Ontario Pharmaceutical Opinion Program: Initial experience

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Introduction

Pharmacy in Canada is facing many challenges but also many new opportunities. With the expanding scope of practice for pharmacists, remuneration is available for a variety of cognitive services.¹ With an aging Canadian population taking increasing amounts of medication, there is great potential for side effects and/or drug interactions. To remedy this, the Ontario MedsCheck program² was launched as a 20- to 30-minute one-on-one meeting with a community pharmacist to review the medication regimen and look for any drug-related problems or areas for optimization. Following a medication review, the pharmacist may receive remuneration for providing clinical recommendations through the Pharmaceutical Opinion Program.

Pharmaceutical Opinion Program

The Pharmaceutical Opinion Program launched in Ontario on September 1, 2011, and is intended to supplement the MedsCheck program that began in 2007.³ It is intended to provide a structured framework for the identification of potential drug-related problems (DRPs) and subsequent collaboration with prescribers. As a component of the expanded scope of practice, this program promotes improving patient outcomes, optimizing drug therapy and reducing inappropriate drug use and wastage. Recommendations for DRPs may be provided during the course of dispensing a new or repeat prescription, or following a medication review.³

With these objectives in mind, the recommendation will fit into 1 of 8 intervention types (Box 1). Following a recommendation, 1 of 3 outcomes is expected³:

1. **Not filled as prescribed:** Prescription not filled resulting from a confirmed forged

or falsified prescription or not filled due to a clinical concern based on prescriber consultation.

2. **No change to prescription therapy; filled as prescribed:** Recommendations by the pharmacist were discussed with the prescriber and no change was made to the prescription therapy, OR prescription filled as prescribed.
3. **Change to prescription therapy:** Recommendations by the pharmacist were discussed with the prescriber and led to a change in therapy as prescribed.

Following 1 of these 3 outcomes, the recommendation is eligible for a \$15 reimbursement for eligible patients.³

Eligibility

The MedsCheck program and the Pharmaceutical Opinion Program have contrasting eligibility criteria for patients. The MedsCheck program is available for any Ontario citizen taking 3 or more medications for a chronic condition or a single medication for diabetes with no age restriction.² Conversely, the Pharmaceutical Opinion Program is eligible only for Ontario citizens covered under the Ontario Drug Benefit program. These patients are primarily older than 65 years, with the remainder on social assistance or in the Trillium program.³

What is not known is whether these new opportunities are feasible, both from a practical and financial perspective. In this article, I present my experiences with these programs in a community pharmacy.

Methods

As a third-year pharmacy student, I conducted medication reviews and provided

BOX 1 Types of prescription interventions in a pharmaceutical opinion³

1. Therapeutic duplication
2. Patient needs additional drug therapy
3. Suboptimal response to a drug
4. Dosage too low
5. Adverse drug reaction; possibly related to an allergy or a conflict with another medication or food
6. Dangerously high dose
7. Nonadherence; patient is refusing to take the drug or not taking it properly
8. Prescription has been confirmed false or has been altered

recommendations between June and August 2012, during a community pharmacy work placement in Thunder Bay, Ontario. The pharmacy completes approximately 10,000 prescriptions per month on average.

Patients visiting the pharmacy who met the eligibility criteria and might have benefited from a medication review were offered a review at that time or the opportunity to schedule an appointment for a later date. The medication review was intended to create the best possible medication record, as well as identify any DRPs. DRPs were discussed with the patient for further insight and, if possible, solved by a pharmacist recommendation during the medication review; these recommendations are not included in this review. If collaboration with a prescriber was required, a summary was provided to the patient and a letter was typed for the prescriber, summarizing the DRPs with recommendations. Since pharmacists in Ontario do not yet have access to patients' medical records, recommendations were provided based on:

- Patient's medication profile at the pharmacy
- Medical history gathered during the medication review
- Clinical practice guidelines and best available evidence

Letters were co-signed by the pharmacist preceptor and faxed to the prescriber with the medication review and any relevant supporting evidence or documentation. To ensure the

maximum number of recommendations was identified for reimbursement, the original letter was attached to the medication review and 2 copies were made. One copy was filed by the fax machine so that if a response was received, it would alert the pharmacy team to enter the prescriber's response for reimbursement. A second was filed in a separate folder for pharmaceutical recommendations. This separate folder was necessary, since some prescribers did not respond directly to the fax but provided a prescription to the patient at his or her next visit with the instructions from the recommendation.

On August 27, 2012, all recommendations that had been filed were reviewed against the patient's medication profile on the computer system. All eligible recommendations and any applicable changes relevant to said recommendation were submitted for reimbursement. For example, recommendations with supporting documentation to discontinue glyburide and rosiglitazone, then start gliclazide MR, would count as 3 eligible recommendations, for a \$45 reimbursement total.

Results

In 3 months, 87 pharmaceutical opinions were provided for 39 patients (21 male) and faxed to 26 different prescribers after completing 522 medication reviews. This averaged to 1.7 recommendations per patient. The majority of DRPs were regarding diabetes, cardiovascular health or pain management. Table 1 summarizes the types of DRPs and most common recommendations. From the total number of recommendations provided, 50 received a response from the prescriber. Only 38 recommendations were then eligible to be submitted for reimbursement. Although this generated \$570.00 in revenue from eligible responses, \$735.00 was not remunerated due to a lack of prescriber response or ineligibility (Figure 1).

Cost analysis

A sample calculation is provided in Table 2 to assess the cost benefit of providing pharmaceutical recommendations if performed by a pharmacist.

Despite the fact that fewer than half of the recommendations were available for reimbursement, this cost analysis demonstrates that the Pharmaceutical Opinion Program is still financially viable and sustainable and has the

TABLE 1 Summary of drug-related problems and recommendations

Number of recommendations	Drug-related problems	Recommendations
Allergies		
1	Uncontrolled allergic rhinitis	Start nasal corticosteroid
Cardiovascular		
17	<ul style="list-style-type: none"> • Ineffective stroke prevention with atrial fibrillation • Uncontrolled hypertension • Orthostatic hypotension • Post-myocardial infarction therapy inappropriate • Prolonged use of colchicine with increased risk for rhabdomyolysis and bone marrow suppression 	<ul style="list-style-type: none"> • CHADS₂ assessment with therapy optimization • Additional antihypertensive therapy and lifestyle modification • Reduce antihypertensive therapy • Addition of medication (eg, statin, ASA, beta blocker, or ACE inhibitor) • Discontinue colchicine, rewritten instructions for use only during gout attacks
Diabetes		
45	<ul style="list-style-type: none"> • Missing guideline therapy for diabetes management • Mechanical/dexterity concerns with insulin pens • Increased risk for bladder cancer and cardiovascular events with glitazone use when alternative therapy is available 	<ul style="list-style-type: none"> • Addition of medication (eg, statin, ASA, ACE inhibitor) • Switch to prefilled insulin pens • Discontinue glitazone and start a trial of alternative antidiabetic therapy
Drug-drug interaction		
6	Proton-pump inhibiting clopidogrel activation	Switch to pantoprazole
Gastrointestinal		
2	Opioid-induced constipation	Start senna at bedtime
Genitourinary		
1	Urinary frequency	Reassess prostate medication by physician
Mental health		
1	Uncontrolled bipolar depression	Discontinue antidepressant and consider a mood stabilizer
Pain		
10	<ul style="list-style-type: none"> • Chronic use of short-acting opioids • Increased risk for liver complications with more than 4 g of acetaminophen per day (usually in combination with opioid) 	<ul style="list-style-type: none"> • Dose conversion provided for long-acting formulations • Reduce acetaminophen intake and recommend alternate analgesia
Women's health		
3	Dysmenorrhea	Alternative contraceptive therapy

ACE, angiotensin-converting enzyme; ASA, acetylsalicylic acid; CHADS₂, Congestive heart failure, hypertension, age, diabetes and stroke scoring system.

FIGURE 1 Breakdown of recommendation response, reimbursement and eligibility

potential to generate significant profit. This analysis is limited by a number of assumptions that will vary between practice sites—most important, the pharmacist's rate of pay. Although a comparative opportunity-cost assessment was not performed, writing recommendations will also take time away from other pharmacist duties.

Discussion

This study was performed to assess the clinical and financial potential of the Pharmaceutical Opinion Program. As this program generates less revenue than other clinical services and requires collaboration with prescribers, it may be less desirable to perform during the daily duties of a community pharmacist.

Although pharmacists' primary duty is to their patients, the financial viability and sustainability of practice must be taken into account. Having a structured reimbursement program for recommendations is essential for the success of the medication review program, but

unfortunately, many barriers exist that impede its functioning. The main barriers experienced in this study were the lack of response from prescribers and ineligibility for reimbursement.

Lack of response from prescribers

Unfortunately, 37 (42.5%) recommendations did not receive a response from the prescriber. The standards of practice for pharmacists encourage collaboration with other health care professionals, since doing so allows each profession to use its strengths and expertise to improve the patient's health.⁵ Since the Pharmaceutical Opinion Program only began in September 2011, prescribers might not have been used to receiving recommendations for changes in pharmacotherapy from a community pharmacist at the time of this study. It may be that existing expectations held by prescribers about the pharmacist's role may be somewhat outdated, which could impede collaboration. For example, if a pharmacist's only communication with

TABLE 2 Cost analysis

Estimated pharmacist costs to providing program Average pharmacist's rate of pay = \$47.90/h = \$0.80/min ⁴ Average time to write a recommendation per patient = 7 minutes (5-10 minutes based on clinical experience) Cost = 7 min/patient × 39 patients × \$0.80/min Cost = \$218.40		
Total potential revenue	Actual revenue generated	Lost revenue not available for reimbursement
Estimation for revenue if all recommendations had been eligible for reimbursement	Positive response from prescriber AND eligible for reimbursement	Lacking prescriber response from prescriber OR ineligible for reimbursement
Revenue = Reimbursement × number of recommendations		
\$15 × 87 recommendations	\$15 × 38 recommendations	\$15 × 49 recommendations
Potential revenue = \$1305.00	Actual revenue = \$570.00	Lost revenue = \$735.00
Cost benefit Profit = Revenue generated – Pharmacist costs Profit = \$570.00 – \$218.40 Profit = \$351.60		
Cost-benefit ratio = Revenue/cost = \$570/\$218.40 = 2.61 For every \$1.00 spent, \$2.61 was generated		

prescribers has been technical in nature, such as calling in refills, clarification for prescriptions or drug availability, then the perceived competency for providing clinical recommendations is diminished. Recommendations may have been further questioned coming from a pharmacy student, even though they were co-signed by the pharmacist preceptor.

There were also several instances when the prescriber did not respond to the recommendations from the fax, but the patient dropped off a new prescription with the same instructions recommended by the pharmacy. Without the letter filing system, these further recommendations would have been missed for reimbursement.

Ineligibility for reimbursement

Another 12 (14%) recommendations that received a response were ineligible for reimbursement. The current restriction of

the program to Ontario Drug Benefit patients may deter pharmacists from providing recommendations. Taking time to document and communicate a recommendation to the prescriber is difficult when the patient is ineligible for service reimbursement. Unlike the MedsCheck program, which has open eligibility criteria, the Pharmaceutical Opinion Program inappropriately restricts access to care.

Future direction

The Pharmaceutical Opinion Program holds great potential to improve patient health and quality of life. Despite the initial short-term costs to the health care system, identification of DRPs has the potential to offset costs such as avoidable hospital visits or physician visits. With proper collaboration following a medication review, pharmacists will be able to develop a more clinically focused practice. Based on

this experience, further steps must be taken to facilitate this collaboration.

Contacting or meeting with prescribers to discuss how to integrate medication reviews and the Pharmaceutical Opinion Program is one suggestion to strengthen the pharmacist-prescriber relationship and increase the response rate. It may be that certain prescribers would prefer to be called rather than receiving a fax. Another approach might be to offer an academic detailing type of service, visiting interested prescribers on a quarterly or biannual basis to discuss any patient concerns or to share new clinical evidence.

Conclusion

Developing strong relationships with prescribers will be critical as the scope of practice for pharmacists continues to expand. As minor ailments prescribing, adaptation and substitution become more common, prescribers must be able to trust the pharmacist to make evidence-based, patient-centred decisions. Even when pharmacists are able to access the patient's medical record, interprofessional collaboration will still be essential. The Pharmaceutical Opinion Program is a great first step for the profession, but more must be taken to reach our full potential. ■

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