# Primary Health Care: Pharmacist Service Framework

## Improving Accessibility and Quality of Primary Health Care Delivery Through An Existing Infrastructure: Pharmacists

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### Executive Summary

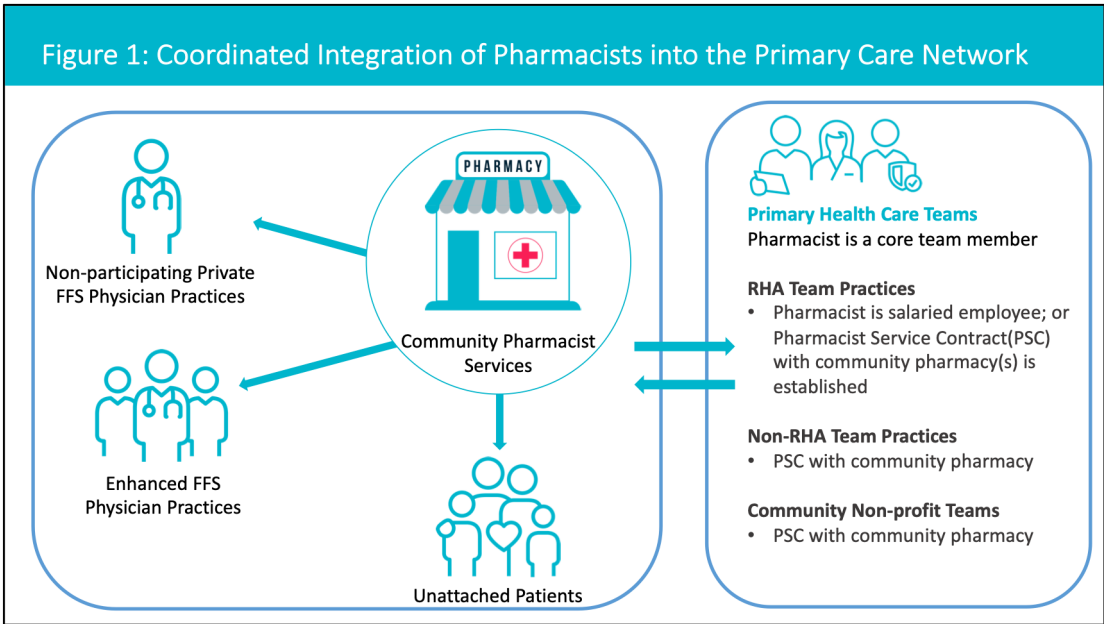
- Evidence from clinical trials indicates that pharmacists are valuable members of the primary health care (PHC) network who lower healthcare costs and improve the quality of care as well as patient experience and provider satisfaction.[1-14]
- To increase capacity within primary care, improve efficiency and health outcomes, we recommend implementing a blended pharmacist service framework that includes the delivery of select primary health care services by community pharmacists as well as the integration of pharmacists into team-based clinics.
- Given the great burden of chronic disease in Newfoundland and Labrador, the role of the team-based pharmacist should focus on providing comprehensive medication management for chronic diseases (e.g., diabetes, heart failure, stroke) as well as those who are taking high-risk medications.
- There is currently no evidence-based standard from which to establish the ideal pharmacist to patient ratio within a PHC team.[15,16] We recommend a maximum ratio of one pharmacist per 7,500 patients.


### Background

Primary care, the foundation of Canada's health care system, is facing unprecedented pressure as the health care needs of individuals and communities increase. Chronic disease rates are rising, people are living longer with more complex health conditions, and drug therapy is playing an increasingly important role in treatment plans.[17] The situation here in Newfoundland and Labrador (NL) is even more catastrophic, as the prevalence of chronic disease exceeds that of other Canadian provinces; our health outcomes are poor and incongruent with the unsustainably high levels of health care spending[18] and approximately 90,000 residents do not have access to a primary care physician.[19] Consequently, the Pharmacists' Association of Newfoundland and Labrador (PANL) stands united with other stakeholder groups to advocate for primary health care (PHC) reform in Newfoundland and Labrador.

PANL has taken an aggressive approach to educate and inform policymakers, the Health Accord NL, and the public of the critical role pharmacists should play in PHC reform. Furthermore, PANL has presented the evidence for A Full Scope of Pharmacist Practice and how pharmacists practicing to full scope is an Evidence-Based Solution to Improve Healthcare Quality. Currently a full scope of pharmacist practice (e.g., prescribing, laboratory testing, disease management) is not available in NL.

Pharmacists, working collaboratively with other providers, can help to ensure that residents of Newfoundland and Labrador receive high quality, safe, accessible, and cost-effective primary health care. Here we describe a pharmacist service framework that has been formulated with consideration of forward-thinking policies and approaches in other Canadian jurisdictions and beyond.




## Recommendations

To increase capacity within primary care, improve efficiency and health outcomes, we recommend implementing a **Blended Pharmacist Service Framework** that includes (i) the delivery of select primary health care services by community pharmacists and (ii) integration of pharmacists into primary health care (PHC) team-based clinics. This blended model (see Figure 1) recognizes the complexity of PHC delivery and enables all residents of Newfoundland and Labrador (NL) to access primary care. It extends the community reach of PHC, using an already-existing infrastructure, while preventing the disruption of the community pharmacy network in this province. This blended service framework is evidence-based and incentivizes high-quality patient care. It will increase the capacity for other providers to receive same day appointments; and it is supportive of all physician practices, not just those that are team-based.

All residents of NL deserve to be able to access care from a pharmacist, whether through a team-based clinic or at their community pharmacy. Below we describe each recommendation in more detail. We have also provided implementation strategies, including areas for future collaboration between policymakers, the Health Accord, and PANL to ensure successful implementation.

### Recommendation #1: A core-basket of collaborative primary health care services should be offered through community pharmacies.

The accessibility of pharmacists is an important asset to primary care, and pharmacists should be able to deliver a core-basket of PHC services to patients in the community. We have compiled a targeted list of evidence-based patient care activties that can be easily integrated into community pharmacy practice. In fact, many of these services have already been implemented in other jurisdictions in Canada. Moreover, we recommend a coordinated and phased approach to implementation:

- Phase 1—Cardiovascular prevention: Hypertension case-finding, smoking cessation
- Phase 2—Cardiovascular prevention: Dyslipidemia case-finding; hypertension and dyslipidemia medication management
- Phase 3— Women's health conditions: Uncomplicated UTI, contraception

- Phase 4—Diabetes case-finding and medication management

Given the significant burden of chronic disease in this province and the high rates of mortality due to cardiovascular (CV) disease and diabetes,[18] it is our position that community pharmacies and pharmacists have a critical role to play in reducing CV risk and improving population health. Pharmacists in this setting will work closely with patients, PHC team-based pharmacists and other providers to achieve the goals of care. Pharmacist care in the areas described above is supported by high quality evidence from clinical trials.[1-9]

In Phase I, we recommend targeting hypertension case finding and smoking cessation. These patient care activities can be implemented immediately, as they are within the current scope of practice for pharmacists. We suggest implementing a remuneration system that balances the pharmacy's extra staffing needs and the benefits to society from better management of these important conditions. We suggest to not incentivize prescribing, but rather to incentivize patient care. For example, we recommend using an implementation and remuneration strategy for hypertension case finding similar to that recently launched in the UK with important caveats:

- To achieve high quality care, pharmacies that wish to provide this service must ensure that their pharmacists complete the Hypertension Canada Professional Certification Program and are using a validated Automated Office Blood Pressure (AOBP) device.
- To incentivize high quality care, pharmacies would receive additional reimbursement when clinical targets are achieved.

To facilitate continuity of care, pharmacists should document their care in the provincial electronic medical record.

In follow-up to this submission, PANL can provide a detailed implementation and remuneration strategy to the Health Accord to inform their costing process. PANL is eager to launch this initiative and support its members to deliver high quality health services to residents of Newfoundland and Labrador.

## Recommendation #2: A pharmacist should be included as a core member of every primary health care team.

Pharmacists, with their expertise in evidence-based pharmacotherapy, are uniquely positioned to provide collaborative care for patients with acute and chronic diseases in team-based settings by ensuring medications are safe and effective. Based on our consultation with numerous pharmacists, community pharmacy managers/owners, and the Regional Pharmacy Directors, we suggest integrating pharmacists as core members of every PHC team:

- **RHA based teams:** pharmacist is hired as a salaried employee OR the pharmacy department initiates a Pharmacist Service Contract (PSC) with a community pharmacy.
- **Non-RHA based teams:** a PSC is established with a community pharmacy using an equitable and transparent tender process.
- **Community non-profit teams:** a PSC is established with a community pharmacy using an equitable and transparent tender process.

Where a PSC is established with a community pharmacy, we suggest a reimbursement rate of $75 per hour. This rate is consistent with the province of Quebec, where a similar scheme has been established. A pharmacy may opt to divide each FTE among their staff, similar to the RHA structure. We recommend that any pharmacist working within a PSC be co-located with the other team members, having access to necessary equipment and space to carry out duties and responsibilities. Collaboration between PANL and policymakers is critical to ensure a fair and transparent tender process for community pharmacy participation in non-RHA team practices.

Regarding roles and responsibilities, we suggest a large proportion of pharmacist time be spent providing comprehensive medication management for patients with chronic disease (e.g., diabetes, heart failure) as well as those taking high risk medications.[15] Indeed, numerous studies indicate that pharmacists who provide chronic disease management in team-based settings lower health care

costs and improve quality of care.[10-14]

Collaborative chronic disease management by pharmacists should serve to increase capacity within primary care by enabling other providers to deliver urgent care services and receive same day appointments. Anecdotal reports from family physicians with whom we work closely, indicate that current wait times in family practice range from two to six weeks, leaving patients who need care today for minor injuries or illness stranded. Patients can be identified for pharmacist care through formal consults by other team members or the electronic medical records (EMRs) disease state registry.

Other core services that team-based primary care pharmacists should be expected to provide are listed in Table 1. These activities are consistent with those described by the Canadian Society of Hospital Pharmacists and practice leaders in other jurisdictions.[15,20]

There is currently no evidence-based standard from which to establish the ideal pharmacist to patient ratio within a team-based service.[15,16] In Ontario, the maximum ratio is set at one pharmacist per 10,000 patients.[21] In the United States, the Veteran Affairs (VA) healthcare system has set the ratio at one pharmacist to a maximum of 3,600 primary care patients.[12] Of importance, pharmacists within the VA spend the majority of their time providing comprehensive medication management for patients with diabetes, hypertension, hyperlipidemia and tobacco addiction. It is our recommendation that the **maximum ratio** be set at **one pharmacist FTE per 7,500 patients**.

**Table 1: Priority activities for PHC team-based pharmacists in NL**[10-16,20]

| | **Prioritized Activities** |
|---|---|
| Direct patient care | • Comprehensive medication management of chronic disease (e.g., diabetes, heart failure, stroke)<br>• Medication reconciliation at transitions of care (e.g., hospital discharge)<br>• Caring for vulnerable populations, including patients prescribed high-risk medications (e.g., opioids, anticoagulants)<br>• Deprescribing<br>• Monitoring drug therapies<br>• Patient-focused medication counselling |
| Drug information and education | • Responding to drug information requests from other HCPs<br>• Facilitating journal clubs<br>• Mentoring students |
| Other | • Facilitating med access<br>• Coordinating care with community pharmacist<br>• Engaging in research/quality improvement |

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