Current and Future Medical, Dental, & Nursing Professional Regulatory Strategies to Reduce Prescription Drug Abuse in Canada

A Report prepared by Dr. Dennis Kendel for Health Canada

May 2015

Preamble

The Working Group on Prescription Drug Abuse was established in 2013 by F/P/T Ministers of Health to spearhead efforts to address the growing problem of prescription drug abuse in Canada. This report was commissioned by the Working Group to inform these efforts, in particular to develop and implement strategies to improve prescribing practices. The report is built upon input provided by all P/T regulatory authorities for physicians, dentists and nurses.

This report is one of a number of important products commissioned by the Working Group to advance this Ministerial priority. Others include: an inventory of prescriber education programs and a report on best practices in prescribing practices undertaken by the Canadian Agency for Drugs Technology and Health (CADTH). Beyond these documents, this work continues to be guided by the national strategy *First Do No Harm: Responding to Canada's Prescription Drug Crisis*, released in 2013 by the Canadian Centre on Substance Abuse, in collaboration with the National Advisory Council on Prescription Drug Misuse.

Alongside these key sources of information, advice and guidance, this report will inform the Working Group's engagement with regulatory authorities and

professional colleges for physicians, nurses, dentists and pharmacists. The goals of this engagement, set by Health Ministers in October of 2014, are to:

- identify and share best practices;
- establish standards of practice;
- strengthen monitoring and enforcement of standards of practice;
- encourage the establishment of prescription tracking databases; and,
- improve pre- and post-licensure training.

Understanding Prescription Drug Abuse

When used appropriately prescription drugs offer much value in the treatment of human disease. Even when used appropriately, all prescription drugs carry some risk of harm. A subset of these drugs carries special risk of harm because of their potential to cause drug dependency and/or addiction. Because of the special risk associated with this subset of drugs, their use has historically been subject to more rigorous regulation.

Across Canada, we are witnessing a very troublesome escalation in the incidence of harm associated with misuse and abuse of drugs that have a risk of addiction and/or death due to overdose. The historical strategies used to regulate the use of these drugs are proving to be inadequate. Our Federal/Provincial/Territorial governments have created a Working Group on Prescription Drug Abuse to explore new strategies for reducing the incidence of prescription drug abuse and harm associated with that abuse.

The Context for this Review

A great deal of excellent work has already been done by The National Advisory Council on Prescription Drug Abuse. The “First Do No Harm” report from the National Advisory Council offered fifty eight action recommendations to deal with Prescription Drug Abuse (PDA). Among those were recommendations to promote

appropriate prescribing of these drugs and identify effective, evidence-informed practices and policies to reduce the incidence of future harm from abuse of these drugs.

The search for effective future policies and practices will need to deal with the full spectrum of social factors which influence risk of chemical abuse including abuse of prescription drugs. The review I was commissioned by Health Canada to undertake is much more narrowly focused. I was commissioned to study the current policies, standards and guidelines of professional regulatory agencies for medicine, dentistry and nursing which are intended to prevent inappropriate prescribing of drugs with abuse risk and foster optimal prescribing of those drugs. I was also asked to identify leading professional regulatory policies and practices and offer suggestions for their pan-Canadian application.

Understanding Professional Regulation in Canada

In Canada, both the power and responsibility to regulate professionals is vested exclusively in provincial/territorial governments. Most P/T governments discharge this responsibility by establishing statutory regulatory authorities governed by Boards populated with a mix of the professionals being regulated and public members. While most such Regulatory Authorities (RAs) operate with considerable autonomy, they are ultimately accountable to the governments that created them. Most P/T governments retain the power to approve bylaws and regulations adopted by RAs before they go into effect. RA policy making is generally more autonomous from P/T governments.

While the Federal government has no power to directly regulate professionals it may promulgate Federal legislation with which professionals are obligated to comply. The Controlled Drugs and Substances Act is a prime example of such Federal legislation and is very relevant to the issue of Prescription Drug Abuse.

Most professions in Canada have created a national agency through which the P/T RAs share information and collaborate in their pursuit of shared goals. Such

national agencies function on a federation governance model which allows them to foster uniform pan-Canadian policies and standards through consensus. They have no power to impose the will of a majority of RAs on any individual P/T RA.

In some professions, P/T RAs will often adopt, endorse and/or promote polices or guidelines developed by national professional organizations. In medicine, an example might be the adoption or endorsement of a clinical practice guideline developed by a specific national medical specialist society.

In most provinces and territories, P/T governments apply a common legislative template to the regulatory statutes for all health sector professionals. In a few P/Ts this is not the case.

While heath sector professional regulation still occurs in distinct professional silos, the RAs in most jurisdictions have mechanisms for inter-disciplinary collaboration and some P/T governments explicitly mandate such collaboration.

Transformative Change in Regulation of Health Professionals

Historically the legislation and bylaws enacted by P/T governments to create RAs are framed is such a way that anticipates most professional regulation will be reactive rather than proactive. It defines how the RA will receive and investigate complaints against individual members of the profession. It defines the processes for conducting discipline hearings and sets out the penalties that may be imposed upon members found to have acted unprofessionally.

This historical regulatory model is incident-driven. There must be an incident of real or alleged patient harm to trigger a regulatory intervention by an RA.

The public certainly expects that RAs will sustain their capacity for incident-driven professional regulation. However, for some time now there has been growing societal expectations that RAs will proactively seek to reduce risk of patient harm from the actions or inaction of their members, not just react when it occurs. And, to their credit, most health sector RAs in Canada have risen to that challenge. An

ever increasing proportion of their organizational resources are now dedicated to mitigating future risk of patient harm as opposed to just reacting to patient harm.

In this transformation to a much more proactive vision for professional regulation, RAs are reaching out to work collaboratively with health authorities (HAs), hospitals, other professions, quality councils, and Ministries of Health. This new way of working has also required a rethink of the funding sources for RA activity which is more focused on quality improvement rather than traditional reactive regulation.

In some jurisdictions, Ministries of Health have recognized the tremendous value of harnessing the expertise vested in RAs to operate harm reduction and/or quality improvement programs and strategies that no other agencies are well-positioned to operate. Methadone programs and prescription review programs are two classic examples where Ministry financial support has yielded impressive returns in respect to reduced downstream healthcare costs.

The transformation of professional regulation to include a balance of continuous quality improvement (CQI) and traditional reactive regulatory activity is uneven across the country. One of the opportunities inherent in this review is an exploration of mechanisms for making more proactive professional regulation a pan-Canadian norm.

The Origin of Systemic Approaches to Reducing PDA

Until the mid-1980s all RAs in Canada relied exclusively on incident-driven reactive responses to PDA. The Medical Regulatory Authorities (MRAs) recognized that some of their members were disproportionately fueling PDA through lax or outright inappropriate prescribing practices, but they were powerless to intervene until they were in receipt of a complaint or allegation that might warrant an investigation.

MRAs were becoming increasingly aware of persons “double-doctoring” to obtain narcotics to fuel their own addiction and/or divert to street sales. However, those

engaging in double-doctoring were not inclined to report lax prescribing physicians to the College of Physicians & Surgeons. And, well-intentioned doctors who were being “duped” had no capacity to check a patient’s history of narcotic prescriptions. Persons engaging in this activity were also careful to fill their prescriptions at different pharmacies to avoid arousing concern on the part of any pharmacist.

In the spring of 1986, the Registrars from both the Alberta and Saskatchewan Colleges of Physicians & Surgeons attended an annual meeting of the Federation of State Medical Boards (FSMB) in the US at which two State Boards reported their early experience with a program known as the Triplicate Prescription Program (TPP). This program required doctors to write all narcotic prescriptions on special tamper-proof pre-numbered triplicate copy prescription pads. The doctor kept one copy for his file and gave two copies to the patient. The pharmacy filling the prescription kept one copy and mailed the third copy (in weekly batches) to the State Medical Board (SMB). The SMB entered the data into a computer database.

The TPP SMB database allowed the SMBs to do two things. First, they could alert doctors of patients who were visiting multiple doctors to get narcotic prescriptions. Secondly, they could identify doctors who appeared to be prescribing these drugs inappropriately and intervene without having to wait for a complaint.

In the fall of 1986, the College of Physicians & Surgeons of Alberta (CPSA) launched a TPP and early in 1988 the College of Physicians & Surgeons of Saskatchewan (CPSS) followed suit. I was the Registrar of the CPSS at that time and can attest to how remarkably the TPP enhanced our capacity to modulate PDA.

Using information from an electronic database that we maintained, the CPSS started sending out “Alert Letters” to notify physicians of patients to whom they had prescribed narcotics and who had obtained narcotic from three or more other physicians. We also offered physicians the opportunity to phone the College

during daytime weekday hours to get information about a patient's narcotic prescription history if they suspected drug shopping behaviour by any patient.

We also began sending "Explain Letters" to doctors who showed evidence of potentially inappropriate prescribing. Most often the ongoing dialogue that ensued from those letters allowed us to modify the inappropriate prescribing habits of physicians. Where they proved unwilling or incapable of learning to prescribe these drugs appropriately, we took action to limit their prescribing privileges.

Implementation of the TPP also created the need and opportunity for very tangible, unprecedented collaboration between the RAs for Medicine, Dentistry and Pharmacy. It also crated the first opportunity for program cost-sharing between the CPSS and the MOH in Saskatchewan. From the outset, the funding of the TPP was shared between the MOH and the RAs in Medicine, Dentistry and Pharmacy. Its successor, the current Prescription Review Program (PRP) remains cost-shared between these four agencies so it has proven to be a durable opportunity for multi-agency partnership.

The MRAs in many, though not all, other P/Ts went on to create TPP's. Although most of these programs have evolved significantly since the 1980s they remain a powerful example of how innovative policies and practices can be spread and applied across national and P/T boundaries.

Building on the Foundation of TPP's

While the TPPs remarkably enhanced the capacity of RAs to modulate the incidence of PDA, these programs, as initially configured, had some clear limitations:

- There was a lag time of several weeks between the filling of prescriptions and data entry into the TPP database
- Because data entry was done manually, it was labour-intensive and costly

- Physicians could only access data from the databank during daytime week-day hours
- The special TPP prescription pads were prone to be stolen and used fraudulently by persons deeply engaged in drug diversion
- Physicians were reluctant to carry their TPP pads so there was often a problem for patients to get a needed narcotic prescription at the time of discharge from hospital
- The TPP made it difficult for medical students and residents to prescribe narcotics if they were not in the immediate presence of a supervising physician with a TPP pad
- The software supporting early TPPs offered very limited data analytical capacity

Beginning in BC and followed soon by Saskatchewan, some provincial Ministries have created prescribing data capture capacity at the moment that every prescription is filled and have given RAs access to this real-time data. In those jurisdictions, the need for using triplicate prescriptions has been eliminated.

Some P/T Ministries now also allow professionals prescribing and dispensing risk-prone drugs 24/7 on-line access to the prescription history of any patient they are attending.

The databases of current PRPs in most P/Ts now extend beyond opioids to capture other psychoactive drugs with potential for dependency and/or abuse.

The software supporting current PRPs allows for much more sophisticated analysis of the data which improves capacity of RAs to modulate PDA.

Defining & Assuring Appropriate Prescribing of High Risk Drugs

When RAs acquire advanced capacity to monitor the prescribing practices of their members, they need always to remain mindful that prescribing occurs in the

context of caring for individual patients with individual needs. Therefore, the raw data from prescribing databases always must be interpreted in the context of the patients being attended by each clinician. When RAs ask clinicians to explain their rationale for prescribing to specific patients, this affords an opportunity for the RA to assess prescribing appropriateness in the context of well-established national guidelines such as The Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.

When flags of concern are raised about any prescribing pattern, RAs must also consider the willingness of clinicians to consistently use clinical decision support tools such as the "Opioid Manager" which was designed to be used in conjunction with the Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. Clinicians who voluntarily use such decision support tools are much less likely to prescribe inappropriately. Clinicians who reject all such support tools as an unreasonable infringement on their professional autonomy are likely to be at higher risk of prescribing inappropriately.

RAs need to strike a balance between guiding their members and constraining their discretion when they exhibit lack of insight with respect to the risk of harm associated with their prescribing practices. While respecting the need for clinicians to exercise professional judgement in their care of individual patients, RAs must always err on the side of patient and public safety as opposed to clinician autonomy. Like all other aspects of professional practice, prescribing is a privilege, not a right. When guidance fails to modify unsafe prescribing practices, RAs must not shirk their responsibility to impose controls or limitations on the prescribing privileges of a clinician.

Understanding RA Standards, Policies & Guidelines

It is important to understand the terms standards, policies and guidelines as used in the context of professional regulation.

Through adoption of explicit standards, RAs define the levels of conduct and performance required of their members at all times. Compliance with standards is required of all licenced professionals and failure to comply may place a professional at risk of formal competency assessment and/or being charged with unprofessional conduct. Such interventions by an RA may culminate in sanctions, including potential revocation of licensure.

Guidelines do not carry the same weight as standards. As the name implies, they are intended to provide guidance to professionals. For the sake of the patients they serve and for their own sake, healthcare professionals are well advised to accept and apply guidelines explicitly adopted or endorsed by their RA. Persistent and willful non-adherence to an RA-endorsed guideline will very likely trigger some RA intervention, though that intervention is more likely to be educational in nature as opposed to punitive.

The term “policy” has somewhat variable usage among RAs. Policies that are embedded in RA bylaws or regulations carry the same weight as standards. Policies not embedded in bylaws or regulations carry less weight than standards but certainly more weight than guidelines.

Sometimes RAs adopt, in whole or in part, statements developed by other organizations. A good example is the Canadian Medical Association (CMA) Code of Ethics which, in whole or in part, is adopted by most MRAs in Canada, excluding the MRA in Quebec. The CMA is not a regulatory agency so it perceives its Code as a guide to ethical physician conduct. Once adopted by an MRA and embedded in bylaws or regulations, the same Code takes on more gravity than a guideline.

Assuring Entry-to-Practice Competencies Related to Prescribing PDA-prone Drugs

Since prescriptive authority is restricted to a subset of nurses, developing competencies related to prescribing is not an integral part of the entry-to-practice education for all nurses. It is an integral part of educational programs for Nurse

Practitioners (NPs). In the wake of expansion of NP prescriptive authority to include controlled drugs, some nursing RAs have established well defined educational programs for NPs seeking authority to prescribe these drugs. British Columbia and Ontario are the two remaining jurisdictions yet to enact authority for NPs to prescribe controlled drugs and substances. Several nursing regulators have approved one or all of three Controlled Drugs and Substances theory courses for NPs as requirements for CDS prescribing. RAs approve or adopt either stand-alone courses (such as those currently in use from Athabasca University, COUPN in Ontario or Saskatchewan Polytechnic) or approve university programs when and if they choose to integrate the content into their NP curriculum.

Prescriptive authority for the prescribing of controlled drugs is inherent in the professional licensure of all dentists and physicians. Since dentists are eligible for licensure upon acquisition of their professional degree, all pre-licensure education related to prescribing controlled drugs is embedded in the undergraduate degree programs in dentistry.

The entry-to-practice educational pathway for physicians is more protracted and complex as physicians are not eligible to be licenced for independent practice upon completion of an undergraduate medical degree. They must complete a two year residency in family medicine accredited by the College of Family Physicians of Canada (CFPC) or a four to six year residency in any of seventy-two other disciplines accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC).

During their residency training, physicians practice medicine under the supervision of designated fully-licenced physicians. They are authorized to prescribe medications during this phase of their training under supervision of their faculty. While the fundamental cognitive medical knowledge of controlled drugs is acquired during undergraduate education, the competencies essential to safe and appropriate prescribing of these drugs are really established during residency.

Because physicians are the dominant prescribers of controlled drugs, I expended some effort to critically assess how effectively competencies for prescribing controlled drugs are acquired and evaluated during residency programs leading to medical licensure.

All medical residency programs in Canada must be accredited by either the CFPC or the RCPSC. These programs must have rigorous in-training evaluation for all residents so that deficiencies in requisite competencies can be identified and remedied before a resident is promoted from one year of the program to the next year. The RCPSC is in the early stages of implementing a transformative change in its residency standards so that residents may master competencies at a different pace rather than having every resident complete a program of fixed duration. The new RCPSC program is called “Competency by Design”.

To be eligible for licensure, physicians in Canadian residency programs must satisfactorily complete the residency, be recommended to sit the certification examinations offered by the CFPC or RCPSC and pass those examinations.

Applicants for medical licensure in Canada must also acquire the Licentiate of The Medical Council of Canada (LMCC) by successfully completing both parts of the Qualifying Examinations offered by the Medical Council of Canada (MCC). The first exam (MCCQE Part 1) is a computer-based examination taken at the end of medical school and before commencing residency training. The second exam (MCCQE Part 2) is an Objective Structured Clinical Examination (OSCE) that cannot be taken until a physician completes one year of a residency program.

International Medical Graduates (IMGs) must also complete an MCC screening examination of medical knowledge known as the Medical Council of Canada Evaluating Exam (MCCEE) before being able to take the MCCQE Part 1. Successful completion of the MCCEE is also a prerequisite for IMGs seeking admission to a residency program in Canada.

I obtained and reviewed information from both the CFPC and the RCPSC about residency educational objectives related to prescribing controlled drugs and also exam question content relevant to this issue on their certification examinations. I

also obtained and reviewed information from the MCC about its examination blueprint relevant to prescribing controlled drugs on each examination.

From my review of the information obtained from the CFPC, RCPSC, and MCC, I have a high level of confidence that physicians entering practice in Canada through the Canadian medical education system have the requisite competencies to safely and appropriately prescribe controlled drugs.

I am considerably less confident that all IMGs who enter practice in Canada with no residency training in Canada have comparable competencies relating to appropriate prescribing of controlled drugs. Successful completion of the MCCEE alone does not assure such competence. With the aid of the MCC's expertise, the National Assessment Collaboration (NAC) developed the NAC OSCE which is a performance-based test for assessing IMG skills. The NAC OSCE is used by some, but not all, MRAs to evaluate the practice readiness of IMG's prior to licensure.

Because prescription drug availability and usage varies considerably between nations around the world, many IMGs enter practice in Canada with inadequate opportunities to learn about appropriate prescribing practices in Canada. In some provinces, IMGs do spend several months in community-based clinical evaluation and/or mentorship programs. However such arrangements are not universally in place in all jurisdictions.

From my interactions with the MCC I learned that the MCC is studying the feasibility of collaborating with the NAC to develop a new Therapeutics Examination for IMGs. That would be a very welcome tool for more rigorously assessing the knowledge and skills of IMGs relevant to appropriate prescribing of PDA-prone drugs.

I have forwarded to Health Canada all of the information I obtained from the CFPC, RCPSC and MCC and I anticipate this information will be accessible from Health Canada.

In dentistry there is a high percentage of internationally trained practitioners in Canada (e.g., 43% of new members of the Royal College of Dental Surgeons Ontario are internationally trained). Dental regulators are unable to assess the

educational curricula of hundreds of non-accredited schools across the globe so their approach is to allow anyone with a valid dental degree to apply for a competency assessment. Competency in prescribing is measured in the examination for foreign-trained applicants for registrations.

Maintaining Career-long Professional Competency

Although a health professional may be competent at the time of initial licensure, competence may not be sustained if professionals do not stay abreast of new knowledge and technologies and apply skills on a regular basis.

It has become a standard policy for RAs in the health sector across Canada to require their members to participate in ongoing professional learning as a condition of licence renewal. There is an increasing expectation that all healthcare professionals will develop and follow continuing education plans based upon some objective assessment of their learning needs.

However, practitioners may lack insight and self-awareness with respect to deficiencies in their knowledge and/or skills. In the absence of credible feedback about performance deficiencies, such as inappropriate prescribing, practitioners may not engage in Continuing Professional Development activities tailored to competency deficiencies. That is why evidence-based feedback to practitioners from RAs about their prescribing practices is vitally important.

Where RAs have any concern about the prescribing practices of a member, they should not hesitate to be assertive in recommending that such members participate in specific programs focused on the prescribing of high risk drugs.

RAs do not have statutory power to compel a member to undertake specific remedial education unless they make a determination of incompetence or unprofessional conduct through a formal competency investigation or discipline hearing process. Those are complex, arduous and expensive processes. However, RAs must be prepared to invoke these processes when faced with evidence of unsafe prescribing and unwillingness of a member to voluntarily undertake remedial education or surrender prescribing privileges.

In the face of prescribing data indicative of unsafe prescribing practices, most practitioners will voluntarily agree to undertake RA-stipulated education as an alternative to going down the "hard road" of a formal competency investigation or discipline hearing.

There is now a vast array of educational opportunities open to clinicians wanting to refresh their knowledge and skills related to pain management and appropriate prescribing.

Not All Inappropriate Prescribing is Attributable to Inadequate Practitioner Knowledge or Skills

For any professional act or service performed by a health professional there is a well-defined set of knowledge and skills which are essential to competent performance of that act or service. Competence speaks to the capacity to perform at an acceptable standard. However there often is a gap between the capacity of a professional to perform acceptably and that individual's actual observed or measured performance. When such gaps are identified, it is critical that RAs determine the root cause(s) of the competency-performance gap so that appropriate interventions are taken to remedy sub-standard performance which is not attributable to inadequate knowledge or skills.

Some of the root causes of sub-standard professional performance not related to knowledge and skill include:

- Physical and/or mental illness, including chemical dependency/addiction
- Sleep Deprivation
- Excessive workload
- Distraction from the task at hand
- Perverse incentives
- Perverted self-interest
- Wrongful motivation
- Exploitation of patients/clients

RAs need to always remain mindful that the goal of professional regulation is to assure safe high-quality patient care. If a member is not delivering safe high-quality patient care, it is the duty of an RA to ascertain why that may be the case and promptly mitigate risk of ongoing harm to patients.

In many instances, the most productive step in search of a root cause for a professional's sub-standard performance is a thorough independent assessment of the health of the practitioner.

Hearing the Perspective of Clinicians

I was unable to locate any data from recent surveys of the dental and nursing professions on the issue of prescription drug abuse. I did locate data from a CMA survey of physicians conducted in April, 2014.

The CMA sent a survey to 2803 physicians on a volunteer e-Panel and received responses from 624 in active practice (22% response rate). Of those who responded, 83% said they prescribe opioids and half of those said they were asked for opioids by patients 10 or more times annually.

This cohort of physicians identified real-time prescription monitoring as the most important step that can be taken to help control opioid prescription abuse in Canada. They also identified Continuing Medical Education on appropriate prescribing and more specialized pain treatment facilities as other important strategies for addressing the issue of PDA.

Insights Gained from Review of RA Standards, Policies, Guidelines and Programs related to PDA

In anticipation of a conference call meeting with all Medical, Dental, & Nursing RAs on September 2, 2014 I was asked to provide an interim synthesis of my review findings to Health Canada by August 29, 2014.

I reviewed all of the RA submissions received by August 28th through Health Canada. Where I felt more detailed information might be helpful, I sought supplementary information from some RAs through searches of their websites, email communications and phone conversations with key staff.

I found universal commitment among all the responding RAs to do whatever they reasonably can to foster appropriate prescribing of risk-prone drugs by their respective members.

All of the responding RAs identified some standards, polices and/or guidelines that have relevance to PDA. These documents varied considerably in their granularity and specificity.

Some of the documents were Codes of Ethics that articulate the precept of "Do no harm". At the other extreme, some documents focused very sharply on the issue of prescribing PDA-prone drugs. As an example of the latter, the College of Physicians & Surgeons of Nova Scotia has a policy dealing explicitly with "Review of Monitored Drug History Before Prescribing".

I found a universally high commitment among the responding RAs to use their traditional statutory regulatory powers to deal effectively with members who are found to be prescribing unsafely.

I found significant variation in the scope and intensity of PDA related programming operated or supported by RAs in the three professions simply because of the differential engagement of nurses, dentists and physicians in prescribing risk-prone drugs.

I found a strong interest from the RAs in the three professions to learn from one another across professional boundaries and to collaborate with one another in shared efforts to reduce PDA.

I will now share some observations about common themes that emerged in the feedback from each of the three professions

Nursing

Across Canada, nursing regulatory authorities (NRAs) s are all deeply engaged in "gearing up" for regulation of nursing prescriptive authority for narcotics and other controlled substances. For example, the Canadian Council of Registered Nurse Regulators (CCRNR) has established a working group to focus on controlled drugs and substances.

Authority to prescribe these drugs will not be automatically conferred on all nurses in the workforce. It would appear that all of responding NRAs will restrict theseprescribing authority to NPs. In Manitoba, for example, nurse practitioners have been authorized to prescribe controlled drugs and substances since May 2013, provided they fulfill the requirements set out by the College of Registered Nurses of Manitoba. These requirements include successful completion of a course of instruction approved by the College, successful completion of a review of the Manitoba Prescribing Practices Program (M3P) provided by the College of Pharmacists of Manitoba, as well as a subsequent multiple choice test on the M3P. NP prescriptive authority for controlled substances in Ontario and British Columbia will have to await changes in legislation.

Regulatory preparation for this new role involves the adoption of bylaws to authorize designated nurses to prescribe controlled substances and policies defining educational prerequisites for nurses to meet the eligibility requirements. NRAs are also in dialogue with MRAs in their respective provinces and territories to become partners in Prescription Review Programs operated by provincial governments or MRAs.

In those provinces where physicians and dentists have online access to patient prescribing histories to assist them in dealing with drug-seeking patients, nursing RAs are in dialogue with governments and/or MRAs to ensure that their members get the same information access. In some RAs, specifically Nova Scotia and Saskatchewan, this has already been established and is operating well.

There is sensitivity for some in the nursing RA community to the challenges of NPs sustaining competency in the use of narcotic and controlled drugs as some NPs may prescribe these drugs very infrequently in their practices; however, NPs are

responsible to ensure they attain and maintain the requisite knowledge and skills if they are to continue to prescribe controlled drugs and substances, which is the same for any intervention they provide.

Most NRAs maintain collegial advisory support services to practicing nurses. As NPs commence exercising their newly acquired authority to prescribe controlled substances, the NRAs recognize that they are likely to get an increase in calls from these nurses for practice advice and guidance. This will require the NRAs to ensure they have nursing practice advisors on staff with appropriate expertise to provide guidance in prescribing these drugs.

Overall I was very impressed with the very high level of "due diligence" being exhibited by all of the NRAs to foster and sustain high practice standards among their members who acquire authorityto prescribe controlled drugs. They have been universally rigorous in considering the risks associated with this expanded scope of practice for a subset of their members and are implementing very appropriate standards, policies and guidelines to mitigate those risks.

Dentistry

The risk of PDA arising from dental prescribing of controlled drugs is low to moderate since most dentists prescribe these medications sparingly for management of short term pain.

Nevertheless the dental regulatory authorities (DRAs) responding to this review have a strong commitment to controlling the risk of PDA associated with the prescribing practices of their members. Their traditional regulatory mechanisms for dealing with evidence of inappropriate dentist prescribing are very similar to those used by MRAs. Also, in those jurisdictions in which MRAs operate TPPs or PRPs, the DRAs function as partners in those programs.

A number of dentists deal more extensively in their practices with very complex dental conditions for which longer-term pain management may be necessary. The

DRAs are very cognisant of the higher risks of PDA associated with dentist prescribing in these practices and more closely monitor those practitioners.

Where there is provincial legislation applicable to dentists, such as the Narcotics Safety and Awareness Act in Ontario, DRAs do require their members to fully comply with such legislation.

Medicine

Of the three professions subject to this review, medical practice is associated with the highest risk for PDA. To a large degree, this is attributable to the fact that physicians are engaged in treating the full spectrum of human disease. The burden of disease treated by physicians has shifted significantly from acute to chronic disease and pain is associated with many chronic illnesses.

With the addition of new drugs and new delivery formats for old drugs used to treat pain, the options for effective pharmacologic pain management have increased. Societal attitudes toward pain have also changed. Whereas pain was formerly perceived as an inescapable facet of some illnesses, more patents now expect to have all pain pharmacologically controlled.

Physician prescriptive authority has historically been open-ended, particularly in private community-based medical practices. And the act of prescribing medications has historically been much less rigorously regulated as compared with other medical acts like performing surgery.

One of the most fundamental tenets of effective professional regulation is that the rigor of regulation ought to be proportional to the comparative risk of harm associated with any professional activity. We have historically underestimated the risk of harm associated with many prescription drugs even when they are used appropriately. When drugs are prescribed inappropriately or used by people other than those for whom they were prescribed, the risk of harm rises exponentially.

All of this would suggest that MRAs have a very high level of obligation to regulate physician prescribing of abuse-prone drugs very rigorously. As I assessed the rigor of MRA regulation of physician prescribing of abuse-prone drugs across Canada, I found that rigor to be disappointedly uneven.

There is no doubt that all of the MRAs across Canada have the statutory authority and power to apply incident-driven regulatory interventions when faced with evidence of egregiously inappropriate or unsafe physician prescribing practices. Although I was not commissioned to objectively evaluate how all of the MRAs actually use their traditional reactive regulatory tools to deal with unsafe physician prescribing practices, I have no reason to doubt their commitment to using these traditional regulatory powers when warranted.

What most concerned me about the unevenness of MRA strategies for mitigating risk of public harm associated with PDA were these two facts:

- Some MRAs still have developed no capacity to actively monitor the prescribing practices of their members when the capacity to do so was developed by other MRAs in the 1980s, and
- Some MRAs have not developed any proactive strategies or programs with potential to prevent PDA as opposed to just responding to incidents that come to their attention.

This is a realm of professional regulation in which technology has empowered MRAs, acting in collaboration with their respective Ministries of Health, to readily collect prescribing data when prescriptions are filled and use that data proactively to reduce future risk of harm. The failure of some MRAs to seize such opportunities to enhance their public protection capacity is troubling.

The good news from this review is that there is ample room for improvement in our capacity to curtail PDA by spreading across Canada leading practices developed by some RAs in collaboration with their governments and other health professions.

In the next section of this report, I will identify leading and promising practices that I perceive worthy of pan-Canadian application.

Leading & Promising RA Strategies to Reduce PDA

Any RA that aspires to reduce the risk of harm associated with the professional activities of its members ought to consider and use all of the possible levers for risk mitigation. In respect to mitigating risk of harm from PDA, the first goal of an RA ought to be that of optimizing the prescribing practices of its members.

Assuming that the overwhelming majority of its members are highly motivated professionals who want to prescribe these risk-prone drugs appropriately, RAs need to do all they can to assist their members in achieving that goal.

(1) Awareness Raising Strategies

Some prescribers may lack full awareness of the incidence and magnitude of harm associated with PDA. Lack of such awareness may cause them to be less than optimally attentive to how their prescribing practices may be contributing to this burden of harm. RAs can and should counter this lack of awareness through regular communication with their members that sensitizes them to the scope of the problem and prompts them to reflect on their capacity to reduce the burden of harm.

Almost all of the RAs that participated in this review are doing something to raise awareness among their members of the risk of inappropriate prescribing contributing to PDA. The most common awareness-raising strategies include articles in their Newsletters and information posted on their websites. I considered some of the awareness-raising strategies employed by some RAs worthy of special mention.

The College of Physicians & Surgeons of Alberta (CPSA) has produced a TPP Prescribing Atlas which visually demonstrates regional differences in the use of risk-prone medications across Alberta. Disseminating information in such a visual format has been shown to trigger reflective thinking and possible practice

changes among physicians when they perceive their practices to be highly variant from those of colleagues in other regions.

Dr. Jack Wennberg at Dartmouth Medical School was one of the first to use Atlas formats to powerfully demonstrate the high degree of variation in surgical rates for common conditions on an age-sex standardized basis across the US. This form of small area variation analysis has proven to be a very effective tool for stimulating deeper inquiry and research into the causes for such variation. Once causation for inappropriate variation can be identified, this is the first step toward quality improvement.

The College of Physicians & Surgeons of Nova Scotia (CPSNS) sends a letter each year to the 100 physicians in that province who are the highest prescribers of narcotics. In clear graphic format, the information package which accompanies this letter demonstrates trends in prescribing of these drugs over a three year period. It provides to the physician, a copy of his/her prescribing profile along with guidance in the interpretation of the profile. It also provides information about Best-Practices for Limiting Misuse/Abuse & Diversion of these drugs, educational opportunities and relevant research references.

The Royal College of Dental Surgeons of Ontario is in the final stages of developing a guideline on “The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice” and plans to aggressively promote this guideline to its members. It has also produced webinars on the use of opioids in dentistry.

(2) Online Practitioner Access to Patient Prescription Histories

To assist and support physicians, dentists and nurse practitioners in making well-informed decisions to prescribe PDA-prone drugs, it is critically important that all authorized prescribers have online access to current and comprehensive information about a patient’s prescription history for these drugs at the time they are attending that patient.

Such information access is assured to all prescribers, as well as all pharmacists, in several provinces. It would appear to me that the best arrangements for assuring such information access are through the Pharmaceutical Information Program (PIP) in Saskatchewan, PharmaNet in British Columbia and The Nova Scotia Prescription Monitoring Program (NSPMP).

The power to make such information readily accessible to practitioners generally rests with P/T governments, but RAs can play an important leadership role by lobbying their respective governments to create and sustain such information access options. RAs can also work with their respective P/T governments to ensure that such online information access is offered through approved EMR/EHR systems.

The Nova Scotia model is unique in the sense that the Nova Scotia Prescription Monitoring Program (NSPMP) is operated directly by the government of Nova Scotia.

Once practitioner access to such information is in place, RAs can and should strongly encourage their members to access this information as a routine part of their interaction with all patients, but particularly for patients who exhibit drug seeking behaviours. For prescribers who show evidence of inappropriate prescribing, RAs can and should make mandatory consultation with such prescribing histories a condition of their retaining prescribing privileges for PDA-prone drugs.

Pharmacists also should have access to and use this information when dispensing these drugs as they have the capacity to detect multiple doctoring as well as unsafe or inappropriate prescribing practices of individual prescribers.

(3) RA Access to a Searchable Electronic Prescribing Database for all their Members

If RAs are to have any hope of moving beyond reactive incident-driven strategies for dealing with PDA**,** they must have access to comprehensive and current information about their members' prescribing practices.

Some RAs established and continue to sustain such databases themselves through very labour-intensive TPPs that have very significant lag time between dispensing of medications and data entry into the database. Manual data collection and entry makes such programs costly and the data entry lag time impairs the capacity of RAs to asses in a timely way the impact of their interventions with members who have exhibited inappropriate prescribing practices. This delay may expose many hundreds of patients to continuing risk of harm.

The optimal mechanism for assuring that RAs have access to data that enables them to readily evaluate the prescribing practices of their members is one in which P/T governments implement policies and programs to electronically capture the requisite data at the moment each prescription is filled and immediately deposit the data in a database accessible to, and/or controlled by, an RA.

So long as all the RAs that regulate prescribers (and, ideally, dispensers) have unfettered access to complete data for all PDA-prone drugs, it likely does not matter where the database is housed and who controls it. In the BC model, the Ministry of Health controls the database through PharmaNet and makes the data accessible to RAs. In the Saskatchewan model the Ministry of Health maintains the PIP database for all drugs but segregates out the data for PDA-prone drugs in a separate database (DUR) that is controlled by the CPSS. The RAs for dentistry and Pharmacy have access to the DUR through the CPSS and the SRNA will have similar access in the future.

Patients can request that practitioner access to their prescription history in the PIP database can be blocked but they cannot block RA access to their prescription history in the DUR database. This policy thwarts any effort by persons engaged in drug acquisition and diversion from having their activity shielded from RA review.

(4) RA Capacity for & Commitment to Effective Data Mining & Application to Reduce PDA

RA access to prescribing data for all of their members has no value unless an RA ensures that it has adequate staff with appropriate expertise to mine that data and apply findings through strategies with potential to mitigate PDA risk.

In respect to all of the RAs that have access to member-specific prescribing data, I was uniformly impressed with their data mining and analytical capacity. There is some variation however in the criteria they use for identifying "flags of concern" about the prescribing practices of individual members. Below is a listing of various indictors of concern that RAs search for in their mining of their prescribing databases:

- 3 or more different prescribers in a month
- Pattern of early prescription refills
- Long-term use of immediate release opioids only
- Prescribing large amounts of medication in small milligram dosages
- Chronic use of Meperidine, Pentazocine and/or large doses of Acetaminophen/Codeine preparations
- Concurrent use of opioids and benzodiazepines
- Prescribing opioids and/or benzodiazepines to patients on Methadone
- Tendency to prescribe the same drug to most patients (i.e. Dilaudid)
- Long term prescribing of very high total morphine equivalents

In the information presented to me, I saw evidence of RAs mining their prescribing databases from both a patient perspective and a practitioner perspective. I also saw evidence of RAs doing special studies that focused more intensely on prescribing patterns in specific regions of their province and/or among selected medical disciplines or groups of practitioners. These special studies were often designed to gain a better understanding of why prescribing patterns may vary between geographic regions or between groups of practitioners.

The RAs that have access to members' prescribing databases and who mine those databases effectively apply their findings through a variety of different strategies. All of them use the data to provide evidence-based feedback and guidance to their membership through Newsletters, bulletins, meetings, mailings, and their websites.

All of them also use the data in rationally staged interventions with members who show evidence of suboptimal to outright unacceptable prescribing practices. They always commence their interaction with individual members with an open mind and intent of hearing a clinician's rationale for his/her prescribing. From that initial information exchange, the interaction between the RA and members may proceed within these options:

- Thank you for explaining the rationale for your prescribing and your explanation alleviates our concerns.
- Your explanations alleviate many of our concerns, but you could improve your prescribing by doing (X) and here is some information and supportive guidance to help you improve your performance. We'll continue to monitor your prescribing and hope to see changes based upon our recommendations to you.
- Your explanations do not alleviate our concerns and you will need to make fairly profound changes in your prescribing practices to sustain the privilege of prescribing these medications. We are recommending that you immediately make (X) changes, and that you enroll in (Y) educational activities. We will very closely monitor your prescribing over the next (time) and meet with you to again review changes in your prescribing practices. If your prescribing practices have not improved sufficiently to be fully compliant with our standards and policies, we will ask you to voluntarily surrender your prescribing privileges for (Z) drugs. If you decline to do so, we will be obligated to apply the formal investigational and hearing procedures which may result in involuntary curtailment of your prescribing privileges and/or other sanctions.
- Your explanations do not alleviate our concerns and we regard your prescribing practices to fall well below our expected standards. We are

asking you to immediately voluntarily surrender your prescribing privileges for (Z) drugs. If you decline to voluntarily surrender your prescribing privileges, we will take immediate steps to temporarily suspend your practice privileges and refer this matter to (____) for formal investigation and hearing.

Most of the RAs participating in this review reported that they very rarely have to invoke the fourth option identified above. Most practitioners highly value the privilege of prescribing these medications and will exert the effort necessary to ensure their prescribing practices are compliant with the standards defined by their RA. A few will permanently relinquish their prescribing privileges.

Some of the RAs that do not have access to member-specific prescribing data reported that they would exercise essentially the same four options for dealing with evidence of inappropriate prescribing derived from an allegation or incident-driven investigation. However, they noted that they would have to go through a formal investigation to determine if allegations were founded and/or if a critical incident was part of a more extensive pattern of inappropriate prescribing. Such investigations may take many months and during such protracted investigations patients would be exposed to continuing risk of harm.

(5) Harnessing the Power of Inter-Disciplinary Collaboration to Reduce PDA

Increasingly the task of delivering safe high-quality healthcare is becoming a team effort that involves many different health professionals. Effective teamwork and inter-disciplinary collaboration is also becoming more vital in our efforts to understand causation of healthcare-related harm and to address those causes of harm.

Historically, RAs for different health professions have operated in relative isolation from one another. The creation of TPP programs in the 1980s created the first opportunity for the RAs in medicine, dentistry and pharmacy to work together in true partnership to tackle the problem of PDA. The experience of inter-disciplinary RA partnership in the operation of TPPs over the past three

decades has created fertile ground for more inter-disciplinary collaboration on other issues.

There are also very obvious efficiency gains to be achieved through greater inter-disciplinary collaboration. I will address this in more detail under the heading of “Cost Sharing”.

Inter-disciplinary RA collaboration in tackling PDA is uneven across Canada and I perceive it to be most mature in **BC, Alberta, Saskatchewan, Manitoba, and Nova Scotia.** A pan-Canadian strategy for more effectively addressing PDA should aim for more robust inter-disciplinary RA collaboration nation-wide.

(6) Strengthening Inter-Jurisdictional RA Collaboration

To date, the most tangible evidence of inter-jurisdictional collaboration in tackling PDA has been in the development of educational programming to foster more optimal prescribing of PDA-prone drugs. The College of Physicians and Surgeons of Ontario was the first MRA to develop education workshops specifically focused on appropriate prescribing and it accommodated referrals of physicians from MRAs in other jurisdictions. The MRAs in BC, Alberta, Saskatchewan and Manitoba collaborated in the creation of education programming on prescribing of psychoactive drugs and this course migrates between the four western provinces. Some of the DRAs have also collaborated on the development of educational programming for dental prescribing.

Two Atlantic Canada provinces have collaborated in funding The Atlantic Mentorship Network on Pain & Addiction. This is a mentor-mentee network designed to assist practitioners in their management of persons with pain and addiction. It is funded by the governments of Nova Scotia and Newfoundland & Labrador and is hoping to expand to other provinces.

RAs in provinces that sustain RA-accessible prescription databases have also collaborated in efforts to facilitate cross-border sharing of prescribing information. This has been a challenge because patient-specific prescription

information is personal health information protected under Privacy Statutes in each of the P/Ts.

Patients are permitted to have prescriptions issued by a provider in one P/T filled at a pharmacy in another P/T. This has made it very challenging to monitor patient use of PDA-prone drugs in communities near P/T borders. Individuals intent on acquiring drugs for diversion are also very adept at exploiting this gap in monitoring.

P/T governments across Canada will need to find ways to support cross-border RA sharing of prescribing information so RAs can work more collaboratively across P/T borders.

(7) Cost-Sharing Proactive Systemic PDA Prevention Strategies

The "social contract" between most heath sector professions, their respective P/T governments and the public is that each profession will self-fund the cost of professional regulation in exchange for the sustained privilege of "professionally-led" regulation. In respect to very traditional models of professional regulation, that social contract remains logical. In almost all health sector professions, the cost of screening and processing registration applications, conducting complaint investigations, holding discipline hearings, and enforcing sanctions for proven unprofessional conduct are borne entirely by the profession through annual registration fees paid to an RA.

The notable exception to this principle is that regulatory costs associated with some "emerging professions" (like midwifery) are very substantially government-subsidized in some P/Ts because the small number of registrants makes self-funding untenable.

However, over the past three decades some P/T governments have entered into contractual relationships with RAs to offer services and manage programs that go well beyond the scope of traditional professional regulation. These services and programs have very tangible public benefits. The RAs are optimally positioned to

harness the expertise of their members in the provision of these services and/or operation of these programs. It is therefore a win-win proposition for governments to fund RAs to do such work.

Most of these arrangements exist between P/T governments and MRAs. Some examples of such contractual arrangements include the operation of Quality Assurance and Accreditation Programs in Medical Laboratories and both public and private Medical Diagnostic Imaging facilities. More relevant to the issue of PDA is the fact that most Methadone Programs in Canada are managed by MRAs but are totally funded by P/T governments.

In the course of my communications with RAs about this issue, I discovered that most MRAs that operate PRPs focused on PDA-prone drugs do receive some funding from their respective P/T governments to support those programs. However, the government funding does not support all program costs and it is uneven across the country.

One of the very sensitive issues with some MRAs is the uncertainty of sustained government funding for these programs when governments change and/or when governments experience a fiscal crisis.

If government financial support for PRPs is cut or fails to keep pace with the impact of inflation, MRAs have no option but to scale back the capacity of these programs. That creates huge “reputation risk” for MRAs as they are still perceived as being publicly accountable for PDA risk mitigation but are unable to do so effectively.

If one steps back to reflect on the ultimate source of funding for professional regulation, the reality is that these costs are all ultimately borne by the public. The linkage to the public purse varies somewhat between the three professions under consideration.

Most dental services are not publicly insured. Dental RA registration fees are a business cost that dentists recover through the fees they set for their services and charge directly to patients and/or to third party insurers.

Most physician services are publicly insured. Medical RA registration fees are a very explicit factor in physician compensation negotiations between provincial/territorial medical associations and their respective P/T governments.

Most nurses practice as employees of publicly funded healthcare institutions and services. Nursing RA registration fees can be a very explicit factor in contract negotiations between nursing unions and their respective P/T governments. There are clauses in many of the union contracts that require employers to deduct a pro-rated amount from each pay cheque and hold it in trust until the annual renewal cycle, at which time the funds are sent to the regulatory body on behalf of the RN/NP. In some instances, employers may pay registration/licensure fees as an incentive to get nurses to come work in remote/isolated areas or places where recruitment and retention have been a challenge but it is generally not the practice that these fees are paid directly from health authority budgets.

So, ultimately PDA risk prevention programs managed by any RA are often publicly funded; either directly through service contracts between P/T governments and RAs or indirectly through registration fees passed on to the public.

This is an "elephant in the room" issue that will have to be addressed candidly by P/T governments and their respective RAs if we are to have any hope of creating a pan-Canadian PDA –prevention strategy.

(8) The Unique Nova Scotia Model

Although the most common model for funding PRPs is through substantial government subsidization of programs operated by MRAs, the province of Nova Scotia elected to implement a unique model. The Nova Scotia Prescription Monitoring Program (NSPMP) is operated directly by the Government of Nova Scotia. Representatives of appropriate RAs sit on the NSPMP Board. The Board is currently chaired by the Registrar of the CPSNS.

The CPSNS is very strongly supportive of the NSPMP and works very collaboratively with the NSPMP. I am not aware of anyone having done independent analysis of the pros and cons of this model as opposed to that in other provinces that have PRPs.

(9) Evaluating the Impact & Effectiveness of PDA Prevention Strategies

From the information submitted by RAs to Health Canada and from my subsequent direct communications with RAs, I sense that most RAs are having difficulty evaluating the impact and effectiveness of their various strategies for reducing PDA. There are understandable reasons for their frustration.

Many of the factors contributing to PDA are outside the control of RAs so it's unreasonable to anticipate that their strategies could influence these factors. It is conceivable that tangible positive impacts of RA interventions could be eclipsed by the negative impact of factors outside their control. None of the participating RAs reported being part of any inter-sectorial alliance in their P/Ts through which all stakeholder agencies might integrate their PDA prevention strategies to achieve greater synergistic impacts and develop cross-sectorial impact-analysis capacity.

The most tangible impact metric for RAs is the extent to which the prescribing practices of their members comply with their published standards and guidelines or national/international guidelines. Because guidelines usually include multiple recommendations, it can very difficult to establish a single compliance metric. Consequently, RAs tend to focus on compliance with very specific recommendations in a guideline rather than more global compliance metrics.

In respect to such focal compliance metrics, some RAs report very impressive results. For example, CPSS reported a 46% drop in inappropriate prescribing of benzodiazepines to elderly patients in Saskatchewan after benzodiazepines were added to the list of monitored prescriptions and the CPSS assessed physician prescribing against the Beers criteria.

However, this focal impact can be analogous to squeezing a balloon. Clinicians who tend to be lax prescribers of PDA-prone drugs may curtail their prescribing of one drug and escalate their prescribing of another drug with comparable risk implications.

One major potential benefit of a more comprehensive pan-Canadian PDA prevention strategy might be the development of pan-Canadian criteria for evaluating the impact and effectiveness of different strategies.

(10) Taking a Deep-Dive Into One of the PRPs

A number of the MRAs that operate electronic PRPs shared with me information about their programs. There are some differences between these programs, but they all are committed to reducing prescription drug abuse through proactive, purposeful use of real-time prescribing data for PDA-prone drugs.

Since one of my key recommendations is that PRPs should exist in every province and territory in Canada, it may be valuable for jurisdictions that do not yet have such programs to better understand how such programs work. I will therefore offer a "deep-dive" view into one Canadian PRP.

I received the most detailed information about the Saskatchewan PRP (SPRP) so I have elected to feature this program. I have appended to this report, the SPRP Annual Report for 2013 and Business Plan for 2014 (Appendix 1). I will offer some contextual information about this program and some commentary on key information in the appended report.

The (SPRP) was founded in 1988 and underwent a major transformation in 2006 when real-time prescription data capturing was implemented and the panel of monitored drugs was expanded to include benzodiazepines.

From its inception, this PRP had been managed and operated by the College of Physicians and Surgeons of Saskatchewan (CPSS) in collaboration with the Ministry of Health (MOH) and the RAs for dentistry and pharmacy. In the wake of

NPs gaining prescriptive authority for controlled drugs, the RA for nursing is joining this collaborative program.

Throughout the history of this program, the MOH has been the primary funder of this program and has seen significant benefits from this investment. Reduction in inappropriate prescribing of controlled drugs through SPRP interventions reduces citizen harm and the societal costs associated with a higher incidence of PDA. The reduction in drug product costs borne by the Saskatchewan Prescription Drug Program through SPRP far exceeds the total MOH annual grant to the program. For 2014, the total program costs are just under $300,000 and the MOH provides $274,613 of this total.

The remainder of the program costs are borne by the RAs for medicine, dentistry and pharmacy with an expectation that the RA for nursing will also contribute in the future.

Pages 3-7 of Appendix 1 provide a detailed and very informative overview of current SPRP activities. At the bottom of page 3 appears an inventory of the key flags that prompt the SPRP to ask a physician to explain the rationale for his/her prescribing of SPRP-monitored drugs. In 2013, the SPRP sent 1205 “explain letters” to physicians. In almost all instances, these interactions do prompt positive changes in future prescribing practices by physicians.

The incidence of patients obtaining prescriptions for controlled drugs from three or more physicians remains a significant challenge in respect to safe and appropriate use of these drugs. In 2013, the SPRP sent out 6,983 letters to physicians alerting them to such multiple sources of prescriptions for patients to whom they had prescribed.

Pages 8-9 of Appendix 1 describe some of the goals for the SPRP in 2014. Those goals include increased collaboration with law enforcement agencies and with community-based agencies committed to stemming the incidence of harm arising from PDA.

Pages 10-16 of Appendix 1 disclose statistical data with respect to trends in use of PDA-prone drugs between 2006 and 2013. While it is difficult to reliably ascertain

the impact of the SPRP on these trends, it is reasonable to assume that it is making a positive difference.

Page 20 of Appendix 1 depicts the budget for the SPRP for the past five years. The SPRP operates with a team of three full-time staff and this team is led by a pharmacist. There are 2648 physicians on the active register of the CPSS. With an annual budget of $300,000, if one removes the $11,767 program support from the dentistry and pharmacy RAs, this translates into an annual expenditure of about $109 per doctor. There may be some economy-of-scale efficiency gains to be achieved in larger programs and/or through greater inter-jurisdiction collaboration.

The report in Appendix 1 also describes the commitment by SPRP staff to work collaboratively with other PRPs and with national agencies like the Canadian Centre on Substance Abuse. Such inter-jurisdictional collaboration is typical of all of the PRPs across Canada and augers well for the possibility of creating a more universal pan-Canadian PDA strategy.

Recommendations to the FPT Working Group

Although this review was limited to the roles of Professional Regulatory authorities for medicine, dentistry and nursing, I believe that pharmacists can and should play a critical role in mitigating PDA risk. I am therefore recommending that the regulatory authorities for pharmacists be included in any pan-Canadian strategies for preventing PDA.

1) Every province and territory in Canada should establish and maintain an electronic database that includes all prescriptions for PDA-prone drugs dispensed in that jurisdiction.
2) Prescription data for all PDA-prone drugs should be electronically captured in all pharmacies as prescriptions are filled and immediately entered into the monitoring database.
3) All practitioners who prescribe PDA-prone drugs and all pharmacists who fill prescriptions for these drugs should have 24/7 online access to the

prescription history of a patient before they write a prescription for a PDA-prone drug or fill such a prescription.

4) Professional regulatory authorities should make prior review of a patient's prescription history for these drugs a standard of practice prior to prescribing a PDA-prone drug and prior to filling a prescription for such a drug.
5) Professional regulatory authorities for all practitioners who prescribe PDA-prone drugs and dispense those drugs should have clear standards for prescribing and dispensing these drugs as well as evidence-based guidelines to support optimally appropriate prescribing and dispensing of these drugs
6) Professional regulatory authorities for all practitioners who prescribe or dispense PDA-prone drugs should have full and continuous access to the electronic prescription database for these drugs.
7) These professional regulatory authorities should be expected to regularly access the information in the provincial/territorial prescription database to assess the extent to which their members are compliant with their standards and guidelines for prescribing and dispensing PDA-prone drugs.
8) Where professional regulatory authorities detect inappropriate and/or unsafe prescribing or dispensing practices, they should intervene expeditiously with effective measures to remedy inappropriate or unsafe practices.
9) Where professional regulatory authorities operate proactive systematic programs to prevent PDA, provincial/territorial governments should fund those programs.
10) FPT governments should collaborate with professional regulatory authorities to establish metrics and analytic capacity to measure the impact and effectiveness of all strategies for preventing PDA and promote/support those strategies that are most effective.
11) The Medical Council of Canada and the National Assessment Collaboration should expedite their co-creation of a Therapeutics Examination for all IMG's seeking medical licensure in Canada.