The Pharmacist Activist

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Editorial

We Must Prevent "Reform" from Taking the "Care" out of Health Care!

This April issue of *The Pharmacist Activist* is reaching you several days late. One of the reasons for the delay was the challenge I encountered in selecting the topic for this editorial. No, I haven't run out of topics. In fact, there were four topics that I considered very important and timely and my difficulty was in choosing just one of them. I made a choice and typed several introductory paragraphs before leaving for a meeting at which I had been asked to speak.

The meeting was at a retirement community at which educational programs are held on a wide range of topics. My topic was "Drug interactions and adverse effects." Approximately 40 people were present, of which I was the youngest (although my students would have difficulty believing this and I should have had a picture taken). By the end of the meeting and the numerous additional questions discussed on an individual basis, I concluded that what I experienced was sufficiently important, and always timely, to change the topic for this editorial.

There is such a great need for the drug therapy knowledge, judgment, and consultation that pharmacists are in a position to provide. All of us in pharmacy recognize this and nowhere is that need more evident than in a gathering of "seniors" (or, as I prefer, the chronologically gifted). The comments I prepared for the meeting did not have to be long because, once the questions started, they continued until the moderator brought the meeting to a conclusion.

Many of those attending quickly identified with adverse events such as dry mouth with medications used for overactive bladder, but were less aware that blurred vision and other visual changes might be drug-related. They quickly agreed with my observation that the development of or change in symptoms should be considered to be drug-related (as distinct from what is too often assumed to be a consequence of the aging process) until that possibility is ruled out.

There were numerous questions about Fosamax, Coumadin, aspirin, and Lipitor, and various medications they had seen advertised on television. Some asked questions regarding Aricept and other possible treatments for Alzheimer's disease, primarily motivated by wanting to be certain

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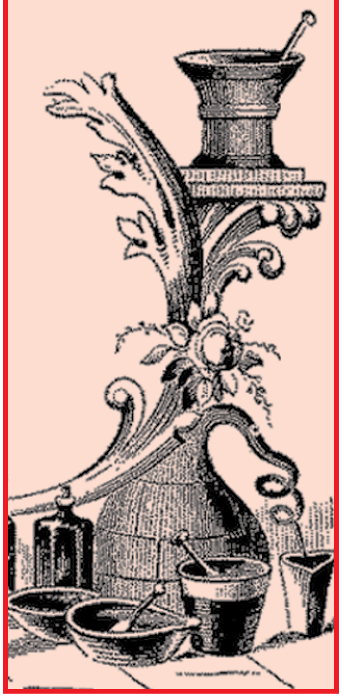

that every possibility had been considered for their spouse with this disease. Others volunteered information about adverse events they had experienced.

One of the individuals spoke with me following the meeting on behalf of a resident who was in the nursing facility of the retirement community. She had a list of her symptoms and conditions, the ten medications being taken, and the adverse events associated with the use of each of the medications. Three of the medications were for high blood pressure and the patient was convinced that one or more of these medications was responsible for the tingling, pain, and occasional numbness she was experiencing in her hands and arms, and for which Neurontin had been prescribed but with little or no benefit. One of her favorite activities was knitting but she was no longer able to do that because of the discomfort in her hands and her reduced dexterity. Her advocate asked how she could obtain a pharmaceutical consultation as the physician was pleased that her blood pressure was stabilized and did not consider her other symptoms to be serious enough to change her therapy. I suggested several possible options with respect to a pharmaceutical consultation but she was not optimistic that those currently providing her health care would be receptive.

We could multiply that experience by *millions*! There are that many individuals who have no or very limited health-care services. Even among those who have access to comprehensive health-care services, many are receiving much less than optimal care and experience drug-related problems.

Health care reform

The federal legislation (i.e., Obamacare) that is promoted as "reform" for a broken health-care system has been claimed to be a program that will provide coverage for millions of currently uninsured individuals and greater scope and quality of coverage for all participants at a lower cost. There is no question that the previous/current health-care system was in great need of reform and has been burdened with extensive inefficiency, waste, and fraud. However, the legislation being implemented (unless the Supreme Court intervenes), after being developed through a secretive and flawed process, has the potential to further weaken the scope and quality of the current system. I have concerns about many of the provisions of the legislation and the flaws, exceptions, and loopholes that continue to be identified. The economics of the system are certainly important as our society must be in a position to financially support whatever health-care system is provided. However, I would contend that the obsession with the economics has masked what will be an unacceptable erosion of the quality of health care.

We have already observed the consequences for health-care services from the increased role and influence of government, insurance companies, and pharmacy benefit managers. Insurance companies are buying hospitals, hospitals are buying physician practices, physicians are expected to see more patients thereby having less time for individual patients, many pharmacists are practicing in stressful workplace environments with a corporate emphasis on how many and how fast prescriptions are dispensed, and patients are being forced or provided with financial incentives to obtain their prescriptions from mail-order pharmacies in distant locations without any personal interaction with a pharmacist. Is it any wonder that drug-related problems such as prescribing, dispensing, and administration errors, adverse events, drug interactions, and patient noncompliance occur so often, resulting in harm to and deaths of patients at a cost of billions of dollars? Patients, as well as health professionals, who attempt to obtain clarity and answers from the chaos of the maze of mandates and policies often receive an inadequate response (sometimes after being "on hold" for a long period of time) and a high level of frustration. Patients far too often have reason to ask, "Does anyone really care?"

We have already observed a trend that has increased the corporatization of health care and reduced the time that health professionals spend with patients. I am convinced that the too frequent absence of care, compassion, and time for communication with patients is the single most important reason for which drug-related problems and their severe consequences and costs occur. My greatest concern regarding the more recent legislative initiatives is that the care provided for patients on an individual basis will be further reduced. We must prevent "reform" from taking the "care" out of health care! (Please also see my editorial, "Both Patients and Health Care Have a Great Need for a Personal Touch!" in the March 2011 issue of *The Pharmacist Activist*, www.pharmacistactivist.com).

Pharmacists have answers

Pharmacists have the expertise and are strategically positioned to greatly improve the appropriateness and effectiveness

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New Drug Review

Indacaterol maleate (Arcapta – Novartis)

Agent for Chronic Obstructive Pulmonary Disease

New Drug Comparison Rating (NDCR) = 3

(no or minor advantages/ disadvantages) in a scale of 1 to 5 with 5 being the highest rating

Indication:

For oral inhalation for long-term, once-daily maintenance bronchodilator treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema.

Comparable drugs:

Other long-acting beta2-adrenergic agonists (LABA) for oral inhalation: salmeterol (Serevent), formoterol (Foradil, Perforomist), arformoterol (Brovana).

Advantages:

- Is administered once a day (whereas comparable drugs are administered twice a day).

Disadvantages:

- Has not been directly compared (when used in its recommended dosage) with other agents in clinical trials;
- Labeled indications are more limited (salmeterol and formoterol are also indicated for the prevention of exercise-induced bronchospasm, and in combination with other agents for the treatment of asthma and prevention of bronchospasm in patients with asthma that is not controlled with conventional therapy);
- Is not available in a combination formulation with an inhaled corticosteroid (compared with salmeterol that is also available in combination with fluticasone propionate [Advair] and with formoterol that is also available in combination with budesonide [Symbicort]).

Most important risks/adverse events:

Increased risk of asthma-related death (boxed warning; is not indicated for asthma; contraindicated in patients with asthma without use of a long-term asthma control medication); should not be used for relief of acute symptoms; treatment should not be initiated in patients with acutely deteriorating COPD; paradoxical bronchospasm (treatment should be immediately discontinued); may increase pulse rate and blood pressure, prolong the QT interval, and cause hypokalemia (must be used with caution in patients with cardiovascular disorders); may increase the possibility of exacerbations of seizure disorders, thyrotoxicosis, and diabetes; formulation contains lactose and a small amount of milk proteins (patients with severe milk protein allergy may be at risk of an allergic response); should not be used concurrently with another long-acting beta2-agonist and must be used with caution in patients who are being treated with another adrenergic agent; concurrent use with a beta-blocker (e.g., propranolol) may reduce the effects of both drugs; hypokalemic effect may be increased by use of xanthine derivatives, corticosteroids, and certain diuretics (thiazides, loop); concurrent use of an antiarrhythmic agent, tricyclic antidepressant, or monoamine oxidase inhibitor may increase risk of ventricular arrhythmia.

Most common adverse events:

Cough (7%), nasopharyngitis (5%), headache (5%), nausea (2%).

Usual dosage:

75 mcg once a day via oral inhalation; patients who have been using a short-acting beta2-agonist (e.g., albuterol) on a regular basis (e.g., four times a day) should be instructed to discontinue the regular use of this medication and use it only for the symptomatic relief of acute respiratory symptoms.

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of drug therapy and to markedly reduce the occurrence of drug-related problems. However, the extent to which we are presently attaining these outcomes is very limited. The depth of the pharmacist's expertise and the potential benefits of our consultation and recommendations are invisible to most. We have not been effective in demonstrating and communicating beyond our profession the value of our services.

In 2004 the national pharmacy practitioner organizations developed the following vision statement:

> "Pharmacists will be the health-care professionals responsible for providing patient care that ensures optimal medication therapy outcomes."

This is a bold and progressive vision and a goal was established for this vision to be implemented by 2015. (Please also see my editorial, "Pharmacy's Vision for 2015 OR a Large Surplus of Pharmacists?" in the June 2011 issue of *The Pharmacist Activist*, www.pharmacistactivist.com).

Notwithstanding the very commendable accomplishments of a relatively small number of pharmacists in implementing medication therapy management and other professional practice initiatives, our profession will not attain the vision by 2015, and some are skeptical as to whether pharmacy will attain the vision at any time. However, the need for "pharmaceutical consultation" as requested by the woman at my meeting is so important for our patients and society, as well as for our profession, that we must not hold back in committing the time, effort, and resources needed to make this vision a reality at the earliest possible time.

> We must start by caring more for our patients.
>
> We must reject the "sign here" mentality and actually provide the information and counseling we say are of great value.
>
> We must volunteer our time and services beyond the extent for which we are being paid.
>
> We must document the results/benefits of our consultation and interventions.
>
> We must hold ourselves and our professional organizations more accountable.

Daniel A. Hussar

New Drug Review (cont.)

Product:

Capsules – 75 mcg; patients should be informed that the capsules must not be swallowed and should be used only with the Neohaler inhaler supplied with the capsules.

Comments:

Indacaterol joins salmeterol, formoterol, and arformoterol in the class of long-acting, beta2-adrenergic receptor agonist (LABA) bronchodilators that are administered by oral inhalation. Its active component is the R enantiomer and it is administered once a day, whereas the other LABA are administered twice a day. In clinical studies it showed significantly greater 24-hour post-dose trough forced expiratory volume in one second (FEV1) compared to placebo, and patients treated with the drug used less rescue albuterol. When used in the recommended dosage of 75 mcg once a day, it has not been directly compared with other LABA, and there are no data that indicate that it is more effective or safer.

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