Making the Value Connection

Helping to prove pharmacists’ value: Paul Blanchard of the New Brunswick Pharmacists’ Association, Brett Jackson, pharmacist, and Tiffany Kennedy, patient
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How do we sustain the value connection?

“Making the value connection” in pharmacy is important now more than ever before. In fact, so much so, we’ve made it the theme of our 2018 Changing Face of Pharmacy report, now in its 9th year of publishing. As governments continue their quest to cut healthcare spending at any cost, proving pharmacists’ value in the real world is going to be paramount to sustaining funding for pharmacy services in the long term.

Quality, value and outcomes are buzzwords making the rounds these days. Regulators are looking to develop new quality measures for the profession (i.e., the Ontario College of Pharmacists is working on “quality indicators in pharmacy,” likely to be introduced next year). Value-based pharmacy and pay-for-performance—first introduced by Green Shield last year—is moving into phase 2 (posting of performance) and phase 3 (the reimbursement model), while chains, banners and independents figure out how it will all work. Patient outcomes are being tested through research and real-world initiatives underway throughout the country, but remain an elusive target for payers and pharmacists alike.

Certainly, we’re seeing more and more demand for proof validating the value of pharmacy services. CFP is supporting several research projects providing hard-line evidence of pharmacists’ worth in areas like urinary tract infection treatment, travel medicine and deprescribing. Similarly, the Foundation is supporting a project looking at how pharmacists are providing care under the Alberta Pharmacy Services Framework and what patients think of these services. So far the stats are showing that when pharmacy services are utilized, they do have a positive impact on patient outcomes.

But where do we go from here? As pharmacy moves towards a value-based model of care for the future, how do we reconcile doing more with less? How can pharmacists deliver quality care on a large scale when the profession continues to be an easy target for healthcare cuts? How can pharmacists be expected to do better if governments don’t see the value in paying for it?

Although the profession is making progress, it’s not enough to make the value connection apparent. The ultimate success will require figuring out how best to sustain it too.

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When the New Brunswick Pharmacists’ Association (NBPA) devised its new strategic plan early in 2017, it identified the demonstration of pharmacists’ value as one of four pillars for moving forward. “The Board recognized there is a bit of a vacuum when it comes to demonstrating the value of pharmacy services,” says Paul Blanchard, Executive Director of NBPA, which represents pharmacists at more than 800 pharmacies in the province.

The association launched a corporate fundraising campaign that raised more than $250,000, and secured additional funding from the Canadian Foundation for Pharmacy. It approached researchers at the University of Alberta’s EPICORE Centre, who have been studying the impact of pharmacists’ expanded scope of practice for the past decade, to study pharmacists’ interventions for urinary tract infections (UTIs). Anecdotally, pharmacists were telling NBPA that patients were especially happy with this service. The association knew it had to get proof, however, before it could build a case for public funding (currently, government does not pay professional service fees for any of the...
32 conditions in the province’s minor ailments program, implemented in 2014). The study, and its results, did not disappoint. About 750 patients enrolled and 39 pharmacies participated. “The biggest benefit was that patients were seen and received treatment 24 hours sooner than if they went to a physician, at a lower cost to the healthcare system,” says Blanchard. “There were no negative stories related to patient outcomes from pharmacists providing this service, and the study proved that pharmacists are more than capable of prescribing the right antibiotic.”

Soon after the release of the results in June this year, the NBPA delivered its report to the province’s Department of Health, and communicated the results to candidates in the recent provincial election. In its report, the association estimates government would need to budget no more than $400,000 to implement pharmacists’ fees for one year, an amount that should be offset by reduced visits to physicians and improved health outcomes.

While the association knew from the get-go that progress with government would take time, the main thing is that it now has a tangible, practical starting point to help guide discussions around public funding for services. And perhaps most important, the evidence indicates that all sides will benefit. “We are confident that public payers, not only in New Brunswick, but across the country, will see the benefit of funding this service by pharmacists,” says Blanchard.

One step at a time
Sharing evidence of the value of pharmacy with payers is an ongoing challenge for pharmacy associations across the country. While expanding scopes of practice have led to a broad range of government-sanctioned pharmacy services, funding hasn’t always followed through. And with pharmacy experiencing a revenue crunch related to lower generic-drug prices, it is difficult to increase service offerings without remuneration.

Still, evidence backing pharmacy services continues to grow. Last year, for example, The Value of Expanded Pharmacy Services in Canada, a study conducted by the Conference Board of Canada and funded in part by the Canadian Pharmacists Association (CPhA), determined that the Canada-wide implementation of three reimbursed community pharmacy services (smoking cessation support, advanced medication reviews and management for cardiovascular disease, and pneumococcal vaccination) could lead to cumulative savings of between $2.5 billion and $25.7 billion over the next 20 years.2 An economic analysis published last year in the Canadian Pharmacists Journal, by Dr. Carlo Marra, et al., found that pharmacists’ interventions in hypertension management under an expanded scope of practice, including independent prescribing authority, saved the healthcare system an average of $6,364 over a person’s lifetime. When you consider the number of Canadians with uncontrolled hypertension, that could translate into billions of dollars in savings.3

“As an industry, I believe we’ve made significant progress with research and evidence-based studies to demonstrate how we can drive better patient care in the community, by leveraging highly accessible pharmacies to create capacity in the healthcare system,” says Justin Bates, CEO at Neighbourhood Pharmacy Association of Canada. The challenge is to communicate how these findings can contribute to sustainability with a reasonable growth in costs (due to new professional service fees for pharmacists). “In both the private and public sectors, the emphasis is on value and return on investment. Governments have to deliver value and increasingly acknowledge the need for greater access and quality of services. If there is a pharmacist intervention, how do you measure the cost and value of the services?”

The value-based pharmacy program from Green Shield Canada (GSC), launched last year and rolling out in stages, is the first to measure pharmacy’s performance around a number of metrics, including adherence and chronic disease management. Beginning in 2019, the measurements will be tied to reimbursement and CPhA is working with GSC to ensure the metrics are practical for pharmacists. “We want to make sure that the program and any subsequent programs work for pharmacists and make sure pharmacists can deliver on what they are measured against,” says Joelle Walker, CPhA’s Director for Public Affairs. “It’s also important that any new programs are truly outcome-based and harmonized across payers.”

As well, CPhA is working to harmonize scope of practice—and consistency in compensation—across the country. “We expected a lot of congruence as pharmacists’ scope expanded, but provincial governments pick and choose what they will allow and pay for,” says Phil Emberley, Director, Professional Affairs for CPhA. “It is concerning that where pharmacists have advanced scope there hasn’t been as much uptake without reimbursement. We’ve identified a framework for harmonization and over the next few months will establish a report card showing how each province is shaping up.”

A closer, tougher look at value
Value is in the eye of the beholder, says Jeff Johnson, a pharmacist by training and health outcomes researcher at the University of Alberta’s School of Public Health. He is currently working with colleagues at Alberta Health to analyze “the efficiencies of government funding” for pharmacists’ care plans for chronic disease management.

“This research is in response to the Auditor General’s report that said a lot of money was being spent on care plans but there was no evaluation of the impact,” says Johnson. A report is expected by the end of this year.

Such an analysis is also necessary due to growing competing pressures on spending. “When 50 percent of provincial budgets go to health, there is less money for schools and roads. So we need to look at value and ensure efficiencies in the system,” says Johnson. He adds, however, that value has many aspects. “Simple fiscal value and net economic value don’t provide a full picture and we need to look more at what defines quality. We’re also interested in the patient’s perspective and whether they are satisfied. It’s not just about dollars and resources—a health service may be more costly, but if it has better satisfaction rates, then it may have good value.”

Christine Hughes, Professor at the Faculty of Pharmacy and Pharmaceutical Sciences at the University of Alberta, agrees that there are many different ways to define value in health care. “Certainly, patient outcomes and cost are ways to measure the value of services and are important,” she says. “However, access to services, convenience
A neurodevelopmental condition that affects the functioning of the brain, attention-deficit/hyperactivity disorder (ADHD) is currently the most common mental health condition affecting 5-12% of school-aged children in Canada. Boys are up to nine times more likely than girls to be diagnosed with the condition, and 60% of children affected remain impaired by symptoms even into adulthood.

ADHD is associated with learning difficulties that impair academic success and an increased risk for later substance abuse and issues with the law. This chronic condition is also linked to additional mental health disorders and ongoing problems with self-esteem.

The good news is that 70% of people with ADHD positively respond to medication—and the evidence shows that medication, in turn, helps with other strategies and approaches to care. However, medication is one component of care. Optimal ADHD management combines pharmacotherapy with behavioral therapy or psychotherapy. As medication experts, pharmacists too play a key part in ADHD management.

**What can pharmacists do?**

Dealing with a child who has ADHD can be stressful on parents and other caregivers. Pharmacists can help alleviate stress by providing credible information on treatment options and by addressing common medication concerns.

Pharmacists can also educate parents/caregivers around common ADHD myths. For example, ADHD is not caused by bad parenting, and it can’t be cured by eliminating sugar or imposing other dietary restrictions.

Ideally, pharmacists can also hone in on what parents feel are acceptable and ideal goals for ADHD treatment—and create a treatment plan with parents and other healthcare providers to meet those goals. Some questions to consider asking patients include:

- “What ADHD symptoms or behaviours do you find the most troubling?”
- “What would an acceptable response to treatment look like” in your child?”
- “What would you like to see as the perfect response for your child?”

As experts in medication management, pharmacists have a key role to play in medication adherence when it comes to treating ADHD. If the child is missing treatment doses, it’s essential for pharmacists to assess the reason why, stress the importance of daily adherence and look for strategies that specifically address the patient’s concerns. Often there is only a little education and encouragement needed on the part of the pharmacist to increase overall adherence.

**More ADHD support**

This year, Teva introduced a number of support resources to help pharmacists educate their patients and caregivers about ADHD and its treatments. These resources are available for pharmacists at [www.TevaPharmacySolutions.com](http://www.TevaPharmacySolutions.com). Patients and caregivers can also download a copy of Teva’s ADHD treatment brochure at [www.tevamakesmedicines.ca/adhd](http://www.tevamakesmedicines.ca/adhd).

Pharmacists can also encourage their patients to check out CADDAC (www.caddac.ca), a national parent support network that is designed to help families. Not only are there links to finding an ADHD specialist, there are resources for classroom accommodations and management strategies.
and improving patient experiences are also important goals.”

A recent study evaluating point-of-care testing for HIV in community pharmacies, conducted by researchers at Memorial University in collaboration with Hughes, showed the value of pharmacists’ contribution to public health. “Pharmacists are now increasingly involved in the delivery of public health-related services, such as immunizations and distribution of naloxone kits,” Hughes says. “The availability of new technology, such as point-of-care tests, allows pharmacists to become more involved in disease screening.”

Hughes is planning to expand the research to the hepatitis C virus and other sexually transmitted infections. “In addition to looking at the impact of these services in terms of outcomes and cost-effectiveness, capturing the ‘value’ in terms of patient experiences is important.”

All this research provides fodder for pharmacists’ advocacy initiatives that call for further expansions of scope and fair remuneration. To that end, CPhA has established a health economics department and hired an economist to provide metrics that support pharmacy’s value proposition. “Our goal is to arm stakeholders with information so they really understand pharmacy care, outcomes, value and cost,” says Emberley.

“We are all working towards translating value to governments and payers,” adds Walker. “Our research and harmonization efforts need to be communicated to decision-makers.” One way CPhA does this is by translating results from research, such as the UTI study, into useable, province-specific data to help provincial pharmacy associations in their talks with governments. The material is tailored to governments’ priorities and shows how pharmacy services would help them achieve their objectives.

Bates, who spends a lot of time communicating the value of pharmacy to public and private payers, agrees that evidence-based research helps “connect the dots.” However, he believes that pharmacy hasn’t done enough to tell the story from patients’ perspectives. “We’re starting to mobilize the grassroots and create a stronger awareness of how pharmacist intervention improves outcomes. Pharmacists are ready and we’re helping with marketing materials to better explain pharmacy services. And at the request of private plans, through our collaborative work on the Pharmacy Health and Insurance Steering Coalition (PHISC), we developed a national suggested reasonable fee guide while encouraging private payers to supplement public plans.”

Unlike public payers, who tend to focus more on the impact on resources in the healthcare system, Bates notes that private payers look more at employee demand and perceptions of value. “Ultimately, our goal is for private payers to view pharmacy services as the core of a drug benefit plan,” he says. “It may seem fiscally challenging, but there is value if services show reductions in presenteeism, absenteeism and disability. We are starting to see more employers bringing in pharmacists, especially in the US, to help manage drug plans.”

### Understanding service fee cuts in Alberta

Since 2012, pharmacists across Canada have viewed Alberta’s scope of practice and payment schedule for services as the gold standard for pharmacy. But the glitter was tarnished somewhat when service fees fell under the province’s new pharmacy funding framework implemented in May 2018. Did this mean that the government no longer saw value in pharmacy services?

Not at all, says Margaret Wing, CEO of the Alberta Pharmacists Association (RxA). After nearly a year of difficult negotiations with government, she stresses no one talked about not seeing value. “The new agreement is simply a reflection of the complexity of our funding model, the complexity of the health system, the political environment and the economic climate,” she says. “It’s important to remember that there was not a lot of change within the agreement, although changes were significant in terms of cost restraints.”

Alberta pharmacists’ scope was expanded in 2007 and the first funding framework for service came in 2012. “We traveled across the province asking pharmacists to step up and make the transition into the patient care service space. But it seems we did too much, too fast and too well,” says Wing. For example, from 2013 to 2018 the number of billings for initial comprehensive annual care plans climbed from 35,000 to 218,500; and the number of follow-ups escalated from 129,000 to more than 1 million (see chart on page 14).

When the NDP came to power in 2015, it faced a much tougher fiscal landscape, due largely to declining oil prices. Further, it faced inter-provincial pressures to align payments for pharmacist services with what other provinces are paying. “It’s sad to have dollars attached to the perception of value in this way, but that’s the reality we face,” says Wing. “We have worked hard in Alberta to demonstrate the value pharmacists are able to provide to the healthcare system, within our province and as an example for other provinces across Canada, and we will continue to lead this effort.”

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How are pharmacy services measuring up?
Alberta’s Pharmacy Services Framework (PSF) is likely the most comprehensive compensation model for pharmacist services in the country. So it was fitting that researchers Christine Hughes, Terri Schindel and Rene Breault set out to determine exactly how Alberta pharmacists are providing care under this framework, and how patients are experiencing care planning services in the “real world.”

With funding from the Canadian Foundation for Pharmacy (CFP) and the Alberta Pharmacists’ Association (RxA), the investigators recruited four different cases, or community pharmacies, in the province and collected data over 12 months per site. Over the course of 83 interviews and 94 hours of observation, they explored the value of pharmacy services to patients, pharmacists, other healthcare providers and policy makers.

Their results showed that patients were generally unaware of care planning services prior to being approached by a pharmacist, however, the perception of value thereafter was related to understanding pharmacists’ expanding roles in primary health care. Not only did the patients interviewed appreciate having immediate access to services, they valued the sharing of health information that occurred. One patient said he’d been waiting more than 15 months to see a specialist, and that the pharmacist was able to provide more information in just five minutes than he’d ever received from the specialist.

Interviewed healthcare providers and other stakeholders, including policy makers, noted similar perceptions of the value of care planning services. “I think this research complements other work looking at medication management services in Canada. It really helps us understand patient perceptions of value, which is useful when considering expansion of these services,” says Hughes, Professor at the Faculty of Pharmacy and Pharmaceutical Sciences, University of Alberta. “Our results are being used by other researchers in Alberta to further explore patient experiences with care planning.”

In September, the team presented study results at the International Pharmaceutical Federation’s 2018 World Congress and RxA’s 2018 Professional Development conference.

Pharmacists making right call for UTIs
“It just makes good clinical sense for community pharmacists to treat UTIs [urinary tract infections],” says Dr. Ross Tsuyuki, Director of the Epidemiology Coordinating and Research Centre at the University of Alberta. That’s why, with funding from the New Brunswick Pharmacists’ Association and CFP, he and his research team set out to track and quantify the impact of pharmacists managing patients with uncomplicated UTIs.

Tsuyuki’s instincts were right. Pharmacists’ treatment of UTIs resulted in a cure rate of 90%, and pharmacists chose the right antibiotic more than 95% of the time. “Here’s a situation where I felt using pharmacists was a no-brainer,” he says. “People are able to access pharmacists more quickly than they can their physicians and when it comes to UTIs, even an extra day of unpleasant symptoms isn’t good.”

The research team is now looking at patterns of antibiotic usage, and conducting an economic analysis. “I’m pretty confident that we will see something very interesting in the evidence,” says Dr. Tsuyuki. “We hope pharmacy associations will be taking this information forward and using it to change policy.” (See page 4 for more on how the New Brunswick Pharmacists’ Association is using the study results).

The group is also developing an online practice tool that will help pharmacists document their work around UTI treatment and keep track of patients treated. “On the one hand a trial is good for evidence, but evidence without implementation is still incomplete,” says Tsuyuki.

Deprescribing, within a pharmacist’s domain?
Community pharmacists can have a vital role in deprescribing, according to the Catalyst Study, which was funded by CFP.

When equipped with training and resources, pharmacists at all four pharmacies in the Catalyst Study were able to effectively integrate the use of deprescribing guidelines via various approaches. “There really is no one-size-fits-all when it comes to successful implementation,” says Barbara Farrell, lead investigator and scientist at the Bruyère...
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A sampling of projects funded by CFP

- Pharmacists' support for high-dose opioid patents
- Strategies to improve diabetes care
- Pharmacists' prescribing for UTIs
- Mobilizing pharmacists for deprescribing
- Clinical effectiveness of pharmacists' travel medicine services
- Pharmacists' value in prescribing for minor ailments
- Home-visit medication reviews
- Pharmacists' role in personalized medicine
- Pharmacists' value in hypertension management
- PLUS 24 grants for personal leadership development since 2012
Research Institute in Ottawa. She notes one pharmacy in particular, which spent a lot of time advertising the service and was able to bring in new patients wanting to learn more as a result.

“I was also really surprised by the involvement of all front-line staff and how engaged they were in figuring out which patients were eligible,” adds Farrell. Data generated from the study helped to populate a business model template that can be used to develop an in-depth business model for deprescribing in community pharmacies.

The Bruyère Deprescribing Guidelines Research Team developed a series of YouTube videos (about the guidelines and recommendations based on drug class) that have been viewed by people in more than 97 countries. The team also hosted a global symposium on the topic early this year, and created a repository for researchers and collaborators to share descriptions of their work and information about ongoing and upcoming deprescribing initiatives. The goal is to facilitate both information exchange and collaboration.

Going forward, Farrell and her team will be working with the Ontario government to look at the resources necessary for the viable implementation of deprescribing initiatives in community pharmacies and other practice settings. For more information on this deprescribing initiative go to deprescribing.org.

**Pharmacists’ fit in travel medicine**

We now know Canadians are very willing to receive a pre-travel consultation and vaccinations from a pharmacist-managed travel clinic, and 94% were satisfied by the care received, thanks to a study conducted by Sherilyn Houle, Assistant Professor at the School of Pharmacy, University of Waterloo. Now that message is getting wider play.

Since the results of this CFP-funded study were published earlier this year in *Travel Medicine and Infectious Disease Journal*, Houle has been invited to share her findings with travel medicine practitioners from around the world at the 2019 conference of the International Society of Travel Medicine (ISTM). She is also working on an Alberta study funded by ISTM to look at trends in adherence to multiple-dose travel vaccine regimes with pharmacists as immunizers.

“Now that we have evidence that supports a role for pharmacists in providing travel services in a specialized setting, I am interested in examining how we can encourage and support community pharmacists to provide care for travellers,” says Houle. In fact, she is currently supervising a graduate student whose thesis aims to develop, validate and test a triage tool for pharmacists to quickly determine if a patient coming into the pharmacy for a travel-related need would benefit from a pre-travel consultation.

Furthermore, Houle points to the business benefits in providing travel medicines. At a consultation fee of $45-$60, coupled with vaccine administration fees and dispensing fees for oral and injectable prescriptions, she says a pharmacy could generate approximately $110-$130 per travel patient.

Find more detail about these and other research projects at www.cfpnet.ca (Grants & Awards).
A Cross-Country Look at Provincial Pharmacy Initiatives

This year’s poll of provincial pharmacy associations provides a snapshot of their current priorities in the areas of expanded scope and proving the value of pharmacists’ services to public and/or private payers.

We asked each association the following two questions:

1. **EXPANDED SCOPE** What is your current top priority for expanded scope of practice in your province?

2. **PROVING VALUE** What is your current top priority in terms of “making value connections” with public and/or private payers?

**BRITISH COLUMBIA PHARMACY ASSOCIATION**

1. Authority for pharmacists to initiate treatment for conditions that patients can self-identify and that are limited, such as urinary tract infections, travel medicine and smoking cessation.

2. We have relaunched our MLA Outreach Program to help drive grassroots advocacy. It is increasingly important for pharmacists to inform local government officials how political decisions may negatively affect the health of their constituents. As well, we can plant the seeds for solutions, such as pharmacist-initiated therapy.

Source: Linda Gutenberg, Deputy CEO & Director, Pharmacy Practice Support

**ALBERTA PHARMACISTS’ ASSOCIATION (RxA)**

1. Expansion of pharmacist access to publicly funded vaccines, including provision of influenza vaccine to include children 5 years of age and older, and the planned addition of pneumococcal vaccine beginning January 1, 2019. Last year, Alberta pharmacists provided over 50% of all influenza vaccinations in the province.

2. As part of our strategic plan, we are aligning resources and operational goals towards establishing, achieving and solidifying relationships between pharmacists and their local elected officials. The MLA Outreach program helps pharmacists plan and conduct meetings with Members of the Legislative Assembly, framed around consistent messaging and factual information.

Source: Matt Tachuk, Director of Pharmacy Practice

**PHARMACISTS MANITOBA**

1. Improved government relations to facilitate a strategy for the delivery of pharmacy services, including compensation.

2. A year ago, we implemented a new strategy to engage with the provincial government, one that focuses on learning about their goals, highlighting the strengths of pharmacy practice and exploring shared opportunities. We successfully met with the former Minister of Health several times and built a relationship that enabled us to talk about pressing issues facing pharmacists. Following a provincial cabinet shuffle, we have begun to build this same type of relationship with the recently appointed Minister of Health.

Source: Dr. Brenna Shearer, CEO

**PHARMACY ASSOCIATION OF SASKATCHEWAN**

1. Legislation for pharmacists to order labs is in place, but system readiness needs to catch up (e.g., technology). We are working with stakeholders to bring the system to readiness so that pharmacists can exercise this authority. We are also working with our regulator and government to add travel health services under pharmacists’ scope of practice, with implementation expected in 2019.

2. System savings and patient outcomes from pharmacists providing minor ailment services continues to be established and confirmed in our province, across the country and around the world. We inform stakeholders and the public on the safety profile and enhanced access to minor ailment services, based on our data. We also showcase the value added to the system when pharmacists administer, and in some cases assess and prescribe for, the host of available vaccines and other injectables.

Source: Myla Wollbaum, Director of Professional Practice
Reconfiguration of the pharmacy funding

1. Universality of reimbursement for expanded-scope services for all patients, rather than only those covered under the provincial drug plan.

2. We are using a variety of methods, such as public workshops and targeted advertising, to educate the public that pharmacists are easily accessible healthcare professionals who can perform minor ailment prescribing, medication adaptations, therapeutic substitution and injection services in all pharmacies, freeing up physicians and nurse practitioners to treat more complex patients.

Source: Glenda Power, Executive Director

Common ailment assessment and prescribing

1. Expansion of vaccines eligible for prescribing and administration by pharmacists, especially travel vaccines, as well as expansion of the minor ailments program to include assessment and prescribing for uncomplicated UTIs and hormonal contraceptives. We also advocate for a common scope of practice for all Canadian jurisdictions.

2. Promotion of the role pharmacists can and should be playing in meeting the needs of the public, through assessing and prescribing for minor ailments, managing issues such as contraception, smoking cessation and other healthcare issues that do not require physician diagnoses, administering injections, etc. We advocate that there is mounting evidence (e.g., the 2018 UTI study conducted in New Brunswick) to support the role of pharmacists in these roles, as providers who can provide the service more efficiently while saving healthcare dollars.

Source: Erin MacKenzie, Executive Director

PHARMACISTS’ ASSOCIATION OF NEWFOUNDLAND AND LABRADOR

1. We are focusing on addressing the government’s desire to end “hallway medicine,” and we offer a robust educational program to help pharmacists prepare for taking on this role.

2. Reconfiguration of the pharmacy funding model to one that fits more with a quality-centric, value-based offering. We are educating public and private payers that an economic model that sees pharmacy as a cost of dispensing rather than an investment in patient care is destined to lead to more funding cuts, which eventually hurts all parties. We are establishing a taskforce to evaluate options for a new model that renumerates the services provided, the pharmacist and the pharmacy. We are re-evaluating current, funded professional services to capture/measure data that correlates to a value proposition for the patient and/or health system.

Source: Allan Malek, Executive Vice-President & Chief Pharmacy Officer

PHARMACEUTICALS’ ASSOCIATION OF NOVA SCOTIA

1. Expansion of prescribing authority to include hormonal contraception and UTIs, as well as expansion of renewal authority and injection authority.

2. We are focussed on working with government to improve access to primary care services, especially in areas of the province with severe physician shortages. We also anticipate positive results from two pilot projects currently underway: the Community Pharmacist-led Anticoagulation Management Service, in partnership with Doctors Nova Scotia and the Nova Scotia Department of Health and Wellness; and the Collaborative Care Demonstration Project, in partnership with Doctors Nova Scotia and partly funded by the Nova Scotia Department of Health and Wellness.

Source: Allison Bodnar, CEO

ONTARIO PHARMACISTS ASSOCIATION

1. Common ailment assessment and prescribing. Our advocacy focuses on addressing the government’s desire to end “hallway medicine,” and we offer a robust educational program to help pharmacists prepare for taking on this role.

2. Reconfiguration of the pharmacy funding model to one that fits more with a quality-centric, value-based offering. We are educating public and private payers that an economic model that sees pharmacy as a cost of dispensing rather than an investment in patient care is destined to lead to more funding cuts, which eventually hurts all parties. We are establishing a taskforce to evaluate options for a new model that renumerates the services provided, the pharmacist and the pharmacy. We are re-evaluating current, funded professional services to capture/measure data that correlates to a value proposition for the patient and/or health system.

Source: Allan Malek, Executive Vice-President & Chief Pharmacy Officer

PRINCE EDWARD ISLAND PHARMACISTS ASSOCIATION

1. Expansion of vaccines eligible for prescribing and administration by pharmacists, especially travel vaccines, as well as expansion of the minor ailments program to include assessment and prescribing for uncomplicated UTIs and hormonal contraceptives. We also advocate for a common scope of practice for all Canadian jurisdictions.

2. Promotion of the role pharmacists can and should be playing in meeting the needs of the public, through assessing and prescribing for minor ailments, managing issues such as contraception, smoking cessation and other healthcare issues that do not require physician diagnoses, administering injections, etc. We advocate that there is mounting evidence (e.g., the 2018 UTI study conducted in New Brunswick) to support the role of pharmacists in these roles, as providers who can provide the service more efficiently while saving healthcare dollars.

Source: Erin MacKenzie, Executive Director

NEW BRUNSWICK PHARMACISTS’ ASSOCIATION

1. Closing the service funding gap with other provinces, starting with public funding for minor ailment assessments and prescribing, and expanding the pharmacist’s role in administering publicly funded vaccines. A renewed agreement with government is also a high priority.

2. We recently completed the RxOUTMAP study, which conclusively shows that pharmacists’ interventions for uncomplicated urinary tract infections benefit both patients and the healthcare system. In our report to government and during the recent election campaign, when we met with many of the candidates, we focused on government’s untapped return on investment for pharmacists’ services. We also focused on the need for an environmental stewardship program for unused medication and used needles and sharps.

Source: Paul Blanchard, Executive Director

ASSOCIATION QUÉBÉCOISE DES PHARMACIENS PROPRIÉTAIRES

1. For the past year we have been part of a joint committee with the Québec Ministry of Health to redefine the pharmacist reimbursement model, with an emphasis on funding services that add value to the system. The complete new model will be implemented as of April 1st, 2020; an interim, two-year agreement recently brought in funding for three existing services and two new ones.

2. We continue to address challenges faced by public and private payers. Our current collaborative relationship with government was precipitated by its drastic cuts in 2015 to fees for compliance packaging. Government eventually repealed the cuts, in large part because we were able to address their objectives in other ways. Out of this process, both sides agreed that the whole pharmacy reimbursement model needed updating in order to compensate and incentivize services that bring value to the total system.

Source: Jean Bourcier, Executive Vice-President & CEO
**PROFESSIONAL SERVICE FEES AND CLAIMS DATA FOR GOVERNMENT-SPONSORED PHARMACIST SERVICES, BY PROVINCE**

*Note: All content in RED indicates that public funding is available only to eligible beneficiaries of the provincial drug plan.*

### BRITISH COLUMBIA | ALBERTA | SASKATCHEWAN | MANITOBA
---|---|---|---
**Patient care plans** | $125 per Comprehensive Annual Care Plan (CACP) with additional prescribing authority (APA) or $100 per CACP without APA (218,510 claims); $75 per Standard Medication Management Assessment (SMMA); $25 per follow-up with APA or $20 (1,074,151) claims for CACPs; $92.940 for SMMA; $75 per follow-up with APA or $60 per SMMA for Diabetes and $25 with APA or $20 per follow-up (10,331 claims combined). See FOOTNOTE BELOW | Medication reviews a component of CACPs and SMMA (see Patient care plans above) | $60 per Medication Assessment (seniors); $30 per follow-up, max. 2 annually ($1,152 claims); $60 per Medication Assessment and Compliance Packaging (1,752 claims) | $60 per Medication Review - Standard, max. 2 annually, 6 mths apart (1,275,953 claims); $70 per Medication Review - Pharmacist Consultation, max. 2 annually, 6 mths apart (16,592 claims); $15 per Medication Review Follow-Up, max. 4 annually (17,540 claims)

**Medication reviews/management** | $10 for dispensing of flu, 15,072 claims for pneumonia, 18,819 claims for pertussis, HPV and other immunizations | $20 ($16,625 claims for flu; $13 for pneumonia, as of Jan 1, 2019; authority for other immunizations, inc. travel vaccines SEE FOOTNOTE BELOW | $13 (118,050 claims for flu) | $10 per Medication Review - Standard, max. 2 annually, 6 mths apart (1,275,953 claims); $70 per Medication Review - Pharmacist Consultation, max. 2 annually, 6 mths apart (16,592 claims); $15 per Medication Review Follow-Up, max. 4 annually (17,540 claims)

**Immunization** | $20 ($16,625 claims for flu; $13 for pneumonia, as of Jan 1, 2019; authority for other immunizations, inc. travel vaccines SEE FOOTNOTE BELOW | $13 (118,050 claims for flu) | $7 (107,162 claims for flu; $7 (107,162 claims for flu, maximum $10 for influenza immunization); $60 per medication assessment | $10 ($16,625 claims for flu, maximum $10 for influenza immunization); $60 per medication assessment

**Administration of drugs by injection** | $20 per medication and administration of drugs by injection (188,228 claims) | Authority to administer drugs by injection | Authority to administer drugs by injection | $20 per medication and administration of drugs by injection (188,228 claims)

**Prescribing authority: adaptation/altering of prescriptions** | $20 per assessment for renewal/adaptation/discontinuation (515,875 claims for renewals; 159,338 claims for adaptations) | Authority to renew, alter dosage form or alter missing information (total of 277,322 claims for all Rx authority, i.e., renewals/adaptations, emergency prescribing and medication reconciliations with prescribing (see "Prescribing authority: initial access" for details) | Authority for continuity of care prescribing and prescription adaptations | Authority to renew, alter dosage form or alter missing information (total of 277,322 claims for all Rx authority, i.e., renewals/adaptations, emergency prescribing and medication reconciliations with prescribing (see "Prescribing authority: initial access" for details)

**Prescribing authority: minor ailments** | As part of CACPs, SMMA as those with additional prescribing authority | $18 per Minor Ailment Assessment for 16 conditions (16,704 claims) Authority to assess and prescribe for 7 additional conditions | Authority to assess and prescribe for 12 self-limiting conditions ("minor ailments") | As part of CACPs, SMMA as those with additional prescribing authority

**Prescribing authority: initial access or to manage ongoing therapy (exc. minor ailment)** | $25 per assessment for initiating medication therapy with APA (300,396 claims). $20 per assessment for emergency prescriptions (19,788 claims). $20 per assessment for continuity of care during declared "state of emergency" (claims data n/a) | Collaborative Practice Agreements with physicians enable pharmacists to select, initiate, monitor and modify drug therapies, 2X dispensing fee, max. $22.80 for emergency contraception prescribing (8,251 claims); $25 for medication reconciliations with prescribing (claims inc. under all Rx authority, see "Prescribing authority: adaptation") | Authority for prescribing by Extended Practice pharmacists within the scope of their specialty. Authority to prescribe in "state of emergency" | $25 per assessment for initiating medication therapy with APA (300,396 claims). $20 per assessment for emergency prescriptions (19,788 claims). $20 per assessment for continuity of care during declared "state of emergency" (claims data n/a)

**Refusals to fill** | $20 | $20 per assessment (5,053 claims) | 1.5K dispensing fee, max. $17.10 per claim | $20

**Therapeutic substitutions** | $17.20 (8,369 claims) | $20 per assessment (claims included under adaptation) | $17.10 per claim | $17.20 (8,369 claims)

**Pharmaceutical opinions** |  |  | Authority to prescribe for smoking cessation |  | Authority to prescribe for smoking cessation

**Smoking cessation** | $10 per dispensing of nicotine replacement therapy, max. 3 annually (140,000 claims) | As part of SMMA and follow-up SMMA; max. 4 follow-ups (32,618 claims) | Up to $300 annually ($2 per minute) for Partnership to Assist with the Cessation of Tobacco (PACT) (4,638 claims) | Authority to prescribe for smoking cessation

**Other services** | $10 for trial prescriptions (claims data n/a) | $20 for assessment of appropriateness of new prescription medications (trial prescriptions) | Authority to prescribe for smoking cessation | $10 for trial prescriptions (claims data n/a)

**FOOTNOTES: Information current as of September 2018, collected from provincial pharmacy associations and ministries of health. Claims data are for fiscal year ending March 31, 2018, with the exception of Quebec per follow-up, with or without APA. The fee for flu shots changed to $13. In Manitoba, claims data for pneumonia and Tdap immunizations include non-publicly funded injections. In all provinces, pharmacists are licensed and governed by the provincial College of Pharmacists. In Quebec, legislation requires private insurance plans to pay the same professional service fees as the public plan, except for refusals to fill and Pharmaceutical Opinions. This chart gives claims data for the province."
### PROFESSIONAL SERVICE FEES AND CLAIMS DATA FOR GOVERNMENT-SPONSORED PHARMACIST SERVICES, BY PROVINCE

#### QUEBEC*

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Fee</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority to administer drugs by injection and vaccination for non-publicly funded</td>
<td>$16.25 per medication</td>
<td>Administration of drugs by injection for non-publicly funded vaccines</td>
</tr>
<tr>
<td>Authority to administer drugs by injection</td>
<td>$18.30 per administration</td>
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<tr>
<td>Authority to administer drugs by injection</td>
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</tr>
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<td>Authority to initiate Schedule 1 smoking cessation therapy; see below for funding</td>
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#### NOVA SCOTIA

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<tbody>
<tr>
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#### NEW BRUNSWICK

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*Quebec where the data is for year ending June 30, 2018. In Alberta, as of May 17, 2018, fees changed to $100 per CACP; $60 per SMMA and $20 to have authority to prescribe emergency refills.

Public plan only. Funding for professional fees kicks in after patients meet the universal drug plan’s requirements for deductibles and co-pays.
Overactive bladder (OAB) is a condition many people are too embarrassed to talk about. Yet according to the Canadian Urological Association (CUA), OAB is common in both sexes and affects up to 18% of Canadians. Those with OAB suffer from urinary frequency, nocturia and urinary incontinence. With this constant need to be close to a bathroom, it’s not surprising that OAB contributes to lower productivity and lower quality of life. In fact, several studies have highlighted the negative impact that OAB can have on daily activities and social interaction—as well as mental health and sexual function. OAB has been linked to depression, and patients report having symptoms that make them feel isolated and truly helpless. Plus, they often wait years and years to seek treatment that could substantially improve their situations.

But it doesn’t have to be that way. Behavioural therapies, lifestyle changes and pharmacotherapy can have a huge impact on improving the quality of life for people with OAB.

As the medication experts and most accessible healthcare professionals around, pharmacists too can play a key part. Not only can pharmacists help identify people suffering with OAB, they can help ensure these patients are managing their symptoms with the right treatment plan. Pharmacists can also make patients aware of the fact there are multiple options available to treat OAB.

A key role for pharmacists in OAB treatment
Once OAB is identified as a concern, pharmacists can educate patients about effective behavioral changes, such as tracking liquid intake, weight loss and bladder training/pelvic floor physiotherapy. One study showed that weight loss in obese women reduced overall incontinence episodes by 47% per week.1

With a wide variety of oral medications on the market to alleviate OAB symptoms, pharmacists can also collaborate with physicians to ensure patients are on the right class of drug to serve their situations best. Some drugs, for example, have cognitive side effects that could increase a patient’s risk of falls and may be less suitable for the elderly and other vulnerable populations. Pharmacists can refer to the CUA guideline on adult overactive bladder for detailed information on treatment options.2

2.  Can Urol Assoc J 2017;11(5):E142-73. http://dx.doi.org/10.5489/cuaj.4586 Published online May 9, 2017

Screening for OAB in the pharmacy
Screening patients, especially seniors who present with other health concerns or are on medications that can prompt symptoms, can be a good way to determine if overactive bladder is an issue. Here are some questions to consider asking patients at risk for OAB:

- Are you bothered or concerned about being able to control your bladder?
- Do you have urine leaks?
- Do you ever have a sudden need to urinate immediately?
- How many times a day do you urinate?
- Have you ever been on OAB therapy in the past? Why did you stop?
- Do you know there are newer medications available with fewer side effects?

By Rosalind Stefanac
Overactive bladder: helping patients get their lives back

The Canadian Foundation for Pharmacy thanks Astellas for its sponsorship of this article.
## Claims data trends

### CLAIMS FOR FLU SHOTS

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<thead>
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<tbody>
<tr>
<td>British Columbia*</td>
<td>193,800</td>
<td>383,300</td>
<td>434,700</td>
<td>420,400</td>
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<td>487,000</td>
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<tr>
<td>Saskatchewan</td>
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<td>54,400</td>
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<td>56,600</td>
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<td>Ontario</td>
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<td>901,400</td>
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<td>100,700</td>
<td>98,100</td>
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<td>124,800</td>
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<td>55,100</td>
<td>63,300</td>
<td>72,700</td>
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<td>5,000</td>
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<td><strong>Total</strong></td>
<td>629,400</td>
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<td>1,980,200</td>
<td>2,035,400</td>
<td>2,451,100</td>
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</table>

*Public funding in BC and NB limited to seniors and high-risk groups
**Public funding in PEI limited to high-risk groups in 2015/2016; expanded to total population in 2016/2017
***Public funding in NL limited to beneficiaries of public drug plan

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### ALBERTA

- **Follow-ups, CACPs**: 538,800
- **Comprehensive Annual Care Plans**: 298,720
- **Minor ailments**: 7,500
- **MedsCheck Annuals**: *In fall 2016, government implemented standardized, detailed documentation requirements*

### SASKATCHEWAN

- **Minor ailments**: 7,500
- **MedsCheck**: 1,074,200

### ONTARIO

- **MedsCheck Annuals**: 777,900
- **Prescribing to manage ongoing therapy**: 461,500

### QUEBEC

- **Prescription renewals**: 281,500
- **Minor ailments**: 248,200
- **Prescribing to manage ongoing therapy**: 238,500

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Go to [www.cfpnet.ca](http://www.cfpnet.ca) for additional provincial claims data, and to download a summary document.

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*Year ending Dec. 2016  **Year ending June 2018*
Caring for patients with no second-guessing

For your patients with diabetes, numbers are always top of mind. Help them move forward with confidence by recommending the OneTouch Verio Flex® meter. It’s the meter that:

• Met and, in a clinical study, exceeded Health Canada requirements for system accuracy*

• Uses ColourSure™ technology to quickly show when your patients’ results are in or out of range

• Connects wirelessly with the OneTouch Reveal® app to help manage diabetes on-the-go

Don’t second-guess. Recommend the OneTouch Verio Flex® meter today.

* In a clinical study, conducted in accordance with the requirements of ISO 15197:2013 in vitro diagnostic test systems – Requirements for blood-glucose monitoring systems for self-testing in managing diabetes mellitus. 95.5% of system accuracy results were within ±0.56 mmol/L (<5.56 mmol/L) or ±10% (≥5.56 mmol/L). 99.5% of results were within ±0.83 mmol/L (<5.56 mmol/L) or ±15% (≥5.56 mmol/L) and 100% (600 of 600) of the results in Zone A, defined as “no effect on clinical action”. In addition for User Performance, 97.6% of results were within ±0.83 mmol/L (<5.56 mmol/L) or ±15% (≥5.56 mmol/L) 

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Taking diabetes care to the next level

When it comes to diabetes management, a greater role for pharmacists makes the most sense

As a certified diabetes educator, pharmacist Susie Jin has been fortunate to work with diabetes patients in a variety of practice settings, including physicians’ offices. Now, as an owner of Pharmacy 101 in Cobourg, Ont., she sees a steady stream of diabetes patients daily and will tell you she really appreciates the advantages of providing diabetes care in the community pharmacy setting.

“With so many pharmacies to choose from, I think it’s a real honour when they come into ours and allow us to be a part of their lives,” she says, noting that follow-up appointments and medication refills provide further opportunities for connecting with this patient group. “These frequent interactions allow pharmacists to support patient self-management of their condition, providing a continuum of care, sometimes little bits at a time.”

As a chronic condition affecting some 3.5 million Canadians, diabetes generates significant health and financial burdens for both patients and the healthcare system. In 2016 alone, this disease cost the Canadian healthcare system $3.4 billion. But more and more research is backing up what Jin is demonstrating in her own workplace: pharmacists in the community can have a significant impact on chronic conditions such as diabetes. Over the long term, this also translates into major healthcare cost savings.

Take the RxEACH study, the world’s largest randomized trial in a community pharmacy setting that demonstrates pharmacists’ case finding, prescribing and care can reduce the risk of major cardiovascular events by 21%, compared to usual care. In a subsequent economic analysis, the team reported that such care could save the healthcare system $4.6 billion over 30 years if it reaches just 15% of the nine million eligible Canadians.

These studies’ overwhelmingly positive findings (for clinical outcomes, patient support and cost savings)—combined with the fact that CVD is the leading cause of death among patients with diabetes—prompted Dr. Yazid N. Al Hamarneh and his co-investigators at the University of Alberta to take action. They developed a practice tool to facilitate pharmacists’ best practices in the provision and documentation of all aspects of diabetes care.

The RxING Practice Tool walks pharmacists through the process of working with patients with diabetes, including documentation forms, an interactive CV risk calculator and a care plan that’s pre-populated with information to prevent duplicate inputting of data. The tool also tracks the individual patient and patient population progress in terms of glycemic control and CV risk, and will send reminders to the pharmacist when it is time to follow up.

So far about 40 pharmacies in Alberta are using the free online tool—accessible through a username and password—and pharmacists are reporting favourable results. “We’d be more than happy to implement it beyond Alberta too if there is interest,” says Al Hamarneh, adding that pharmacists can contact him directly for more details.

“At the end of the day we are all in this for the patients and there are many people with diabetes who are not at target and need our help,” he says. “We have an obligation as pharmacists to work with these patients to improve their outcomes and bring them back to the healthcare system if need be.”

The RxING Practice Tool will also serve as a source of real-world evidence to demonstrate the value of community pharmacists’ services beyond clinical trials. “This tool will help to take the fantastic evidence supporting pharmacists’ interventions in patients with diabetes to the next level, as it will provide an opportunity to implement such interventions on a wide scale and will provide a very large ‘real world’ dataset on pharmacists’ day to day interventions.”

In the meantime, researchers such as Dr. Lori MacCallum, Program Director at the Banting and Best Diabetes Centre at the University of Toronto, are looking into getting a better understanding of what is preventing community pharmacists from doing more for their diabetes patients. Her research was prompted by the finding that, while 50% people with diabetes in Ontario
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At Apple Drugs in La Crete, Alta., pharmacist Nella Fehr is ready, willing and able to administer immunizations, including influenza and travel vaccines. But it can be a challenge convincing locals to take advantage of her service.

“This is a faith-based community, where many people believe that sickness and healing is in God’s hands,” Fehr explains. “Even though we do all the education and promotion for flu shots, the uptake is very little.” As a result, Fehr tends to focus on travel and other vaccinations, for example for shingles and pneumonia. Slowly, people are realizing the importance of protecting themselves. In fact, this fall Apple Drugs is going to promote flu shots again and expects to do some 20 to 30 injections. “I know that sounds really low compared to other pharmacies but it would be great for us. We’re working hard to make immunization rates better in this small community.”

Like Fehr, thousands of injection-trained pharmacists are doing their part to improve immunization rates across Canada. In Richmond, B.C., Alex Dar Santos, pharmacist associate with Shoppers Drug Mart, agrees that it can be hard to convince some individuals to be immunized. But since 2012, the number of flu shots given at his pharmacy has gradually increased and last year his team administered more than 1,500.

“In Richmond there’s been a shift for people to get flu shots in pharmacies rather than doctors’ offices,” Dar Santos explains. “Over the years, we’ve developed a good relationship with Public Health so last year we were able to get extra vaccine that physicians weren’t picking up. Although we went over our allotment of vaccine, we still ran out of supply, otherwise we could have given even more flu shots.”

No doubt many Canadian pharmacists could share similar anecdotes that illustrate how pharmacist-administered injections have a positive impact on individuals and the broader healthcare system. And there is a growing body of research to back them up.

For example, according to the latest report on flu vaccine coverage by the Public Health Agency of Canada, for the 2016-2017 season, surveyed Canadians were almost as likely to go to pharmacies (28%) as they were to physicians’ offices (33%) when it came to getting their flu shot.

“Pharmacists have an important role to play in enhancing vaccine uptake among adults and this role is evidence-based,” says Dr. Susan Bowles, past chair of Immunize Canada. She was part of the research team that found an increase in overall vaccination coverage in Nova Scotia from 2013 to 2015, after pharmacists gained authority to administer flu shots. More recent studies drew similar conclusions. Citing a study published in 2017 in the Canadian Medical Association Journal, Bowles says that early data from multiple Canadian jurisdictions show a moderate increase in the rate of influenza immunization following implementation of pharmacists as immunizers.

Pharmacists who administer other types of vaccines can also have a positive impact on immunization rates. Bowles points to two studies published in 2016, one in the Journal of the American Pharmacists Association and the other in Vaccine, that demonstrated overall vaccination rates for a variety of vaccines—including influenza, herpes zoster, pneumococcal and Tdap—increased two- to three-fold when pharmacists immunize. And a 2017 U.S study in Population Health Manager also demonstrated that pharmacists are able to identify unmet vaccine needs, such as for pneumococcal disease, herpes zoster and Tdap, among patients who presented for influenza vaccine. “Pharmacists were either able to provide these vaccines or refer to another practitioner, thereby enabling patient access to immunization services,” notes Bowles.

Meanwhile, researchers at the Ontario Pharmacy Evaluation Network (OPEN) have spent years studying the impact of pharmacists as immunizers. An OPEN study co-led by Dr. Sherilyn Houle and Dr. Nancy Waite looked at administrative data...
Allison Tario sees the transformation time and again when speaking about naloxone—people’s faces are initially polite, then suddenly brows furrow in concentration, or eyebrows lift in surprise. “With the scope of the opioid crisis in Canada being what it is, people are coming to realize that the risk of overdose can be real for someone they know, or for themselves. This is not something that’s a concern only for people taking illicit drugs, but for prescription opioid users as well,” says Tario, a pharmacist at Roulston’s Pharmacy in Simcoe, Ontario.

Tario has become a champion of naloxone distribution in Simcoe and surrounding counties. Her journey began about two years ago, when she learned that the local public health unit was not yet distributing naloxone. Tario connected with the unit’s harm reduction team and offered to help with community education and distribution. Their collaboration quickly grew to include other pharmacists, physicians, mental health support teams, first responders, the school board and the First Nations community, among others.

“We recognize that naloxone is not the only answer to the opioid crisis, but it’s a piece of the puzzle in keeping people safe. Pharmacists have a huge role to play,” says Tario.

She sees raising awareness as one of pharmacists’ biggest roles, both in the pharmacy and community. Tario has given presentations at the library, service clubs, for seniors’ groups, schools and crisis centres—wherever she’s asked, or whenever someone accepts her offers to speak. “It’s a new way to engage with the community. We are de-stigmatizing the conversation about naloxone and opioid use. The focus is really on supporting each other, and building a stronger community as a whole. It’s all very fulfilling for me as a pharmacist,” says Tario.

Since the nasal spray format became available last year, the conversation has become that much easier. “The nasal spray has really broken down the barrier in terms of people’s fear of needles. They see it as an easy-to-use option. I’d say 98% of our distribution now is for the spray,” says Tario.

Tario offers the following action steps for pharmacists:

- **Train all pharmacy staff and ask if they’d like a naloxone kit of their own.** “I started carrying a kit because I visit patients in their homes, I hear about people using party drugs, and I could come across someone in the community who needs help. It’s another tool in your first aid kit, and something people should think about having on hand,” says Tario.
- **Actively identify patients who are at risk of opioid overdose, such as patients with cognitive impairment, a history of substance use disorders, lung disease, or people who mix opioids with alcohol or other depressant drugs.** “We don’t wait for people to ask for the kit. We offer it, and help them understand why it may be important for them personally,” stresses Tario.
- **Remember to review the safe storage of opioids as well, and remind people to return unused opioids to the pharmacy for disposal.**
- **Take advantage of educational materials from your province or the manufacturer.** “Something as simple as a poster is a way to start the conversation,” says Tario.
on influenza immunization rates before and after 2012, when Ontario pharmacists began administering flu shots. “In general we have found that while physicians remain the primary immunizers in Ontario, the number of individuals being immunized by pharmacists is increasing,” says Sherilyn Houle, who is Assistant Professor at the School of Pharmacy, University of Waterloo. “Once a person receives a vaccine from a pharmacist, they are two times more likely to be vaccinated by a pharmacist again the following year.”

This trend doesn’t simply represent a shift of patients from physician to pharmacist vaccinators, but also an increase in newly vaccinated individuals, Houle says, adding that her research found an overall increase in the number of Ontarians being vaccinated after pharmacists adopted the service. “People vaccinated by pharmacists are more likely to be younger, have fewer medical conditions and have higher income than those vaccinated by physicians, suggesting that the pharmacy may be seen as a convenient and accessible option for working adults.”

Houle is currently analyzing administrative data from Alberta to see if the availability of pharmacist immunizers can be associated with improved completion rates for travel vaccines requiring multiple doses (see page 11 for more details).

She has also completed a research paper, soon to be published in *ClinicoEconomics and OutReach Research*, that shows the impact of pharmacists as immunizers against influenza in Ontario. “Given that working adults appear to prefer to be vaccinated in pharmacies…the biggest impact by far was on productivity,” she says. “Millions of dollars are saved when these working adults don’t have to take the time off of work to be vaccinated, or because of illness. Looking at the economic impact of immunizations from only the healthcare system perspective, as most studies do, misses these benefits from the societal perspective.”

Bowles stresses that pharmacists’ accessibility provides ample opportunities to reduce the incidence of disease in communities. “The need to increase vaccination rates has highlighted how pharmacists can contribute to this effort and advance public health by identifying vaccine requirements and educating patients about the importance of vaccination.”

Her own experiences with vaccine hesitancy have made Fehr more determined than ever to encourage immunization. “People aren’t as reluctant to get travel vaccines because they see that [risk of illness] as a higher threat,” she says. “So if we start there and show the importance of preventing disease, hopefully more people will start to understand the importance of immunization against other diseases such as shingles, pneumonia, whooping cough, meningitis and influenza.”


**Diabetes continued from page 19**

had an initial medication review within the first 3.5 years of the MedsCheck program, only 3% had a follow-up.1

“This is surprising, given the complexity of medications these patients were taking,” says MacCallum. “Why are we missing this opportunity to follow up with patients with chronic diseases, especially when we have the tools in place with MedsCheck for Diabetes?” (Patients with diabetes are eligible for one MedsCheck for Diabetes annually, as well as multiple follow-ups as long as they are performed at the same pharmacy.)

With financial support from the Canadian Foundation for Pharmacy’s Innovation Fund, MacCallum and her team are currently surveying pharmacists to get answers. The survey, sent to 8,000 pharmacists, asks about attitudes and experiences around conducting follow-ups for diabetes care. “Even if they are following up, but aren’t documenting, that means there is no continuity of care and other healthcare providers don’t know about it,” says MacCallum. “A person with diabetes continues to be at risk for side effects, so doing a MedsCheck once a year is not enough.”

The second phase of the study, launching this fall, will see community pharmacists testing solutions to improve follow-ups with diabetes patients in their own pharmacies, over a period of several months. “We keep hearing about the lack of time and software and reimbursement as potential barriers, but I think there’s also something in the pharmacist’s confidence level and skillset that’s worth exploring,” says MacCallum. “If you never do follow-up, you never become good at it.”

Jin suggests pharmacists interested in increasing diabetes services within their pharmacies start with those patients who are already asking questions about their condition. “When patients are engaged, they are often in the preparation or action stage of change,” she says. “It makes patient-pharmacist interactions very effective.”

Then it’s important to follow up with a letter to their diabetes healthcare team, noting what was discussed and recommended, adds Jin. “I think pharmacists offer the best of both worlds: patients can benefit from easy access to pharmacist care while communication and collaboration continues with the whole diabetes healthcare team, which supports improved patient outcomes.”

MacCallum hopes uncovering the true barriers currently holding pharmacists back—and delivering tools to overcome them—will open the door to a much more active role for pharmacy in diabetes care. “We know that diabetes medications are life-saving and prevent complications,” says MacCallum. “Pharmacists as medication experts need to have a very central role in helping optimize these drugs for patients.”

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THE EVOLVING WORLD OF BIOLOGICS

Biologic medications have asserted their place in the pharmaceutical landscape and, judging from the current pipeline for new drugs in Canada, they will steadily stake a larger claim. The evolving market may also signify a growing role for pharmacists in community practice. Here’s an overview of what you need to know. By Karen Welds

WHAT’S ON THE HORIZON

Of the 86 drug submissions currently under review by Health Canada, 41 percent (35 drugs) are biologic in nature. “Some of those are biosimilars, and some are for new indications of existing drugs, but this still represents a sizeable share of new submissions,” notes Mark Jackson, consultant pharmacist at TELUS Health.

As the market matures, product development is increasingly diverse. In addition to continued new offerings for the major autoimmune diseases such as rheumatoid arthritis and Crohn’s disease—including the reformatting of some existing biologics so they can be administered by self-injection rather than by infusion—we will see more in the following areas:

1. To treat orphan diseases; these drugs typically cost hundreds of thousands of dollars per year and are administered in hospitals or specialized facilities;
2. For targeted subsets of patients with more common conditions, such as high cholesterol and asthma; these biologics are relatively lower-cost, typically less than $10,000 per year, are usually self-injectable and can be distributed through traditional community pharmacy;
3. For cancer patients, typically administered in hospitals (and not to be confused with the higher-cost, non-biologic specialty cancer drugs that can be taken orally).

The growing number of biologics in category 2 is of particular interest to community pharmacies, due to their self-injectable format as well as lower inventory costs. PCSK9s are one example, indicated for people with uncontrolled high cholesterol (see sidebar). Another example is erenumab, the first in a new class of biologics to prevent migraines, expected in Canada by the end of this year.

Research and development are also underway for Alzheimer’s disease, chronic pain and mood disorders. “These are still further out on the horizon, but it speaks to just how many areas biologic therapies may impact,” says Jackson.

As more self-injectable biologics become available, community pharmacists can also play a greater role in patient support. For one thing, the risk of nonadherence is higher.

People who take biologics also likely take multiple other medications, possibly for multiple comorbidities, which require extra vigilance from all healthcare providers.

Based on claims data from both public and private payers, it’s fair to assume that for every 100 of your patients, one or two are taking a biologic. Do you know who they are, and how you can support them?

Continued on next page...

CASE STUDY:

PCS9 INHIBITORS FOR HIGH CHOLESTEROL

- Introduced in Canada in 2015; a self-injected biologic
- As outlined in the Canadian Cardiovascular Society Guidelines, proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors are recommended as a second line of therapy, post statins, for a subset of patients with uncontrolled hyperlipidemia: such as patients with the genetic condition, heterozygous familial hypercholesterolemia, and patients with clinical atherosclerotic vascular disease (e.g., have had a heart attack). Within these patient groups, the drug is limited to those who are unable to bring their cholesterol to recommended target levels despite taking maximum recommended amounts of first-line statin drugs and efforts to maintain proper diet and activity levels.
- Several studies have shown that PCSK9s reduce levels of “bad” cholesterol by between 50 and 70 percent. There is also evidence that demonstrates reductions in heart attacks and strokes in those patients receiving PCSK9s.
- Approximate cost of $6,000 to $7,000 per year (list cost)
- While payers were initially concerned about the financial impact of PCSK9s, insurers’ prior authorization processes and manufacturers’ patient support programs have ensured appropriate utilization. 2017 claims data from TELUS confirm its gradual uptake.
PHARMACISTS’ ROLE IN PATIENT CARE
First, do your best to find out which patients currently take biologics, keeping in mind that insurance policies may require people to go through a specialty pharmacy, or a pharmacy that’s part of a preferred network, in order to get maximum coverage. “When doing medication reviews, always ask patients if they are receiving any medications from outside of your community pharmacy,” suggests Carolyn Whiskin, Pharmacy Manager at Charlton Health, a specialty pharmacy for the treatment of autoimmune diseases in Hamilton, Ont.

Once you’ve identified which of your patients are taking biologic drugs, Whiskin offers the following suggestions:

Know the patient support programs Physicians commonly forward a biologic prescription to the drug manufacturer’s patient support program (PSP) before it is received by a pharmacy. The PSP plays a critical role in facilitating coverage from private and public plans, and may provide funding to offset the patient’s co-pay. However, the idea of a PSP contacting patients is a new concept to most people, and the start of therapy can be a confusing, stressful time. “A patient may come in with a script for a biologic, but they’ve forgotten about the PSP so when you put it through for adjudication the patient is shocked by how high their co-pay is. That may lead to them having second thoughts about getting the drug. Whenever this occurs, contact the support program, as the majority or all of the cost difference will likely be covered. A patient could also change jobs and be between insurance companies, and is concerned about how they’ll afford their biologic. Remind them about their patient support program, which will bridge them with compassionate doses,” says Whiskin, adding that the 1-800 number is usually right on the product package, and most patients will have contact information for their case manager.

Be ready with injection tips While injection site reactions are not common, it’s important that pharmacists are ready with suggestions should they occur, so patients don’t stop treatment. “For example, remind the patient they can take the drug out of the fridge half an hour before injection, to bring it to room temperature,” says Whiskin.

Double check that vaccinations are up to date A major treatment goal for patients with inflammatory conditions is to avoid infection. Not only do infections take longer to clear in patients taking biologics, but once they start taking an antibiotic for an active infection, they have to suspend their use of the biologic until the infection is clear. “It’s a real double whammy for patients, as not only are they ill, but their disease may flare when delaying their biologic treatment. Therefore being on the side of prevention and updating vaccines are recommended,” emphasizes Whiskin. Patients with inflammatory conditions are at higher risk of pneumonia and shingles, so these vaccinations are especially important—as is, of course, the annual flu shot. On the other hand, live vaccines are to be avoided while on biologic treatment (e.g., for yellow fever), due to concerns that even a small amount of live virus could cause an infection.

Ease concerns, dispel myths Patients may be reluctant to try a biologic because they think they are “too dangerous,” notes Whiskin. “They assume that because it has to be injected or infused, there are more adverse effects, when in fact the side effect profile is generally very low. It’s important to explain that biologics need to be injected because they are made of protein and going through the gut would break down the biologic into fragments that would prevent it from working.”

As well, Whiskin asks pharmacists to be mindful of what they say when patients present their first prescription. “Community pharmacists are very trusted, and we’ve had cases where patients have changed their minds about starting a biologic therapy because their pharmacist was concerned.” This is especially true for younger patients. “We are being more aggressive in starting patients on a biologic sooner, to prevent permanent damage from the disease. Comments such as, ‘Geez, you’re awfully young to be starting on this,’ can invoke unmerited fear.”

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