

Advanced Practice Pharmacist Registration

The right direction for health authority pharmacists
in British Columbia

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Outline

- Background and purpose of BC Health Authorities Advanced Practice Pharmacist Working Group
- Definition of an Advanced Practice Pharmacist (APP)
- Standards to full scope of practice
- Proposed registration requirements
- Patient case examples
- Partnering with CSHP
- Why now?

Background

- BC Pharmacy Directors recognized an opportunity to improve care delivered to patients by recognizing and giving authority to the advanced pharmacy practices that exist in health authority settings
- Working group formed with membership from all health authorities in Nov 2007
- Developed an APP model

Members of the Working Group

- Robin Ensom (VCH/PHCC)
- Don Hamilton (W&CH)
- Roxane Carr (W&CH)
- Steven Shalansky (PHCC)
- Jane de Lemos (VCH/PHCC)
- Sue Corrigan (FH)
- Wendy Gordon (FH)
- Richard Bachand (VIHA)
- Dana Cole (NHA)
- Richard Slavik (IH)
- Shirin Abadi (BCCA)
- Mario de Lemos (BCCA)
- Glen Brown (PHCC)
- John Hope (PHSA)
- Shallen Letwin (FH)
- Michelle Babich (VIHA)
- Guest
 - Marshall Moleschi (CPBC)

Advanced Practice Pharmacist (APP)

- Clinical Pharmacist PLUS
 - When the APP **encounters a patient** experiencing signs, symptoms or unmanaged risks requiring intervention;
 - The APP **will take appropriate action** to prevent or resolve drug related problems;
 - And the APP is **responsible for providing or engaging appropriate follow-up** to monitor for therapeutic response or detection of adverse events.

Of course!!!

- Patients and the health system need all health professionals to effectively use **all our skills and abilities**
- We have been providing **accredited, supervised, experiential training** for pharmacists beyond the competencies necessary for basic registration for almost 40 yrs
- We (hospital pharmacists) have an **ideal practice environments** that support safe and effective care beyond current limits to our scope of practice
- We have **oversight and standards** to ensure quality practice and outcomes

Full scope of skills & abilities

- The “**recommendation and permission**” model is inefficient and removes accountability from the pharmacist for their recommendations;
- An “**action and communication**” model ensures that patients receive timely care while fostering a multidisciplinary approach to coordinated care;
- Many professionals formally differentiate scope of practice based on training and practice environment

Ideal Practice Environment

- Established **relationships and confidence** of other healthcare providers;
- Enhanced **access** to the patient and their complete healthcare record for assessment and follow-up;
- Established **record of effectiveness**, using delegated functions and collaborative practices;
- Opportunity to observe the impact of interventions on patient outcomes has established **clinical acumen**

Oversight and Standards

- Subject to hospital/health authority review
- Departmental oversight of individuals
- Individual standards
 - Practice within scope of expertise
 - Seek out and use available information
 - Make evidence-based decisions
 - Incorporate patients' goals/preferences
 - Provide complete documentation
 - Initiate prompt communication
 - Ensure continuity of care

What should the requirements be for registration in an Advanced Practice Pharmacist category?

Accredited, post-graduate, supervised experiential training in patient-care

- Residency program has been in place in Canada for almost 40 yrs with increasing emphasis on direct patient care and has a robust accreditation process
- Doctor of Pharmacy programs have been in place in Canada since the early 1990's with a focus on clinical practice and have an accreditation process
- Canadian pharmacists have been getting clinical training from accredited US Pharm D programs for decades

Proposed APP Licensure Process

- Determine eligibility for APP registration through a *"qualifying process"*
 - Accredited, post-graduate, experiential training
- Alternate pathways to the APP registration other than an accredited program
 - Involve an *"evaluating process"* in order to be eligible for the *"qualifying process"*
- Details to be determined
- Administered by the BC College of Pharmacists
 - Legislation change is required to incorporate a scope of practice change

How will this change my current practice?

PPP-58 (Medication Management, Adapting a Prescription)

- Currently, BC pharmacists have the authority to change, renew (if they have the original prescription in their possession), and substitute a prescription
- This expanded authority is an important step but does not fully address the opportunities and needs encountered in a health authority practice

Why have an APP category?

A Bit of History...

- In 1995 and 1999 BC College of Pharmacists submitted a Scope of Practice Brief to the Health Professions Council
 - Advisory body appointed by government
- Requested scope of practice changes; including:
 - Initiating drug therapy
 - Monitoring drug therapy including physical assessment
 - Performing screening and monitoring lab tests
 - Administering medications / immunizations

Opposition ensued...

- The Health Professions Council sought input from stakeholder groups including:
 - BCMA, College of Physicians & Surgeons, BC Assoc of Laboratory Physicians, Nursing and other Pharmacy bodies
- Strong opposition to the proposal from physician groups
- College of Pharmacists could not demonstrate adequate undergraduate training and ongoing professional competency

- A quote from their responses:
 - “ The College of Physicians and Surgeons of BC does not believe that pharmacists have the education and practical experience to undertake physical assessments in a community pharmacy setting. It clarifies however, that the context of pharmacy practice in hospitals is quite different.”

Health Profession Council's Findings – Mar 2001

“Prescribing, monitoring and adjustment of medications, including physical assessment and access to laboratory testing are all advanced competencies that should be reserved for practitioners who have documented advanced training with established credentialing and monitoring processes by the College of Pharmacists.”

Where are we now?

- We do have an ongoing competency assessment program administered by the College
- We do have advanced, accredited, credentialed training programs such as the Residency and Pharm D programs
- We have the additional layer of oversight and collaborative practice of the health authority setting

Patient Case Examples

Mrs. C Aidee

- 68 yr old female admitted for community acquired pneumonia
- PMH: recent MI 7 weeks ago, hypertension, glaucoma and high cholesterol
- Meds ordered in hospital: Moxifloxacin 400 mg po daily, ASA 81 mg daily, Ramipril 5 mg daily, Hydrochlorothiazide 12.5 mg daily, Metoprolol 50 mg po twice daily, Nitroglycerin spray prn
- Upon interviewing pt you determine
 - She stopped taking her Rosuvastatin 10 mg daily after her supplies ran out because she didn't realize it was to continue
 - She mentions that she was having some leg cramps
 - She is quite overwhelmed with all her new heart medications
 - She takes Latanoprost drops at home for her glaucoma

C. Aidee cont'd

- | | |
|--|---|
| ■ Current Scenario – YOU: | ■ APP Scenario – YOU: |
| <ul style="list-style-type: none">- Page the doctor and wait for return call for ½ hr- Suggest restarting Latanoprost and Rosuvastatin but you are concerned about leg cramps and would like to check LFTs and CK (this is refused)- Leave a note about the need for the labwork- Suggest a referral to a Healthy Heart Program | <ul style="list-style-type: none">- Order follow-up LFTs, CK level- Re-start Latanoprost- Document your actions and indicate your plan to restart Rosuvastatin depending on lab results- Send a referral to Healthy Heart Program- Send a summary of above to GP and Cardiologist |

Mr. Sore Bak

- 40 yr old male admitted to orthopedic unit with infected rod in his spine post-MVA; 90 kg
- PMH: recent MVA (6 wks ago), Left leg DVT post-MVA, Hypertension
- Medications ordered: Warfarin 7.5 mg daily, Diltiazem CD 240 mg daily
- ID team assesses and orders: Blood cultures, CRP, Vancomycin 750 mg iv q12h (with peak & trough around 3rd dose) and Rifampin 300 mg po daily
- Upon interviewing patient you determine:
 - He was testing in INR once weekly and just recently stabilized on this dose
 - Last INR was 2.6 three days ago
- Problems: Vancomycin dose is insufficient, strong drug interaction with Rifampin and Warfarin

Sore Bak cont'd...

- Current Scenario – YOU:
 - May or may not have delegated functions
 - Contact the ID team to change the Vancomycin
 - Contact the hospitalist to suggest ordering daily INR
 - Indicate LMWH bridging may be necessary due to drug interaction; they are agreeable but want to wait on the INR results
- APP Scenario – YOU:
 - Cancel the Vancomycin peak level
 - Order SeCr, BUN twice wk
 - Increase the Vancomycin to 2000 mg IV load then 1500 mg IV q12h
 - Order daily INR and a conditional Dalteparin order 18000 units subcutaneous if the INR drops below 2
 - Document the above issues for the team

I.M. Hot

- 13 month old, previously well, girl admitted to general pediatrics ward with febrile seizures and rule out meningitis
 - Weight = 10 kg
 - No known drug allergies; not immunized
- PMH: term uncomplicated birth, previously healthy
- Medications ordered:
 - Vancomycin 10 mg/kg/dose IV q8h
 - Cefotaxime 60 mg/kg/dose IV q8h
 - Phenytoin 20 mg/kg IV x 1 (given in emerg) then 2.5 mg/kg/dose IV q12h
 - Diazepam 0.5 mg IV prn seizure

I.M. Hot...

- Blood cultures and LP ordered
- Phenytoin level 1 hr post-load = 105 umol/L (N 40-80 umol/L)
- Renal function tests: normal
- You note the patient is drowsy and has nystagmus
- Problems: antibiotic doses are insufficient and patient has signs of phenytoin toxicity

I.M. Hot...

- | | |
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| <ul style="list-style-type: none">■ Current Scenario – YOU:<ul style="list-style-type: none">– Contact the attending to:<ul style="list-style-type: none">■ Change the vancomycin and cefotaxime doses■ Order appropriate monitoring■ Suggest holding phenytoin & order follow-up labs– Contact the primary care physician to clarify immunizations required– Discuss providing immunizations with attending | <ul style="list-style-type: none">■ APP Scenario – YOU:<ul style="list-style-type: none">– Increase the Vancomycin to 15 mg/kg/dose IV q6h and Cefotaxime to 75 mg/kg/dose IV q6h– Order Vancomycin levels and renal function monitoring– HOLD the phenytoin and order repeat level in 24 hrs– Order immunization catch-up after discussion with parents– Discuss & document above issues with the team |
|---|--|

Mrs J.S.

- 62 yr old female recently diagnosed with metastatic breast cancer
- PMH: seizure disorder diagnosed 10 yrs ago, managed with phenytoin 350 mg/day (prescribed by GP)

- Upon interviewing patient you determine:
 - She was recently prescribed capecitabine
- Problem: capecitabine may increase her phenytoin level

J.S. cont'd...

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| <ul style="list-style-type: none">■ Current Scenario – YOU:<ul style="list-style-type: none">– Call the GP office – they ask you to fax your concern– Fax a memo to the GP regarding the drug interaction and suggest monitoring plan– Advise JS to watch for potential symptoms of phenytoin toxicity | <ul style="list-style-type: none">■ APP Scenario – YOU:<ul style="list-style-type: none">– Order phenytoin and albumin levels– Document your plan to reduce phenytoin dose based on lab results– Send a summary to the GP and oncologist |
|---|---|

J.S. – Current Scenario

- 2 months later, JS came to the pharmacy for her 3rd cycle of capecitabine treatment
- Upon interviewing the patient you determine:
 - She has increasing irritability, fatigue, nausea, anxiety and poor memory over the past month
- You call to check with the GP office about their actions related to your fax and “they never received your fax”
- No phenytoin levels have been drawn
- You suggest JS go see her GP but she is not feeling well enough for another appointment

J.S. cont’d...

- | | |
|--|---|
| <ul style="list-style-type: none">■ Current Scenario – YOU:<ul style="list-style-type: none">– Page the oncologist to inform her of the potential phenytoin toxicity. She asks you to contact the GP– GP calls JS the next day to go to the lab for phenytoin level (116 umol/L)– GP calls JS to skip 2 days of phenytoin and restart on a lower dose– Additional days of phenytoin toxicity– Counsel JS on symptoms of toxicity | <ul style="list-style-type: none">■ APP Scenario – YOU:<ul style="list-style-type: none">– Order the phenytoin level today while JS is at the clinic (97 umol/L)– Advise JS to skip today’s phenytoin dose and re-start tomorrow at 300 mg/day– Instruct JS to get a follow-up level drawn in 5 days– Counsel JS on symptoms of toxicity– Document your actions and monitoring plan– Send a summary to GP and oncologist |
|--|---|

Other examples

- Improved efficiency, safety and outcomes for patients
 - Febrile neutropenia requiring empiric antibiotics
 - Dystonic reaction or Extrapyramidal symptoms requiring intervention for relief
 - Pain and symptom management
 - Culture results or electrolyte imbalances
 - Initiating / managing chronic therapies for risk reduction
- Current system – can *usually* accomplish what is needed for patient care but it is cumbersome
- Having full scope of practice will *improve access to timely and appropriate care for patients*

Changes to accountability

■ Current system

- Nurses and physicians can "usually" expect a clinical pharmacist on weekdays (unless the pharmacy dept is 'short-staffed' that day)
- Depending on the pharmacists' personal practice some may
 - Delve in complex drug related problems
 - Provide pharmaceutical care
 - "Trouble-shoot"
 - Review their "target drug" reports
 - Focus on medication reconciliation
 - Provide patient teaching
- No clear expectations of clinical responsibilities

Changes to accountability

■ Proposed system

- Need to have a clear hand-over of patient care between pharmacists
- You are responsible for follow-up of therapies you initiate/stop or lab tests you order
- New philosophy of clinical services beyond Monday to Friday
- Communication of interventions & care plan to other care providers
- Practice within your scope of expertise
- Refer to appropriate care providers for issues outside your competencies

Next Steps

BC College of Pharmacists

- Hospital Advisory Committee
 - Endorsed the APP model in Sept
- College of Pharmacists Staff
- College of Pharmacists Board
 - Presentation set for January 2010
- If approved, work to change the legislation and scope of practice begins
- Develop an implementation plan

Partnering with CSHP

- A dynamic society
- The influential voice for hospital pharmacy
- Inspiring practice excellence
- Fostering leadership and professional growth
- Committed to the advancement of safe, effective medication use and patient care

- CSHP should be leading the change from within our profession to seek recognition for the advanced practices of health authority pharmacists

- Other advocacy bodies have different priorities

Why Now?

- This is about improving efficiency and effectiveness of PATIENT CARE
- It will take a long time for the whole profession to get to this stage of readiness
 - Lack of post-graduate experiential training
 - Lack of collaborative practice environment and access to patient information
 - We NEED to lead this change in the health authorities
- We need TRAIL BLAZERS to initiate the change for all of us

The time for CHANGE is
now!

ADVANCED PRACTICE PHARMACIST – FREQUENTLY ASKED QUESTIONS

Scope

1. *Why do we need the advanced practice pharmacist (APP)?*

Drug therapy is complex and patients require timely clinical decisions on safe and effective drug therapy. Currently within the health authorities, clinical pharmacists and clinical pharmacy specialists guide decisions to meet the drug therapy needs of the patients. In defined circumstances, the safety, effectiveness, efficiency, and timeliness of drug therapy will be improved if these pharmacists can order drug treatments, associated tests and referrals, with appropriate communication to the healthcare team.

The APP, with an advanced scope of practice, working in collaboration with an interdisciplinary healthcare team caring for a patient, could decrease the delays and improve efficiencies to achieve desirable health outcomes for that patient. The APP could also lead to improved system efficiencies, e.g.,

- Fewer unnecessary interruptions and enhanced collaborative interactions with physicians can improve efficiencies for patient care flow. As an example, patients assessed in ambulatory care settings will have optimal use of their appointment time with APP's, who can respond to the unanticipated drug therapy needs by initiating drug treatments, and associated tests and referrals. This will lead to fewer re-scheduled appointments and less wastage in the booking process.
- Enhanced continuity of care with community providers reduces adverse medication events and associated resource utilization, such as investigations and readmissions.

2. *What is the role of the Advanced Practice Pharmacist (APP)? How would the role of the APP differ from clinical pharmacists and clinical pharmacy specialists under the Medication Management (Adapting a Prescription) under the current Health Professions Act?*

Currently, the pharmacists in BC have the authority to change, renew, and substitute a prescription, according to the Professional Practice Policy-58 (PPP-58, medication management – adapting a prescription) of the College of Pharmacists of British Columbia. While this expanded authority is an important step it does not fully address the opportunities and needs encountered in Health Authority Practice.

The role of the APP would be to ensure the patient achieves the best possible health outcomes, by performing all the activities currently carried out by clinical pharmacists and clinical pharmacy specialists. In addition, the APP will be independently initiating, modifying, and stopping drug treatments and ordering associated tests and referrals. This will include situations in which the APP would

encounter a patient experiencing signs, symptoms, or unmanaged risks requiring intervention. Within their framework of practice, the APP would take action to prevent or resolve these drug related problems, while taking into account the acuity of the care setting, access to clinical information, and the availability of other healthcare providers. The APP would take full responsibility for their actions, thus any orders written by the pharmacist in this context would be signed with the pharmacist's name and contact information, without reference to a physician's verbal order or telephone order. In addition, the APP would be responsible for providing or engaging appropriate follow-up to identify therapeutic response or detection of adverse events.

One of the key differences in practice will be the requirement that pharmacists take full responsibility for after hours follow-up (i.e. 24 hours per day, 7 days a week) related to any clinical interventions they have initiated. Ensuring continuity of care and appropriate communication is very important. Models to accommodate this follow-up could differ depending on the setting. For example, where weekend and after-hours pharmacy services are provided, a mechanism for handing-off outstanding issues to the weekend and on-call pharmacist should be implemented. In smaller settings where after-hours pharmacy services are not provided, communication of these issues to the on-call physician would be required.

Examples:

For further information outlining differences between current clinical practice and care provided under the proposed Advanced Practice Pharmacy model, see the examples in the accompanying slide presentation titled "Advanced Practice Pharmacist" by Robin Ensom and Sue Corrigan.

3. *Would the authorities of an APP include administration of medications?*

Currently the administration of medications by a pharmacist is considered a separate issue from APP designation, and the proposed APP credentials do not include training in this area. However, as there appears to be interest and progress in this area in B.C. (e.g. pharmacist administration of vaccines), the administration of medications may be addressed under the umbrella of APP designation at a later date.

4. *Does the APP designation apply to pharmacists practicing employed by the Health Authorities only?*

Yes. This includes pharmacists who practice in any facility run by a BC Health Authority including acute care hospitals, extended care faculties, primary care clinics, home care, nursing homes, etc. Enhancing the scope and accountability of the APP is particularly appealing in the context of health authorities.

Contributing factors to this optimal care environment include the following:

- a) Preparation and Training of the pharmacists within health authorities

- b) Environment - APPs, working within a health authority, have established relationships and confidence of other healthcare providers, who work with APPs in multidisciplinary teams; enhanced access to the patient and their complete healthcare record; established record of effectiveness, using delegated functions under the Hospital Act
- c) Organizational and pharmacy department's infrastructure provides clinical governance to ensure quality, consistency, and appropriateness of activities.

5. *Will the scope of practice of the APP cover for the continuum of patient care outside the Health Authorities? For example, will community pharmacy or biomedical laboratories accept orders from the APP?*

Yes, if the Health Professions Act is amended accordingly. The scope will include the recognition of the APP designation by healthcare providers and facilities outside the Health Authorities, as well as PharmaCare and Medical Services Plan.

6. *What issues will affect how or if the APP prescribes?*

When the APP exercises the authorities consistent with the expanded scope of practice, the APP would have an increased accountability and responsibility for that care. As a part of this accountability, the APP would be required to incorporate the following into their practice:

- i) Obtain Health Authority Review
- ii) Practice within scope of expertise
- iii) Use available information
- iv) Make evidence-based decisions
- v) Provide complete documentation
- vi) Initiate prompt communication
- vii) Ensure continuity of Care

7. *How does the prescribing of the APP differ from that currently practiced by the pharmacists in other provinces and territories?*

See appendix.

APP Registration

8. *Will the APP be registered as a separate category by the College of Pharmacists of BC?*

This is the intent, if approved by the College

9. *Will the current Health Professions Act need be revised to allow APP registration?*

This is the intent, if approved by the Ministry of Health

10. Who is eligible for the APP registration?

To be eligible for the APP registration “*qualifying process*”, pharmacists will have graduated from a post-licensure, accredited, supervised, experiential training program. An accredited hospital pharmacy residency program and/or a graduate level Doctor of Pharmacy (PharmD.) program would fulfill this requirement.

Pharmacists who have developed the skills and abilities necessary to practice as an APP through pathways other than an accredited program as described above would need to successfully undergo an “*evaluating process*” to be eligible for the APP registration “*qualifying process*”. Examples of alternate pathways include: extensive experience providing pharmaceutical care in an institutional care setting, a clinical masters/PhD, a post-graduate practice/research fellowship program.

11. What would the “evaluating process” and qualifying process involve? Who would oversee this process?

The evaluating and qualifying processes will be overseen by the College of Pharmacist of British Columbia.

12. Is the APP registration voluntary?

Yes

13. When is APP Registration expected to be passed by the BC College of Pharmacists? How long will it take before the evaluating process and qualifying process are formally implemented?

We are currently waiting for a response from the College of Pharmacists and will update this document as soon as further details are available.

14. Will APP registration become a requirement for any clinical pharmacy job?

The APP registration requirements will be determined by the individual Health Authorities in the context of the Collective Agreement.

15. Where will we find resources for APP positions given the current limitations of healthcare labour budgets?

It will be up to the local Health Authorities to decide whether to implement APP positions, or how to implement APP positions within their labour budgets. At this point there are no plans to include requirements or deadlines for implementation.

For example, Health Authorities may choose to gradually incorporate APP positions into their staffing plans over several years.

CSHP members can submit comments to Mario de Lemos (mdelemos@bccancer.bc.ca) or Steve Shalansky (sshalansky@providencehealth.bc.ca).

APPENDIX: Prescribing by Pharmacists in Canada, 2009¹

<i>Province or territory</i>	<i>Prescribing privileges or type of prescribing</i>	<i>Requirements to prescribe</i>	<i>Effective date*</i>
British Columbia	Prescribe in an emergency, adapt a prescription (renewals, dose or formulation adjustments, and therapeutic substitutions)	Registered pharmacists, upon completion of orientation session	Jan 2009
Alberta	Prescribe in an emergency, adapt a prescription (renewals, dose or formulation adjustments, and therapeutic substitutions) Additional prescribing authorization (initiate or manage ongoing therapy) Pharmacists on the ACP clinical register, upon completion of the orientation to new standards	Pharmacists who have been given authorization after application to ACP	Apr 2007
Saskatchewan	Emergency Contraception SCP can create supporting bylaws for prescribing by pharmacists Proposed: Level I Authority Prescribing – refills, continuing therapy, emergency medications, medications for selfcare, nonprescription medications (for third party), seamless care Level II Authority Prescribing – independent, collaborative agreements; therapeutic substitution; dosage adjustments	All registered pharmacists, with additional training Level I – all registered pharmacists Level II – pharmacists with additional training (evidence of proper training must be submitted)	TBA

Province or territory	Prescribing privileges or type of prescribing	Requirements to prescribe	Effective date*
Manitoba	Continued care prescription (renewal or refill of a prescription) New regulations will include provisions to prescribe and administer drugs, to interpret results of point-of-care patient self-tests, and to order and receive results for screening and diagnostic tests (pending acceptance by a majority vote of pharmacists registered in Manitoba).	All registered pharmacists Extended practice – application to MPhA Clinical assistant specialist – registered under The Medical Act (can currently prescribe)	TBA
Ontario	Interim report from HPRAC recommended authority to prescribe for minor ailments, to extend prescriptions, to adapt prescriptions on the basis of laboratory test results, and to administer drugs. Prescribing is referred to as “professional collaboration”.	Under development	TBA
Quebec	Initiate or adjust medication therapy according to a prescription by a physician (authorizing the pharmacist), prescribe emergency contraception	All registered pharmacists (specific training required for emergency contraception)	Jan 2003
New Brunswick	Renew or extend prescriptions, adapt prescriptions under certain conditions, prescribe in emergencies, and initiate therapy for pre-existing conditions	All registered pharmacists	Oct 2008
Nova Scotia	Conditional authority (written agreements with College of Physicians and Surgeons of Nova Scotia) Extend prescriptions Further regulations to expand practice are under development	All registered pharmacists	2006
Prince Edward Island	New Act added “giving prescription for a drug” to the practice of pharmacy; regulations currently under development	Under development	TBA
Newfoundland And Labrador	Under discussion; changes to the Act have not yet been proposed	NA	NA

Province or territory	Prescribing privileges or type of prescribing	Requirements to prescribe	Effective date*
Northwest Territories	<p>Immediate need for refill</p> <p>Substitute a pharmaceutically equivalent drug for the drug prescribed by the practitioner, in accordance with the territory's formulary</p> <p>Modify or include instructions in respect of medical devices or packaging requirements</p>	All registered pharmacists	2007
Nunavut	Cannot prescribe	NA	NA
Yukon	Cannot prescribe	NA	NA

Abbreviations: ACP = Alberta College of Pharmacists, SCP = Saskatchewan College of Pharmacy, HPRAC – Ontario Health Professions Regulatory and Advisory Council, NA = not applicable, MPhA = Manitoba Pharmaceutical Association, TBA = to be announced.

* *Date of implementation of regulations.*

¹Adapted with permission, "Canadian Society of Hospital Pharmacists. Prescribing by pharmacists: information paper. Ottawa (ON): Canadian Society of Hospital Pharmacists; 2009."