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So, What is Holding the Pharmacists Back?

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Alberta Health, the provincial ministry that sets policy, legislation and standards for the health system in Alberta. They also allocate health funding and administer provincial programs such as the Alberta Health Care Insurance Plan. Since pharmacists are one of the key members of Alberta's health care team, Alberta Health supports pharmacists as integral members of the health care system in Alberta. Since July 1, 2013, the government began to compensate community pharmacies for providing cognitive services to people in Alberta. These services include:

Comprehensive Annual Care Plan (CACP)

a. To be eligible:

i. The Albertan is a member of the Alberta Health Care Insurance Plan;

ii. Meet the criteria of a patient with "complex needs";

iii. Provide consent to participate in the assessment and;

iv. Are available to meet with the pharmacist in person

b. "Complex needs" is defined as a patient with multiple complex health needs including chronic conditions and other risk factors identified by the pharmacists. The Alberta Health categorized chronic conditions and risk factors as below:

i. Group A (chronic conditions): Hypertension, diabetes mellitus, COPD, asthma, heart failure, ischemic heart disease and mental health disorder;

ii. Group B (risk factors): tobacco, obesity and addictions;

iii. The patient must have two or more chronic conditions from group A or one chronic condition from group A and one risk factor from group B to meet the criteria for reimbursement.

c. The compensation is $100 or $125 for pharmacists with additional prescribing authority (APA) for the initial assessment and $20/$25 for follow-up within 14 days [1].

Standard Mmanagement Assessment (SMME)

d. Albertans are eligible if:

i. They are members of the Alberta Health Care Insurance Plan;

ii. Have at least one chronic medical condition (from group A of CACP) and are currently taking at least four medications or insulin;

iii. Patients provide consent to participate in the assessment;

iv. They are available to meet with the pharmacists in person.

e. The compensation is $60 or $75 for pharmacists with APA for initial assessment and $20/$25 for follow-up within 14 calendar days.

Other Services

f. Assessment and administer medications by injection and the fee is $20 per injection that is qualified under the Alberta Health Care Insurance Plan.

g. Assessment and adaptation of a prescription or renewal of a prescription. Pharmacists are compensated $20 per each adapted prescription. In another word, the pharmacists receive $20 for providing assessment and refill of a prescription without changing the dose or frequency of the original prescription.

h. Patient assessment for initiating a new therapy. This only applies to pharmacists with APA. The pharmacists receive $25 per assessment per day.

Despite such program put in place to compensate pharmacists for their cognitive services, many pharmacists still do not engage in these activities. So, what are the barriers?

Pharmacist Perspectives

There are several reasons why pharmacists are not embracing the new expanded scope of practice. The main reason that pharmacists working in chain, banner or franchise drugstores and grocery store pharmacies are not motivated to embrace the expanded scope of practice is, currently, only pharmacies could receive reimbursements for the cognitive services, not the pharmacists. The system does not incentivize and empower the pharmacists to go above and beyond the duties to provide cognitive services.

As of 2014, there are more than 1,081 pharmacies in Alberta [2]. Less than 50% are chain, banner or franchise drugstores, 30% are grocery store pharmacies and 20% are independent pharmacies. Currently, anyone could own a pharmacy as a business as long as there is registered pharmacist on duty while the store is open. In the cases of the chain, banner, franchises and grocery store pharmacies, the profession of pharmacy is considered a business rather than a health profession. The ultimate goal is to reduce wait time and increase productivity, e.g. increase number of prescriptions filled each day to meet the bottom line. As of April 1, 2014, the government of Alberta has approved the following dispensing fees (Table 1) [3].

On average, a pharmacist could dispense up to 300 prescriptions in a 12-hour shift. This is approximately 25 prescriptions per hour, which could total up to $307.50 per hour. This does not include the allowable upcharges for each medication dispensed. On the other hand, it takes a pharmacist at least 30 minutes to one hour to complete a CACP ($100-$125 per CACP) and 15 - 30 minutes for SMME ($40-$50 per

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Year	April 1, 2014	April 1, 2015	April 1, 2016	April 1, 2017
Medication Cost	Manufacturer list price as published in Alberta Drug Benefit List			
Allowable upcharge #1	3%	3%	3%	3%
Allowable upcharge #2	5.5% to a maximum of $100	6% to a maximum of $100	6.5% to a maximum of $100	7% to a maximum of $100
Dispensing Fee	$12.30	$12.30	$12.30	$12.30

Table 1: Dispensing fees.

SMME). It is quite obvious that as a business fulfilling the dispensing duty would generate most revenue.

The other reason is some pharmacists felt that they may offend the family physicians by stepping out of boundary. Since the introduction of the new pharmacy service compensation model, many family physicians are opposed of the pharmacists expanded scope of practice.

Family Physician Perspective

The future direction of primary care is toward a team approach of delivery of care. This is especially true of chronic disease management as the prevalence of these conditions rises with the age of the population. One of the cornerstones of the team-based approach is that each health professional works to their full scope of practice and takes a share of responsibility for the final overall outcome.

Currently family physicians already work together in a variety of ways for the good of patients. The first and simplest is in co-operation. We each do our own jobs (prescribing or dispensing) without getting in each other's way but only communicating when necessary. The second way is by collaborating when we work with each other to avoid harm or potential problems for patients. We don't just leave messages; we actually speak to each other for advice on drug interactions or discussion of available formulations. We collaborate over management of our long-term narcotic users is another example. True teamwork goes a step further; we divide the job between us according to agreed principles. Characteristics of a good team include knowing the other members by names and also their training, their capabilities, trusting them to do their part well and letting them do it. Good teamwork does not mean that we all like each other and go round in huddles but it does mean respecting each other's abilities.

As a family physician for over 40 years, I have seen the role of the pharmacist develop from a pill counter to a highly trained professional with a scientific understanding of chemistry and physiology, pharmacodynamics and human behavior. It was the community pharmacist that gave me my first instruction in cough linctuses when I first went into practice and I have been willing to learn from the pharmacist ever since.

Why are more community pharmacists not taking advantage of the new regulations allowing discretionary prescribing and supplying of repeat prescriptions until the patient can review with the physician? Certainly there are practical factors as Dr. Banh outlines above but is there a lack of confidence in the profession? Has the daily grind of high output dispensing worn down the enthusiasm of the pharmacist to be involved in the care of their patients? It would be a pity not to use all that training and expertise. Some pharmacists are actively expanding their role. There are numerous reported examples of ways in which pharmacists can be involved as members of the primary care team [4,5], of how pharmacists can prevent adverse drug reactions [6] or contribute to screening and prevention [7].

I am always pleased to see a fax from one of the local community pharmacists recording a prescribing decision they have made and I am always happy to ask my pharmacy colleagues' advice. We do not have to work in the same building for this to occur. The phone is always available and the automated direct line really has overcome the long waiting to get through to the pharmacist that used to happen. I am not alone in this welcoming attitude but I think that the stories of the crabby physician or the dragon-like receptionist are a bit out of date now. Rural family physicians and pharmacists have long had a close and realistic relationship, partly because like team members they depend on each other.

Perhaps the pharmacy journals could help build pharmacists self-confidence by spreading the good news about what some pharmacist/physician teams are doing. I look forward to hearing more, as I know it is already happening in the community and is about to reach that critical launch point when it becomes the norm instead of the unusual. I am confident that there is a bright future for the clinician pharmacist in the near future and I will be glad to be a part of it.

References

1. Alberta Health (2012) Compensation for pharmacy services. Alberta Health, Health Benefits and Compliance Compensation for Pharmacy Services.
2. NAPRA.
3. Albert Health.
4. Dolovich L, Pottie K, Kaczorowski, Farrell B, Austin Z, et al. (2008) Integrating family medicine and pharmacy to advance primary care therapeutics. Clinical Pharmacol Ther 83: 913 – 917.
5. Makowsky MJ, Cave AJ, Simpson SH (2014) Feasibility of a self-administered survey to identify primary care patients at risk of medication-related problems. J Multidiscip Healthc 22: 123 – 127.
6. Kassam R, Farris KB, Burback L, Volume CI, Cox CE, et al. (2001) Pharmaceutical care research and education project: pharmacists' interventions. J Am Pharm Assoc 41: 401 – 410.
7. Tsuyuki RT, Johnson JA, Teo KK, Simpson SH, Ackman ML, et al. (2002) A randomized trial of the effect of community pharmacist intervention on cholesterol risk management: the study of cardiovascular risk intervention by pharmacists (SCRP). Arch Intern Med 162: 1149 – 1155.