

Blueprint for Action for the Pharmacy Profession in Canada

BACKGROUND PAPER

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TABLE OF CONTENTS

I	Introduction	1
II	Seeking a Preferred Future for the Pharmacy Profession	2
	a) How Pharmacy Practice Benefits Society	2
	b) How Pharmacists Will Practice in Their Preferred Future	2
	c) Making Change Happen	3
III	Context for Pharmacy Change	4
	a) In Canada	4
	b) Internationally	8
IV	The Challenge of Change.....	9
V	Change Management and Models for Practice Change	11
VI	Critical Elements for Change in the Pharmacy Profession	12
	a) Role Change and Pharmacy Practice Models	12
	b) Pharmacy Human Resources.....	17
	c) Pharmacy Education and Continuing Professional Development	20
	d) Information and Communication Technology	23
	e) Financial Viability and Sustainability	26
	f) Legislation, Regulation and Liability	28
	g) Leadership for the Profession	31
VI	Conclusion.....	33
	APPENDIX – Background Readings List	34
	REFERENCES	35

I Introduction

Pharmacy has accomplished much in the past decade to move the profession forward, but many challenges remain. What is needed is a strategic action plan to provide direction on the changes that are essential if the profession is to expand to better meet the needs of Canadians – a “Blueprint for Action for the Pharmacy Profession in Canada”. This strategic action plan will guide and coordinate action over the short, mid and long-term so that the pharmacy profession is “fit for purpose” for the health care system of the future.

Recent health reform initiatives have highlighted and emphasized the social and economic benefits of improved drug therapy for Canadians. Change in the pharmacy profession is inevitable, whether initiated internally by the profession, or imposed on the profession by others. Although much work is being accomplished in this area, much remains to be done. Present efforts in Canada parallel the work of pharmacy groups internationally, as well as the initiatives of other Canadian health care professional groups. These initiatives involve pharmacists seeking to respond and adapt to a rapidly changing health care environment and to the health care needs of the public. In addition, there is recognition of the growing need for enhanced collaboration among health care professionals.

The goal of this initiative is to develop a “Blueprint for Action for the Pharmacy Profession in Canada” that will be widely endorsed by all key stakeholders—pharmacy, other health professions, governments. To succeed, there must be a commitment from Canadian pharmacy groups to the principles and values implicit in a preferred future for the pharmacy profession in Canada, and to a structured process to drive practice change.

The Blueprint will identify structural, legislative, policy, program and funding requirements to support transitioning of the pharmacy profession. It will also identify key actions over the next 5-10 years that are necessary for moving the pharmacy profession forward. Elements that need to be addressed to achieve a preferred future for the pharmacy profession include: role change and pharmacy practice models; pharmacy human resources; pharmacy education and continuing professional development (CPD); information and communications technology (ICT); financial viability and sustainability; legislation, regulation and liability; and leadership for the profession.

Development of the Blueprint will require a broad consultation process, both within the profession itself and with other key stakeholders, such as governments (federal, provincial and territorial), and with other closely related health care professions, such as medicine and nursing. A comprehensive action and implementation plan must be developed to provide direction to the many pharmacy groups involved to ensure that the profession speaks and acts with a unified voice. These groups must work together with a commitment to address the many complex and integrated issues that are involved in substantial practice change.

The process of developing the Blueprint began with a think-tank workshop involving a small group of pharmacists and leaders from across Canada hosted by the Canadian Pharmacists Association (CPhA) in December 2005. This background paper has been revised based on the input from this workshop. The next step is a meeting of pharmacy stakeholders on June 21-22, 2006 in Ottawa. The goal for the June workshop is to achieve consensus on the preferred future, the actions required in each of the key elements, and to map out the plan to move forward on the action plan (e.g., prioritization, who, when, how). Following this, CPhA will continue to facilitate and coordinate planning, development and endorsement of the Blueprint—providing leadership without ownership. The next step will involve consultation with other stakeholders in health care and governments.

II Seeking a Preferred Future for the Pharmacy Profession

Drawing from many sources and from various strategic exercises, including the workshop in early December 2005, CPhA and other pharmacy organizations in Canada have developed a draft vision for a preferred future for pharmacy.

Change will only occur when essential values are also present in pharmacy, such as professionalism, altruism and business and job satisfaction.

There is much work to be done to move the pharmacy profession forward. However, other health care professions are also facing similar challenges and issues and many are quickly evolving to better meet the health care needs of Canadians. Pharmacists must match the pace of health care reform or risk losing parts of their role to other professions.

a) How Pharmacy Practice Benefits Society

Improving the health of Canadians is paramount. The underlying premise of this preferred future is that meeting patient needs is the key determinant for any future change in the role of Canadian pharmacists, irrespective of their pharmacy practice setting

By using the full extent of their education and training, pharmacists can make the following improvements in the health of Canadians and in addressing the rising cost of drugs:

- Ensure that all Canadians can access drugs and pharmaceutical advice easily and conveniently.
- Increase benefits to patients by ensuring more support to achieve the optimal use of medications.
- Reduce harm by decreasing unnecessary, unsafe and inappropriate use of medications.
- Improve outcomes of drug therapy by monitoring and evaluating a patient's response to therapy and ensure that desired patient outcomes are more frequently achieved.
- Support public health by providing education and interventions to prevent disease.
- Encourage wellness of Canadians by promoting healthy lifestyles.
- Increase benefit to Canadians by providing advice and treatment to support self-care, where appropriate.
- Assist in ensuring that the cost-effectiveness of medication therapy is optimized.
- Build on the trust and confidence that Canadians place in pharmacists and pharmacy services.

b) How Pharmacists Will Practice in Their Preferred Future

From a broad perspective, pharmacists require the authority and autonomy to manage medication therapy and to be accountable for the therapeutic outcomes of their patients. In doing so, they need to communicate and collaborate with patients, care givers, other health care professionals and qualified support personnel.

More specifically, pharmacists will need to assume the roles outlined below to fulfill their professional responsibilities. These roles and responsibilities are expressed as draft statements of a preferred future; they are not presented in any order of priority. Most of these developments are seen as evolving over the next 3-7 years. A first step in the June 2006 consensus workshop will be to validate these statements.

- Pharmacists will be perceived by themselves, key stakeholders and the public as essential medication managers on primary health care teams, in hospitals, in home care environments and in other patient-centred practices.
- Pharmacists will gain greater responsibility within the health care system for ensuring patient safety with respect to medications.
- Pharmacists will access all relevant information in a patient's health care record and will document care provided in the electronic health record.
- Pharmacists will retain responsibility for directing and supervising the safe custody and distribution for pharmaceuticals.
- Pharmacists will continue to provide direct patient care including promotion of non-pharmacological, disease prevention and lifestyle interventions.
- Pharmacists will delegate the technical aspects of dispensing and checking of prescriptions to regulated pharmacy technicians.
- Pharmacists will have defined responsibilities, with defined protocols, to initiate and to modify drug therapy with appropriate collaborative drug therapy management authority.
- Pharmacists will be responsible for managing medication (including refills) for chronic diseases.
- Pharmacists will initiate medication therapy for an expanded range of minor ailments (e.g., as nasal corticosteroids for allergic rhinitis).
- Pharmacists will have independent prescribing authority.
- Pharmacists will provide services under a new reimbursement framework that recognizes, respects and compensates appropriately for pharmacy care and expanded services.
- Pharmacists will be compensated for consultation regarding Schedule II medications.
- Pharmacists will be recognized and paid for performing triage to support patient self-care.
- Pharmacists will perform clinical assessment including limited physical assessment.
- Pharmacists will order limited lab tests and make referrals to other healthcare providers.
- Pharmacists will participate in public health surveillance and act as sentinels.
- Pharmacists will administer immunizations, when desirable for public health reasons.
- Pharmacists, as part of public health policy and the related infrastructure, will perform triage, in person or by telephone, for the general public during emergency situations, such as pandemics, to alleviate the burden on acute centres.

c) Making Change Happen

In order to achieve the societal and economic goals cited above and to realize this preferred future, the pharmacy profession needs to institute a series of overlapping and integrated changes to ensure that the profession adapts to and responds to the internal and external demands that are being placed upon it.

Pharmacists will need:

- To be incorporated into new models of health care delivery.
- To be compensated differently and appropriately.
- To further develop their professional knowledge and skills.
- To develop practice tools to improve the efficiency and effectiveness for their services.

- To work with governments and other providers to clearly define the services to be included and paid for in primary health care and in other practice environments such as home care and palliative care.
- To develop and implement protocols and outcome measures for quality pharmacy services in primary health care.
- To obtain access to patient care information in electronic health records and the power to enter patient information into these records.
- To obtain new powers under legislation to initiate and modify drug therapy.
- To be recognized and accepted in their new roles by the public and other health care providers.
- To be supported during the transition, in particular by community pharmacist owners.

III Context for Pharmacy Change

System change is imperative to improve the health of Canadians and to ensure that the health care system is sustainable in the future.

Resources must be used well by governments in their responsibility of funding health care services. Likewise, individual health professionals must assume responsibility for delivering services that are of high-quality and cost-effective.

a) In Canada

From a broad Canadian perspective, there have been a number of recent government commissions and reports that have highlighted the need for health care system reform and for a change in the way health care professionals practice. One of the common themes from many of these initiatives is that health care professionals, including pharmacists, must change their roles to better meet the health care needs of the Canadian public.

Economic factors are also driving the urgent call for change as drugs continue to be the fastest-growing category of health care spending. Retail drug costs in Canada now represent the second-largest share of total health care expenditures after hospitals, with retail drug spending estimated to have reached \$24.8 billion in 2005 (17.5% of total health expenditures; an 11% increase over the previous year). In 2003, the most recent year for which data are available, drug expenditure in hospitals reached over \$1.5 billion, accounting for 3.9% of total hospital expenditure.¹ In 2005, Canadian pharmacies filled 396 million retail prescriptions (at \$20.6 billion, or just over 83% of total drug spending). The public sector paid for 37.8% of drug costs and the private sector 62.2% (through private insurance or direct pay).²

Although pharmacists do not have direct control over drug expenditures, they must, in their role as medication management experts, work with governments and others to ensure that medications are used appropriately and in a cost-effective manner.

Pharmacists also represent the third largest health care professional group in Canada, next to nurses and physicians. There are over 29,000 pharmacists licensed to practice in Canada, working in a wide range of practice settings including community pharmacies (71% of the workforce) and hospital pharmacies (15%).³ Other settings include long-term care institutions, academia, professional and regulatory associations, government, the pharmaceutical and insurance industry (14%).

Pharmacists must seek solutions to the present problems of the health care system. They must be active in addressing broad Canadian and global health policy issues, as well in addressing professional challenges.

There have been major recent calls for change in the way health care professionals practice in Canada. In the fall of 2002, two major national health care reviews issued their final reports: the Romanow *Commission on the Future of Health Care in Canada*⁴ and Senator Michael Kirby's *The Health of Canadians—the Federal Role*.⁵

In its 2001 submission to the Romanow Commission, CPhA noted:

As the most accessible health care provider with the greatest knowledge of drugs within the health care system, pharmacists make significant improvements to obtain better value for money from drugs. Detailed analysis by previous independent reports...recognized the potential of pharmacists and described them as underutilized.⁶

From the pharmacy perspective, the key theme throughout the Romanow report is the need to review scopes of practice and develop the roles of pharmacists and other health care providers. There is a strong emphasis on teams, collaboration and integration. As noted in the report:

“It also means that pharmacists can play an increasingly important role as part of the primary health care team, working with patients to ensure they are using medications appropriately and providing information to both physicians and patients about the effectiveness and appropriateness of certain drugs for certain conditions. This expanded role would allow pharmacists to consult with physicians and patients, monitor patients’ use of drugs and provide better information and communication on prescription drugs. In the future, there may also be a role for pharmacists who are not engaged in the retail sale of prescription drugs to prescribe certain drugs under specific, limited conditions.”

The Romanow report had a number of other key messages and recommendations that are important to the pharmacy profession. Similarly, there were numerous recommendations in the Kirby report that could, if implemented, positively affect the profession. A summary of recommendations relevant to the pharmacy profession is included with the package of background readings.

As noted above, many groups within pharmacy have been active in voicing their views on the future of pharmacy. For example, in their submission to the Romanow Commission,⁷ the Canadian Society of Hospital Pharmacists noted that:

The long-term sustainability of Canada’s health care system requires significant improvements in medication use and avoidance of drug misadventures. We cannot continue with our current situation of inappropriate drug use—this is unacceptable from both a health and an economic perspective.... Within the hospital environment, pharmacists have demonstrated that effective use of their expertise results in improved health outcomes and reduced costs. However, to achieve significant gains throughout the entire system, an appropriate level of pharmaceutical care must be provided across the continuum of care.⁸

In the CPhA submission to the Romanow Commission, the Association used the example of a patient with chronic disease to demonstrate how a change in the role of pharmacists could assist in leading to a more sustainable, affordable and accessible health care system with improved quality of care for Canadians. In particular, the Association noted that pharmacists could play a greater role in public education about wellness and disease, in screening to detect early disease, through improving control of risk factors, and in improving drug management and the appropriate use of drugs. As CPhA noted:

We address the challenges in developing new models of pharmacy practice, because we too must change. The main thrust of our argument is that any reforms to Canada’s health care system must provide incentives to promote better drug policy and better use of the health

care providers responsible for patient outcomes. Greater use of the knowledge and skill of pharmacists can significantly improve the health outcomes and cost effectiveness of drug use.⁹

In 2000, the federal, provincial and territorial (FPT) First Ministers agreed on a vision, principles and an action plan for health system renewal. Following this, there was significant activity and collaboration among FPT governments, leading to the September 2003 Accord—*The First Ministers' Accord on Health Care Renewal*.¹⁰ The Accord stressed that improvements to primary health care are crucial to renewal of health services and they highlighted the importance of interdisciplinary teams. The Accord led to the First Ministers releasing an action plan in September 2004—*A 10-year Plan to Strengthen Health Care*.¹¹

The 10-year Plan included \$41 billion of new federal funding over ten years to support the action plan. Increased Canada Health Transfer payments included an additional \$500 million in 2005-2006 to support progress on home care services and catastrophic drug coverage. \$4.5 billion was allocated over six years in the Wait Times Reduction Fund.

The Health Council of Canada was established by the First Ministers to track and report on progress of the 2003 Accord and the 10-year Plan, and to provide advice on improving Canada's health care system. The Council reports annually on health status and health outcomes.

The Council sees its job as one of witness and advisor: we review progress, we assess success and we advocate for change where we see a need. We delivered our inaugural report in January 2005, highlighting the jurisdictions and projects where renewal had taken root, identifying priority areas for action, and issuing an overall message of "Hurry up!"¹²

In February 2006, in its second annual report to Canadians, *Health Care Renewal in Canada—Clearing the Road to Quality*, the Council focused on the need to enhance the quality of primary health care and to deliver that care using interprofessional teams and health technology.

Twelve months later our view has not changed. The challenges remain despite large investments. We still need health care renewal to happen faster and on all fronts. The Health Council has a blunt and simple message—the health of Canadians will not be improved by a focus only on access to health care services. There is no single route to a healthier Canada... Are we providing the safest, most suitable care? Are we investing enough in prevention? Are we reducing inequalities in health? The answer to these questions is no, not yet. But we could. It is the Council's belief that we already have strong evidence and enough experience to pursue a quality agenda. But clearing the road to quality health care will require sustainable investments, coordination between governments and health care providers, and accountable leadership... Waiting too long for renewal is as damaging to our health care system as waiting too long for appropriate care is to individuals. Canadians deserve more.¹³

As a further example of recent FPT collaboration, Health Canada has invested \$50 million over five years in patient safety initiatives and created the Canadian Patient Safety Institute (CPSI). CPSI has a national mandate to build and advance a safer health system for Canadians, by performing a coordinating and leadership role across sectors and systems, promoting effective strategies and leading practices to improve patient safety, and raising awareness. With adverse drug events (ADEs) comprising a large percentage of total adverse events and errors, pharmacy has a key role to play in improving patient safety. In particular, one of CPSI's six targeted interventions in their *Safer Healthcare Now!*¹⁴ campaign is to prevent ADEs by implementing medication reconciliation in hospitals across Canada.

In its January 2005 report to Canadians, the Health Council of Canada's advice on pharmaceutical management was:

- Define a minimum standard for drug coverage that applies across the country
- Establish a process to review and compare formularies
- Identify drugs that cost more than \$5,000 per person a year and review their status across public plans
- Build upon the existing common review process for new products and include existing products
- Ensure that a strong evidence base underlies the development of a strategy
- Invest in developing drug information for physicians, pharmacists and patients.¹⁵

As noted above, at the September 2004 First Ministers' Meeting, there was an agreement on a *10-Year Plan to Strengthen Health Care*. At this time, First Ministers directed FPT Health Ministers, through a task force, to develop a National Pharmaceuticals Strategy (NPS). The Health Ministers noted that the NPS, among other priorities, must protect Canadians from catastrophic drug costs if it is to be viewed a success.¹⁶

There are nine key elements of the NPS under three themes:

- Improving Canadians' access to medicines:
 - Develop, assess and cost options for catastrophic drug coverage
 - Common National Drug Formulary
 - Accelerated access to breakthrough drugs through regulatory improvements
- Safe, effective and appropriate drug prescribing and use:
 - Strengthen the evaluation of real-world safety and effectiveness
 - Influencing prescribing behaviours
 - e-Prescribing implementation (linked to electronic health record)
- Sustainability:
 - Accelerating access to, and improving pricing of non-patented medicines
 - Pricing and purchasing strategies for drugs and vaccines
 - Analysis of cost drivers and cost-effectiveness.¹⁷

The overall outcomes of the NPS are expected to be:

- Better coverage and more equitable access
- Safer, more effective drugs for Canadians
- Better evidence for listing decisions and post-listing assessment, best practice prescribing, patient information needs and self-management
- Greater value for patients and the health system for the significant investment involved.

In October 2005, Health Ministers met and reaffirmed their commitment to the NPS.¹⁸ At that time, they asked their officials to:

- Accelerate the work on catastrophic drug coverage and to undertake research on expensive drugs for two rare diseases—Fabry's disease and MPS1-Hurler Schie syndrome.
- Expand the scope of the Common Drug Review (the national committee that recommends whether drugs should be funded) to consider all drugs, not just new ones.
- Work towards a common national formulary (a listing of drugs that are approved for public funding).
- Give the Patented Medicine Prices Review Board (PMPRB) responsibility to monitor and report on non-patented drug prices.
- Collect, integrate and disseminate information on the real-world risks and benefits of drugs.

The Health Council of Canada's 2006 report also advises sustained action on pharmaceuticals management to improve patient safety and reduce adverse drug events.¹⁹ The report proposes: standardizing public drug coverage, focusing on those without coverage; evidence-based decision making about prescribing and drug coverage; electronic drug information systems for health care providers; and banning of direct-to-consumer advertising (DTCA). The Council recognized the need to:

Develop and use better drug information tools for health care providers to ensure that prescribing decisions are based on the best scientific evidence and that patients receive only the safest and most effective medications.²⁰

Although it is beyond the scope of this background paper to go into more detail, other important initiatives related to pharmaceuticals management include:

- the Common Drug Review (CDR) and the Canadian Optimal Medication Prescribing Utilization Service (COMPUS), both developed and managed through the Canadian Agency for Drugs and Technologies (CADTH; until April 2006 CADTH was known as the Canadian Coordinating Office for Health Technology Assessment or CCOHTA)
- the National Prescription Drug Utilization Information System (NPDUIS), through the Canadian Institute for Health Information (CIHI)
- e-Prescribing and development of Pharmaceutical Information Networks or Drug Information Systems (PINs or DIS) through the Canada Health Infoway and provincial initiatives
- Provincial academic detailing programs.

Overall, the current policy environment, both federally and provincially, is supportive of change within pharmacy—new money, new roles, infrastructure to support change. The timing is right and the opportunities are there for the profession to benefit and to positively affect health outcomes for Canadians.

b) Internationally

Countries around the world are facing similar challenges and many are very active in efforts to bring about required change. For example, one of the major themes evident in recent pharmacy role change initiatives in the United Kingdom, Australia, New Zealand and the United States is the recognition of the need for a range of necessary pharmacy services to meet the health care needs of the public. There is further recognition that not all pharmacy practices need to deliver all levels of service but that it is essential that all levels be available within the system to maximize the health care outcomes of their respective populations.

Pharmacists in the US, for example, through the Joint Commission of Pharmacy Practitioners (JCPP), have developed a vision for pharmacy practice that outlines how pharmacists will practice and how this will benefit society (see background readings package).²¹

The American Society of Health-System Pharmacists (ASHP) recently released a draft of a long-range vision for the pharmacy work force in hospitals and health systems (included with background readings).²² It describes the desired work force characteristics of pharmacy practitioners. The paper recognizes that common to all health-systems settings is an interdependent and interdisciplinary work force, collaboratively developed medication-use processes, and an ongoing assessment of performance using externally established quality standards. The primary driver of ASHP's vision is the need for safe and effective medication therapy in hospitals and health systems.

In the U.K., the Department of Health, in collaboration with the pharmacy profession, published a document, *A Vision for Pharmacy in the New NHS*,²³ which set out three challenges: meeting the changing needs of patients; responding to a changing environment (including a more competitive retail environment for community pharmacy); and maintaining professional standards. A vision for community pharmacy is put forward, including ten key roles for pharmacy (see both in background readings package).

Under their new National Health System (NHS) approach, all community pharmacies will provide a greater range of “essential” services set out under their new contractual agreement, including: dispensing, repeat dispensing, disposal of drugs, promotion of healthy lifestyles, promotion of self-care for patients with minor ailments and referral of patients to other health care providers. Furthermore, the provision of “enhanced” services will require the accreditation of the pharmacist, usually with additional training. “Enhanced” services might also encompass quality measures relating to pharmacy premises such as a consultation area. Also, there is recognition that “additional” services should be developed locally to meet identified need and to improve patient care. Examples of this type of initiative include: supplying drugs to improve access to care for emergency contraception and smoking cessation; monitoring patients and recommending alteration of doses; medication reviews where there is clinical need; medication management support for those who experience difficulty with this; supplementary prescribing within an agreed clinical management plan; and diagnostic or monitoring services (e.g., for hypertension or diabetes) and substance misuse services (e.g., needle exchanges and supervised consumption).²⁴

The Pharmacy Guild of New Zealand has developed a *Blueprint for the Future of Community Pharmacy*. In their report, they note that investment in new services and a commitment to change requires pharmacy owners to have confidence that the environment and the service agreements that they are entering into are sustainable.²⁵

Recently, in Australia, researchers looked at change management and community pharmacies with the objectives of assessing the product-service business mix and to develop business models applicable to cognitive service provision. This work will be expanded upon more in section V (Change Management and Models for Practice Change). In addition, they sought to develop practical change strategies to support community pharmacies in the uptake of such services.²⁶

In Scotland, a recent study looked at the role of the community pharmacist within a paradigm shift from the technical dispensing role to a cognitive role. In addition to other factors, this study explored the market environment and the structure of community pharmacy.²⁷

The results of these important studies and others must be examined, evaluated and incorporated into the “preferred future” for the pharmacy profession in Canada. A critical part of any plan for the future must include an assessment to ensure continued financial sustainability of any new models of practice or services.

IV The Challenge of Change

There is recognition in all of the reform initiatives above that future change is critical in the health care system. To realize this needed change, significant commitment and effort will be required by the pharmacy profession and by individual pharmacists.

There is a large and growing body of research on change management. Recent work on change management and the pharmacy profession point to the numerous challenges in moving the profession forward. For example, Zellmer notes:

In too many practice settings, the pulse of pharmacist professionalism is weak or nonexistent. Resuscitation is needed. Unless the revival occurs, there is no assurance that pharmacists will continue to be required in the prescription-dispensing process.²⁸

Furthermore, Zellmer states that:

People need a readily accessible and knowledgeable professional activist to help them make the best use of medicines. Pharmacists have an opportunity to fulfill this vital public health role. Profound changes in the attitude and orientation of practitioners will be required for this to happen on a large scale, and it may take generations before these changes become instilled into pharmacy practice... The profession should make its work force development and deployment more rational. Pharmacists should migrate from routine technician functions in dispensing to patient care functions that produce better value for society's investment in the education of pharmacists. Two specific work force changes needed are the development of a system of credentialing pharmacists who are qualified to collaborate with prescribers in managing drug therapy and the establishment of minimum standards for the education and training of pharmacy technicians. These are the big unresolved issues in pharmacy. They are not new issues. It is not too late to face them head on.²⁹

Leading change in pharmacy practice and fully engaging pharmacists in patient-oriented health care was the subject of a recent paper developed by Tsuyuki and Schindel from the Centre for Community Pharmacy Research and Interdisciplinary Strategies (COMPRIS) at the University of Alberta³⁰ (copy included with the background readings package). In addressing the process of change management, Tsuyuki and Schindel outline Kotter's eight critical steps for change:

- establishing a sense of urgency for change
- creating a vision
- communicating the vision
- removing obstacles to a new vision
- systematically planning for and creating short-term wins
- not declaring victory too soon
- making change part of the culture.

Tsuyuki and Schindel note that successful change requires a significant investment of time and effort and that skipping any of these steps, or making mistakes in the implementation of these steps, can slow momentum in the process of change.³¹ In establishing a sense of urgency in the profession, the authors write:

Health care reform is on the contemporary agenda. Pharmacists *could* be part of the solution, but currently are not. If pharmacists do not step up to fulfill these needs, other health care professionals will. The increasing use of advanced practice nurses, many with prescribing authority, is evidence that the opportunity is here, but we must act now.... We must recognize that there will be little need for traditional dispensing pharmacies in the very near future... Do patients and society need pharmacists to dispense and prepare medications when trained technicians and dispensing technology can meet those needs? Pharmacists who merely dispense are no longer fulfilling a societal need, and in this era of greater accountability in health care, can no longer be justified.³²

The authors offer the following recommendations (associated with their necessary eight steps to change) towards engaging pharmacists in patient-oriented health care. They are as follows:

- Establish a sense of urgency for change by communicating unmet patient needs to pharmacists, payers and health care policy makers, and the general public.
- Further drive this sense of urgency by announcing that traditional dispensing roles for pharmacists are no longer viable.
- Form a coalition of all pharmacy organizations. Pharmacy organizations must be united by the desire to show the value of pharmacists in patient care... This coalition should also include pharmacy practice-based research centres to continue to create the evidence, and to share results and methodological skills.
- Use this coalition to develop a clear, easily communicated vision for the profession.
- The vision statement should be communicated widely.
- Begin addressing the major obstacles to the vision: pharmacists' mental models, education/ training and health-system obstacles.
- Communicate the short-term wins that we already have.
- Use these wins to tackle more obstacles and keep the change effort moving forward.
- Make patient-oriented health care part of the new culture for pharmacy by showing pharmacists the benefits of practice change, raising expectations and instilling the new values into our trainees.
- Encourage continued research to build the evidence base for the efficacy of patient-oriented care by pharmacists.³³

The nursing profession is also looking towards the future and what roles nurses will play in our future health care system. In a report released by the Canadian Nurses Association in May 2005, *Toward 2020: Visions for Nursing*, scenarios under six key themes were identified if nursing is to be ready for the health and social challenges of 2020.³⁴ Some of these themes are similar to the critical elements for the pharmacy profession identified in this Blueprint paper:

- The system: health and illness care in 2020
- The roles, scopes and practice settings of nurses in 2020
- Nursing human resources: the number and mix of nurses in 2020
- Nursing education in 2020
- Ensuring responsiveness, quality and patient safety: regulating nurses in 2020
- Diversifying nursing: careers in nursing for all Canadians.

The time for action is now. The profession must rise to this challenge or risk that others will usurp their role.

V Change Management and Models for Practice Change

There is a growing literature on change management and pharmacy practice. Much work needs to be done to address the many aspects of developing model(s) for pharmacy practice change in Canada. A brief summary of some selected work to-date is presented below. It is not comprehensive but is intended to provide additional background information for the following section on the seven critical elements of change in the pharmacy profession.

From a broad perspective, researchers, such as Issetts and McKone,³⁵ note that there are three basic components of pharmaceutical care practice: the philosophy, the patient care process and the practice management system. They argue that the critical element in this framework is the practice

management plan. It should include a clear description of the service, a list of resources required, an evaluation process and revenue stream.

Having a structured approach to planning and implementing change in pharmacy practice is seen as critical. For example, Holdford described a community-based disease management approach consisting of a number of steps including: identifying the target population; assessing available resources; defining quality indicators; implementation (including goal setting, ensuring understanding of the disease and determining implementation strategies); assessment and continuous quality improvement.³⁶ In addition, Williamson and Kemper developed a framework for cognitive services implementation that included the following factors: identifying a market; adapting the layout of the pharmacy; determining the payment structures; marketing to patients and health professionals; evaluation of patient satisfaction; developing an implementation strategy (which covers the assessment of human resource requirements); sharing ideas and goal creation; and development of a policy and procedures manual.³⁷

As noted above, several other countries have undertaken initiatives to address practice management change. For example, in 2005, the pharmacy profession in Australia released a major report, *Change Management and Community Pharmacy*, cited earlier.³⁸ The researchers involved in this study (2003-06) have employed a number of techniques to identify a wide range of opportunities for pharmacy, including an innovative “characterizing opportunities filter”. The study also used three change wheels (Pharmind Wheel, Pharmacy Change Readiness Wheel and the Pharmacy Change Implementation Wheel) to provide a structured way of analyzing and making recommendations for introducing industry-wide pharmacy practice change that involves greater pharmacy service provision. These, along with other relevant studies, will be important resources to draw upon and learn from as practice change is addressed in Canada.

VI Critical Elements for Change in the Pharmacy Profession

Change does not come easily—it needs resources, organization and commitment.

This section provides background on seven areas within pharmacy that need to be addressed. Each key element includes a list of some of the things that will need to be done to move forward and gives examples of current leading initiatives. Presently, these lists may not be comprehensive and have not been prioritized. As stated earlier, an ongoing consultation process will seek feedback and input to revise the steps required to move forward. This will then lead to the development of an implementation plan for future action. The June 2006 consensus workshop will work towards finalizing the list, selecting key action areas and developing a plan for how to move forward on priority areas.

It is important to note that there are many potential agents for practice change within the pharmacy profession. Future change in pharmacy in Canada, will, by its very nature, need to be a collaborative effort by all the various bodies involved. These bodies and groups include: FPT governments, other funding bodies such as private third party insurers, professional pharmacy groups, pharmacy regulatory and licensing bodies, pharmacy university faculties, other related health care professional groups and consumer groups.

a) Role Change and Pharmacy Practice Models

As discussed throughout this paper, role change is essential if pharmacists are to achieve their preferred future. For example, in its funding proposal on pharmacy human resource planning,³⁹ CPhA highlighted the growing awareness that the full potential of the pharmacy workforce has not been

realized. This is particularly true of its role in ensuring that patients and consumers are provided with the most appropriate treatment and have the knowledge and skills to use medications to their best effect.

Members of the “medication team”—doctors, pharmacists, nurses and consumers—each have a role to play in ensuring pharmaceuticals are used judiciously, appropriately, safely and efficaciously. Reforms in the Canadian health care system and the increasing shift towards greater self-care by patients are provoking changes in traditional roles, including those of pharmacists and pharmacy technicians, and this needs to be addressed.⁴⁰

Also, in its 2004 report, *Pharmacists and Primary Health Care*,⁴¹ CPhA noted that pharmacists could assume greater responsibility in health care delivery. Pharmacists are exploring roles that would allow them to provide health promotion and disease prevention strategies, administer vaccines, perform limited physical assessments and initiate medication therapies with the appropriate collaborative drug therapy management authority. In addition, the report stated that the silos, which currently exist in the health sector, act as barriers to better health outcomes and work to increase costs while decreasing services.

As pharmacists strive to provide increased quality primary health care for Canadians, there is a need to develop new practice models for pharmacy.

Theoretical models, developed by the Canadian Health Services Research Foundation and applied to pharmacy include:

- The pharmacist as an integral member of the primary health care team in a clinic setting or a physician’s office.
- The pharmacist as a consultant to a number of pharmacies, clinics or physicians’ offices.
- Pharmacist directed and managed primary care health care clinics or primary care practices in established community pharmacy settings.
- Primary health care in community pharmacy setting.⁴²

CPhA’s primary health care paper demonstrates, with examples, a number of these possible expanded roles with actions required to bring about change and position pharmacists in primary health care (examples included in background readings package).⁴³ Another approach to change is the development of specific new services provided in a traditional community pharmacy setting, such as anticoagulation monitoring, lipid screening, and smoking cessation. This approach is a key feature of the new NHS contract in the UK, as highlighted earlier.

In 2001, the federal government established the \$800M Primary Health Care Transition Fund (PHCTF) that is providing support for the transitional costs associated with introducing new approaches to primary health care delivery. In addition to direct support to the provinces and territories, the PHCTF supports various pan-Canadian initiatives to address common barriers and support participation by health care stakeholders. Two of the national collaborative care projects have implications for future models of practice for pharmacists: Enhancing Interdisciplinary Collaboration in Primary Care (EICP, www.eicp.ca) and Canadian Collaborative Mental Health Initiative (CCMHI, www.ccmhi.ca).⁴⁴

For example, the EICP Steering Committee has developed principles and a framework that will encourage and enhance interdisciplinary collaboration in primary health care in Canada.⁴⁵ The six principles are patient/client engagement; population health approach; best possible care and services; access; trust and respect; and effective communication. Similar to the elements for change outlined in this paper, EICP has identified seven key framework elements that require attention to sustain

interdisciplinary collaboration: health human resources; funding; liability; regulation; information and communications technology; management and leadership; and planning and evaluation.

The importance of interdisciplinary practice is also recognized in the May 2005 final strategy report from the physician human resources sector study, Task Force Two. The final report proposes long-term strategies for moving forward in five key aspects of physician human resources: education and training; interprofessionalism; recruitment and retention; licensure, regulatory issues and liability; and, infrastructure and technology.

Making Teamwork Work—Interprofessional Practice and Education: Interprofessional collaborative practice where physicians and other health care providers have clearly identified and valued roles.⁴⁶

Several provincial governments have recognized new and expanded roles for pharmacists, in particular, the participation of pharmacists in primary health care teams and better management of those with chronic diseases. For example, the Ontario government is funding a number of demonstration projects, under the PHCTF, that examine the role of pharmacists and other health professionals, through interdisciplinary health care teams, to optimize drug therapy and to better support specific high-risk groups such as people with congestive heart failure, those with vascular disease and the elderly.⁴⁷

The IMPACT project (Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics) is an Ontario-funded PHCTF project in which the pharmacists' main service was to do individual patient assessments to identify, prevent or resolve drug-related problems.⁴⁸ IMPACT examined the experiences of pharmacists and physicians during the implementation of the program and looked at factors that facilitate and hinder the integration process:

Pharmacists characterized the integration process as an emotional “rollercoaster,” complete with successes (feeling valued and contributing concretely to patient care), frustrations (feeling underutilized) and fears (being a nuisance, working too slowly). Pharmacists relied on various adaptive strategies and practical demonstration of their potential value to physicians to facilitate their integration process. Pharmacists identify mentors, allied health professionals and accommodating doctors as key supports. System supports included office space promoting accessibility, communication tools, and participation in practice meetings or education sessions. Physicians' initial concerns (medical legal implications and workflow issues) decreased markedly as physicians began to know and appreciate the role of the pharmacist. A key challenge for physicians was adapting long-established routines. Important system level supports included office space and activities to promote physician-pharmacist communication, such as pharmacist participation in practice meetings.⁴⁹

IMPACT has developed toolkits to support pharmacists' integration into family practice, one for pharmacists and the other for the lead physician and site manager. Sustainability and expansion of this model appears promising, as Family Health Teams (FHT) can apply to the Ontario Ministry of Health and Long-Term Care to have a full- or part-time pharmacist as a salaried member of the FHT.⁵⁰

In another initiative in Ontario, the Ontario College of Pharmacists' (OCP) Task Force on Optimizing the Pharmacist's Role developed a framework⁵¹ to support and guide pharmacists who currently provide medication consultation services in their practice and who are looking to provide consultation services to their patients. This framework is intended to compliment the OCP's Standards of Practice.

Also, the Alberta government has funded similar projects to improve the quality of medication use through coordinated and better integrated primary health care teams comprising pharmacists, physicians and nurses.⁵²

Pharmacist groups and associations have also been looking in more depth at the role of pharmacists in specific segments of the Canadian population. For example, CPhA in 2003 produced a report on pharmacists and home care.⁵³

In the fall of 2004, in a group exercise at the Pharmacy Advisory Board meeting of Sanofi Aventis (N=17), participants identified increased prescribing rights as one of the key possible role changes in the next three years for the profession. All of the group noted that it was highly likely that pharmacists would be engaged in filling repeat prescriptions by 2007 and most thought it was highly likely that pharmacists would be making modifications to therapy (e.g., dose, addition, substituting within a drug class) by 2007. There was also some, but less agreement, about the likelihood of collaborative initiation (e.g., the doctor writes the therapeutic intent). There was no or little agreement on independent initiation or modification of therapy (dose, addition, substitution).⁵⁴

Evidence to support the value of pharmacists' services is essential. The Canadian Pharmacy Practice Research Group (CPPRG) is a network of pharmacy practice researchers and practitioners committed to developing and strengthening the evidence base and pharmacy practice research across Canada. In November 2005, CPhA hosted the *Working Better... Together* workshop, involving leaders in pharmacy practice, policy and practice research.⁵⁵ Follow-up on priorities continues through the work of the CPPRG. The top four priority actions identified at the workshop were:

- To strengthen networks between leaders in pharmacy practice, policy and research across Canada (to develop the human infrastructure needed to support better links and more effective communication between leaders).
- To build human capacity in pharmacy practice research (to ensure that pharmacy practice research can effectively contribute to improvements in health service delivery and patient outcomes).
- To develop a coordinated program of research in the areas of medication safety, primary care, and continuity of care (to ensure that pharmacy effectively contributes to priority areas in health practice and policy).
- To track progress.

As noted in a paper by Jones, MacKinnon and Tsuyuki,⁵⁶ varying degrees of prescribing privileges have been given to pharmacists in several provinces and are expected to increase in the future. These privileges include minor prescription changes (Québec), provisions of interim or refill supplies (Manitoba, Québec), therapeutic modifications based on protocols (Nova Scotia, Québec), and collaboration or independent prescribing arrangements with physicians (Newfoundland and Labrador, Nunavut).⁵⁷ Significant change is underway in both Manitoba and Alberta with legislative changes.^{58 59}

Despite this support for pharmacists' prescribing, a critical statement by Romanow needs to be addressed by the profession:

“... there may also be a role for pharmacists who are not engaged in the retail sale of prescription drugs to prescribe certain drugs under specific, limited conditions.”⁶⁰

Critical questions remain but other countries are addressing and seeking to resolve similar issues in pharmacy practice; the pharmacy profession in Canada must as well. Should pharmacists be allowed to prescribe in a retail setting when physicians are legally prohibited from dispensing when in reasonable proximity to a pharmacy? What are the risks to pursuing full-scale prescribing for all pharmacists regardless of practice environment? Might this move lead to physician dispensing?

The following summarizes and highlights the broad actions necessary to address the many issues regarding the roles and responsibilities of pharmacists in the future. These action items were identified at the December 2005 Blueprint workshop.

To move forward, the pharmacy profession will need:

- ✓ *To identify, define, test and evaluate new professional services and expanded pharmacy practice models.
Best practice models must be drawn from existing innovative models for broader implementation at the local, regional and national level. Potential barriers to adoption and implementation must be addressed to ensure success.*
- ✓ *To define the relevant needs and enhance education and training opportunities to implement new practice models.
This will necessitate changes in credentialing, certification and the development of an increased interdisciplinary, cross-training approach.*
- ✓ *To fully delegate technical tasks to pharmacy technicians and to promote the necessary enabling regulation, legislation and competency assurance.
This will be an evolving process and tools such as e-Therapeutics and the Electronic Health Record (EHR) must be considered in such delegation.*
- ✓ *To develop, with relevant others, a reimbursement framework that provides appropriate incentives and compensates pharmacy services within new practice models.
Such a reimbursement framework needs to be developed and implemented in all provinces and jurisdictions. Concomitantly, funding should be sought to develop and implement demonstration projects of new models and services with financial and other incentives to support practice change.*
- ✓ *To develop and implement targeted advocacy and communication strategies to promote acceptance of new future roles for pharmacists.
Focus first on improving pharmacists' perception of the value they bring. Additional strategies should involve other health care professional groups, particularly those who may be resistant to pharmacy role change, such as physicians. Advocacy strategies should also be directed to the public and consumers of pharmacy services to ensure that pharmacists are viewed as essential in the same way as physicians and nurses.*
- ✓ *To energize the pharmacy profession to create new leaders and champions for the acceptance, planning and implementation of new practice models.*

Examples of current leading initiatives:

- CPPRG's work to develop and strengthen pharmacy practice research across Canada
- Anticoagulation services, BC and NS
- Asthma services (e.g., BC Asthma Study)
- Cardiovascular screening and monitoring services (e.g., SCRIP: Study of Cardiovascular Risk Intervention by Pharmacists)
- Ontario PHCTF IMPACT Project (Integrating family Medicine and Pharmacy to Advance primary Care Therapeutics)
- Ontario College of Pharmacists' (OCP) Framework for Medication Consultation Services
- CPhA PRIME project (Practice Innovation Made Easy)
- National PHCTF Initiatives: Enhancing Interdisciplinary Collaboration in Primary Care (EICP) and Canadian Collaborative Mental Health Initiative (CCMHI)
- Others...

b) Pharmacy Human Resources

In 2003, the *First Ministers' Accord on Health Care Renewal* recognized the importance of health human resource (HHR) planning, including the role of pharmacists.

Appropriate planning and management of health human resources is key to ensuring that Canadians have access to the health providers they need, now and in the future. Collaborative strategies are to be undertaken... to ensure the supply of needed health providers (including nurse practitioners, pharmacists and diagnostic technologists).⁶¹

National consultations on health service priorities in Canada, held in 2001 and 2004, identified health human resource planning as the top priority needing attention if Canadians are to enjoy a strong and sustainable health system in the future. The inaugural report to Canadians of the Health Council of Canada, released in January 2005, also identified HHR planning as a priority area in need of "accelerated action". The report noted that while significant HHR planning activity is currently underway, it is primarily focused on physicians and nurses. Further, "... Canada is not self-sufficient in producing health care professionals and we continue to rely on a pool of internationally trained individuals."⁶²

The Council sponsored a national summit on health human resources in June 2005 at which four themes were examined: interprofessional education and training; scope of practice; issues in the workplace; and planning efforts. The Council's February 2006 report proposes: intensified, interprofessional education of adequate numbers of healthcare workers; enabling each health care professional to practice to his/her full potential in new delivery models; and collaboration in workforce planning to reduce the competition among jurisdictions for scarce health professionals.⁶³

Canadian governments have invested extensively in HHR planning for physicians and nurses for many years. The pharmacy sector, which represents the third-largest health workforce group, deserves urgent attention in light of the repositioning of its role. Pharmacy has just recently benefited from such an investment, with approval in October 2005 of \$1.48 million in federal funding for a Pharmacy Human Resources Study.

In the last five years, substantial resources have been committed by federal, provincial and territorial governments to support health care renewal initiatives across Canada. Many of these initiatives have implications for HHR planning, and more specifically pharmacy HR planning. The FPT governments have identified seven health professions (Medicine, Nursing, Pharmacy, Physiotherapy, Occupational Therapy, Medical Laboratory Technology and Medical Radiation Technology) which they believe should receive priority actions when planning for human resources in health.

Through its Health Human Resources Strategy Division (HHRSD), Health Canada is working with the provinces, territories and other health-related organizations to implement the Health Human Resource Strategy to improve HHR planning and coordination. The strategy focuses on three key areas: HHR planning (including modeling future workforce demands); recruitment and retention; and inter-professional education. The FPT Advisory Committee on Health Delivery and Human Resources (ACHDHR) has been a major conduit for the collaborative work that has taken place in the key area of HHR planning. Pharmacy HR planning is part of this group's mandate.

Significant funding has been allocated to a wide range of projects under the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP), many of which will be applicable to the pharmacy workforce practice.⁶⁴ Health Canada is also leading other initiatives to develop modelling tools to forecast future health workforces, and is working with the Foreign Credential Recognition (FCR) Program of Human Resources and Skills Development Canada (HRSDC) to develop a pan-Canadian approach to assessing and recognizing foreign credentials in the targeted health occupations, including pharmacy.

Health Canada's HHRSD is also funding the Canadian Institute for Health Information's (CIHI) Health Human Resources Databases Development Project (HHR-DDP) to develop a pharmacist database (cost is approximately \$1 million, running from January 2005 to October 2007). This initiative involves the provincial pharmacy licensing bodies, CPhA, the National Association of Pharmacy Regulatory Authorities (NAPRA), Canadian Association of Chain Drug Stores (CACDS) and Canadian Society of Hospital Pharmacists (CSHP).

Through the annual licensing process, the pharmacy regulatory authorities will collect a minimum set of data for inclusion in the database. The new standardized pharmacist database will support HHR monitoring and evaluation, planning, research and policy activities. A report will be produced annually by CIHI, similar to that now produced for physicians and nurses. The annual report typically includes basic information on the health profession and presents supply-based information on demographics (age, gender), education (entry level education, country) and employment (employment status, primary area of responsibility) characteristics.

CPhA, on behalf of the Pharmacy Sector, has received \$1.48 million in funding for a study titled *Pharmacy Human Resources in Canada: a Study of Pharmacists and Pharmacy Technicians*. The study is funded by FCR Program of HRSDC and will run from October 2005 through March 2008. The Pharmacy HR Study is a joint initiative led by CPhA, in collaboration with CSHP, CACDS, NAPRA, the Canadian Association of Pharmacy Technicians (CAPT), Association of Deans of Pharmacy of Canada (ADPC), Association of Faculties of Pharmacy of Canada (AFPC), and the Pharmacy Examining Board of Canada (PEBC) (see summary in background readings).

As highlighted in the funding proposal,⁶⁵ there are currently over 29,000 licensed pharmacists in Canada. Pharmacists make up the third-largest segment of health professionals in Canada. Pharmacists are the only health professional whose education is entirely devoted to medications and their use. Approximately 75% of practicing pharmacists work in community pharmacies, representing about one pharmacist for every 1,500 Canadians. Another 15% of pharmacists (around 4,200) work in hospital pharmacies. The remaining 10% of licensed pharmacists work in other settings. CPhA also noted that, at present, there are no accurate estimates of the total number of pharmacy technicians in Canada.

International Pharmacy Graduates (IPGs) now represent a significant portion of the pharmacist workforce. In 2004, over one-third of pharmacists who became eligible for licensure in Canada were IPGs (excluding Québec). It is recognized, however, that IPGs require considerable support to successfully meet the licensing requirements and to effectively integrate into pharmacy practice in Canada.

The *Pharmacy Human Resources in Canada* study will be completed over a 30-month period and has four primary aims:

- To develop a comprehensive understanding of the pharmacy workforce in Canada, and the factors that influence its structure and the skills and competencies of its members.
- To identify short and long-term human resource challenges facing the pharmacy sector that need to be addressed in a pan-Canadian pharmacy HR plan.
- To identify challenges facing the pharmacy sector that might be specific to individual Canadian provinces and territories.
- To offer recommendations that will help ensure a pharmacy workforce fit for purpose for the future needs of Canadians and the Canadian health care system.

There are many questions concerning the structure of the Canadian pharmacy workforce that will be answered by this important study through a series of fact-finding surveys, focus groups, targeted

interviews, consultations and analysis. Although the results of this HHR study will inform many aspects of planning for the pharmacy profession, it is critical that the process of developing a Blueprint for Action for pharmacy proceeds in parallel with this process.

A significant piece of research will be undertaken by the Pharmacy Human Resources Study to explore pharmacy technician issues. The role and related competencies of pharmacy technicians will be examined, as well as certification and accreditation processes. There is now consensus among the various pharmacist and pharmacy technician stakeholder groups that action is urgently needed at the national level on these issues. An environmental scan, completed in May 2006, examined recent provincial, national and international progress relating to regulation and certification of pharmacy technicians and the accreditation of technician education programs.⁶⁶ (included with background reading package). A research study, *Quantifying the Pharmacy Technician Workforce in Canada*, will gather quantitative demographic information on the pharmacy technician segment of the workforces, as well as qualitative/attitudinal information relating to roles, responsibilities and readiness for change.⁶⁷

CSHP has been working to address what it calls a management leadership crisis in hospital pharmacy.⁶⁸ Of particular concern is the appointment of non-pharmacists as heads of hospital pharmacy services. Letters were sent in early June 2006 to hospital Chief Executive Officers and other pharmacy stakeholders.

In recent years, papers have documented the severe shortage of hospital pharmacy directors and the related problems of recruitment and retention, and gaps in the managerial competencies of current hospital pharmacy directors. With pharmaceuticals being the second largest and fastest rising category of healthcare expenditures, and the demand for a safe and effective medication use system, the ramifications of a leadership crisis in hospital pharmacy departments are widespread.⁶⁹

CSHP held a workshop in August 2005 in conjunction with their Annual General Meeting to solicit the input of key hospital pharmacy directors across Canada. Participants addressed three questions: 1. What are the best approaches to improving the recruitment and retention of hospital pharmacy directors? 2. Which training/experiential methods are most effective at nurturing the next generation of leaders in hospital pharmacy practice in Canada? 3. How do changing demographics influence the work experiences and expectations of hospital pharmacy directors?⁷⁰

CSHP recently released a position paper that endorses the proposition that the position of department head of a hospital pharmacy be held by a licensed pharmacist and explains the five rationales for this:

- The complexity of the medication use system necessitates a comprehensive and specialized knowledge base.
- Pharmacists are best suited to have the knowledge, skills, and abilities required of a head of hospital pharmacy services.
- Several provincial pharmacy regulatory bodies in Canada specify that the head of hospital pharmacy services must be a pharmacist.
- National and international professional practice guidelines recommend that heads of hospital pharmacy services be pharmacists.
- Pharmacists are needed in management roles for leadership and advancement of the profession of pharmacy.⁷¹

In summary, the following future initiatives concerning pharmacy human resources will be necessary to ready the profession for the future.

To move forward, the pharmacy profession will need:

- ✓ *To make an assessment of future pharmacy human resource requirements to meet existing and new roles.*
Much of this work will be happening through the HRSDC-funded Pharmacy HR Study.
- ✓ *To describe new roles and required skills for pharmacists within a collaborative primary health care team.*
- ✓ *To develop a national database of pharmacists that is updated annually.*
This is in progress through the CIHI HHR database development project.
- ✓ *To ensure that pan-Canadian health human resource planning includes pharmacists and recognizes the complexity of the profession.*
- ✓ *To promote an increased number of pharmacy technicians with higher qualifications and expanded responsibilities.*
Pharmacy technician work is considered integral for the profession to move forward.
- ✓ *To define the roles, responsibilities and competency requirements of regulated pharmacy technicians.*
- ✓ *To promote a greater understanding of pharmacy workplace satisfaction factors and to address pharmacist recruitment and retention issues.*
- ✓ *To address international pharmacy graduate (IPG) needs (e.g., education, culture, language).*

Examples of current leading initiatives:

- Pharmacy Human Resources in Canada Study, CPhA. Many of the HHR objectives above are presently being addressed by various sub-studies within this broad pharmacy HR study.
- Pharmacy technician regulation initiative, OCP
- Pharmacist Database Project, CIHI
- Interdisciplinary project in geriatric care, University of Manitoba
- CSHP's advocacy initiative on leadership in hospital pharmacy management
- Others...

c) Pharmacy Education and Continuing Professional Development

Change necessarily pushes and revolutionizes many aspects of the profession; therefore, it is inevitable that radical change in the structure of the profession requires significant change in pharmacy education and continuing professional development (CPD).

The education and training of pharmacists needs further examination as the profession evolves towards its “preferred future”. Current university curricula prepare new pharmacists to practice in a manner that is patient-focused, playing a key role on the health care team by actively managing drug therapy. Pharmacists who are in practice may need educational support (e.g., CPD) to maintain an up-to-date knowledge base in an area that is rapidly changing. Incorporating interdisciplinary education into the university curricula of all health professionals, including pharmacists, will be essential to build strong primary health care teams.

CPD requirements across the country vary with some jurisdictions requiring a specified minimum level of accredited continuing education units while others have moved or are moving towards requiring pharmacists to take responsibility for their CPD activities in the form of maintenance of a learning portfolio. The implementation of learning portfolios has met with mixed reaction from the pharmacist community, but has the potential to be a strong tool to guide pharmacists as the profession evolves.

Presently, in some faculties there is a push to move to an entry-level PharmD program, and two Canadian universities (University of Toronto, University of British Columbia) offer the PharmD program as an advanced degree. However, further deliberation must follow in Canada as to how this degree will be integrated into future role changes within the pharmacy profession.

Much still remains unanswered, particularly with regards to the structure of the pharmacy workforce and the related knowledge and competency requirements. The following questions require answers:

- What changes are needed in the education and training of pharmacists in the “preferred future”?
- How are Canadian university faculties of pharmacy responding to the changing knowledge and competency requirements of pharmacists? What issues and challenges exist?
- Should all Canadian universities shift to entry-level PharmD programs?
- What education and credentialing process is needed for pharmacy technicians in the future across Canada? What are the skills and competencies and roles and responsibilities of this important group?
- How well are university-based bridging programs preparing International Pharmacy Graduates (IPGs) for PEBC exams and integration into pharmacy practice in Canada? What issues and challenges exist? What are the expectations of IPGs who successfully complete such programs?

In defining a Blueprint for Action for pharmacy, it is imperative that education and credentials for pharmacy technicians be explored. Presently, pharmacy technicians are not regulated; there are no national competency standards. As a result, skills and competencies, as well as roles and responsibilities, vary widely.

In 1998, the Ontario College of Pharmacists’ (OCP) Council identified as one of its priorities the establishment of a separate class of registration for pharmacy technicians. OCP has a voluntary certification program for pharmacy technicians that include guidelines on roles and responsibilities in the following four key areas: assisting the pharmacist in the preparation of prescriptions; clerical activities; communication skills; and inventory management. In December 2004, OCP Council approved the release of the *Proposed Standards of Practice for Registered Pharmacy Technicians* for consultation with stakeholders. In 2005 the Ontario Minister of Health requested that the Health Professions Regulatory Advisory Committee (HPRAC) consider whether it would be appropriate to regulate pharmacy technicians under the Regulated Health Professions Act.⁷² On May 19, 2006, HPRAC recommended that pharmacy technicians be regulated under the Ontario College of Pharmacists.⁷³ The regulated pharmacy technician would have an expanded scope of practice and responsibilities beyond what unregulated pharmacy assistants/technicians currently perform. The expanded role for regulated pharmacy technicians would directly support the current and expanded future roles of the pharmacist.

The Canadian Pharmacy Technician Educators Association (CPTA) is a newly formed national voluntary organization of pharmacy technician educators established to lead, advance, support and promote excellence in pharmacy technician education. A major program for CPTA this past year, with the support of the OCP, has been the development of a draft set of national educational outcomes for pharmacy technician programs. The organization is also working closely with the Canadian Council for Accreditation of Pharmacy Programs (CCAPP) in seeking the establishment of an accreditation process for pharmacy technician programs that would be based on the CPTA educational outcomes document.

At an April 2005 forum and workshop on the future of pharmacy practice and education, hosted by the Association of Deans of Pharmacy of Canada (ADPC), the following priority changes for pharmacy education were identified and some solutions were offered:

- Become more interdisciplinary through exposure to other disciplines early and throughout the pharmacists' education program.
Solutions: Work with other disciplines via experiential clinical rotations in multidisciplinary teams; therapy case studies with physicians, nurses, etc.; interprofessional team activities.
- Integrate more experiential learning/training with qualified practitioners.
Solutions: Students will have individual rotations in therapeutic areas along with medical students starting in first year; practitioners, in preceptor role, will be actively engaged, supported, maintained and recognized.
- Strengthen training of "soft skills" through program entry selection and effective teaching approaches.
Solutions: Select appropriate students and develop culture and confidence; teach using a practice/feedback loop as well as role modelling.
- Improve preceptors' accessibility and skills to ensure they are qualified as role models and demonstrate best practice environments and models.
Solutions: Implement a collaborative approach to define standards for preceptors and sites; implement a formalized process (certification/agreement) to maintain and/or develop a sufficient number of competent preceptors.⁷⁴

Discussions at the December 2005 Blueprint for Action workshop⁷⁵ also assisted in further identifying areas for change in the education and CPD of pharmacists. This and the work of many other initiatives have led to the following recommendations to improve the system of education and CPD for future pharmacists.

To move forward, the pharmacy profession will need:

- ✓ *To increase experiential training for pharmacy students, recognizing the new responsibilities of future pharmacy practice models.
Need to address the quality of experiential learning, not just the quantity ;(e.g., need many demonstration sites where clinical role can be modeled for the students and practiced by pharmacists).*
- ✓ *To promote and increase an interdisciplinary approach (including soft skills, such as communication skills and confidence building) at the undergraduate level and in continuing professional development (CPD) programs.*
- ✓ *To develop support programs (e.g., bridging programs) to meet the specific needs of international pharmacy graduates (IPGs).*
- ✓ *To define the skills and competencies needed by pharmacy technicians and to develop programs to accredit pharmacy technician training programs, programs to certify pharmacy technicians, as well as bridging programs to facilitate existing pharmacy technicians to become regulated and be able to take on new responsibilities.*
- ✓ *To develop CPD and practice support programs for pharmacists seeking to implement new services, specialty practices or new practice models.
CPD is imperative so that existing pharmacists have the opportunity to enhance their skills to participate in new pharmacy roles.*

- ✓ *To work with pharmacy owners to address infrastructure change necessary for pharmacies to integrate into new models, and to develop a business case to support such change.*
- ✓ *To facilitate infrastructure change in the education system and elsewhere necessary for pharmacists to integrate into new health care models.*

Examples of current leading initiatives:

- Development of short courses to meet the needs of international pharmacy graduates, University of Toronto, University of British Columbia
- Development of short courses to meet the needs of pharmacists returning to practice, University of British Columbia
- Structured practical experience programs, all universities
- Certificate programs for certain disease states; e.g., Ontario Pharmacists' Association (OPA) program
- CSHP's advocacy initiative on experiential learning
- Others...

d) Information and Communication Technology

Information technology has the potential to revolutionize health care, and in particular, the profession of pharmacy. However, learning about and adapting to rapidly expanding communication technologies will be another challenge for the profession.

In primary health care, sharing information among team members is essential to improving continuity of care and service delivery. Information and communications technology (ICT) creates those critical information pathways.

As discussed in the principles and framework document from the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) initiative:

Continuity of information between and among health professionals correlates with improved quality of care and administrative processes, and improved patient safety. Technological communication supports, such as e-mail and even telehealth systems involving satellite technology, mean that health professionals and administrators can collaborate more easily and access accurate and up-to-date information when they need it. The result is improved access and more effective services for patients and clients and the communities they live in. Learning about and adapting to communication technologies is a key challenge for health professionals. Hastening their comfort with electronic information systems, through education and training, is a priority if collaborative teams are to become commonplace.⁷⁶

Several national initiatives are underway. Canada Health Infoway is leading the development of a national Electronic Health Record (EHR) and electronic pharmacy/prescribing networks in collaboration with federal and provincial/territorial governments to facilitate improved health information access and transmission. For example, EHRs, which are presently evolving in Canada, are forming an information "backbone" for all health care professionals. The integration of this new technology is fundamental and a priority if pharmacists want to be part of collaborative primary health care teams.

Electronic prescribing systems have also been shown to decrease medication errors, improve the safety and appropriateness of prescribing, and increase the efficiency of the drug use process. Prevention of

medication errors is anticipated to be achieved through implementation of computerized physician order entry (CPOE). CPOE systems are electronic prescribing systems that intercept error when they most commonly occur—at the time the medications are ordered. Orders are entered directly into the computer system and are integrated with patient information, including laboratory and prescription data.⁷⁷

Provincial drug information systems (DIS) or pharmacy information networks (PINs) will enable physicians to view a patient's complete drug profile online, order a prescription electronically and receive notification of drug interactions automatically. These systems will allow pharmacists to view the order online and send a message for inclusion in the patient's drug profile once the prescription is filled. It is expected these systems will help to reduce prescription errors and adverse drug complications, improve diagnosis support through availability of a patient's complete drug profile, result in fewer call-backs by pharmacists to physicians for clarification, and lower costs through reduced hospitalization, long-term care admission and physician visits.

To support e-health applications, pan-Canadian standards are required. The CPhA Pharmacy Claim Standard is used across Canada to electronically adjudicate about 300 million prescription drug claims annually. The CPhA Standard has now evolved into the National e-Claims Standard (NeCST).⁷⁸ NeCST is an HL7-V3 internationally approved claim standard, for use by pharmacists and other health professionals. The NeCST standard has yet to be implemented and issues of a sustainable funding model and standards maintenance are still being addressed. Canada Health Infoway's Canadian Electronic Drug Messaging Standard (CeRx), for clinical messages to support e-prescribing and PINs/DIS, is nearing completion.

As a result of e-pharmacy initiatives, it is clear that a number of patient/practice-based policy issues and business/implementation issues need to be addressed. Integration and implementation of provincial PINs/DIS require fundamental changes in the work practices of pharmacists and pharmacy technicians and significant investment in software. These changes need to be recognized, explored and planned for.

In January 2006, CACDS, CPhA and CSHP approved a joint e-pharmacy document, *Principles and Elements for Optimal Pharmacy Participation in the Development of Pharmacy Information Networks*.⁷⁹ These principles and elements were presented at the Pan-Canadian Drug Information Systems (DIS) workshop hosted by Canada Health Infoway in January, with provincial governments in attendance. Work has now begun on establishing a National e-Pharmacy Group to ensure that pharmacy interests are well represented with EHR implementation. Key areas include e-prescribing, e-dispensing, e-health standards and technologies, with a particular focus on impacts on practice and pharmacy operations.

Canada Health Infoway recognizes that health provider acceptance and adoption are clearly critical success factors for realizing the full benefits from the Infoway investments. Infoway is doing a lot of work on end-user acceptance and has a number of projects related to this underway.

End users—physicians, nurses, pharmacists and other health care practitioners—are the people who must make the solutions work in their everyday activities in hospitals, clinics and communities. They are the people who must adopt and properly use these modern health information systems and communication technologies.⁸⁰

Infoway is establishing a team of clinicians including Senior Medical Advisors, a Senior Nursing Advisor and a Senior Pharmacy Advisor to support the implementation of their end-user initiatives. In addition, Infoway is putting together advisory groups with representation from pharmacists, nurses, physicians and the academic/learning community to provide strategic, operational and delivery advice on the design and implementation of their end user acceptance strategy.⁸¹

The following initiatives and efforts have been identified as necessary in order for the profession to embrace ICT in the future.

To move forward, the pharmacy profession will need:

- ✓ *To develop and obtain agreement for pharmacists to read and write to all of the relevant parts of a patient's electronic health record.*
- ✓ *To ensure that pharmacists are engaged in the development of health informatics programs across Canada, and that programs are developed based on pan-Canadian standards and platforms.*
- ✓ *To ensure that pan-Canadian e-health standards (e.g., CeRx and NeCST) are in place to support integration and data access across systems and that they are sustained on a national level.*
- ✓ *To develop policies and practices relevant to electronic prescribing and electronic transfer of prescriptions.*
- ✓ *To effectively address policy issues identified by Canada Health Infoway's work on PINs/DIS and to promote implementation and adoption.*
- ✓ *To establish a national pharmacy taskforce to address policy, privacy, business and patient care issues.*
- ✓ *To ensure that the development and application of ICT improves patient safety and does not increase the potential for errors.*
- ✓ *To ensure that the development of ICT in hospitals and primary health care settings facilitates continuity of care with respect to a patient's drug therapy (e.g., medication reconciliation).*
- ✓ *To ensure that a coordinated, phased-in, change-management approach, which is endorsed by pharmacy, is developed to manage the system, the workflow and practice changes.*
- ✓ *To develop a provider level business case to support end-user adoption of ICT changes.*

Examples of current leading initiatives:

- The completion of the National e-Claims Standard (NeCST) as a fully internationally compliant HL7 Version 3 Standard
- CACDS, CPhA and CSHP's development of a joint statement on principles and elements relating to pharmacy information systems
- Work underway to establish a national e-Pharmacy Group to address pharmacy issues relating to EHR
- Canada Health Infoway's project on clinical messaging standards for DIS/PINs and e-prescribing (CeRx)
- Infoway's work on standards for provider and client registries
- Infoway's change management and end user acceptance strategy initiative
- Others...

e) Financial Viability and Sustainability

Community pharmacy businesses need to implement significant change in order to respond to the evolving roles of pharmacists.

Some components of potential business models were highlighted earlier. Presently, there is an understandable tension between a vision for the preferred future for pharmacy and the corporate or business perspective of pharmacy. These differing perspectives underlie much discussion of future change in the profession and must be addressed. To promote the buy-in of community pharmacists in a competitive retail market, change must ensure the financial viability and sustainability of these private businesses. In order to accomplish this, various practice models must be explored with all the stakeholders involved.

Currently, pharmacies are generally paid a fee for each prescription dispensed. This fee-for-service model of payment discourages collaboration with other providers and the expansion of focused medication management. Models for obtaining compensation and professional credit for patient care services must continue to be addressed.

There is a significant body of evidence from Canadian pharmacists and researchers on the benefits of enhanced care and, as a result, some provincial governments have gradually been introducing reimbursement programs for cognitive pharmacy services. CPhA maintains an online directory of pharmacy practice research.⁸²

For example, in Alberta, the 675-patient SCRIP (Study of Cardiovascular Risk Intervention by Pharmacists) was stopped before target enrolment was reached due to overwhelming evidence of benefit in the intervention group.⁸³ Similarly, the BC Community Pharmacy Asthma Study demonstrated the positive impact of pharmaceutical care on economic, clinical and quality of life outcomes in patients with asthma.⁸⁴ In British Columbia, Saskatchewan and Québec, the government pays pharmacists a consultation fee for emergency contraception services. For many years, Québec pharmacists have been paid for providing pharmaceutical opinions.

Translation of research results into policy and funding for new practice models needs to be supported. The Canadian Pharmacy Practice Research Group⁸⁵ (CPPRG) facilitates the generation, dissemination and application of practice-based research evidence to optimize the role of pharmacists in medication management and improved patient outcomes. The Centre for Community Pharmacy Research and Interdisciplinary Strategies⁸⁶ (COMPRIS) is a multidisciplinary health research centre based at the University of Alberta that fosters the development of new and renewed roles for pharmacists in community-based health care. The continued work of CPPRG and COMPRIS, and follow-up on priority areas from the November 2005 *Working Better Together Workshop* will continue to strengthen the evidence base.⁸⁷

In mid-April the Ontario government introduced *Bill 102—the Transparent Drug System for Patients Act*.⁸⁸ This bill is seen to have significant and far-reaching consequences for pharmacists in Ontario and across Canada. While parts of the bill were welcomed as it acknowledged the value of pharmacists' direct patient care services and the need to pay for such services, there was great concern about its impact on the sustainability and viability of community pharmacy. Bill 102 directly impacts many of the areas that pharmacists in Canada see as needing to be addressed through the Blueprint project; however, while the Blueprint seeks to address the future of pharmacy in a comprehensive manner, Bill 102 has the potential to produce profound change in the profession but not necessarily in a comprehensive or integrated manner.⁸⁹ A number of pharmacy organizations presented to the

government on the Bill and/or put forward submissions on proposed amendments; some proposed amendments have since been included.^{90 91}

As noted earlier, pharmacists in other countries face similar issues and are exploring new roles and different business models. Some of these models have also been discussed earlier under section V, Change Management and Models of Practice Change. For example, new payment models and contracts have been developed in the UK, Australia, Scotland and Germany. The results of the research on new practice models and the positive experiences of other countries must be studied, evaluated and incorporated into the “preferred future” for the pharmacy profession in Canada.

A critical and underlying part of any plan for the future must include a comprehensive assessment of the business environment, followed by the implementation of practice models that ensure the continued financial viability and sustainability of pharmacy services. In order to accomplish this, the profession must be open to business change. They must define their business needs based on public need, both expressed needs and those that are not expressed but derived through research-based evidence. Pharmacists in the future must collaborate more with physicians and other health professionals and document, in official publications, their success in measuring and improving therapeutic outcomes and impacts.

Pharmacy groups must examine the funding of pharmacy practice in the future. Global funding will be required for change management, ICT, business development and education changes. In addition, new pharmacy reimbursement models must be examined and developed. Pharmacy may need to reexamine the fee for dispensing prescriptions model and also look to reallocate current resources paid to pharmacists. New incentives may need to be developed to promote best practices in pharmacy.

Furthermore, pharmacy groups will need to develop and create an inventory of existing services and practice models. They must determine the costs associated with providing these innovative services and identify ‘early wins’ in practice model development and success in improving patient outcomes. Practice models groups should be created provincially and then moved to a national perspective as information and evidence grows. Ultimately, a business case for new models of pharmacy practice must be presented to governments, both provincially and federally.

What is clear is that the present business model will not move the profession forward to its vision of a preferred future. Pharmacy groups in many other countries have reached this conclusion; some have already moved forward significantly in changing their business practice. As discussed at the December 2005 Blueprint workshop, the following highlights changes that must occur in Canada to promote a healthy business and practice environment for the future of the pharmacy profession.

To move forward, the pharmacy profession will need:

- ✓ *To develop proposals to win resources from governments to support practice development and practice change.*
More specifically, to acquire global funding to support the following: ongoing change management in the pharmacy profession; ICT initiatives that move the profession to its preferred future; business development pilot projects and necessary educational CPD change.
- ✓ *To obtain funding for practice model research and pilot studies.*
Practice models must be needs-based and market-driven. Business models for pharmacy must be practice-based and practice change must be incremental and transferable to other settings.
- ✓ *To obtain evidence to support the cost-effectiveness of new pharmacy practice models and services for long-term health problems.*

Also need to address the inherent difficulties in practice models and budgeting for short- and long-term health issues.

- ✓ *To develop, evaluate and embrace a business model for drug distribution where there is less direct involvement of the pharmacist.*
- ✓ *To develop defensible financial models of pharmacy practice and business cases to support change so that pharmacy owners and corporate investors will provide support.*
- ✓ *To establish partnerships and develop business cases for presentation to partners. Includes partnerships with governments, insurers, other health care providers, the pharmaceutical industry and with patients.*
- ✓ *To develop reimbursement programs for professional services that ensures financial sustainability.*
- ✓ *To develop clear incentives for change in business models for pharmacy and to develop transition strategies that include the development of alternative/tiered funding models, incentives for change and a transferable practice model of patient care.*
- ✓ *To develop practice models for billing that differentiate services for primary health care interventions and for chronic disease management.*

Examples of leading initiatives:

- Fee guides, Ontario Pharmacists' Association and Alberta Pharmacists Association
- Activity-based cost accounting study, BC & CACDS
- CPhA's series of drug purchasing and cost-containment strategy papers
- Funding for Home Medication Review in Australia
- New NHS contract for pharmacists in England
- Studies demonstrating economic benefits
- Others...

f) Legislation, Regulation and Liability

Change cannot occur without support from the provincial pharmacy regulatory authorities and their commitment to reviewing and adjusting their policies to address and encourage initiatives, such as an interdisciplinary approach. As with other health professions in Canada, regulation is an important process to protect the public.

The present process of certification and regulation in pharmacy is outlined below. Future changes in pharmacy roles and education will likely necessitate change in these processes.

After a pharmacy degree has been obtained, all domestically and internationally-trained pharmacy graduates wishing to practice in Canada (except Québec) must be certified by the Pharmacy Examining Board of Canada (PEBC, www.pebc.ca). A major responsibility of PEBC is to assure the achievement of at least a minimal level of competence to practice at an entry-level. Certification requires successfully passing an Evaluation Examination (for pharmacy graduates trained outside Canada) and a Qualifying Examination (for all pharmacy graduates). In 2004, 951 pharmacy graduate candidates passed the PEBC Qualifying Examination (Parts I and II): 590 (62%) were Canadian pharmacy graduates and 361 (38%) were international pharmacy graduates (IPGs). In this same year, nearly all the Canadian graduates were from the seven English-speaking pharmacy faculties in Canada, and a small number of graduates from the two French-speaking faculties in Québec.

In addition to PEBC certification, all pharmacy graduates must be licensed to practice as pharmacists in Canada. The profession of pharmacy is regulated on a provincial/territorial level. The provincial Pharmacy Regulatory Authorities (PRA) are directly responsible for granting pharmacist licenses, assessing the competency of pharmacists and ensuring public safety. All pharmacists must meet the entry-to-practice standards as established by the provincial/territorial PRA. National competency standards for the practice of pharmacists in Canada have been defined by the National Association of Pharmacy Regulatory Authorities (NAPRA, www.napra.org).⁹²

Furthermore, legislated requirements are needed to support pharmacy regulation change and to give regulators of all the various health professions the mechanisms to work together.⁹³ For example, changes to provincial and federal legislation are necessary so pharmacists can initiate and modify drug therapies. At the December 2005 Blueprint for Pharmacy workshop, there was discussion that pharmacists must be given the authority to provide services such as physical assessment and patient immunization. In addition, the role of pharmacy technicians must be clearly defined and regulated, perhaps using the hospital model.⁹⁴

In mid-May, the Manitoba government introduced Bill 41, an update to the Pharmaceutical Act, to improve patient safety and accountability, and also to ensure that pharmacists will be able to better meet the needs of patients. Some of the changes in the proposed Act are to:

- Create the College of Pharmacists of Manitoba to replace the Manitoba Pharmaceutical Association.
- Modernize pharmacists' practice to include prescribing drugs under limited conditions and having greater involvement in drug and device selection, drug administration and drug regimen reviews.
- Allow collaborative practice between pharmacists and other regulated health-care practitioners with prescriptive authority including medicine, extended-practice nurses, registered clinical assistants and midwives.
- Improve access to health care in rural and northern communities by allowing pharmacy operations to include licensed off-site facilities as part of a pharmacy's practice⁹⁵.

Significant change is underway in Alberta—on May 30, 2006 the Cabinet passed an Order in Council, approving the *Pharmacists Profession Regulation* to the *Health Professions Act*.⁹⁶ These changes will give Alberta pharmacists the most comprehensive scope of practice in Canada. It is anticipated that once the regulation to the *Pharmacy and Drug Act* (PDA) is also approved by Cabinet, implementation of both regulations will occur in the fall 2006. As indicated in an FAQ from the Alberta College of Pharmacists (ACP), a number of steps will occur over the next few months, including:

- ACP will complete development of the draft standards for pharmacist practice and for pharmacy operations and distribute for consultation.
- All pharmacists registered on the new clinical register (practising members) will be required to participate in an orientation program about the new standards and regulatory environment.
- Pharmacists whose practice may include initiating new drug therapy will be required to demonstrate that they have completed additional requirements approved by Council. An expert panel is being appointed to further define these requirements which will take some time; therefore, no pharmacists will be authorized to initiate new drug therapy until sometime in 2007.⁹⁷

ACP provided some specific comments regarding prescriptive authority:

- The authority to prescribe recognizes what pharmacists already do, e.g., provide interim refills, adjust dosages and dosage forms, and accommodate substitution of drugs to meet the unique drug therapy needs of clients.

- The decision of a pharmacist to prescribe and the appropriateness of that decision will be determined by multiple factors including, but not limited to: the availability of information required to make an informed decision to treat; the needs of the client; the competence of the pharmacist (knowledge, skill, attitude); the availability of other health professionals; relationships with other health professionals; adherence to the standards of practice and code of ethics of the college; and the pharmacist's willingness to accept responsibility for the therapeutic decision he or she has made.
- Pharmacists will document their decisions and communicate them with other members of the patient's health team so that care is complementary and synergistic.
- Pharmacists will not diagnose. Pharmacist prescribing activities will take place in a collaborative environment where communication among health professionals is paramount and the pharmacist will have access to the physician's diagnosis.

Presently across Canada, pharmacy technicians are not regulated and do not have minimum educational requirements. The Ontario College of Pharmacists (OCP) offers a voluntary certification for pharmacy technicians. OCP is now moving forward in establishing a distinct class of registration for pharmacy technicians who are able to perform an expanded role.⁹⁸ This is in concert with OCP's work to expand the role of the pharmacist.

In the spring of 2005, the Ontario Government's Health Professions Regulatory Advisory Council began a process of stakeholder consultation on the OCP's submission to the Ontario Ministry of Health and Long-Term Care to regulate pharmacy technicians. Establishing a new class for Registered Pharmacy Technicians (RPhT) will involve many steps: legislative change, finalizing code of ethics, developing educational requirements, accrediting educational providers, developing registration process, complaints and discipline procedures, and a QA program. The proposal was to allow an RPhT to perform additional functions, including receiving a new or repeat prescription from prescribers and checking pharmaceutical products prepared by another technician. On May 19, 2006, the Ontario Minister of Health released HPRAC's report which recommended that pharmacy technicians be regulated under the Ontario College of Pharmacists.⁹⁹ HPRAC did, however, feel that there was significant risk of harm in the communication and completion of verbal prescriptions. As such, HPRAC recommended to the Minister that regulations under the *Pharmacy Act* specify that receiving verbal prescriptions not be approved for registered pharmacy technicians.

Liability is a key issue for pharmacists and for other health professionals as role changes occur and there is more focus on working in a collaborative nature. Liability was discussed in the principles and framework document from the EICP initiative:

Two directions are needed: an integrated approach to liability insurance that links the various systems now in place and recognizes shared decision-making in ways that are consistent with patient safety and risk management; and clearly legislated scopes of practice for each health profession for collaborative services.... An insurance system that supports an interdisciplinary collaborative approach will allow team members to give full attention to the care of the patient/client. To support informed legal decisions related to liability, an educational program is recommended for those working in the judicial/legal system about collaborative practice.¹⁰⁰

With the changes in Alberta to the *Health Professions Act* and the *Pharmacy and Drug Act*, the Alberta College of Pharmacists is recommending that pharmacists should:

- Ensure that they hold personal malpractice insurance that provides at least two million dollars of claims-made coverage. This means that the insurance policy is in the name of the pharmacist, and is transportable with the pharmacist regardless of where they practice pharmacy.

- Use the self-assessment tool provided by ACP to assess their personal practice and competencies to better understand personal limitations and areas where further learning and experience is necessary.¹⁰¹

All of these issues must be addressed if pharmacists are to attain their “preferred future”. A number of actions have been identified.

To move forward, the pharmacy profession will need:

- ✓ *To obtain/retain support to move pharmacists forward to a preferred future.
For example, major pharmacy groups must be ‘on the same page’; there must be the political will to move on; the support of patient advocate groups and other health care professionals will be necessary.*
- ✓ *To build on the experiences of other health professions and pharmacists in other countries.*
- ✓ *To promote and achieve enabling legislation and/or regulations to give more authority to pharmacists to initiate and modify drug therapy in collaborative and independent practice models.
This must include enablers for pharmacists to access necessary patient information.*
- ✓ *To address pharmacy technician issues of competency requirements, roles and responsibilities, regulation, certification and accreditation of programs.*
- ✓ *To promote enabling legislation and/or regulations to give more authority to pharmacy technicians.*
- ✓ *To establish an understanding of how liability will be assessed and insured in collaborative practice models.*
- ✓ *To develop scopes of practice that support and not hinder the development of new services and practice models.*

Examples of leading initiatives:

- Alberta Prescriptive authority legislation: government approval on May 30/06 of Pharmacists Profession Regulation that grants prescribing powers to pharmacists
- Manitoba proposed update to the Pharmaceutical Act to include prescribing drugs under limited conditions and to allow collaborative practice
- Québec legislative changes
- Work on liability as a part of the PHCTF EICP Project
- Pharmacy Technician Regulation, OCP
- Others...

g) Leadership for the Profession

Leadership will be required at all levels of the pharmacy profession to guide the profession as it moves toward its “preferred future”.

Leaders must be committed to a vision for the pharmacy profession. As Tsuyuki and Schindel quote from Henry Kissinger:

The task of the leader is to get his people from where they are to where they have not been.¹⁰²

The above authors note that helping pharmacists see how practice change can impact patient care requires a substantial amount of communication. The communication must be undertaken often and in a variety of formats. They state that:

Practice change will only become permanent when it becomes part of the shared value and social norms for the profession. This requires strong and sustained communication in a conscious effort to show pharmacists how their new practice has improved performance, such as patient outcomes and patient satisfaction. It also requires coalition with the educators of our new colleagues in practice and research to ensure that the vision is supported in the future.¹⁰³

To move forward, the pharmacy profession will need:

- ✓ *To make sure to “keep the ball moving” and continue to move forward toward a preferred future with a strategic action plan.*
- ✓ *To have “buy-in” by pharmacists and by their organizations and employers for the preferred future and action plan, and to recruit champions.*
Need to create an understanding of the risk of “no action” and build a sense of urgency.
- ✓ *To create a national task force to act as a steering committee to guide pharmacists toward a preferred future and to possibly hire a project manager or coordinator.*
- ✓ *To develop an explicit, clear governance model that permits all organizations to contribute.*
- ✓ *To develop an implementation plan with targets and timelines and to allocate particular initiatives to selected organizations.*
- ✓ *To develop and implement a communications strategy to inform the profession, public, governments, and other health care providers and stakeholders.*
- ✓ *To integrate the Blueprint action plan into the strategic plans of all pharmacy organizations.*
- ✓ *To make a commitment to advocate for change at all levels of government, particularly provincial governments, and to lobby with the same message.*
- ✓ *To ensure that the Blueprint initiative links into other health care reform initiatives, in particular primary health care and pharmaceuticals management.*

Examples of leading initiatives:

- The work of Ross Tsuyuki and Theresa Schindel: *Leading Change in Pharmacy Practice: Fully Engaging Pharmacists in Patient-Oriented Healthcare*
- The Pharmacy Association of Nova Scotia’s focus groups on the Blueprint as part of their process to develop the PANS’ 2006-2009 Strategic Plan¹⁰⁴
- The process followed by organizations in the establishment of the Canadian Patient Safety Institute
- The governance structure created by IBM/CPhA for the e-Therapeutics project
- Others...

VI Conclusion

As highlighted in this paper, the pharmacy profession has accomplished much in the past decade to move the profession forward, but many challenges remain.

Presently, general consultation and buy-in must be sought for a preferred future for the pharmacy profession from all the major Canadian pharmacy groups. Consultation must also involve governments and other key health care professional groups. This must result in the creation of a strong collective will, with the necessary resources to formulate a detailed implementation plan to ensure that the process of change is accelerated.

Governance issues must also be addressed to provide guidance, momentum and to provide ongoing leadership for this major change management process. Indicators and milestones must be developed with a commitment to review progress towards the preferred future.

This paper will be distributed for broad consultation. Feedback and input both from internal and external sources is invaluable at this time and will be actively sought in the months ahead. Action has begun on many of the initiatives discussed in this paper. It is hoped that change in pharmacy practice will continue, accelerate and lead to pharmacists reaching their potential as *the* medication management experts in the Canadian health care system.

APPENDIX – Background Readings List

Pharmacy Practice in Canada

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