BHIVA Standards of care online consultation comments

7 October 2012

Standard 4: Safe ARV prescribing: Effective Medicines Management

14 September 2012
Mia Huengsberg sent the following message:

"Proportion of patients prescribed first-line therapy that have not developed evidence of new drug resistance one year later (target: <2 %)"

I think you mean >98%?

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14 September 2012
Babs Evans sent the following message:

'There should be evidence of self-reported adherence at each clinician visit'. How is adherence defined - is it taking 100% of doses at same time each day, 100% of doses but not necessarily on time, 98% of doses etc etc? What is the critical level (where it starts to impact on viral load supression)? Does this take into account the fact that some regimens allow more flexibility than others?

'Any patient reporting missed medication or viral load rebound should receive adherence support'. Again what is the critical indicator for this? If a patient misses one dose each month but viral load remains supressed why would adeherence treatment support be necessary? What are the realistic expectations and when is intervention with adherence support actually necessary?

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18 September 2012
John Evans-Jones sent the following message:

Does every service need their own written adherence support policy ? Would a reference to a national policy (e.g. BHIVA treatment guidelines / BHIVA Adherence guidelines / MedFASH psychology) be sufficient ? We are too small to have our own policy for everything !

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19 September 2012
Graeme Calf sent the following message:

Can we be reassured that, if a medication comes along which is more efficatious and with fewer side-effects, we will automatically be transfered onto it? How is this modified by cost? Does the patient have to be proactive and ask for new drugs?

Also, the tablets often change appearance in shape and colour between prescriptions, presumably bought from different suppliers. This can be confusing when you take many medications, and introduces an element of doubt as to whether new tablets are correct dosage etc.

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2 October 2012
Hilary Curtis from BHIVA clinical audit coordinator sent the following message:

Given that the goal of ART is long term, durable virological control, there is a serious omission in only auditing VL at 12-24 months after starting treatment. (This error is also in the treatment guidelines and, I suspect, reflects outcomes used in research studies. This is a wrong approach - routine practice is not research and clinical audit outcomes can and should be designed differently to reflect this.)

Suggested addition:

Number of patients whose VL is less than 50 copies/ml after being established on therapy (numerator: those in denominator with most recent VL <50 copies/ml measured within the last six months; denominator: those who started therapy at any time more than 12 months ago, unless this was short term therapy for MTCT prevention.

[I've said 12 months because that avoids anomalies resulting from the precise timing of VL measurements but in fact VL <50 copies/ml should be achieved within 4 months of starting.]

This could be even be INSTEAD of the harder to measure 12-24 month timepoint outcome.

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2 October 2012
Paul Decle from Forum Link sent the following message:

Section 1 Rationale

Paragraph 4. I would like to see some reference to quality of life issues here.

Section 2

Quality statements (change 11th bullet point)

From...

HIV clinics should provide pharmacist- and nurse-led interventions that provide educational information and outreach services to support antiretroviral therapy prescribing for difficult-to-reach patient groups in the local community.

To...

HIV clinics should provide pharmacist- and nurse-led interventions that provide educational information [in an appropriate language or media] and outreach services to support antiretroviral therapy prescribing for difficult-to-reach patient groups [or individual patients] in the local community.

(change 12h bullet point)

From...

HIV services should collaborate with commissioners to develop strategies to maintain cost-effective prescribing.

To...

HIV services [and patient representatives (PPE Reps)] should collaborate with commissioners to develop strategies to maintain cost-effective prescribing.

Section 3

Measurable and auditable outcomes

Third bullet point.

I would like to see this metric set at a higher value.

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4 October 2012
Lisa Haddon from Department of sexual health, RCHT sent the following message:

ART prescribing is complex but the team here are concerned in principle about putting a minimum limit to numbers of clinical PAs an individual should be doing in order to do this effectively.

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5 October 2012
David Ogden from HIV Pharmacy Association sent the following message:

Rationale

“There is evidence that between 20% and 40%... Robust engagement with primary care to minimise potential drug interactions with access to specialist HIV pharmacist advice, is an essential aspect of good prescribing practice.

Quality Statements

Add three quality statements and others amended below:

“All antiretroviral prescriptions should be clinically verified by a specialist HIV pharmacist or HIVPA accredited pharmacist, prior to dispensing, with respect to appropriateness with other prescribed medication and co-morbidities.”

“Specialist HIV pharmacist advice should be sought on drug interactions with respect to ARV prescribing, herbal, OTC, GP-prescribed medication, monitoring and management of treatment including those related to co-morbidities.”

"Drug histories should be undertaken at each clinic visit and medication review done at least annually. All should be documented in the clinical record."

“HIV clinics should provide specialist HIV pharmacist- and nurse-led interventions that provide educational information, adherence support, and medicines optimisation to support antiretroviral therapy prescribing for difficult-to-reach patient groups in the local community. This may include liaison with primary care teams and/or outreach services.”

“Mechanisms should be in place to alert primary care to HIV drug-drug interactions and for primary care to verify non-HIV related prescriptions issued to people with HIV.”

“People with HIV should be able to choose how they have their antiretroviral medication supplied whether collected from a community or hospital pharmacy, or delivered directly to home.”

Measurable and auditable outcomes

Proportion of ARV prescriptions clinically verified by a specialist HIV pharmacist or HIVPA accredited pharmacist (target 90%).

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5 October 2012
Dr Frances Keane from Royal Cornwall Hosptial sent the following message:

the PA allocation, if adopted should be pro-rata ed depending on HIV cohort

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7 October 2012
Philippa James from SDHIV group of RCGP sent the following message:

We wondered whether there should be reference to the types of mechanisms that could be in place for primary care to check prescriptions such as access to HIV hospital pharmacists; liverpool interactions website; and the use of computerised interaction checks on GP systemns.

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7 October 2012
Jacqueline Stevenson from African Health Policy Network (Ffena) sent the following message:

We believe there should be an additional quality standard relating to patient involvement in prescribing decisions, which should be meaningful and ensure the patient is informed fully about the options and eventual decision. This should build on the learning from the recent London-wide treatment changes, and reflect the experiences of ALL communities.

We welcome the call for provision of education and outreach services in the community.