Certified Pharmacist Prescriber Initiative Draft Framework

BC Pharmacy Association submission to the College of Pharmacist of BC

July 2016

Executive Summary

The College of Pharmacists of BC has developed the Certified Pharmacist Prescriber Initiative Draft Framework, which outlines the societal need for pharmacist prescribing in British Columbia. The framework includes an environmental scan of expanded scope of practice for pharmacists in other jurisdictions as well as other non-physician prescribers in BC. In its document, the College proposes eligibility criteria, renewal requirements and the standards, limits and conditions to qualify as a Certified Pharmacist Prescriber. The document was developed by the Certified Pharmacist Prescriber Task Group at the direction of the College Board and is being used for stakeholder engagement.

The pharmacist prescriber initiative has been identified as a strategic priority by the College Board. In its proposal, the College makes the case that allowing pharmacists to initiate prescribing for Schedule I drugs will meet a number of key priorities in the health-care system, including reforming primary health care, better and more effective use of health human resources and strengthening multidisciplinary collaborative environments.

Pharmacists have the professional responsibility to both improve their patients' drug therapy outcomes and improve the health-care system. Pharmacist prescribing authority is not new in British Columbia. Since 1999, BC pharmacists have had the authority to provide emergency refill supplies of medication. In 2000, BC pharmacists were the first to be granted independent authority to prescribe emergency contraceptives. In 2009, pharmacist scope of practice was expanded to include adapting prescriptions written by authorized prescribers as well as administering injections. The College's current proposal would expand pharmacists' scope, allowing them to prescribe Schedule I medications. However the use of term "prescribing" for Schedule II and III drugs is unclear in the framework.

Since 1999, pharmacists have been prescribing and dispensing drugs with the ethics and professionalism benefitting the profession.

Since 1999, pharmacists have had limited prescribing and dispensing authority (emergency refills) with the ethics and professionalism benefitting the profession. The BCPhA was surprised by the proposal's recommendation to exclude pharmacist owners from prescribing because of ethical challenges, since there has been no evidence to show this is an issue.

The BC Pharmacy Association supports allowing pharmacists to initiate prescriptions. Pharmacist expansion of scope reflects the aspiration of BC pharmacists, and one of the Association's key goals is "Pharmacists are able to practice the profession of pharmacy at the highest levels and to its fullest extent."

We urge the College to provide greater clarity on pharmacist authority around the dispensing Schedule II and III drugs[1]. It is well understood that both the public and private payers have challenged pharmacist authority to dispense Schedule II and III drugs, most notably vaccines. They have done this based on the position that pharmacists do not have the authority to prescribe even Schedule II and III drugs.

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[1] *Certified Pharmacist Prescriber Initiative Draft Framework*. (2016, February).

During the development of the final framework, the BCPhA recommends the College explore three areas: physician, payer and patient attitudes toward pharmacist prescribing; impact on accessibility to care, especially in rural areas; and reputational impact on the profession. Without taking these into consideration, even if the legislation is passed, having the authority to prescribe is a hollow victory.

Attitudes toward pharmacist prescribing: prescribers, payers and patients

While we support allowing pharmacists to initiate prescriptions, gaining prescriber input and support is key to the framework being accepted by government and obtaining widespread adoption of this practice. Pharmacists in BC have had the authority to adapt a prescription since 2009, yet prescription renewals far outweigh therapeutic substitution prescriptions by 25 to 1.[2] Studies have shown that prescriber attitudes are a critical factor influencing pharmacists' adoption of this scope of practice. In 2016, community pharmacists participating in two BC Pharmacy Association town halls on therapeutic substitutions and adaptations cited pushback from prescribers as their top reason for not undertaking therapeutic substitution prescriptions.

In a 2013 study on what factors influence pharmacists' adoption of prescribing, Alberta pharmacists, who were the first to have the full range of prescribing authority in 2007, said the relationship with the physician was the primary consideration when deciding whether to undertake prescribing a medication for a patient. If they believed the patient's primary care physician would not be supportive of pharmacist prescribing, they would be reluctant to undertake this expanded scope.[3]

Gaining prescriber input and support is key to the framework being accepted by government.

In fact, figures show that although pharmacists in Alberta have a wide range of prescribing privileges, pharmacists were more likely to prescribe to adjust ongoing medications rather than initiate a new prescription. The most common forms of prescribing were ensuring continuity of therapy, adapting, and substituting medication due to shortage.[4]

Simply citing resource shortages as a reason for pharmacist prescribing is not enough to assuage concerns by physicians. In a January 2010 position statement, the College of Family Physicians of Canada explicity said decisions to allow other health-care professionals to prescribe should not be made merely on the fact that there are resource shortages, but must be based on evidence showing efficacy. They recommended a collaborative care model, which includes the patient's physician.[5]

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[2] BC Ministry of Health Number of Prescription Adaptations and Renewal Fees Claimed in 2014/15.

[3] Makowsky, M. J., Guirguis, L. M., Hughes, C. A., Sadowski, C. A., & Yuksel, N. (2013). Factors influencing pharmacists' adoption of prescribing: Qualitative application of the diffusion of innovations theory. *Implementation Science Implementation Sci*, 8(1). doi:10.1186/1748-5908-8-109

[4] Guirguis, L. M., Makowsky, M. J., Hughes, C. A., Sadowski, C. A., Schindel, T. J., & Yuksel, N. (2014). How have pharmacists in different practice settings integrated prescribing privileges into practice in Alberta? A qualitative exploration. *J Clin Pharm Ther Journal of Clinical Pharmacy and Therapeutics*, 39(4), 390-398. doi:10.1111/jcpt.12165

[5] College of Family Physicians of Canada. (2010, January). Prescribing Rights for Health Professionals [Position Statement].

And in response to the 2007 legislation change in Alberta allowing pharmacist prescribing, the Canadian Medical Association (CMA) said forcefully "that pharmacists not be given independent prescribing authority."[6]

Closer to home, a 2011 study of BC family physicians' perceptions of pharmacists adaptations showed that physicians felt they had not been communicated with enough and felt they were not sufficiently included in the development of the adaptation initiative. The study recognized that physicians were "essential stakeholders". To receive their support, doctors' concerns should be addressed and they should be provided with detailed communication.[7]

Using this learning, the BCPhA recommends the College engage with physicians while developing the final framework to ensure successful implementation across the province.

Physician attitudes toward pharmacist prescribing is only one factor in the success of this proposed framework. A critical piece of its success is ensuring payment for pharmacist prescribing. Other Canadian jurisdictions have demonstrated that having authority to provide a service, but no one willing to pay for it, is of little value to the system. For a cross Canada comparison on similar pharmacist services and payment, the Canadian Foundation for Pharmacy has published a chart online[8].

Services that are not funded by payers have little uptake by patients, who would have to pay out of pocket. For example, in a survey about pharmacists' medication management services, 81 per cent of patients said they would use the service if it were 100 per cent paid for by the government. Only 8 per cent said they would use the service if they had to pay out of pocket for it.[9]

And while the BCPhA appreciates that pharmacists have been making available and selling Schedule II and III drugs to patients, the Association questions the framework's use of the term "prescribing" when describing this activity. Because the term "prescribing" has not been formalized for Schedule II and III, payers do not currently pay for pharmacists to provide this service. It's important for the College to be aware of this issue and address it in the development of the final framework.

Another challenge is having an expanded authority that patients don't embrace. In October 2015, the McMaster Health Forum convened a citizen panel to explore models for pharmacist prescribing in Ontario. The purpose of the panel was to guide the efforts of policymakers, managers and professional leaders who make decisions about the health-care system. What they found was that patients overwhelmingly preferred allowing pharmacists to prescribe medications for minor aliments without the patient having to see their family doctor, but patients were not in favour of allowing pharmacists with special training to prescribe them a broad range of prescription drugs without patients seeing their physician.[10]

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[6] Kondro, W. (2007). Canada's doctors assail pharmacist prescribing. *Canadian Medical Association Journal*, 177(6), 558-558. doi:10.1503/cmaj.071212

[7] Henrich, N., Joshi, P., Grindrod, K., Lynd, L., & Marra, C. (2011). Family physicians' perceptions of pharmacy adaptation services in British Columbia. *Canadian Pharmacists Journal*, 144(4), 172-178. doi:10.3821/1913-701x-144.4.172

[8] Fees and claims data for government-sponsored pharmacist services, by province [Chart]. (n.d.).

[9] Lynd, L., & Marra, C. (2013, December 31). *BC Medication Management Project: Qualitative Evaluation Final Report* (Rep.).

[10] Exploring Models for Pharmacist Prescribing in Ontario: Citizen Brief (Rep.). (2015, October 17).

This was the same conclusion from another review, which said effectively communicating the benefits of pharmacist prescribing with individuals is key.[11]

In order to ensure success of pharmacist prescribing, the BCPhA recommends the College consider undertaking a thoughtful process that engages patients and helps the College understand potential barriers to providing this service to patients and how to effectively remove these barriers.

Rural access to care

The College rightly maintains that the pharmacist prescriber initiative will improve patient safety and aligns with primary health-care reform. While patient safety is a key component of public health, access to care is just as critical.

The College's proposal states "that a pharmacy owner cannot prescribe drugs pursuant to the BC Pharmacy Operations and Drug Scheduling Act (PODSA)". The BCPhA urges the College to pursue regulations so this prohibition does not negatively impact access to health care, particularly in rural areas. We understand the College's concerns about the "perverse incentive", but believe the solution lies not in prohibition but in enhancing the existing Conflict of Interest Standards developed by the College.

One only needs to look at the worsening state of access to care in British Columbia to recognize the impact this ban would have. The number of British Columbians without a family doctor continues to climb. As of 2016, more than 200,000 British Columbians looking for a family doctor can't find one. This number is higher than it was in 2010, when the government began an investment of millions of dollars, promising that all British Columbians would have access to a family doctor. This demonstrates that the current approach will continue to leave far too many British Columbians without a medical home and dependent on a patchwork of services to meet their health-care needs.

Rural care is a case in point. As studies show, one of the main obstacles in providing access to health care in rural communities is attracting and retaining health-care providers.[12]

The BCPhA recognizes that rural areas can be defined in many ways. The BCPhA used the physicians' Rural Practice Subsidiary Agreement (RSA) which assigns isolation points to rural communities. The higher the number of points, the more isolated a community is. The most isolated communities are designated as 'A' communities.

The BCPhA mapped community pharmacy locations to RSA-designated communities. There are currently 89 community pharmacies that serve 66 rural-designated communities in BC. Of those 66 communities, 60 per cent have only one pharmacy in town. (See Table 1: Number of Community Pharmacies in Rural Communities). In these areas, it is not unusual for the primary pharmacist on duty to be the owner of the pharmacy. And a 2015 survey of pharmacists in rural BC, respondents said that more than 80 per cent of their patients would have to travel between one to two hours to access health

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[11]Faruquee, C. F., & Guirguis, L. M. (2015). A scoping review of research on the prescribing practice of Canadian pharmacists. *Canadian Pharmacists Journal / Revue Des Pharmaciens Du Canada*, 148(6), 325-348. doi:10.1177/1715163515608399

[12] Romanow, R. (2003). Building on Values. The Future of Health Care in Canada: Executive Summary. *HealthcarePapers Hcpap*, 3(4), 11-22. doi:10.12927/hcpap.2003.17376

services if they were not operating.[13] While likely not the intention of the College's proposal, in its current form the prohibition would deny patients in these rural areas access to primary health care.

In order for the pharmacist prescribing framework to solve the issue of accessibility to primary care, the BCPhA urges the College to pursue regulations so that this prohibition does not negatively impact access to health care, especially in rural areas. We know that 87 per cent of BC's population lives in urban areas, yet BC is unique in the Canadian context as it has many remote communities with a few hundred residents.[14] Given this unique situation, at the very least, the College should consider a separate program for pharmacist owners in rural and remote areas.

The ban on pharmacists who own pharmacies also inadvertently creates a disadvantage for small business owners. The ban would favour corporate ownership and create an uneven playing field that harms independent pharmacy operators across the province. In fact, in rural areas 85 per cent of community pharmacies are independent operators.

Reputational impact on the profession

Not only is the College's proposed ban on pharmacy owners prescribing medication on the basis of "perverse incentive" an issue of access to care, it negatively impacts the profession as a whole.

Pharmacists are one the most trusted professions. In a 2012 poll by Ipsos, pharmacists ranked fourth out of all professions in Canada.[15]

Pharmacists like all other professionals are consistently faced with challenges and ethical dilemmas that they must solve on a daily basis. Pharmacists must take an oath adhering to the College's Code of Ethics that lists ten standards they must abide by. One of these standards explicitly states, that registrants must "act in the best interests of their patients and…not exploit the professional relationship for any…financial…gain."

The BCPhA believes that there is little evidence to support the belief that pharmacist owners cannot manage this ethical challenge, while other prescribers who also run health-care businesses (e.g. physicians, dentists, naturopaths, midwives, optometrists) can. Based on discussions with other provinces there have been no reports of such unethical practices by pharmacists.

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There are varying challenges that face all professionals who are working for compensation. In a health-care environment the pledge to put a patient's best interests first always drives professional judgement. Regulators of other professionals and in other jurisdictions have not put this in place, so the BCPhA asks the College to be sensitive to the impact this will have on the reputation of a self-regulating profession.

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[13] BC Pharmacy Association. (July 2015). Time to Fix the Rural Health-Care Deficit

[14] Strengthening Rural Canada: Fewer & Older: The Population and Demographic Dilemma in Rural British Columbia (Rep.). (2015, April).

[15] Ispos. (2012, June 16). Life-Savers, Medical Professionals Top the List of Most Trusted Professionals [Press release].

If the profession itself does not believe it can adhere to ethical codes of conduct, then it would seem that putting this requirement in place would be a vote of no confidence in the professionalism of its registrants.

There are other models on how to best manage conflicts besides outright banning of pharmacist owner prescribing. The BCPhA urges the College to monitor this issue over time and bring in the appropriate regulation based on evidence, not conjecture.

Final Summary

The BC Pharmacy Association supports the College's proposal for pharmacist prescribing. We urge the College to clarify dispensing of Schedule II and III drugs in the framework and to further explore key areas that may be a barrier to making pharmacist prescribing successful.

This includes engaging with physicians early in the process, seeking understanding of patient attitudes toward pharmacist prescribing and understanding whether the government and other payers will support funding this proposal.

The BCPhA also recommends removing the restriction on pharmacist owner prescribing through appropriate regulation under PODSA, and we recommend looking at other ways of addressing this ethical challenge such as enhancing the Conflict of Interest Standards. This will allow for expanded scope of practice for the profession of pharmacy and better health outcomes at optimal costs for patients.

British Columbia has been a leader in expanded scope of practice (e.g. immunizations, therapeutic substitutions, and renewals). We believe that BC can demonstrate this same leadership by coupling expansion of pharmacist prescribing authority of Schedule I drugs with payment of this service.

Table 1: Number of Community Pharmacies in Rural Communities

A, B, C, and D Communities

RSA communities are designated A, B, C, or D based on the number of isolation points they receive as outlined below:

'A' communities – 20 or more

'B' communities – 15 to 19.9

'C' communities – 6 to 14.9

'D' communities – 0.5 to 5.9

COMMUNITIES	NUMBER OF PHARMACIES	RSA CATEGORY
Alert Bay	1	A
Armstrong	2	
Ashcroft	1	A
Barriere	1	B
Brentwood Bay	2	
Chase	1	B
Chetwynd	1	A
Christina Lake	1	A
Clearwater	1	A
Cobble Hill	1	
Elkford	1	A
Enderby	2	C
Fort Langley	1	
Fort Nelson	2	A
Fort St. James	1	A
Fraser Lake	2	A
Fruitvale	1	
Gabriola Island	1	C
Garibaldi Highlands	1	
Golden	2	A
Houston	1	A
Invermere	2	A
Kaslo	1	A
Keremeos	2	C
Kimberley	2	A
Ladysmith	2	C
Lake Cowichan	2	C
Langford	1	
Lantzville	1	
Lillooet	2	B
Logan Lake	1	C
Lumby	1	
Lytton	1	

COMMUNITIES	NUMBER OF PHARMACIES	RSA CATEGORY
Mackenzie	2	A
Madeira Park	1	C
Marysville	1	
Midway	1	
Mill Bay	2	C
Nakusp	1	A
Nanoose Bay	1	
North Saanich	1	
Okanagan Falls	1	
Osoyoos	2	C
Peachland	1	
Pemberton	1	C
Pender Island	1	B
Port Hardy	2	A
Port McNeill	1	A
Princeton	2	A
Quathiaski Cove	1	
Queen Charlotte City	1	A
Revelstoke	2	A
Rossland	1	
Saanichton	2	
Salmo	1	
Scotch Creek	1	
Shawnigan Lake	1	C
Sicamous	1	
Sooke	2	
Sorrento	1	C
Sparwood	2	A
Tofino	2	
Tumbler Ridge	1	
Ucluelet	2	A
Vanderhoof	2	A
TOTAL	**89**	