The Pharmacy Guild of Australia

Community Pharmacy Roadmap Program Development Template

Program/Service:	**Pharmacist Prescribing – Protocol Driven**
Quadrant:	**D – Outreach Health Services and Programs**

1. Program/Service Description

a) Background

In Australia, prescribing rights have been extended to a number of health professional groups within their scope of practice. These include dentists, optometrists, podiatrists, nurse practitioners and midwives. It can be said that community pharmacists have prescribing rights for *Pharmacist Only Medicines* (Schedule 3), which has been the case for many years. Pharmacists are the most highly trained health professional in medication issues and have traditionally authorised the supply of pharmacy medicines based on their training and expertise. Over more recent years, a range of prescription medicines have been down-scheduled to the Schedule 3 category, including for emergency contraception, chloramphenicol eye drops and some Proton Pump Inhibitors. Community pharmacists utilise protocols and guidelines to meet their professional obligations when recommending such medicines, thus protocol driven pharmacist prescribing could be seen as a natural extension of a framework which already exists within the pharmacy profession.

Countries such as Britain, the United States of America and Canada have extended prescribing rights to pharmacists and these can be separated into two general categories[1]:

- Independent prescribing – in which the pharmacist is responsible for the clinical assessment of the patient and diagnosis of the condition prior to prescribing therapy, without the requirement for supervision by another health care professional.
- Dependent prescribing (also known as supplementary prescribing) – in which the authority to prescribe is delegated to a pharmacist by an independent prescriber, usually a medical practitioner. Responsibility is shared according to a written agreement, with the independent prescriber assessing, diagnosing and making treatment decisions and the pharmacist selecting, monitoring, modifying or discontinuing treatment according to the agreement.

The Pharmacy Council of New Zealand has developed the competence and registration requirements for the Pharmacist Prescriber scope of practice[2] and the subject of pharmacist prescribing has been examined and discussed through various forums in Australia over recent years. There are existing models of dependent prescribing in Australia's acute care sector and a research project[3] conducted under the Third Community Pharmacy Agreement identified Australian evidence for this prescribing model for anticoagulant therapy. Anticoagulant INR monitoring services have also been trialled in some parts of New Zealand. The September 2011 Final Report[4] of the Community Pharmacist-led Anticoagulation Management Service (CPAMS) concluded that this is a 'safe, effective and cost-effective alternative to 'standard' anticoagulation management'.

---

[1] An international overview of some pharmacist prescribing models; A.P.Tonna, D.Stewart, D.McCraig; Journal of the Malta College of Pharmacy Practice; Issue 14 Summer 2008

[2] http://www.pharmacycouncil.org.nz/cms_display.php?sn=225&st=1&pg=1800

[3] Improving Australian's access to Prescription Medicines: Development of pharmacy practice models; Dr T.Bessell, Dr L.Emmerton, Dr J.Marriott, Dr L.Nissen; Final Report June 2005; www.guild.org.au

[4] http://www.nzdoctor.co.nz/media/1519782/pharmacy_ams_final_report.pdf

b) Brief Description	Protocol Driven Pharmacist Prescribing (PDPP) is a type of dependent prescribing in which the management of the medication aspects of patient care is delegated by an independent prescriber to a pharmacist according to pre-defined protocols. This model of pharmacist prescribing would be suitable for disease states which can be clearly diagnosed by the medical practitioner, for example asthma, diabetes, hypertension or hypercholesterolaemia. Such arrangements could be implemented within a community pharmacy or other primary health care or hospital setting.
c) Alignment with Government Policy	The government's health reform agenda promotes greater collaborative team care and more efficient use of the skills and expertise of all health care professionals. We have seen over recent years prescribing rights extended to optometrists, podiatrists, nurse practitioners and midwives. Creating a more flexible health system by extending prescribing rights to pharmacists as part of a PDPP model is similarly consistent with these government objectives.
d) Expected Outcomes for Government and Community Pharmacy	Pharmacists are highly trained health care professionals with expertise in pharmacology and therapeutics. With the current shortage of general medical practitioners along with a potential oversupply of pharmacists, efficiency gains can be achieved through better use of pharmacist and medical practitioner time, and a more streamlined approach to medicine management[5]. This would contribute to more cost-effective use of health resources. From a community pharmacy perspective, there will be increased recognition of the role of pharmacists as members of the health care team. This will flow onto increased job satisfaction, as pharmacist's skills are better utilised, providing enhanced opportunities for pharmacy graduates. This will benefit both the pharmacy profession and the community.
e) Consumer Benefits	Consumers will benefit by having the most qualified expert in medicines working intimately with their medical practitioner to monitor and assess the effectiveness of their medicine therapy, streamlining the management of their chronic condition. This should see improved health outcomes for the consumer and an improved quality of life.
f) Who Performs the service?	The PDPP model can be provided by a pharmacist within a community pharmacy or other primary health care or hospital setting.
g) Collaboration with Other Health Care Professionals	*Will Service Delivery require any formal collaboration with other health care professionals?* Yes - The PDPP model is a dependent pharmacist prescribing model requiring collaboration between the pharmacist and the independent prescriber, usually a medical practitioner. Specific patient-centred protocols will be prepared and agreed to between the pharmacist and independent prescriber, with both sharing the responsibility of patient care. The separation of prescribing and dispensing provides a safety mechanism for the dispensing pharmacist to check the prescriber's intent. This concept remains fundamental to good prescribing and dispensing practice and must be retained as part of the collaborative arrangements between the dispensing pharmacist, prescribing pharmacist and independent prescriber to maintain patient safety and avoid any perceived moral hazard.
2. Implementation and Enablers	
a) Stakeholder Consultation	*Representative bodies from the following areas will need to be consulted in order to fully develop and implement a program:* • Pharmacy Academia • Pharmacy Board of Australia • Consumer organisations • Disease management organisations • Funders • Government health and regulatory bodies • Medical organisations

[5] Op.cit Bessell et al

	• Pharmacy organisations • Pharmacy software vendors • Professional insurers • Representative groups for allied health professionals
b) IT Requirements	*Is pharmacy software required to deliver this program?* Yes – IT systems should be implemented to support a PDPP model. Improved communications and expanded use of health information technology such as e-health records will be useful for pharmacists to access patient diagnostic and medication history, and to facilitate communication with the independent prescriber.
c) Infrastructure and Staffing	*Is a private consultation area required to deliver this program?* Yes - PDPP consultations not only involve prescribing of medications, but monitoring and assessing their effectiveness and will take place within a private area of the pharmacy. *Is the Program within the pharmacist's/pharmacy assistant's normal scope of practice?* A PDPP model is within a pharmacist's scope of practice but will require training for the respective condition and therapy options as well as relevant standards and guidelines. *Is an additional pharmacist likely to be needed?* Yes – Where prescribing takes place within the community pharmacy, the pharmacist conducting the PDPP consultations cannot be simultaneously responsible for other professional activities within the pharmacy. This may be managed by engaging an additional pharmacist on either a permanent or sessional basis.
d) Training	*What additional formal training is likely?* Pharmacists will need to be adequately trained and competent to participate in a PDPP model for particular disease states. Pharmacists will be responsible for assessing, maintaining and working within their professional scope of practice. *Does any suitable training exist?* PDPP training is unlikely to exist specifically for the Australian context. However, preliminary training models and overseas models (for example in New Zealand) are likely to be available that could be adapted to meet the needs of an Australian PDPP model.
e) Supporting Standards, Procedures and Templates/ Checklists	*Will an amendment to the QCPP requirements be necessary?* Yes - Adherence by pharmacists to professional protocols/checklists set out in an auditable standard will be required. *Will professional guidelines and/or standards be required?* Yes *Are there any other national guidelines which need to be taken into account in developing the program to ensure consistency with best practice?* Yes - The service will need to align with the National Medicines Policy[6] and associated guidelines, such as the National Strategy for the Quality Use of Medicines[7]. There is a raft of other strategies and guidelines that will need to be considered in developing a PDPP service model, including: • APAC Guiding principles to achieve continuity in medication management[8] • APAC Guiding principles for medication management in the community[9] • APAC Guidelines for medication management in residential aged care facilities[10]

[6] http://www.health.gov.au/internet/main/publishing.nsf/Content/National+Medicines+Policy-2
[7] http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-natstrateng-cnt.htm
[8] http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-guiding
[9] http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-guide-medmgt-jul06-contents~nmp-guide-medmgt-jul06-background
[10] http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-resguide-cnt.htm

	• National Chronic Disease Strategy[11] The development of specific prescribing protocols between independent prescribers and pharmacists should consider relevant guidelines for specific disease states if available, such as those developed by the National Health and Medical Research Council (NHMRC)[12].
f) Legislation/Regulation Implications	Commonwealth and State and Territory legislation will need to be amended to allow a pharmacist to prescribe medicines under the PDPP model.
3. Funding	
Funding Options	*Possible funding options include:* Community Pharmacy Agreement Medicare Benefits System User-pays backed up by Private Health Insurance arrangements *Has any funding for this program been secured?* No
4. Timelines	
Timelines	☐ Established community pharmacy practice √ Immediate to short-term implementation (< 30 June 2015) √ Medium-term implementation(1 July 2015 to 30 June 2020) ☐ Longer-term implementation (> 1 July 2020)

[11] http://www.health.gov.au/internet/main/publishing.nsf/Content/pq-ncds
[12] http://www.nhmrc.gov.au/