had delivered a total of almost 19 million medicine parcels. At the moment, the CDU delivers an average of 340 000 PMPs per month, with the highest number (394 460) delivered in October 2015.

Patients have the option of collecting their PMPs at their clinical facility or at an alternative collection point (as decided and agreed upon by the local clinic). These sites may include facility-based clubs, mobile clinics, community halls, community-based service projects and not-for-profit (NPO)/non-governmental organisation (NGO) partners.

Benefits of the CDU

- Reduces waiting times
- Reduces facility staff workload
- Improves access – convenient collection times
- Alternate collection points in the community
- Improves information management
- English, Afrikaans & isiXhosa label

Critical Success Factors of CDU

- Full-time Contract Manager; Service User
- Standardised Procedures
- Prescription management
- Patient selection
- Facility communication

2.3 Central Chronic Medicine Dispensing and Distribution (CCMDD) Programme – Ricardo Kettledas

The CCMDD Programme is a national programme which provides alternative access to chronic medicine for stable public sector patients. It has been initiated in response to the increasing number of patients in the country requiring regular medication for HIV or other chronic conditions, which are causing an enormous strain on resources at public sector health facilities. Phase one focused on specific categories of patients on antiretroviral therapy (ART) and Phase 2 will include further ART patients and patients with other chronic conditions (such as hypertension, diabetes, asthma and epilepsy) who do not require active clinical management.

Key features of the programme include:

- the recruitment of patients in 10 pilot districts across eight provinces;
- central dispensing and distribution of prescriptions by contracted service providers (currently 3 different providers are used);
- contracted pick-up points, which are closer to homes and therefore more convenient for patients
 - initial phase: pharmacies and general practitioners (GPs)
 - subsequent phases: adherence clubs, community-based service points
- call centres established for queries;
- enrolment and renewal of prescriptions captured on TIER.net, will be automated in future, thus providing useful data on medicines utilisation and retention; and
- payment by the NDOH for the service and for the antiretrovirals (ARVs) provided (currently, all are fixed-dose combinations (FDCs)), with the provinces paying for medicines for co-morbidities and other chronic medication.

At end of 2015 there were 340 423 patients registered on the programme across the pilot districts in the eight participating

provinces (all apart from the Western Cape), with plans to increase this to 1 million by 2018.

Benefits for patients

- fewer clinic visits;
- increased availability of medicines;
- shorter waiting times;
- choice of collection points;
- collection points closer to home; and
- after-hours collection.

The programme provisions of contracting private health care providers and improving access to pharmaceutical services are in line with the National Health Insurance (NHI) White Paper published in December 2015.

2.4 Mediclinic, George Hospital Initiative – Margaret von Zeil

A recent intervention at Mediclinic George illustrates the challenges and opportunities in the private hospital environment for patient education regarding their medication use. Several professional and patient practices contribute negatively to patient education and information transfer, including the removal of package inserts when dispensing medicines for individual patients, patient reliance on the Internet for unverified medicine usage information and the impersonal nature of some chronic medication delivery systems currently promoted by medical aid schemes, for example postal deliveries.

At Mediclinic George, approximately 50% of all hospital admissions are for patients aged 65 years and older, who are often admitted with co-morbidities which may be unrelated to the condition for which the patient is hospitalised. Patients may therefore be admitted with poor chronic medication use, which is not the primary reason for their hospital care, for example, a hypertensive, diabetic patient admitted for an orthopaedic procedure such as a total knee replacement.

In view of most medical aid chronic medication authorisation processes, patients on chronic medication are expected to bring their own chronic medication supply for use during their hospital stay. This period of hospitalisation may provide a useful opportunity for the pharmacist to provide medicine usage information or education to selected patients. Patient satisfaction surveys have previously indicated potential areas of improvement, including information about new medication prescribed; advising on what common side effects may be experienced as result of treatment; and understanding the purpose of taking all prescribed medication.

At Mediclinic George, even without a comprehensive or robust clinical ward pharmacy service, the nursing staff, admitting clinician, surgeon or the patient themselves can identify where a targeted intervention should be made and alert the pharmacists to this need by using a Pharmacist Counselling Request sticker placed on the front of the patient's prescription chart. The pharmacist then makes an appointment to meet with the patient at a mutually suitable time, in order to provide the patient with clear, unambiguous usage information and inform him/her on the common side effects likely to be experienced.

In practice, this intervention has been slow to initiate, with buy-in required from nursing personnel and clinical staff, as well as capacity demands on pharmacists to provide a sustainable service. At this stage, this is not a clinical intervention or medicine use evaluation and no value judgement is offered on the range of medication, unless deemed harmful to the patient. However, the process creates an opportunity for pharmacists to have more direct patient contact, address patient satisfaction and support patients in making safe and rational decisions regarding their chronic medication use.

3. Buzz group questions and discussion

After the presentations, five questions were posed, discussed in small buzz groups and then presented to a final plenary facilitated by Prof Richard Laing. The main discussion points that were raised in this lively interaction are highlighted below.



Animated discussion at one of the buzz groups

3.1 What lessons from HIV/TB management could be applied in the future to NCDs?

Some of the key lessons delegates felt could be learned from HIV/TB management included the provision of dedicated resources and systems for managing the conditions. These comprised trained and dedicated staff and systems that ensured the availability of medicines and a variety of measures to facilitate access and adherence, such as electronic monitoring systems for HIV patients (tier.net) and TB registers, counselling sessions, the buddy system, pill boxes, adherence clubs and the involvement of community-based organisations. Prevention campaigns for NCDs similar to those for HIV and TB were also mentioned. In a few settings it was reported that some of these initiatives have already been incorporated into NCD care, but it was reported that lack of resource constrained wider implementation.

3.2 What lessons from the Western Cape CDU could be applied in other settings in South Africa. What would the opportunities and challenges be?

Delegates identified several lessons from the Western Cape CDU that could be applied in other settings in South Africa. These included the

use of standardised prescription pads and the importance of ongoing training of prescribers to issue CDU prescriptions, due to high staff turnover at PHC settings; presence of pharmacy staff at off-site settings, if possible, to oversee control of medicines and answer patient queries; flexibility to adapt the model to individual settings.

Several challenges were noted and included:

- definition of a 'stable patient';
- patients do not always collect medicines on their appointment day for a variety of reasons;
- systems need to be in place if all patients do not collect the medicine parcel on the appointed day;
- no-one is available at the site to answer patient queries or oversee storage of medicines;
- many sites do not have access to electricity or storage facilities for items requiring refrigeration;
- the administration of the CDU requires dedicated staff and if a facility has several off-site distribution points, then it will require resources, including staff time, to optimally service those sites.

At the same time several opportunities emerged. A critical aspect was the improved access for patients – in some settings medicines were available for collection from facilities before work and at others collection sites were closer to patients' homes. Pharmacist's assistants could be trained to provide basic medicines information and support at off-site collection points and specific days could be allocated to particular morbidities, which could facilitate education opportunities. Finally, electronic information from CDU records could be used to monitor the collection of medicines and facilitate follow-up of defaulting patients to retain them in care.

3.3 What are the opportunities and challenges for involving the private sector and other role players in medicines distribution?

The opportunity to include independent private community pharmacies in the distribution of medicines for public sector patients was strongly recommended by the delegates. They felt it would be important to ensure adequate financial incentives to bring these important stakeholders on board and to make the initiative sustainable.

3.4 What successful private sector practices could be introduced to the public sector?

A variety of successful private practices were recommended for the public sector – in many instances they emphasised a patient-centred approach to care. They included the introduction of appointment systems and extended-hours services for collection of medications; use of mobile technology for reminders of appointments and to let patients know when prescriptions were ready for collection; and call centres for answering queries about medicines. Several suggestions, likely to be more challenging in the resource-constrained public health sector, included courtesy follow-up telephone calls 48-72 hours after receiving new medication and a reward system for patients to motivate them to look after their health, similar to an app Metropolitan Health is developing for adherence.

3.5 What other innovations are you aware of that should be considered?

In view of the nature of chronic conditions, and building on lessons from HIV/TB, it was not surprising that one of the key additional innovations mentioned was setting up systems to monitor patients. This included 'SMS' reminders and mechanisms for contacting patients if they default on appointments for clinical visits or collection of medication. Delegates highlighted the importance of prioritising high risk patients for pharmacist visits and follow-up. Others mentioned partnering with other members of the healthcare team and other sectors to support public health initiatives to promote health and prevent disease, such as the recently proposed sugar tax and the promotion of healthy lifestyles, such as the Discovery Vitality Programme.

4. Concluding comments

The workshop benefited from first-hand experiences of local colleagues involved in credible innovations to improve access to medicines for patients with chronic conditions. Judging by the lively discussions in

the buzz groups and final plenary session the workshop had touched on issues that resonated with many of the delegates. The workshop ended with delegates being challenged to reflect on the workshop and identify what they would 'take home' from the workshop and apply in their own work environment.

References

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