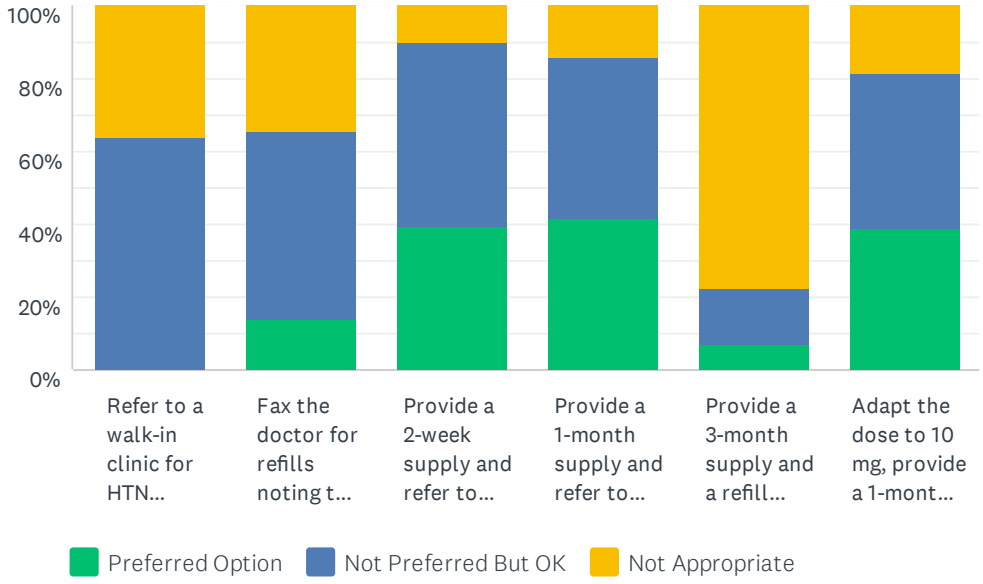
Q1 JT is a 48 yo male with hypertension (HTN). He is currently taking amlodipine 5 mg once daily but has run out tablets and refills. He has a family doctor but cannot get an appointment to see his doctor for 2 weeks. He normally gets a 3-month supply with one refill. You check his blood pressure, and it is 152/93. This is consistent with his home blood pressure readings from his logbook that he brought in. He reports no adverse effects. The rest of his medical background is unremarkable. How should a pharmacist respond?

Answered: 64 Skipped: 0



	PREFERRED OPTION	NOT PREFERRED BUT OK	NOT APPROPRIATE	TOTAL
Refer to a walk-in clinic for HTN assessment.	0.00% 0	63.79% 37	36.21% 21	58
Fax the doctor for refills noting the increased blood pressure.	13.79% 8	51.72% 30	34.48% 20	58
Provide a 2-week supply and refer to his doctor for HTN assessment.	39.34% 24	50.82% 31	9.84% 6	61
Provide a 1-month supply and refer to his doctor for HTN assessment.	41.38% 24	44.83% 26	13.79% 8	58
Provide a 3-month supply and a refill and refer to his doctor for HTN assessment.	6.90% 4	15.52% 9	77.59% 45	58
Adapt the dose to 10 mg, provide a 1-month supply with no refills, create a follow-up plan.	38.98% 23	42.37% 25	18.64% 11	59

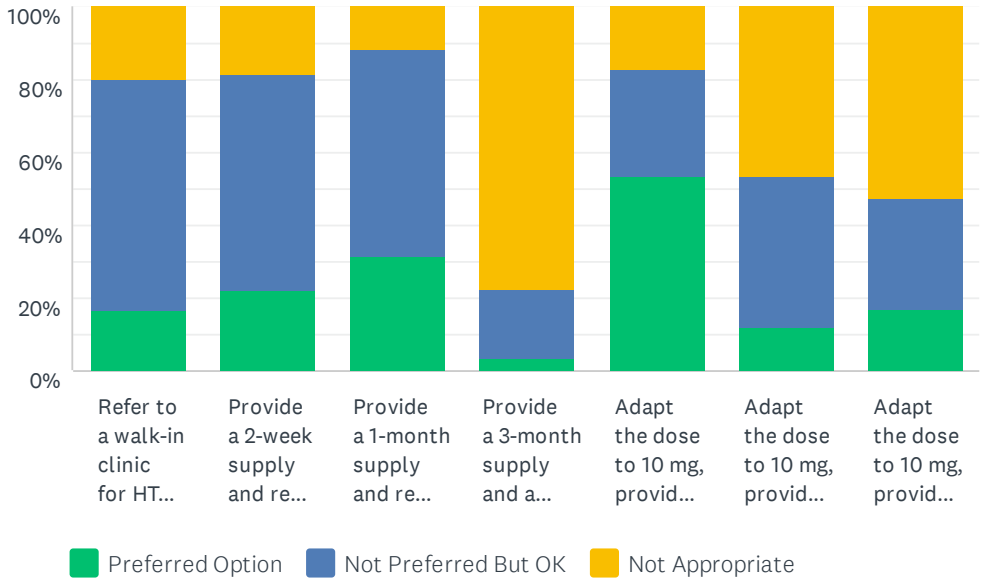
Panel of Peers – Reflections From Select Panel Members

Question 1

- Urgency- For a 48 yo male, BP is higher than recommended guidelines so hypertension therapy modification would be warranted. It's not critically high.
    - There is no need to refer to a walk-clinic (another practitioner, patient delay and increased costs). (Refer without providing a Renewal 0% Preferred Option)
- Maintain vs. Change
    - Maintaining dose at current level for short term bridging is not ideal but not dangerous or unacceptable. (86-90% Prefer/Not Pref but OK)
    - The pharmacist could make the change as this is part of their scope of practice. (81% Prefer/Not Pref but OK for Adaptation)
- Quantity supplied
    - Giving more than 1 month at current dose seems ill-advised since dose may be changed and we would be responsible for providing an inadequate dose for an extended time. (78% Not Appropriate for 3 months and a refill)
    - May want to give 1 month in case unexpected appointment cancellation occurs. (86% Prefer/Not Pref but OK)
    - Usual minimum quantity limit prescribed for MSI for renewals does not apply as there is a clinical reason to provide a lower days supply.
- Faxing the doctor
    - Asking a physician to prescribe without assessing the patient is usually not appropriate. Some with a more collaborative physician approach indicated we have provided information to inform the decision and MD has option of adding low dose of a second agent which could be a reasonable alternative that is not available to the pharmacist.
    - Collaboration could also look like the pharmacist makes the change and notifies MD.
    - Two schools of thought - 35% indicated faxing the doctor was Not Appropriate while 18% thought Adapting was Not Appropriate
- Adapting the dose is allowed on renewals with notifying the physician.
    - May be unpopular with physicians without a collaborative relationship
    - May be preferred as it is part of scope of practice and reflects better use of health care resources even though unpopular. Does the patient need to see MD?
- BP Measurement – Need to use appropriate device.
- Evolving Practice - As pharmacy practice advances or in pharmacies with excellent collaboration with local primary care providers, the norm may be pharmacist managing medication in a collaborative relationship like INR (CPAMS) or upcoming HTN pilot program through PANS. In this case, as with CPAMS, we move to a model where appointments with MD/NP solely for the purpose of medication management would not be necessary. This may be more likely with practitioners that are in alternate payment models rather than fee for service. This would potentially increase patient access to primary care. Like CPAMS an economic model needs to be established for chronic disease management.

Q2 JT is a 48 yo male with hypertension (HTN). He is currently taking amlodipine 5 mg once daily. He does NOT have a family doctor. His last prescription from a walk-in clinic was for a 3-month supply with 3 refills. You check his blood pressure and it is 152/93. This is consistent with his home blood pressure readings from his logbook that he brought in. He reports no adverse effects. The rest of his medical background is unremarkable. How should the pharmacist respond?

Answered: 63 Skipped: 1



	PREFERRED OPTION	NOT PREFERRED BUT OK	NOT APPROPRIATE	TOTAL
Refer to a walk-in clinic for HTN assessment.	16.67% 10	63.33% 38	20.00% 12	60
Provide a 2-week supply and refer to a walk-in clinic for HTN assessment.	22.03% 13	59.32% 35	18.64% 11	59
Provide a 1-month supply and refer to a walk-in clinic for HTN assessment.	31.67% 19	56.67% 34	11.67% 7	60
Provide a 3-month supply and a refill advising the patient he should be assessed for HTN.	3.45% 2	18.97% 11	77.59% 45	58
Adapt the dose to 10 mg, provide a 1-month supply with no refills, follow up in 1-month.	53.45% 31	29.31% 17	17.24% 10	58
Adapt the dose to 10 mg, provide a 1-month prescription with 5 refills, follow up in 1-month.	12.07% 7	41.38% 24	46.55% 27	58
Adapt the dose to 10 mg, provide a 3-month supply with 1 refill, follow up in 1 month.	16.95% 10	30.51% 18	52.54% 31	59

Panel of Peers – Reflections From Select Panel Members

Question 2

- For a 48 yo male, BP is higher than recommended guidelines so hypertension therapy modification would be warranted.
- Giving the same dose for an extended time 3-6 months is not appropriate given the patient's blood pressure. (78% - Not Appropriate)
- Do we take responsibility and adapt or refer to a clinic? The ER may be the only clinic in some communities but if a referral is warranted, we need to refer. For example:
    - Does this require physical assessment beyond our scope? (e.g. palpation)
    - Does this require updated blood work? (e.g. INR, diabetes) Some may prescribe and refer to a clinic to get blood work. If another HCP orders a test, they would be responsible for the result. There may be some resistance.
    - Does the patient require add-on therapy? Beyond our scope of practice.
- In this situation the pharmacist could assess blood pressure. If the patient has a history of stable normal renal function, given their age and medication, blood work may not be urgent for HTN. Other antihypertensives (ACE's/ARB) could warrant K+/eGFR. While other options could be added, increasing the dose is a viable option.
- Adapt versus Refer.
    - Referral with or without a Renewal (<32% Preferred Option, 11-20% Not Appropriate)
    - Adapt with no refills (53% Preferred, 17% Not Appropriate)
- If we did adapt, adding refills may not be appropriate. If the patient took the original prescription elsewhere or transferred the refills, would you add refills or would you want to see the patient before extending it? This may use up one of the patient's Renewal Fees but that can't be a deciding factor in prescribing appropriately. (47-53% indicated putting refills on the adaptation was inappropriate)
- If we take responsibility is this A) limited to a renewal in the absence of their physician or B) are we held accountable for more comprehensive disease management.
    - The standards would indicate more comprehensive care cannot be ignored including lifestyle factors (diet, weight, smoking, exercise).
    - The pharmacist could refer to chronic disease management programs (fee for service/funded) or refer to other local HCP to provide the support in a funded manner. This may limit the pharmacist's ability to provide extended ongoing refills without ensuring comprehensive care is in place.
- Reimbursement is an issue. A renewal fee of $12 is priced for renewal of up to 3 medications which could include 3 different disease states. This is not a chronic disease management fee. Some may feel a renewal for $12 is okay but doing chronic disease management for $12 to be Not Appropriate or Not Preferred but OK. The funding/service model is evolving. Some plans reimburse higher levels for chronic disease management (Medavie, Green Shield) and will allow direct billing. In NS, CPAMS covers $50/month (including strips) for anticoagulation management. Bloom reimburses $75/month for 6 months and $30/month thereafter for mental health care. PANS is piloting a HTN management program. Reimbursement models evolve slowly but it is a work in progress and pharmacy is now getting compensated for services from funds outside the drug budget.