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DIALOGUE SUMMARY

EXPLORING MODELS FOR PHARMACIST PRESCRIBING IN PRIMARY AND COMMUNITY CARE SETTINGS IN ONTARIO

16 JUNE 2015

EVIDENCE >> INSIGHT >> ACTION

Dialogue Summary:
Exploring Models for Pharmacist Prescribing in Primary and Community Care Settings in Ontario

16 June 2015

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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Dialogue

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SUMMARY OF THE DIALOGUE

The deliberation initially focused on identifying some of the key challenges facing the health system in Ontario, such as providing timely access to care, and supporting people who are living with multiple chronic health conditions and taking a number of medications. In light of these challenges, participants generally agreed that there was a need to explore whether granting prescribing authority to pharmacists could help address these challenges. The deliberation then shifted to four challenges associated with developing new models of care and reconfiguring scopes of practice: 1) managing public expectations is difficult; 2) there is a lack of information sharing and communication among healthcare providers; 3) there is a lack of resources and incentives that could enable system-wide changes; and 4) planning for the system we need will take time, resources and commitment from many health-system policymakers and stakeholders.

Preferences for particular policy options shifted over the day as dialogue participants came to appreciate the research evidence about pharmacist prescribing now available, experiences from other jurisdictions, and the groundwork that has been laid over years by the Ontario College of Pharmacists, schools of pharmacy, and other stakeholders. Participants were generally supportive of option 2 – establishing a pharmacist-prescribing program for minor ailments – since this was a natural next step for which the regulatory college and educational institutions had been preparing. Participants noted for this option the importance of being clear about how program effectiveness will be measured, finding ways to feed information back to each patient's regular primary-care providers, ensuring that patients retain a choice about where they fill their prescriptions, and finding an appropriate and sustainable compensation model. Some dialogue participants also supported a re-framed version of option 1 that focuses on facilitating the system-wide adoption of collaborative practice agreements (instead of collaborative prescribing agreements), particularly for Family Health Teams and other team-based practice environments. Some dialogue participants expressed an interest in option 3 – establishing an advanced practice pharmacist model –particularly in light of the Alberta experience, but as a possible second step. Others worried about credentialism (i.e. assuming that a formal qualification is the best measure of preparedness to play this role).

Dialogue participants highlighted four key implementation considerations: 1) positioning the ways forward in relation to the provincial government's 'Patients First' agenda; 2) being attentive to parallel conversations about prescribing currently underway in the province (e.g., prescribing by registered nurses); 3) pushing for any reinvestments in continuing professional development to focus on interprofessional teams (not just physicians, who have been the focus of investments until now) and to be based on the best available research evidence; and 4) managing potential conflicts of interest.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

The deliberation initially focused on identifying some of the key challenges facing the health system in Ontario, and whether there was a need to reconfigure scopes of practice to achieve key health-system goals. Providing timely access to care, as well as supporting people who are living with multiple chronic health conditions and are taking a number of medications, were among the most cited health-system challenges that needed to be considered.

Early in the dialogue, participants generally agreed that there was a need to explore whether granting prescribing authority to pharmacists could help to tackle these challenges. Several participants indicated that pharmacists are already the first point of contact for many people. Others pointed out that allowing pharmacists to prescribe could expand patients' choice around how to access appropriate assessment and treatment. Still others indicated that granting prescribing authority to pharmacists would be an opportunity to leverage the full array of existing capacity in the system, and ensure that pharmacists can work at their full and optimal scope. This was seen as a way to keep patients out of resource-strained or resource-intensive parts of the system (e.g., patients visiting their family physicians, walk-in clinics, or emergency departments to treat minor ailments). Building on this, several participants emphasized the need to develop new models of care to ensure that patients could access "the appropriate professional at the appropriate time."

However, at this point in the dialogue, a few participants were unclear about the extended role that pharmacists could play: "There is a role. How far and wide remain the questions." Other participants questioned the need to expand or reconfigure pharmacists' scope of practice. As one participant said: "We have to think carefully about what we are trying to fix, instead of creating a new model of care." A second participant said: "Re-configuring scopes of practice may not be the way. … We spent of lot of energy on this. We should have spent more energy on clarifying roles." This resonated with a third participant who said: "I'm not convinced that we have yet reached our full scope of practice." A fourth participant talked about the problem of over-prescribing and worried that granting prescribing authority to another profession could make things worse: "We should start talking about what is good prescribing,

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in Ontario;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three options (among many) for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three options for addressing the problem, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

We did not aim for consensus given our goal was to instead provide a space where diverging opinions could be shared and discussed, and to identify where synergistic efforts among stakeholders to address the problem might be possible.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

not who should do it. When nurses asked for prescribing privileges, they said '*well physicians do it*.' That was our first problem. I'm worried about complexifying the problem. [Look at] antibiotics. We are still doing it wrong after all these years." A fifth participant expressed the concern that pharmacist prescribing could exacerbate the lack of integration in the system: "The biggest travesty would be to create a new silo of care."

The deliberation then shifted to four challenges to developing new models of care and reconfiguring scopes of practice to address pressing health-system challenges: 1) managing public expectations is difficult; 2) there is a lack of information sharing and communication among healthcare providers; 3) there is a lack of resources and incentives that could enable system-wide changes; and 4) planning for the system we need will take time, resources and commitment from many health-system policymakers and stakeholders.

Beginning with public expectations, several participants indicated that the public generally want three things: 1) being "CEOs of their own health" (i.e., being actively engaged in self-directed care); 2) having timely access to primary and community care; and 3) getting 'continuous' care. These participants highlighted that it was imperative to explore how pharmacist prescribing could help us meet such expectations. A few participants argued that we still know little about the public's expectations, particularly around the issue of timely access to care: "We don't have sufficient evidence about what patients want. Access to what? Access to whom?" In addition, some participants worried that the current culture fuelled expectations that could not be met: "We have trained the public to believe that there is a drug for every health problem." This led several participants to stress the need to bring in the patient perspective to better understand the problem and to find solutions that are aligned with their needs and preferences. This was seen as crucial to understand and manage public expectations. Failing to do so could lead to serious backlash: "At some point, we will be too slow and won't be able to meet patients' expectations. The patients will not be patient and wait for this to happen." One participant noted that there are plans to conduct a follow-up citizen panel to elicit patients' views and experiences about this very issue.

The next set of challenges was the lack of information sharing and communication among healthcare providers. Information sharing was seen as a "game changer" and a crucial facilitator to meet pressing health-system challenges. However, there is currently no comprehensive information and communication infrastructure in the province that allows primary and community care providers to interact with one another. As one participant said: "We're not connected to each other, except by a fax machine or a telephone." Some participants have also described similar experiences in other Canadian jurisdictions, where current regulations are impeding seamless communication among providers: "We're not allowed to send patient information that way [via the internet]. We are the last industry to use fax machines." Several participants indicated that we should continue to push for full information sharing (e.g., electronic health records), but that we should not wait for it before moving forward. Similarly, they indicated the need to push for enhanced communication among healthcare providers, such as opening up the ONEMail system (an email service allowing registered healthcare providers to share patient information) to all physicians, which could allow greater physician-pharmacist communication.

The deliberations then moved to the lack of resources and incentives that could enable system-wide changes. Several participants emphasized that pharmacists need a support system to work to their full and optimal scope. One participant pointed out that we currently have "live cases" of pharmacist prescribing across Canada, which have shown that the implementation of a pharmacist-prescribing model will not happen overnight: "We need to enable the system and the providers. We need to put [in place] the mechanisms to help it grow organically. Let's enable the system and the profession. No more research needs to be done on this, let's get on with it." Other participants focused on potential funding arrangements that could support a shift in the system. One participant said that financial compensation can be a motivator, but that we may need to become more sophisticated when we think about compensation, such as paying for outcomes for teams and individuals as has been discussed for physicians, or paying for assessments instead of prescribing. While referring to the Alberta experience, another participant questioned the impact of financial incentives since "the money flows to the pharmacy, not the pharmacists." This participant suggested that, in terms of

sequencing, putting in place the information and communication infrastructure may be more important than the payment model: "[In Alberta], we have this unparalleled access to information. … The information infrastructure came at the same time as the new roles for pharmacists, and the payment model came right after." Beyond financial compensation, some dialogue participants noted that it will also be necessary to ensure the uptake of new services offered by pharmacists. To do so, several participants highlighted the need to leverage community pharmacies' advertising abilities to support system-wide changes.

Lastly, participants emphasized the need to plan for the system we need, which will take time, resources and commitment from many health-system policymakers and stakeholders. These participants suggested that carefully planning for the future was essential to ensure that we address all facets of the problem and other problems that may come up (e.g., a provincial or national pharmacare programs, new and emerging technologies, point-of-care testing, changes to what are considered over-the-counter drugs, new forms of immunization, and both over-prescribing and de-prescribing). They noted that this forward-planning orientation would also ensure that our investments in structures, lists, training and research maximize value for money. To do this, several participants indicated the need to engage citizens, providers, practices, pharmacies, policymakers and other relevant stakeholders in an on-going conversation about how to address these challenges and plan for the future.

DELIBERATION ABOUT POLICY OPTIONS

Preferences for particular policy options shifted over the day as dialogue participants came to appreciate the research evidence about pharmacist prescribing now available, experiences from other jurisdictions, and the groundwork that has been laid over the years by the Ontario College of Pharmacists, schools of pharmacy, and other stakeholders. Participants were generally supportive of option 2 – a pharmacist-prescribing program for minor ailments – since this was a natural next step for which the regulatory college and educational institutions had been preparing. Some participants also supported a re-framed version of option 1 that focuses on facilitating the system-wide adoption of collaborative practice agreements (instead of collaborative prescribing agreements), particularly for Family Health Teams and other team-based practice environments. Some participants expressed an interest in option 3 – establishing an advanced practice pharmacist model – particularly in light of the Alberta experience, but as a possible second step.

Option 1 – Facilitate the system-wide adoption of collaborative prescribing agreements in primary and community care settings

The deliberation about the first option focused on facilitating the system-wide adoption of explicit collaborative prescribing agreements negotiated in primary and community care settings. Several participants pointed out that they have already been practising prescribing with the use of collaborative agreements, but that there were both challenges and limitations to this option including the following: 1) collaborative agreements do not address a major component of the access issue (i.e., only those with a pre-existing relationship with a primary-care provider may benefit); 2) such agreements rely on medical directives that are cumbersome (e.g., they take time to develop and revise, they are difficult to manage when multiple providers are located in different settings, and they are difficult to personalize to the specific needs of each patient); 3) medical directives maintain a hierarchical and top-down approach to health care; 4) medical directives may be scary to some healthcare providers (e.g., they are legal documents that carry with them significant liability), which perhaps explains why they haven't really taken hold since they were introduced in 1991; and 5) they don't leverage community pharmacists (e.g., the majority do not work in teams and could not work under medical directives with the large numbers of primary-care providers that their patients see). As one participant said: "On paper, [option 1] looks really good. Operationally, it may fall apart."

While several participants indicated that option 1, as a 'system-wide solution', may be too rigid, other participants noted that this option could be beneficial as a tool in Family Health Teams and similar team-based settings, for specific patient populations (e.g., Health Links patients, long-term care patients) and/or for specific risk factors or disease priorities (e.g., diabetes and hypertension).

Many participants also suggested changing how the option was framed, referring to collaborative *practice* agreements instead of collaborative *prescribing* agreements. As one participant said: "I like the idea of collaborative practice agreements because it integrates clinical pathways for different conditions. If we're trying to be visionary and [support] effective prescribing, that's the way to go."

To support the uptake of such collaborative practice agreements, participants suggested that two conditions would need to be met. First, collaborative practice agreements should not be seen as dependent on physicians. As one participant said: "The common denominator is the patient. The patient should be the carrier of the agreement." Second, there was a need for a supportive regulatory framework. A few participants suggested that a good regulatory framework could help to get rid of (or to better control) barriers that make collaboration difficult: "If you want collaboration, you've got to reinforce it through policy initiatives."

Option 2 – Establish a pharmacist-prescribing program for minor ailments

Participants generally agreed that option 2 could be used as a tool to assist all pharmacists in functioning up to their full and optimal scope of practice. As one participant indicated, prescribing would be a natural extension for pharmacists: "Pharmacists are already involved in assessing and triaging. Often, the pharmacist will scribble down the name of a prescription drug and hand it to the patient to go see their family physician." A second participant went further: "Pharmacists have been prescribing for minor ailments forever. Students are tested, quality-insurance processes are in place, [there is a] minor ailments' book [i.e., the Compendium of Therapeutics for Minor Ailments] from the Canadian Pharmacist Association." Thus, participants generally felt that pharmacists in Ontario can "already jump in for minor ailments", and that it would be "one of the biggest ways to gain efficiency in the system."

A few participants suggested that doing nothing could have unintended consequences. More specifically, these participants referred to the inappropriate use of over-the-counter products to treat minor ailments. When a patient can't get to their primary-care provider, they usually call their pharmacist for recommendation. As one participant said: "Left to their own devices, they try to self-medicate with OTC [over-the-counter] products, which may interact with their [prescription] medication." These participants also thought that it would be better to have pharmacists become an intermediary and prescribe drugs for minor ailments, rather than move more prescription drugs to OTC status.

While option 2 appeared promising, participants highlighted six elements to consider for its successful operationalization, as follows: 1) be clear about how program effectiveness will be measured (e.g., high-symptom resolution rates, low re-consultation rates); 2) find ways to feed information about pharmacist assessments and prescriptions back to each patient's regular primary-care providers so that pharmacists' contributions don't negatively affect care coordination; 3) be careful that patient choice about where they can fill their prescriptions is not restricted; 4) think carefully about the funding arrangements for a minor ailment programs; 5) consider how to address possible resistance from physicians (as one participant noted, physicians in the United Kingdom are salaried, which may explain their favourable perceptions about the introduction of a pharmacy-based minor ailment program: "Here, there may not be this enthusiasm to send their minor ailment patients to pharmacists"); and 6) harmonize minor ailments programs across the country (as one participant said: "Ontario could make a significant contribution in this area.").

Regarding the third point, one participant said: "keep the [current] rules [about patient choice regarding where prescriptions are filled], communicate them, and enforce them." The financial implications for the system, and the compensation model (the fourth point), were discussed at length. Several participants

expressed concern about a fee-for-service reimbursement model, which they feared could create incentives for more not better care: "Do not press the 'fee-for-service' button. It's a perverse incentive. We need to find other ways to deal with it." A few participants, based on the experiences in other jurisdictions like Nova Scotia, suggested compensating the assessments instead of the prescribing, although this only partly addresses the concern about fee-for-service as a funding mechanism.

Option 3 – Establish an advanced practice pharmacist model

The deliberation about the third option focused on expanding the scope of practice of pharmacists by establishing an advanced practice model, similar to the 'advance prescribing authorization' (APA) model in Alberta. Several participants saw an advanced practice authorization as a recognition that pharmacists can take on addition roles, a way to develop specialization in the profession, and a way to ensure that pharmacists are better equipped to address patients' needs related to managing chronic health conditions. Others also emphasized that by 2019, all Canadian provinces will have a PharmD program in place, which means that newly trained pharmacists will be well equipped to take on an advanced role and work in a more sophisticated practice environment.

Other participants articulated four considerations in moving ahead with this option: 1) there is still limited evidence regarding the effectiveness of this option; 2) there is a need to establish a robust quality-assurance infrastructure and relevant continuous professional development; 3) there may be a risk for credentialism (i.e., assuming that a formal qualification is the best measure of preparedness to play a role); and 4) it will require intensive behavioural interventions to support the uptake of advanced prescribing authorization among pharmacists.

First, some participants indicated that we don't know enough yet about the contribution of pharmacists with APA status in Alberta, especially among community pharmacists. One participant estimated that only 20% of pharmacists in Alberta have APA status. However, one participant pointed out that, although no systematic review has examined the effectiveness of this option, there is a growing number of primary studies (mostly randomized controlled trials conducted in Alberta) suggesting promising results.

Second, several participants emphasized the need to establish a robust quality-assurance infrastructure and relevant continuous professional development to support option 3. While new pharmacy graduates from the PharmD programs may be equipped, the current pharmacy workforce may not be fully prepared. As one participant said: "We're walking a tight rope here. … How do you bridge 'older' pharmacists from the past 'regime' without creating unnecessary hurdles?"

Third, a few participants expressed concern that option 3 could lead to credentalism and potentially greater fragmentation within the profession. As one participant said: "The language [of 'advanced practice'] itself makes it sound like an additional credential." A second participant went further: ". . . [new credentials] do not necessarily lead to improved patient outcomes." Other participants did not share this concern. One participant pointed out that the Ontario College of Pharmacists has already shown its capacity to deal with an advanced role for pharmacists, without being bogged down by credentialism. A second participant drew from the experience in Alberta, where obtaining APA status does not require additional credentials: "You don't need an extra credential or education. They just need to show they are competent and have expertise. You originally needed [just] two letters from independent prescribers [attesting to their competence]."

Lastly, several participants indicated that option 3 is, as one participant put it, "a big behavioural issue to implement." Ensuring the uptake of APA status by pharmacists across the province will require interventions to boost their confidence and increase their recognition as primary-care providers.

Considering the full array of options

Several dialogue participants agreed that the current context does not make the status quo a viable option for the province. "If we're sitting back and doing nothing, we'll be in the same situation five years from now. These are serious issues and we can't wait." A second participant said: "It seems like Ontario is the birthplace of *analysis paralysis*."

Participants pointed out the need for planned sequencing. Option 1 – collaborative practice agreements – garnered less enthusiasm as a system-wide solution, but participants recognized the benefit of pursuing this approach in specific settings and patient populations. On the other hand, option 2 – a pharmacy-based minor ailment program – was seen as a logical first step where efforts should be invested, particularly since pharmacists appear ready to take on this role and the groundwork has already been laid. As one participant said: "Minor ailments is a no-brainer. We can go right away with this. It has been done in other jurisdictions in Canada and beyond." A second participant went further: "It's a quick fix and it's politically good." Option 3 – an advanced practice pharmacist model – was seen as a potential second step given that the introduction of an advance prescribing authorization (APA) designation may face more hurdles. As one participant said: "If the world was perfect, I would do options 2 and 3 at the same time, but we'll probably learn a lot by doing option 2 on its own." A few participants expressed divergent views about the planned sequencing approach, and argued that we should aim to introduce comprehensive and new prescribing roles for pharmacists at the same time. These participants highlighted that there is a rigorous quality-assurance system in place with the Ontario College of Pharmacists, that the profession will be able to self-regulate in this new area, and that the regulatory cycles in the province are too slow to take a 'baby-step approach.' As one participant said: "Given the slow regulatory cycles in the province… do it all and let the profession self-regulate. … We know it takes time to bring about change."

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Dialogue participants highlighted four key implementation considerations. First, participants emphasized the need to position the ways forward in relation to the provincial government's 'Patients First' agenda. The Ontario government recently released a home and community care action plan, and is expected to release another one specifically on primary care. These actions plans reflect a commitment to put patients at the centre of the system by putting their needs first. Aligning the issue of pharmacist prescribing with these action plans could help to move the issue higher on the government's agenda. Second, participants indicated that there was a need to be attentive to parallel conversations about prescribing currently underway in the province. For instance, the recent decision of the province to move forward with registered-nurse prescribing was seen as an important situation to monitor. A decision needed to be made by pharmacist leaders as to whether to align both agendas, or whether to pursue pharmacist prescribing independently given the many years of preparations that have already been devoted to it. Third, participants highlighted the need to push for any reinvestments in continuing professional development to focus on interprofessional teams (not just physicians, who have been the focus of investments until now) and to be based on the best available research evidence. This was seen as essential to enable and nurture collaborative practices. Some participants considered the current system to be unfavourable to interprofessional teams because healthcare providers are trained in silos, and regulated by different colleges and different legislation. As one participant said: "We need blended cultures and behaviours." Lastly, there is need to consider how to manage the potential conflicts of interest raised by pharmacist prescribing. This constitutes an issue that may challenge the implementation of pharmacist-prescribing models. A few participants indicated that the profession's code of ethics should help, while others suggested the need to implement penalties "high enough to scare people off." As one participant said: "It's a significant [implementation] issue, but not insurmountable."

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

During the final deliberation, participants articulated six key goals that should guide us moving forward:

1. crafting a vision for the future;
2. ensuring excellent patient experience (including enabling patient choice and providing timely access to care);
3. enabling effective interprofessional collaboration;
4. supporting optimal patient care (and prescribing);
5. achieving health-system efficiency; and
6. harnessing pharmacists' expertise.

While the pharmacist-prescribing models discussed during the day were promising tools to achieve such goals, participants emphasized the need to "go around some key barriers to get the conversation going." These work-arounds included finding ways to deal with scattered patient information in the absence of a comprehensive and seamless information and communication infrastructure, finding ways to drive the behavioural changes necessary to move forward (e.g., among pharmacists and other providers), and finding an appropriate and sustainable payment model that will not negatively affect our goals.

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