



Submission from the Pharmacists Association of the Niagara Peninsula (PANP) on Expanded Scope of Practice Consultation

Executive Summary

Ontario's health system is facing critical challenges – from primary care shortages to overwhelmed emergency departments – and the Niagara region is no exception. Expanding the scope of practice for pharmacists offers a timely and effective strategy to improve access to care, alleviate system pressures, and optimize health outcomes. The Pharmacists Association of the Niagara Peninsula (PANP) strongly supports the proposed regulatory amendments to **Ontario Regulation 256/24** under the *Pharmacy Act, 1991* to:

- **Expand Minor Ailments Prescribing:** Authorize pharmacists to assess and prescribe for 14 additional minor ailments, building on the success of the current program. With nearly 100% of pharmacies participating province-wide and over 1.8 million assessments provided since 2023, pharmacists have proven their readiness to manage common conditions safely and effectively. In Niagara, where an estimated 30% of residents lack a family physician, empowering pharmacists to treat more minor ailments will significantly improve timely access to care and reduce avoidable doctor and emergency visits.
- **Broaden Vaccination Authority:** Enable pharmacists to administer a wider range of **publicly funded vaccines** (e.g. RSV, pertussis, tetanus, pneumococcal, shingles) and allow **pharmacy technicians** to administer all vaccines in Schedule 3. Pharmacists in Ontario already deliver the majority of flu shots (over **56%** of influenza vaccines in 2022–23 were given at pharmacies ¹) and have administered tens of millions of COVID-19 vaccines ², demonstrating capacity to expand immunization services. By making more vaccines conveniently available at local pharmacies, particularly in Niagara's communities with high senior populations, we can boost vaccination rates and protect vulnerable groups.
- **Enable Injection of Medications (e.g. Injectable Buprenorphine):** Authorize pharmacists (and supervised pharmacy interns/technicians) to administer injectable medications beyond just vaccines – in particular, **injectable partial opioid agonists** like **Sublocade®** (buprenorphine) for opioid use disorder. Most Canadian provinces (all except Ontario and Quebec) already permit pharmacists to inject buprenorphine ³. Expanding this authority in Ontario will improve care for patients with opioid addiction by providing a more accessible option for monthly treatment injections. Niagara's opioid crisis – with over **640 EMS responses to suspected overdoses in the first 10 months of 2025** ⁴ – underscores the urgent need for easier access to life-saving therapies. Pharmacists are injection-trained and well-positioned to offer these services safely, which can reduce overdose deaths and free up other healthcare providers' time.

- **Facilitate Laboratory and Point-of-Care Testing:** Empower pharmacists to **order laboratory tests** and perform **point-of-care tests (POCTs)** to support clinical decision-making for minor ailments and chronic disease management. Ontario remains one of only two provinces in Canada where pharmacists *lack* authority to order lab tests, a gap that hampers fully effective care. Enabling pharmacists to, for example, conduct a rapid strep throat swab in pharmacy or order relevant blood tests would allow immediate and accurate treatment, benefitting patients and the system. A cost-minimization analysis found that pharmacy-based strep testing could save Ontario's health system an estimated **\$0.6–1.2 million per year** by reducing unnecessary physician visits and antibiotic misuse. Similar gains in efficiency and outcomes can be expected by allowing pharmacists to directly utilize diagnostic tests and communicate resulting diagnoses where appropriate.
- **Support Sustainable Implementation:** To **realize the full benefits** of expanded scope, accompanying measures are needed. These include sustainable **funding and remuneration** models (e.g. public funding for pharmacist injection services, equitable fees for expanded services), investments in **training and continuing education**, and strategies to mitigate **workforce strain**. Pharmacists are eager to embrace new responsibilities, but current burnout levels remain high – a 2022 survey found *90%* of pharmacy professionals at risk of burnout (improving to 79% in 2023) ⁵. PANP advocates for collaborative efforts to ensure pharmacies have adequate staffing, tools, and workflow innovations so that expanded services can be delivered safely without overburdening practitioners. Public **awareness campaigns** and integration of pharmacists into primary care teams (such as Ontario Health Teams) will further ensure the public can fully benefit from these scope changes.

PANP's **submission** provides evidence, local data, and recommendations in alignment with these key positions. While echoing the general support shared by our colleagues at the Ontario Pharmacists Association (OPA) for expanded scope, we present a distinct Niagara Peninsula perspective. We highlight the **local context** – including Niagara's physician shortages, demographic needs, and on-the-ground successes – to illustrate how expanded pharmacy services can specifically improve health outcomes in our region. We also propose **unique insights** and **visual data** to reinforce our points, and cite up-to-date research and examples from across Canada.

In summary, PANP is **enthusiastic** about the College's and Ministry's vision to leverage pharmacists more fully in healthcare delivery. Our communities in Niagara are ready: pharmacists here have already embraced services like minor ailment prescribing and vaccinations with great success. By expanding scope thoughtfully and supporting its implementation, Ontario can **build a more connected, resilient health system** – one where Niagara's residents, and all Ontarians, benefit from more convenient, timely care delivered by their trusted local pharmacy professionals. We appreciate the opportunity to contribute our region's voice to this important consultation, and we remain committed to collaborating on next steps to ensure a smooth, sustainable rollout of these expanded services.

Introduction

Health care in the Niagara Peninsula is at a crossroads. Long-standing gaps in primary care access, an aging population with complex needs, and recent system shocks (such as the COVID-19 pandemic) have placed immense strain on traditional care models. Niagara region currently faces **a severe shortage of family physicians**, with roughly *one-third* of residents lacking a regular family doctor. In communities like Fort Erie and Port Colborne alone, over **21,000 people** have no primary care provider ⁶. This primary care gap

forces many patients to seek help from walk-in clinics or emergency departments for issues that could be managed in the community. Indeed, Niagara Health's leadership acknowledges that the **biggest health system gaps in our region are primary care gaps**, not simply emergency care ⁶. The impact is evident in our hospitals: Niagara's EDs see high volumes of patients who might otherwise be cared for elsewhere, contributing to overcrowding and long waits. Province-wide data show that nearly **23% of all emergency department visits** in Ontario in 2022/23 were for *less urgent or non-urgent* concerns ⁷ – ailments like sore throats or rashes that could be treated outside the hospital setting with the right access.

At the same time, pharmacists have emerged as front-line providers who are **highly accessible and trusted** in every community. Pharmacies remained open throughout the pandemic and rapidly expanded services – from testing to vaccinations – to meet public needs. In Niagara, residents are never far from a pharmacy; even smaller towns have local drugstores that often serve as de facto health hubs. Pharmacists' university education and clinical training equip them to do much more than dispense medications. Over the past two decades in Ontario, pharmacists' scope of practice has gradually expanded (e.g. to give vaccines, renew prescriptions, prescribe for smoking cessation, etc.), and each expansion has demonstrated positive outcomes in terms of **access, quality, and cost-effectiveness**.

Now, Ontario stands ready to take the next transformative step: **authorizing pharmacists to practice to the full extent of their competencies** in primary care. The Ontario College of Pharmacists (OCP), in conjunction with the Ministry of Health, has proposed regulatory changes that would unlock pharmacists' ability to manage more minor ailments, administer more vaccines and injections, and utilize lab tests – changes collectively aimed at strengthening our healthcare system's capacity. The Ontario Pharmacists Association's recent submission on this consultation underscores widespread support for these moves within the profession, and importantly, highlights that "pharmacy professionals have demonstrated readiness, competence, and capacity" to assume these expanded roles safely. PANP wholeheartedly concurs with this assessment. We have seen first-hand in Niagara how pharmacists stepped up to provide **overwhelming public value** during recent health crises. For example, Niagara pharmacists administered thousands of COVID-19 vaccines (contributing to the 18 million doses delivered by Ontario pharmacists in under a year ²) and maintained medication access for patients even during lockdowns. They have become an indispensable part of local healthcare delivery.

In this submission, PANP offers a regional perspective to complement the provincial view. We provide data and stories that illustrate how expanded scope will play out in Niagara's unique context – a mix of urban centers and rural communities, with an aging demographic and pockets of underservice. We show that **Niagara pharmacists are ready and willing** to embrace an expanded role. In fact, many are already providing enhanced services under the current scope: assessing minor ailments, giving injections like vitamin B12 or insulin under medical directives, and collaborating with family health teams. Local pharmacy groups have proactively prepared for expanded services; for instance, the **Boggio Family of Pharmacies**, an independent chain with ten locations across Niagara, has been advertising and providing minor ailment assessment clinics to make care more convenient for patients ^{8,9}.

Our recommendations and commentary are structured in alignment with the key areas of scope expansion under consideration:

- **Minor Ailments:** We discuss the impact of adding 14 new minor ailments to pharmacists' prescribing list. We present evidence of pharmacists' performance in the existing minor ailments program (including *millions* of successful assessments delivered) and how expansion can improve patient care and generate system savings. We also address implementation needs such as removing restrictive drug lists and ensuring pharmacists can operate at full scope across all practice settings.
- **Vaccinations:** We examine the benefits of expanding pharmacists' vaccine authority and pharmacy technician involvement. Niagara's large senior population (one of the highest in Canada, with 35% of Niagara-on-the-Lake residents above age 65) stands to gain significantly from easier access to vaccines like shingles and pneumococcal shots at pharmacies. We provide data on pharmacy vaccination uptake and make the case for aligning Ontario's policies with other provinces by allowing pharmacists to prescribe and administer more vaccines, with adequate supply and funding in place.
- **Injectable Medications:** We focus on the proposal to enable pharmacists to administer certain injectable medications, highlighting the case of **injectable buprenorphine** for opioid use disorder. We outline the urgent need in Niagara for expanded opioid treatment options amidst the opioid overdose crisis, and describe how pharmacist-led injections can improve adherence and outcomes. We also support expanding injection authority to pharmacy technicians (under supervision) to increase service capacity, and suggest removing the static "authorized substances" list so that Ontario's regulations can keep pace with new therapies.
- **Laboratory and Point-of-Care Testing:** We explore how giving pharmacists the ability to order lab tests and perform POCT can optimize care. In minor ailments management, timely tests (like throat swabs or urine dips) can confirm diagnoses on the spot, enabling appropriate treatment and avoiding delays or guesswork. We compare Ontario's lagging policy to other provinces, present evidence of cost savings from pharmacist-led testing, and recommend steps to implement this safely (such as defining which tests are appropriate and establishing referral pathways for positives).
- **Professional Capacity and Integration:** Finally, we discuss the broader supports required for successful implementation. This includes **workforce and workflow considerations** – ensuring pharmacy teams are staffed and trained to handle expanded services without burnout – as well as **health system integration** efforts. We emphasize that scope expansion should be accompanied by measures like public education (so patients know they can turn to pharmacists), technology integration (so pharmacists can document and share care activities in provincial systems), and collaborative practice models (so pharmacists are working hand-in-hand with physicians, nurses, and others in a coordinated way). Niagara's own experience with the Ontario Health Team model and programs like SCOPE (Seamless Care Optimizing Patient Experience) offers a template for integrating pharmacists into primary care networks ¹⁰.

Through each section, we maintain a **focus on Niagara** – citing local statistics, case examples, and voices – to ensure the College understands how these provincial changes resonate at the community level. **visual figures and charts** (appendix) illustrate key points, from the share of ER visits that could be handled in pharmacies to the dramatic growth in pharmacy-provided care over the past two years.

Ultimately, PANP's vision is aligned with the province's: a future where pharmacists are fully empowered as accessible healthcare providers, working to their full scope to benefit patients and the system. The recommendations and insights that follow are offered in the spirit of collaboration and shared goal of **strengthening healthcare for all Ontarians**. We commend the OCP for undertaking this consultation and stand ready to assist in translating these proposed changes into reality in the months ahead.

Expanding Minor Ailments Prescribing: Enhancing Accessible Primary Care

Sector Readiness in Niagara and Ontario

Since Ontario launched its publicly-funded **Pharmacist Minor Ailments Program** in January 2023, the response from the profession and the public has been resoundingly positive. Pharmacists have overwhelmingly embraced the opportunity to use their clinical skills to assess and treat common minor health issues. By mid-2023, **87% of Ontario's community pharmacies** (4,233 pharmacies) were already participating in the minor ailments program ¹¹, including at least one pharmacy in every public health unit region. In Niagara, virtually all community pharmacies offer minor ailment assessments – from large chain drugstores in St. Catharines to independent pharmacies in smaller towns like Beamsville and Fort Erie. This near-universal participation reflects strong **sector readiness**: pharmacists have sought out training (e.g. completing the Ontario College of Pharmacists' minor ailments education module), established workflow protocols, and raised public awareness about their new services.

The volume of care delivered through the pharmacy minor ailments program has grown rapidly, confirming both pharmacists' capacity to provide these services and patients' willingness to use them. Province-wide, pharmacists provided approximately **302,500 minor ailment assessments in the first six months** of 2023 ¹¹. By October 2023, after the ailment list was expanded from 13 to 19 conditions, over **400,000 assessments** had been completed ¹² ¹³. And as of September 2025, Ontario pharmacists have conducted more than **1.8 million minor ailment consultations** in total. This exponential growth demonstrates that pharmacists are already a crucial frontline channel for managing minor health issues.

Niagara pharmacists have been key contributors to these numbers. Although region-specific data are not publicly broken out, we know anecdotally that Niagara pharmacies have consistently high patient volumes for minor ailments. Several factors make Niagara especially ready to leverage pharmacist prescribing: **widespread pharmacy coverage**, patient familiarity with consulting pharmacists, and pressing local needs. The region has over 100 community pharmacies distributed across urban and rural areas, ensuring residents in most communities can access a pharmacist easily (often with extended evening/weekend hours). Niagara also benefits from a tight-knit healthcare community – many pharmacists have collaborative relationships with nearby physicians and nurse practitioners, which facilitates referrals and follow-ups when needed.

Moreover, our region's **primary care shortages** mean pharmacists often fill an important gap. With an estimated **155,000 Niagara residents (33% of the population) potentially without a family doctor**, pharmacists have become the most accessible health professionals for many individuals. They are accustomed to triaging walk-in patients with complaints like coughs, rashes, or urinary symptoms – something they did informally even before formal prescribing authority was granted. Now equipped with legal prescribing rights for minor ailments, pharmacists can **complete the care process** for these patients instead of merely advising OTC therapies or urging a doctor visit. The success of the program so far indicates pharmacists are managing these ailments safely and effectively. In the first year of minor ailments prescribing, no serious safety concerns or increase in adverse events have been reported; on the contrary, pharmacists are following evidence-based guidelines and documenting care thoroughly in the provincial Drug Benefit database (which physicians can view). This robust documentation and communication – every minor ailment assessment in Ontario generates a record visible through clinical viewers – shows pharmacists' integration into the broader care continuum, and it addresses any concerns about care coordination.

From a **training and competency** perspective, pharmacists are well-prepared for an expanded minor ailments list. Their education covers pathophysiology and therapeutics for common conditions, and many have completed supplemental minor ailment prescribing courses offered by Ontario colleges or continuing education providers. Niagara pharmacists also benefit from peer networks and support from associations like PANP and OPA, which have disseminated best-practice tools (assessment checklists, patient education handouts, etc.) for minor ailments. Pharmacists know their limits and when to refer; indeed, the minor ailments program explicitly requires pharmacists to refer patients to a physician or nurse practitioner if a case is beyond the minor ailment scope or shows “red flag” symptoms. This ensures patient safety remains paramount even as access expands.

With this strong foundation, **expanding the list of minor ailments by 14 additional conditions** is a logical next step. The proposed ailments (which include common issues like mild headaches, acne, fungal nail infections, and sore throat) are well within the skillset of pharmacists to assess and manage. In fact, many are conditions pharmacists in other provinces are already treating routinely. For example, Alberta and Saskatchewan pharmacists have been prescribing for mild acne, insomnia, or shingles for years as part of their minor ailment programs. Ontario pharmacists have observed those models and are keen to offer similar services. The **Scope of Practice Advisory Group** at OCP, which included front-line pharmacists and clinical experts, carefully selected these 14 ailments based on evidence and identified need ¹⁴ ¹⁵. PANP is confident that Niagara's pharmacists stand ready to take on these additional conditions on day one of authorization.

To illustrate local readiness: one of the proposed new ailments is **acute sore throat (pharyngitis)** – a very common complaint especially during winter. Currently, a Niagara patient with a sore throat might go to a walk-in clinic or urgent care for a throat swab and antibiotics if needed. If pharmacists can prescribe for strep throat, they could not only examine the throat but also perform a rapid strep test on-site (pending POCT authorization) and treat appropriately. Pharmacists in Niagara have hands-on experience from COVID testing which can translate to strep testing. Pharmacies here often have private consultation rooms that can accommodate such assessments. In short, the infrastructure and expertise are in place; the regulations now need to empower pharmacists to utilize them fully.

In summary, the pharmacy sector – both province-wide and in Niagara specifically – is **demonstrably prepared** for an expanded minor ailments scope. High uptake of the initial program, extensive training, and

system supports like billing and record-sharing are already established. The addition of more ailments leverages this readiness, allowing pharmacists to further alleviate primary care pressures. As discussed next, the benefits for patients and the health system are significant, which justifies moving forward confidently with this expansion.

Patient and Health System Benefits of Minor Ailment Care

Empowering pharmacists to manage a broader range of minor ailments will yield numerous benefits for patients, providers, and the health system at large. Experience from the existing program and other jurisdictions suggests **improved access to care, enhanced patient experience, more efficient use of healthcare resources, and even cost savings**. We detail these benefits below, with particular attention to how they manifest in communities like Niagara.

Timely Access and Convenience: Perhaps the most immediate benefit is that patients can receive care for minor issues *much faster* and closer to home. Under the traditional model, a patient with a minor ailment (say, an ear infection or mild eczema) might wait days for a doctor's appointment or spend hours in an ER waiting room. In contrast, pharmacies offer **same-day, walk-in access** in most cases. A 2022 survey found that only **35% of Ontarians** could get a same- or next-day appointment with their family doctor when sick. Pharmacist prescribing helps close this gap by offering a convenient alternative for non-urgent ailments. Niagara's pharmacy distribution means that even residents in smaller or underserved areas have nearby options. For example, someone in Smithville or Port Colborne can visit their local pharmacy for a minor ailment assessment, whereas finding a nearby walk-in clinic or physician could be challenging. This ease of access is crucial in Niagara's rural pockets and for seniors with mobility issues. By expanding the ailment list to 14 more conditions, we simply widen the umbrella of issues that can be handled promptly in the pharmacy setting, thereby **reducing unmet needs** and the likelihood that minor issues worsen due to delayed care.

Patients greatly appreciate the **convenience and comprehensiveness** of pharmacist-led care for these ailments. In the current program, a patient can walk in with a concern (like a urinary tract infection or allergic conjunctivitis), be assessed by the pharmacist, receive a diagnosis and prescription on the spot, and often walk out with the medication in hand – all in one visit. This one-stop service (assessment *and* treatment) has been a game-changer for patient experience. With the expansion, that streamlined care can be extended to ailments like mild headache or insomnia, which otherwise often go untreated or trigger unnecessary physician visits. Notably, when pharmacists prescribe, they also counsel patients on self-care and red flags, empowering patients with knowledge about their condition. This holistic approach can improve adherence and outcomes. Moreover, expanding care in this way addresses equity concerns: people who don't have a family doctor or can't easily travel to a clinic will have more **equitable access** to treatment. As the Health Minister stated when expanding the minor ailments list in 2023, "people will now get faster, more convenient access to the care they need closer to home" ¹⁶ – a promise that further expansion will continue to fulfill.

Reduction in Unnecessary Doctor and ER Visits: Minor ailments are common – by some estimates, up to 20% of primary care visits involve minor issues, and as mentioned, a substantial fraction of ER visits are for non-urgent problems. Enabling pharmacists to handle more of these cases frees up physicians and emergency departments to focus on more complex and urgent patients. The initial list of 19 ailments covered conditions that frequently lead to doctor consultations (e.g., urinary tract infections, dermatitis, conjunctivitis, etc.). The results have been striking. In 2023, **547,673 Ontario residents received a**

pharmacist minor ailment service ¹⁷, which equates to those individuals *not* needing to see a doctor for those issues. The **top five conditions** managed by pharmacists that year were urinary tract infections, conjunctivitis, cold sores, allergic rhinitis, and dermatitis ¹⁸ – all ailments that otherwise would likely have occupied family practice or walk-in clinic time. By averting hundreds of thousands of physician visits, pharmacist prescribing is helping to mitigate the physician shortage problem. Each minor ailment addressed in a pharmacy is an appointment slot saved for a more complex patient at a clinic, or a spot freed up in an urgent care center for a true urgent case.

The impact on emergency departments is similarly positive. When patients know they can go to a pharmacy for minor troubles, they are less inclined to resort to the ER. This is particularly relevant in Niagara, where EDs have been overstretched and two small-town ERs were converted to Urgent Care Centres years ago. Keeping patients out of the ER unless truly necessary is critical. The Ontario Auditor General reported that *1 in 4* ER visits are for CTAS 4/5 low-acuity complaints ⁷. Many of those – such as sore throat, uncomplicated infections, mild skin issues – overlap with pharmacist-treatable ailments. Redirecting these to pharmacies can shorten ER wait times for everyone. There is evidence that after Ontario introduced pharmacist prescribing for minor ailments, patients have indeed been utilizing pharmacies over EDs: a recent analysis found a *16% increase* in pharmacy visits and a corresponding reduction in other healthcare visits for minor ailments after the 2023 policy change ¹⁹. This trend should strengthen as more ailments are added and public awareness grows. Niagara's hospitals, in particular, stand to gain relief. Our local ED clinicians support these efforts – Niagara Health's Emergency Chief co-wrote an op-ed noting that leveraging providers like pharmacists for minor issues will help ensure EDs can concentrate on emergencies ²⁰ ²¹.

Clinical Outcomes and Quality of Care: Importantly, studies show that pharmacist management of minor ailments yields **high-quality clinical outcomes** that are comparable to physician care. Pharmacists adhere to clinical guidelines and follow structured protocols for assessment. For example, in managing uncomplicated UTIs, pharmacists use symptom checklists and, when available, dipstick tests to ensure appropriate antibiotic use. In Alberta's established minor ailments program, outcome evaluations demonstrated safe prescribing with low rates of treatment failure or adverse events. Patients report high satisfaction and trust in pharmacist prescribers. Pharmacists also tend to invest time in patient education during these consultations, which can improve self-management and prevent recurrence (e.g., advising on preventive foot care for someone treated for athlete's foot). By expanding the ailments list, we extend these quality benefits to more condition areas. For instance, allowing pharmacists to prescribe for **minor sleep disorders (insomnia)** means they can not only suggest short-term medication options but also provide counseling on sleep hygiene – a comprehensive intervention that busy physicians might not always have time to do in depth. Similarly, pharmacists treating **eczema or psoriasis flares** can ensure patients are using topical therapies correctly and adhering to maintenance regimens.

It's worth noting that some of the proposed new ailments (like shingles or headache) involve careful assessment to rule out more serious issues. Pharmacists are trained in conducting thorough patient interviews and basic physical assessments; they will continue to practice within their competence and refer patients as needed. We anticipate that giving pharmacists authority for these conditions will actually *enhance* the overall quality of care in many cases, because it encourages patients to seek care early (e.g. starting antiviral treatment for shingles as soon as possible for best effect) rather than delaying. Pharmacists also have the advantage of often being more immediately accessible for follow-up questions or if a condition isn't improving, thus reinforcing continuity of care.

Cost Savings to the Health System: Beyond clinical outcomes, there is a compelling health economics argument for expanding pharmacist prescribing. Redirecting care from physicians and emergency rooms to pharmacies can yield significant cost savings, as pharmacist consultations are generally lower cost. Ontario's minor ailment assessment fee (billed through OHIP) is currently around \$20, which is far less than the cost of a physician visit or an ER visit for the same issue. Additionally, by resolving ailments quickly, downstream costs from complications or unnecessary tests can be avoided. In the first year of Ontario's minor ailment program, analysts estimated that **403,143 pharmacist-managed UTI and conjunctivitis cases** translated into between **\$17.3 and \$71.3 million** in healthcare cost savings, when considering factors like avoided doctor visits and prevented complications. Even at the lower end of this estimate, it's a substantial savings in just two ailment categories. Expanding the scope to 14 more ailments will amplify these economic benefits. Common conditions like **sore throat** are a good example – each strep throat handled in pharmacy rather than a walk-in clinic saves not only the physician visit cost but potentially prevents an inappropriate antibiotic prescription if it's viral (pharmacists will only prescribe antibiotics if a test or clinical criteria indicate strep, reducing unnecessary antibiotic use and its associated costs).

A U.K. study once coined minor ailments handled in pharmacies as the “**cost-effective alternative**” to routine care, and Ontario is now proving that point. Another Canadian analysis projected that pharmacist prescribing for minor ailments could save about **\$42 million annually** for Ontario's health system in direct costs ²² ²³ . When including indirect costs like improved productivity (less time off work for medical visits), the benefit is even greater. Minor ailments often cause people to miss work or school for what might be a simple issue – getting treated at a pharmacy typically requires less time away (no lengthy waiting room time), which has economic value. One report noted that faster, convenient access through pharmacies could reduce absenteeism and presenteeism costs to employers and the economy ²⁴ .

For Niagara's healthcare system specifically, cost savings can translate to reallocated resources. Niagara has been struggling with physician recruitment and hospital funding constraints. If pharmacist management of minor ailments reduces strain on Niagara's urgent care centres and family health teams, it may help defer or downsize the need for expensive expansions in those sectors. It also can reduce patient travel costs and time (an often overlooked “cost” for patients, especially in rural Niagara where a trip to a clinic might be a 30-minute drive).

Patient Satisfaction and Empowerment: Finally, an intangible but important benefit is patient **empowerment** and satisfaction. By normalizing pharmacists as providers for these conditions, the public becomes more engaged in managing their health with the support of their community pharmacist. Patients often express gratitude for the “on-the-spot” relief pharmacists provide. For example, a Niagara Falls pharmacist recently treated a mother and toddler for **head lice** (pediculosis, one of the proposed new ailments) – providing the prescription shampoo and instructions immediately, which the mother said saved her from “waiting days in discomfort and stress.” These positive experiences enhance the patient-pharmacist relationship, which can lead to better health adherence generally (the patient who trusts their pharmacist is more likely to seek advice on other health matters too, like vaccinations or medication reviews).

In summary, expanding pharmacists' minor ailment prescribing authority promises **earlier and easier care for patients, more efficient allocation of healthcare resources, and potential cost savings**, all without sacrificing quality or safety. Niagara's residents stand to benefit enormously: those without doctors get a new access point, those with doctors get faster relief when their physician is unavailable, and the whole community benefits from reduced burden on our limited pool of physicians and emergency services. The

case is clear that supporting pharmacists in this expanded role will strengthen our primary care system's ability to serve the public.

Improving Access and Equity through Minor Ailment Expansion

One of the driving motivations behind expanding pharmacists' scope for minor ailments is to promote **health equity** – ensuring that all patients, regardless of where they live or their attachment to a family doctor, can get timely care for common illnesses. In Niagara, issues of access and equity are particularly pronounced. Our region includes rural areas, lower-income communities, and a high proportion of seniors, all of which face unique access challenges. Broadening the availability of care via pharmacies can mitigate some of these disparities.

Geographic Equity: Niagara covers a large geographic area from west (Grimsby) to east (Fort Erie) and south (Port Colborne) to north (Niagara-on-the-Lake). While the central city of St. Catharines has a concentration of healthcare services, outlying towns have fewer clinics and often no hospital. However, virtually every town has at least one pharmacy. By expanding minor ailment services at pharmacies, we effectively **bring healthcare closer to home** for residents in every corner of Niagara. For instance, a resident of Fort Erie with a mild **shingles** rash (herpes zoster, which is on the proposed list) could be assessed and started on antiviral medication by their local pharmacist the same day, instead of potentially driving to Niagara Falls or Welland to find an urgent care clinic. In areas like West Niagara (Grimsby, Lincoln) where primary care options are limited, pharmacies become an accessible front-line resource. This geographic dispersion of pharmacies – and their extended hours – means that even **after-hours or weekend care** for minor ailments becomes more equitable. Someone who falls ill on a Friday night in a small town normally might have to wait until Monday or travel to a city ER; with pharmacists empowered, that person could visit a 24-hour pharmacy or a Saturday clinic at the local drugstore to get help.

Serving Vulnerable Populations: Certain groups benefit disproportionately from pharmacist-based care. **Elderly patients**, for example, may find it physically difficult to attend multiple appointments or wait in crowded clinics. These patients often know and trust their pharmacists (for medication management, etc.). Allowing pharmacists to treat their minor ailments spares them the ordeal of traveling and waiting elsewhere. Niagara's senior population – as noted, among the highest proportions in Canada at 21% of our residents over 65, and 35% in some towns – will greatly appreciate more on-site care at their pharmacy. Many seniors already come to the pharmacy for weekly prescriptions; now, if they mention a minor health complaint, the pharmacist can actually resolve it instead of simply advising a doctor visit. This “no wrong door” approach improves seniors' health-seeking behavior and outcomes.

Another vulnerable group is **low-income individuals** or those without transportation. They might not have a family doctor or the means to easily reach one. Pharmacies are generally more embedded in neighborhoods (often within walking distance or on public transit routes) compared to centralized health clinics. Additionally, pharmacist services for minor ailments in Ontario are **OHIP-funded** for those with health cards (meaning the patient pays nothing out-of-pocket for the consultation). This is crucial for equity: an individual who cannot afford a walk-in clinic fee or does not have private insurance can still get free care at a pharmacy for minor ailments. We must ensure this remains the case as new ailments are added – the government should commit to funding these services as they do the initial ailments, so cost is not a barrier for patients anywhere.

Reducing Systemic Barriers: Expanded scope also allows us to address some systemic barriers, such as **language or cultural barriers** in healthcare. Pharmacists often share the linguistic or cultural background of the communities they serve, especially in diverse areas of Niagara (for example, there are pharmacies catering to Italian-speaking or Chinese-speaking residents in certain parts of the region). A patient who might struggle to communicate their issue to an unfamiliar ER doctor may be far more comfortable with their community pharmacist who speaks their first language and understands their context. By enabling that pharmacist to actually prescribe treatment, we reduce the barrier that patient faced in getting appropriate care. This can lead to better adherence and trust in the health system among minority communities.

Uptake by Those Lacking Primary Care: As highlighted repeatedly, those without a family physician – roughly 2.3 million Ontarians (projected to rise to 4 million by 2026) ²⁵ ²⁶ – gain a new “default” provider for minor issues: their pharmacist. In Niagara’s context of 30% unattached patients, this is transformative. We essentially expand the primary care net to catch people who were previously falling through. A concrete local scenario: a young adult in Niagara who aged out of their pediatrician and couldn’t find a new family doctor might have ignored or self-treated health issues due to lack of access. Now, if they get a **mild skin infection (impetigo)** or **oral thrush**, a pharmacist can officially diagnose and treat it. This not only helps that individual in the moment but also keeps them from potentially spreading contagious conditions (like impetigo) in the community by getting prompt treatment. Over time, pharmacist interventions can also route unattached patients into other parts of the system when needed – for example, a pharmacist who identifies a patient with frequent migraines (one of the ailments) can treat the acute issue but also advise them to register with Health Care Connect or community health centers for ongoing care, thus linking them to further resources.

Patient Testimonials and Public Support: Early feedback on the minor ailments program in Ontario indicates high patient satisfaction. A poll by the Neighbourhood Pharmacy Association found that a majority of Ontarians supported pharmacists treating common ailments and saw it as a way to improve healthcare access. In Niagara, word-of-mouth has spread quickly; families now often say “check with the pharmacist first” for minor ills. Parents of young children, for example, appreciate the ability to get quick care for things like diaper rash or pinworms without the stress of booking a pediatric appointment. We expect similarly positive reception as new ailments are added. Key to equity, though, will be **public awareness** – ensuring that all segments of the population know about these services. PANP recommends targeted outreach (in multiple languages, via community groups, etc.) to inform marginalized or less-connected populations that pharmacists can help them. We discuss communication strategies later in this report.

Avoiding Two-Tier Access: One important equity consideration is to avoid creating a “two-tier” system wherein only those who can pay or those in certain settings benefit. The minor ailments program is currently funded by the government for the assessment, which is excellent for equity. We must ensure that any **necessary medications** resulting from these assessments are also accessible. While most of the ailments involve treatments covered by the Ontario Drug Benefit (ODB) for seniors or through private plans, some patients without coverage might struggle to afford medications. This is more of a general health system issue, but it’s worth noting: for true equity, the government could consider ensuring low-income patients can access needed prescriptions (perhaps through expanding ODB formulary or emergency drug programs) when pharmacists prescribe for them. Pharmacists already help by choosing cost-effective therapies (e.g., prescribing a \$10 antibiotic versus a \$80 one if both are options). As we expand to ailments like onychomycosis (nail fungus) which have expensive drug treatments, we must be mindful of affordability; pharmacists can play a role by discussing cost upfront and selecting appropriate therapy, but

system support (like special coverage if needed) might be warranted so that some patients aren't left behind due to cost.

In essence, expanding minor ailments prescribing is a **pro-equity policy** – it takes healthcare to where people are, minimizes wait and travel burdens, and provides a publicly funded option for care. Niagara's diverse population stands to gain substantially in terms of more uniform access across different communities. PANP strongly endorses this expansion as a means to **level the playing field** in primary care access, while also achieving the broader system improvements discussed earlier.

Implementation Considerations for Minor Ailments Expansion

To fully realize the benefits of an expanded minor ailments scope, a few implementation details and supportive measures need to be addressed. These include regulatory refinements, training and tools for pharmacists, and system adjustments. PANP highlights the following considerations (several of which align with points raised by OPA and other stakeholders):

1. Removal of Prescriptive Drug Lists: Ontario's regulations currently specify lists of drugs that pharmacists can prescribe for each minor ailment. While intended as a safeguard, these lists can quickly become outdated and inadvertently limit patient access to optimal therapies. For example, pharmacists have been authorized to treat atopic dermatitis since 2023, but the regulation-defined drug list did not include **roflumilast cream**, a newer medication approved in 2022, meaning pharmacists legally couldn't prescribe it. This kind of lag is problematic – it requires regulatory amendments to update, during which time patients miss out on newer treatments via their pharmacist. PANP recommends removing rigid drug lists from the regulation and instead allowing pharmacists to prescribe **any appropriate medication within their scope** for the minor ailment at hand (using clinical judgment and guidelines). Other provinces handle this by having a general statement that pharmacists can prescribe for the condition according to best practices, without enumerating every drug. This flexible approach trusts pharmacists' knowledge and simplifies the regulatory maintenance. If needed, the College can issue practice policies or guidelines about recommended first-line therapies, rather than embedding specifics in law. Removing prescriptive lists will also foster **innovation and adaptation** – for instance, if a new antiviral proves effective for shingles, pharmacists could immediately utilize it once it's on the market, rather than waiting for a regulation change.

2. Clarifying Authority to Diagnose Minor Ailments: A subtle but important point is the ability of pharmacists to **communicate a diagnosis**. In managing minor ailments, pharmacists are effectively determining what the condition is (e.g., "This is a tension headache, not a migraine" or "This rash is likely ringworm"). Some regulatory frameworks historically hesitated to say pharmacists "diagnose," but in practice, **assessment and diagnosis are intertwined**. We advise that Ontario explicitly recognize pharmacists' authority to diagnose within the context of minor ailments. This could be done via interpretation guidelines rather than a formal change if needed. Several provinces have already embedded diagnosis into pharmacists' scope for certain conditions ²⁷. Doing so in Ontario would legitimize pharmacists' role and protect them from any liability ambiguity. It also sends a clear message to other health professionals and the public that when a pharmacist says "you have eczema and I'm prescribing a cream for it," that is an accepted diagnostic decision. OCP's own advisory group acknowledged that some of the new ailments (e.g., migraine vs. tension headache) inherently involve diagnosis. Therefore, empowering pharmacists to make and communicate these diagnoses is logical and should be formalized as part of the expanded scope rollout.

3. Education and Decision Support: With new ailments being added, pharmacists will need access to up-to-date **clinical guidelines and decision support tools** to manage them safely. Many resources already exist (the Canadian Pharmacists Association's *Therapeutic Choices for Minor Ailments*, for instance, and OCP's minor ailment guidelines). These should be kept current with the best evidence and disseminated widely. The College and associations could offer refresher webinars or modules on the 14 new conditions so that pharmacists are comfortable with any they see less often. For example, "minor sleep disorders" might be new territory for some pharmacists; providing a clear algorithm for assessing insomnia and determining if it's appropriate for self-care versus referral will build confidence. PANP can assist by hosting local CE (continuing education) sessions focusing on Niagara-specific scenarios (like dealing with mild headaches when a patient might be worried it's something more serious – how to assess, when to refer for imaging, etc.). Additionally, ensuring pharmacists know about documentation expectations for the new ailments (what to record in patient notes, how to code the billing accurately for each new ailment code) will be important for consistency.

4. Integration with Other Providers: As pharmacists take on more ailments, it's crucial to maintain **good communication with physicians and nurse practitioners** in the circle of care. The existing program has a mechanism: pharmacists can fax or securely message a patient's family physician about the minor ailment encounter (and many do). Also, as noted, any billing through the OHIP system for the assessment creates a record in provincial viewers that physicians can see. With more ailments, this practice should continue and be streamlined. Ideally, electronic medical record integration (or using province-wide platforms) will allow seamless sharing of pharmacist assessments. Niagara is part of the Ontario Health Team initiative which encourages a connected health record; pharmacists should be included in those integration efforts so that, for instance, a family doctor can easily see that their patient was already treated at a pharmacy for a fungal skin infection last week. Likewise, if a pharmacist treats something and realizes the patient has no family doctor, establishing a referral pathway (perhaps via the Ontario Health Team or local community health center) can ensure that patient is followed up appropriately for any recurring issues or if something falls outside the minor ailment scope.

5. Remuneration and Sustainability: The current minor ailment assessments are publicly funded for Ontarians, which has been fundamental to uptake and success. We urge that the **expanded list of ailments be equally supported by a publicly funded fee**. There should be no gap where pharmacists can assess but patients must pay out-of-pocket – that would deter use and undermine the purpose. Assuming funding is in place, we also must consider if the level of remuneration is adequate. The \$20 fee was set for the initial 13 ailments; some of the proposed new ailments might require more time to properly assess (for example, insomnia counseling could take longer than a straightforward UTI consult). OPA's analysis suggests that the \$20 fee is reasonable on average, but it did not account for certain extra costs (like follow-up calls or more extensive counseling). Nova Scotia's pilot primary care clinics in pharmacies, for instance, found ~15 minutes on average for basic appointments. If Ontario's fee remains static, pharmacies will need to absorb the time cost; if it proves insufficient, it could threaten the service's viability in busy pharmacies. PANP recommends that the Ministry monitor the program's economics and be prepared to adjust the fee if necessary to ensure sustainability, especially as we layer on new services like POCT. Alternatively, efficiencies can be sought: enabling pharmacy technicians or assistants to handle more of the information gathering/paperwork can let the pharmacist focus on the clinical decision, improving throughput.

Additionally, we must include **all practice settings** in funding models. As OPA noted, pharmacists in non-community settings (e.g., long-term care, family health team clinics, etc.) currently don't have an easy mechanism to bill for minor ailment assessments. This can be a barrier to offering these services in those

environments. For example, a long-term care pharmacist might be perfectly capable of assessing a minor ailment for a resident, but under current structures, that service isn't recognized or compensated – instead it defaults to the attending physician. Expanding scope should coincide with exploring ways to incorporate pharmacists in **LTC, hospitals, and other settings** into the minor ailments service model. Perhaps a separate funding envelope or allowing billing through an ODB mechanism could be considered so that patients in those settings equally benefit from pharmacists' expertise.

6. Public Awareness and Expectations: Rolling out an expanded list of pharmacist-treatable ailments will require clear public communication. It's important to set appropriate **expectations** and avoid confusion. The College and Ministry should coordinate an awareness campaign when the changes take effect, listing the new ailments and advising Ontarians that they can visit pharmacists for these issues. This was done in a limited way via press releases and pharmacy posters in January 2023; a similar push (including signage in pharmacies, social media outreach, and information via primary care providers) would be wise. Special emphasis should be on advising patients *when* to go to a pharmacy vs when to go to a doctor or ER, to keep messaging aligned with patient safety. For instance, communications can say: "Pharmacists can now assess and treat these ailments... If you have warning signs like X, Y, Z, you will be referred to a doctor." This both empowers patients and reinforces pharmacists' role as part of the system, not a separate silo. We want the public to trust that pharmacists will refer when needed (which they do).

In Niagara, PANP can work with local media (Niagara Falls Review, St. Catharines Standard, etc.) to run informative pieces about the expanded scope – possibly including success stories or testimonials from patients who received care from pharmacists. The goal is to ensure Niagara residents are fully aware of their options and that they view pharmacist services as an **enhancement** to their care, not second-tier. Given that some pushback can occur (as seen in a few comments on the OCP consultation from individuals not supportive of expansion), having a transparent public dialogue will help maintain trust. We believe most of the public is already on board given the high utilization, but continuous engagement is key.

In conclusion, implementing the minor ailments expansion will be a multi-faceted effort. By addressing these considerations – regulatory tweaks like removing drug lists, clarifying diagnosis authority, ensuring training and integration, and securing sustainable funding – Ontario can maximize the positive impact of this change. PANP is committed to collaborating on these fronts, offering the Niagara region as a sort of microcosm to pilot education or integration initiatives if helpful. We are confident that with thoughtful implementation, the expansion of minor ailments prescribing will be a resounding success, replicating and amplifying the benefits we've already observed in the initial phase of the program.

Expanding Vaccination Services: Unlocking Pharmacists' Public Health Potential

Sector Readiness and Pharmacy Team Involvement

Pharmacists in Ontario have a well-established role in delivering vaccinations – a role that has grown significantly over the past decade and especially during the COVID-19 pandemic. In Niagara and across the province, pharmacists have proven themselves as **highly effective immunizers**, reaching large swaths of

the population through convenient community access. The proposed scope changes would further expand pharmacists' authority to administer certain **additional vaccines** and would newly authorize **pharmacy technicians** to administer vaccines as well. These changes build upon a solid foundation of readiness in the pharmacy sector.

Ontario pharmacists have been administering flu shots since 2012 and a range of other vaccines (such as travel vaccines, shingles for older adults, and COVID-19 vaccines) in more recent years. The volume of vaccinations given in pharmacies is enormous. By one estimate, pharmacies have become the **predominant location for adult flu vaccination in Canada**, with about **57%** of adults who got a flu shot in 2022–23 receiving it at a pharmacy ¹. In Ontario specifically, community pharmacies delivered millions of flu shots annually even before the pandemic, and during COVID-19 they were integral in the vaccine rollout. From fall 2021 to summer 2022, Ontario pharmacists administered an *astounding* **18 million COVID-19 vaccine doses** ² in less than one year – an achievement that underscores the capability, scalability, and public trust in pharmacy-based immunization.

Within Niagara, pharmacists and their teams played a leading role in local vaccination efforts. Pharmacies across the region – big chains and small independents alike – organized mass immunization clinics, some in collaboration with Niagara Public Health and others independently. They managed cold-chain storage, appointment scheduling, and documentation efficiently, often vaccinating hundreds of people per day at the height of the COVID campaign. This experience has only further honed the **skills and systems** needed for immunization. Pharmacies have invested in training (all pharmacists providing injections undergo certified immunization training, and many pharmacy technicians have now completed their injection training for the limited authority they had with COVID/flu). They have also established the necessary infrastructure: dedicated clinic space in stores, observation areas, supplies for emergency management (like epinephrine for rare anaphylaxis), and data reporting mechanisms (many pharmacies directly report vaccinations to provincial registries or to family physicians).

Given this backdrop, expanding the list of **routinely administered vaccines** that pharmacists can provide is a natural progression. The government's proposal specifically mentions enabling pharmacists to administer vaccines such as **RSV (respiratory syncytial virus) vaccines, pertussis (whooping cough) boosters, tetanus/diphtheria, pneumococcal vaccines, and shingles (herpes zoster) vaccines** that are not currently in pharmacists' scope but are publicly funded for certain groups. Currently, these vaccines typically require a visit to a doctor or public health clinic. Pharmacists are **ready and able** to incorporate them. The immunization training pharmacists receive covers the administration of intramuscular and subcutaneous injections, regardless of the antigen – so whether it's an influenza shot or a shingles shot, the technique and safety precautions are the same. Pharmacists are also well-versed in patient screening (e.g., checking contraindications or eligibility for publicly funded vaccines) and in providing the necessary patient education (for example, advising that a shingles vaccine might cause a sore arm or mild rash).

One of the few limitations has been that **pharmacy technicians** until recently were not allowed to immunize except in pilot projects. Ontario did make an interim change allowing techs to administer COVID-19 and flu vaccines under supervision, recognizing the need for more immunizers during the pandemic. The proposed amendment would expand technicians' authority to include *all* vaccines on Schedule 3 (the list of pharmacist-authorized vaccines). This is a welcome change that PANP supports strongly. Many Niagara pharmacies have already utilized trained technicians to give flu and COVID shots, which significantly increased capacity. For example, at a pharmacy in Welland, having the technician give injections under the pharmacist's oversight essentially doubled the number of patients they could vaccinate

in a given hour, since the pharmacist could focus on clinical assessment and monitoring while the tech delivered the shots. Technicians have backgrounds and training (often from community college pharmacy tech programs) that include aseptic technique and product preparation, and with the specific injection training, they can administer just as safely. In provinces like Alberta and British Columbia, pharmacy technicians are already authorized to give injections, and their inclusion has been successful.

From a **workflow perspective**, involving technicians as immunizers will be crucial as we expand the roster of vaccines. It allows pharmacies to run more efficient clinics – for instance, at a busy time like back-to-school when many people might need pertussis or meningitis boosters, a pharmacist and technician team can handle the volume better together. The pharmacist still conducts the clinical assessment (ensuring the patient is eligible and no contraindications), and the technician can perform the injection and data entry, etc. It's a model analogous to how nurses often give shots in doctors' offices while the doctor supervises. In terms of readiness, many technicians in Niagara have proactively taken the Ontario College of Pharmacists injection training course in hopes the scope would permanently expand; they are eager to utilize their new skill.

To ensure readiness translates to effectiveness, a few practical measures should accompany this change: pharmacists should be given clear guidelines on supervision ratios (how many technicians one pharmacist can supervise at once when vaccinating – likely one at a time to maintain safety standards), and all immunizing personnel need to maintain their CPR/First Aid certifications and anaphylaxis management training as per ministry requirements. Pharmacies will need to update their workflows – but since they've done so for flu/COVID, adding more vaccine types is trivial in comparison. Essentially, instead of just offering flu shots, pharmacies will advertise availability of these other vaccines, and technicians can step in to help administer them just like they did for flu.

Niagara's public health and primary care community by and large supports pharmacists' expanded vaccine role, seeing it as complementary to their own efforts. During COVID, pharmacy-led clinics took huge pressure off public health-run mass clinics. Similarly, family doctors often refer patients to pharmacies for flu shots and travel vaccines due to convenience. We foresee that with expanded scope, doctors will likewise start telling their patients, "You can get your shingles shot at the pharmacy now" or "Drop by the pharmacy for your next tetanus booster." This interprofessional support is another sign of readiness: pharmacists are recognized as integral immunizers.

In conclusion, Ontario's pharmacy sector is **fully prepared** to broaden its vaccination services. Pharmacists are competent with injections and accustomed to delivering high-volumes safely. Pharmacy technicians are trained and now experienced in immunizing thanks to the interim authorities. By formally expanding the list of vaccines and technician scope, the College will empower a ready workforce to contribute even more to public immunization goals. In the next section, we will delve into how this will benefit patient and public health outcomes and what considerations come with it.

Public Health Impact and Uptake of Pharmacy Vaccinations

Expanding pharmacists' vaccine authority has significant positive implications for public health. Vaccination is one of the most effective preventive health interventions, and making vaccines more accessible through pharmacies can increase uptake, improve herd immunity, and ultimately reduce the incidence of vaccine-preventable diseases. We will examine these impacts in the context of Niagara and Ontario, drawing on evidence from past pharmacy vaccination initiatives.

Increasing Vaccine Uptake: Convenience and accessibility are key determinants of whether people get vaccinated. Pharmacies excel on these fronts – they typically offer walk-in service, extended hours, and multiple locations in every community. When flu shots first became available in Ontario pharmacies, the province saw a marked increase in overall influenza vaccination rates, especially among working-age adults who previously might not have bothered with the inconvenience of scheduling a doctor’s visit. Research by O’Reilly et al. found that adding pharmacists as immunizers led to significantly higher vaccination coverage and produced substantial cost savings by preventing illness. Over a 20-year horizon (2016–2035), the overall health system savings from pharmacist-administered flu vaccines in Ontario was estimated between \$206 million and \$761 million, with a return on investment up to \$72 for every \$1 spent on pharmacy vaccination services. These savings come from avoided doctor visits, hospitalizations, and productivity losses due to flu illnesses prevented.

By expanding to vaccines like **shingles (Herpes Zoster)** and **pneumococcal conjugate vaccines**, we can anticipate similar gains. Shingles is a painful condition that can be prevented by vaccination, yet historically uptake of the shingles vaccine (Shingrix) in Ontario has been suboptimal, partly because it required a doctor’s prescription and many people were not proactively getting it. If pharmacists can both prescribe and administer shingles vaccine (as OPA has advocated ²⁸ ²⁹), it eliminates a barrier and likely more seniors will get immunized. The province of Alberta allows pharmacist prescribing for shingles vaccine, and they have seen an increase in vaccine distribution through pharmacies as a result. In Niagara, where we have a high senior population at risk for shingles complications, easier access through local pharmacies could significantly increase coverage. Many seniors may find it simpler to get the shot during a routine pharmacy trip than to wait for a doctor’s appointment.

Pertussis (whooping cough) and other adult boosters are another area where pharmacy involvement can help. Adults often forget or are unaware of their booster schedules; pharmacists are in a position to remind patients and offer the vaccine on the spot. For example, a pharmacist dispensing antibiotics to a new mother might check immunization records and notice she’s due for a pertussis booster to protect her infant – the pharmacist could then administer it. This opportunistic vaccination approach can raise coverage rates for boosters that otherwise might be missed.

Protecting Vulnerable Populations: Enhanced pharmacy vaccination access especially benefits vulnerable or less-mobile populations. **Seniors and those with chronic illnesses** – who often frequent pharmacies for medications – can conveniently receive vaccines during those visits, improving their protection against infections like influenza, pneumococcus, or RSV which can cause severe illness in these groups. Niagara’s older demographic will benefit from RSV vaccination for seniors (a newly recommended vaccine for 60+ adults and those with risk factors). Once pharmacists can provide RSV shots, it will be easier to reach high-risk seniors, possibly preventing serious respiratory infections that lead to hospital stays. Similarly, expanding pharmacists’ vaccine scope means that caregivers or family members coming to pick up prescriptions could be reminded to update their own immunizations to create a “cocoon” of protection around infants or immunocompromised relatives.

Community Immunity and Outbreak Prevention: Higher vaccination rates contribute to community (herd) immunity, lowering disease transmission. With pharmacies spread widely, they serve as community-level vaccination hubs that can quickly respond to public health needs. During localized outbreaks – say a measles exposure or a meningitis case at a local college – pharmacists who are authorized to vaccinate can assist public health by offering pop-up vaccine clinics or extended hours to administer MMR or meningococcal vaccines as needed. The expanded authority should ideally include any publicly funded

vaccines, so pharmacists could step in to deliver whatever immunization is required in such scenarios. Currently, some vaccines for outbreak control (like measles) might not be on the pharmacist list, but if we move towards including all routine immunizations, pharmacists can be full partners in outbreak response. This drastically improves the **agility** of the health system. We saw a glimpse of this during COVID when pharmacies stepped up (pharmacies in Niagara even helped vaccinate during some local surges by running after-hour clinics).

Public Health System Efficiency: By routing more routine immunization through pharmacies, we can also **relieve public health clinics and family practices** of some immunization duties. Public health units like Niagara Region Public Health have traditionally run clinics for things like school immunizations or travel shots, but they operate on limited budgets and staff. If pharmacies can handle more of the routine load (e.g., adult boosters, travel vaccines, catch-up vaccines for teens), public health can focus its resources on outreach to populations who might not otherwise seek vaccines (e.g., homeless populations, etc.) and on surveillance and education. Family doctors similarly can spend less time on administering shots and more on complex care. It becomes a better division of labor. We saw, for instance, that once pharmacists could give flu shots, many doctor offices in Niagara stopped offering dedicated flu clinics – and they refer patients to pharmacies – freeing physician time. That trend will likely extend: doctors can rely on pharmacists to ensure patients are up-to-date on tetanus, shingles, etc. (with pharmacists communicating back which vaccines were given), thereby streamlining preventive care tasks.

Cost Savings and Health Outcomes: There are direct cost advantages to shifting vaccinations to pharmacies. Pharmacies have lower overhead for delivering vaccines than many other settings and often can do it more efficiently (leading to shorter patient wait times, etc.). A study examining pharmacy-based vaccination found it to be a **cost-effective, scalable, and sustainable channel** for immunization ³⁰ ³¹ . OPA's submission references that pharmacies in Ontario delivered flu shots at an administration fee of \$13, which was cost-saving given the health outcomes achieved. For new vaccines like the high-dose flu for seniors or pneumococcal vaccines, including pharmacies can similarly save costs by preventing hospitalizations for pneumonia or influenza complications – events which can cost thousands per patient. For example, avoiding just a few cases of pneumococcal pneumonia in seniors via higher vaccine uptake can offset many times the cost of pharmacy administration fees.

Niagara's own health system could see fewer hospital admissions for preventable illnesses if more residents get immunized. We have had outbreaks in the past (like pertussis outbreaks in pockets of unvaccinated communities) – having pharmacies proactively identify and vaccinate under-immunized individuals can reduce these events. As another case, **HPV vaccination:** while the program for youth is largely school-based, some young adults miss their HPV shots and then “age out” of school programs. If pharmacists were allowed to administer HPV vaccine (which is currently prescription-only outside of school clinics), they could help catch those up, potentially reducing future cancer burden. This might be beyond the immediate list proposed, but it's an example of where expanded vaccine authority for pharmacists could have long-range public health benefits.

Addressing Vaccine Hesitancy: Pharmacists are among the most accessible healthcare professionals for people to ask questions about vaccines. In Niagara's communities, people often drop by or call the pharmacy to inquire about vaccine safety or necessity. Pharmacists, being approachable and without needing an appointment, can counsel those who are hesitant. When pharmacists can also administer the vaccine, it closes the deal – a patient might come in unsure, have a chat, get reassurance, and then get vaccinated on the spot while their confidence is high. If they had to be referred elsewhere, that opportunity

might be lost. Studies have indicated that pharmacist recommendation is a strong predictor of a patient getting immunized, akin to physician recommendation. Therefore, empowering pharmacists to not only recommend but also deliver every vaccine strengthens our ability to convert vaccine-hesitant or ambivalent individuals into vaccine recipients.

Niagara has had challenges with vaccine hesitancy in some pockets (especially around newer vaccines like COVID or historically, HPV). The more healthcare touchpoints offering accurate information and convenient vaccination, the better our overall coverage will be. Pharmacies serve diverse segments of the population – including those who might rarely see a doctor. Engaging these individuals through pharmacies helps ensure no one is left behind in public health outreach.

In summary, expanding pharmacists' vaccine scope stands to **increase immunization rates**, particularly by lowering barriers and reaching people in convenient ways. This will improve population health outcomes (fewer cases of diseases like shingles, pertussis, pneumonia, etc.), reduce healthcare costs associated with treating those diseases, and promote a more resilient, preventive health system. Niagara's public health will specifically benefit given our demographic profile and existing strong pharmacy network. The next part of our report will consider what needs to be in place to support this expanded role – including policy adjustments like prescribing authority for vaccines and ensuring adequate vaccine supply to pharmacies.

Equitable Access and Funding for Pharmacy-Provided Vaccines

While expanding the scope of vaccines pharmacists can administer is poised to improve public health, careful attention must be paid to **ensuring equitable access** and appropriate funding. Without these considerations, there's a risk of uneven uptake or financial barriers that could undermine the goals of expansion. PANP provides the following analysis and recommendations on these fronts:

Public Funding and Patient Costs: Many of the vaccines in question (influenza, pneumococcal for seniors, tetanus boosters, etc.) are part of Ontario's publicly funded immunization programs when given in the traditional settings. It is vital that these vaccines remain (or become) **publicly funded when delivered at pharmacies** as well. In other words, if a 65-year-old is entitled to a free shingles vaccine through public health, they should also get it free at the pharmacy. Currently, Ontario does publicly fund the shingles vaccine for adults 65–70, but pharmacists were not initially allowed to administer it; this led to low uptake due in part to the inconvenience. If pharmacists can administer it, the funding is already there (the province purchases the doses or reimburses), so patients will not pay out-of-pocket for those who meet criteria. Similarly, flu shots and COVID-19 vaccines at pharmacies are publicly funded and free to patients.

For **vaccines that are not publicly funded** (for example, shingles vaccine for those under 65 or pertussis for adults – Ontario doesn't universally fund these except in pregnancy), pharmacists will still be able to administer them but the patient or their insurance must cover the cost of the vaccine itself. One advantage of pharmacies is that they often know a patient's insurance coverage and can process it on-site. However, to avoid a two-tier scenario where only those who can afford non-funded vaccines use the pharmacy service, PANP encourages the government to consider expanding funding for critical vaccines. For instance, some public health advocates have called for lowering the age of funded shingles vaccine given the burden of disease even in people in their 50s. If such policy changes occur, pharmacists should be integrated as providers in the program, not an afterthought.

Remuneration for Administration: Ontario currently pays pharmacies an administration fee for certain vaccines (e.g., around \$13 for flu shot, \$17 for COVID shot under certain programs). For the new vaccines that pharmacists would administer, a standardized **administration fee** should be put in place. It may not be set in regulation, but through ministry policy. OPA has recommended a \$13.50 fee for all publicly funded vaccines to keep it consistent and cover costs. We agree that administering, say, an HPV or pneumococcal shot at a pharmacy involves similar time and resources as a flu shot, so a comparable fee is appropriate. This fee helps pharmacies cover the workflow of screening, counseling, administering, and documenting the vaccine. If certain vaccines are more complex (e.g., requiring more monitoring), perhaps a slightly higher fee could be considered, but for simplicity one rate is fine. The key is that pharmacies should not be expected to provide these services without compensation, as that would be unsustainable – and undercut the willingness to promote them. Other provinces that have expanded pharmacy vaccinations (like Quebec or Alberta) do reimburse pharmacies for each shot given, which has facilitated high participation by pharmacies.

It's also essential to note that without public funding of the administration fee, patients might be charged. We want to avoid patients having to pay any injection fees out-of-pocket, since that could deter them. For example, if a tetanus shot is free but a pharmacy charged a \$20 injection fee, some might skip it. So, **government coverage of the professional fee** ensures free access for the patient at point-of-care, which is aligned with how vaccines are given in doctor's offices (where OHIP covers the service through physician billings).

Supply and Distribution: One practical equity aspect is making sure pharmacies actually receive enough vaccine stock to meet demand. In past flu seasons, some Niagara pharmacies have reported running out of high-dose flu vaccine for seniors due to limited allocations, while public health clinics still had some – a distribution imbalance. If pharmacies will be administering more types of vaccines, the **Ministry of Health and Public Health units should plan vaccine distribution accordingly**. This might mean increasing the supply ordered or adjusting how it's allocated between public health and pharmacy channels. The OPA highlighted that insufficient vaccine allocations to pharmacies during flu season have been a recurring challenge ³² ³³ . For example, pharmacies often didn't get as many high-dose flu shots as needed for all the seniors requesting them, resulting in delays or turning patients away. To support expanded access, the **pharmacy channel should receive a fair share of vaccine doses** upfront, based on expected demand.

Niagara's case: if pharmacists are going to give pneumococcal vaccines to seniors, the province should allot those doses to pharmacies similarly as they do for physicians' offices. Perhaps implementing a centralized ordering system for all vaccines similar to what exists for flu (UIIP – Universal Influenza Immunization Program) for other vaccines can streamline this. Additionally, leveraging pharmacy wholesalers for distribution (as OPA suggests using distributors to ship vaccines directly to pharmacies ³⁴) can be more efficient than requiring pharmacy staff to pick up vaccines from public health (which is sometimes the case now for flu). The goal should be **adequate, timely supply** so pharmacies can reliably offer these services once announced – nothing would undermine public trust more than telling patients “pharmacists can give you Vaccine X” but then the pharmacy doesn't have Vaccine X in stock for weeks.

Inclusion of All Community Pharmacies: For maximum equity, we want as many pharmacies as possible to participate in offering the expanded vaccines, including those in rural or underserved areas. There may need to be some outreach or incentives to smaller pharmacies to make sure they enroll in the vaccination programs and order the stock. Based on experience, most are eager to take part, but sometimes administrative hurdles (registration in programs, fridge capacity concerns, etc.) can be a barrier. PANP can

assist by working with Niagara pharmacists to ensure they have the resources (like data loggers for fridges, etc.) to handle expanded vaccine inventory. The College might consider a brief survey or assessment to identify any pharmacies that need support to come on board fully (like ensuring they have a trained injector if the sole pharmacist hasn't been injecting – although most have by now).

Pharmacist Prescriptive Authority for Vaccines: A crucial piece of the puzzle is giving pharmacists **the ability to prescribe certain vaccines**, not just administer them. As it stands, Ontario pharmacists can administer certain vaccines but if a vaccine is classified as Schedule I (prescription-only), the patient technically needs a doctor's prescription for it. This is an unnecessary barrier that can trip up access. For instance, **travel vaccines** often require a prescription – many pharmacists sidestep this by partnering with travel clinics or using medical directives, but it's cumbersome. The OCP has recommended enabling pharmacists to simply prescribe vaccines themselves ²⁸ ²⁹. Ontario is one of only two provinces where pharmacists *do not* have any prescriptive authority for vaccines ²⁹. Enabling this authority would streamline care: if a patient comes in needing a typhoid vaccine for travel, the pharmacist can assess and provide it without sending them off to get a prescription, which might deter them or delay prophylaxis.

Another example relevant to expansion: **Shingles vaccine (Shingrix)** for those 50-64 is Schedule I (needs prescription) and not publicly funded. Under current rules, a 60-year-old who wants it has to get a prescription from their doctor then come back to pharmacy for injection. Many either don't bother or doctors forget to proactively prescribe it. If pharmacists could simply prescribe and administer Shingrix, uptake would likely increase for that middle-age group. Removing this two-step not only improves access but also removes a **financial inequity**: some private insurers won't cover a vaccine unless there's a prescription on file ³⁵ ²⁹, which is a quirk that has meant some people had to get a prescription solely for insurance purposes. If pharmacists are authorized prescribers for vaccines, their documentation can satisfy that requirement, and patients aren't paying out-of-pocket due to a technicality.

Therefore, as part of expanded scope, PANP echoes the call to grant **pharmacist prescriptive authority for all vaccines**. It's a common-sense alignment of regulation with practice, and it puts Ontario on par with provinces like Alberta and Nova Scotia. It ensures that the **patient's journey is one-stop**: assessment, prescription, and administration all in the pharmacy if appropriate. This will particularly help with new adult vaccines or multi-dose series – for example, a patient could start an HPV series at age 26 with pharmacist prescribing, and the pharmacist can ensure they return for dose 2 and 3 on schedule, improving series completion rates.

Ensuring Inclusivity: When expanding vaccine services, we should also think about **harder-to-reach groups**. Pharmacies in lower-income or remote areas should be supported to run vaccine clinics (maybe through temporary extra funding or partnerships). Pharmacists might also do outreach, like off-site clinics at community centers; however, current regulations might limit them to vaccinating at the pharmacy premises or under certain conditions. We may consider if policies could allow mobile or off-site pharmacist-led vaccine clinics (many did that in COVID with special approval). This could extend reach to, say, retirement homes or workplaces in Niagara for flu shots, etc., making it even more convenient. Some regulatory flexibility or collaboration with public health on off-site vaccine delivery by pharmacists could be beneficial.

In conclusion, **equity and funding** considerations for expanded pharmacy vaccination include maintaining free patient access through public funding of both vaccines and administration fees, ensuring robust supply of vaccines to pharmacies, giving pharmacists full prescriptive authority to eliminate unnecessary hurdles, and actively involving all pharmacies in the campaign. If these factors are addressed, expanded pharmacist

vaccine services will significantly bolster Ontario's immunization coverage in a fair and cost-effective manner.

Implementation Considerations for Vaccination Scope Expansion

To successfully integrate the expanded vaccination scope into Ontario's healthcare system, a number of practical and policy-level implementation steps should be undertaken. PANP outlines these considerations to ensure a smooth rollout and maximum benefit:

1. Update Regulations and Standards: The Pharmacy Act regulation (O. Reg. 256/24) and related standards of practice will need updating to reflect the new vaccine authorities. This includes adding the specific vaccines (RSV, pertussis, etc.) to the pharmacist vaccination list (Schedule 3) or ideally broadening the language to allow "any routine immunization" to reduce the need for constant updates. Likewise, pharmacy technician scope of practice must be updated to permit administration of substances by injection/inhalation for the same range of vaccines. The College should also update its **Practice Policies** or Guidelines on Injection Administration to incorporate technicians. Clear guidance on supervision (e.g. a pharmacist must be physically present and available to assist the technician, one pharmacist can supervise X number of techs vaccinating simultaneously, etc.) should be provided. The regulatory changes should aim to be **future-proof** as much as possible – for instance, stating pharmacists can administer any vaccine that is part of Ontario's publicly funded immunization schedule or any vaccine for which an Rx would be valid, so that we don't require a new change every time a vaccine is added (like if a new adult vaccine is introduced in 2026, pharmacists should automatically be able to give it).

2. Training and Competency: While pharmacists and many technicians are already trained, the College may want to mandate, or at least encourage, some refresher training or certification verification for those who will provide the new vaccines. For example, if RSV vaccine for seniors is new, pharmacists should be aware of its indications and side effects. This can be handled via continuing education sessions. Pharmacy technicians who haven't yet taken the injection training course will need to do so before participating – OCP might coordinate with training providers to ensure the courses are available and cover all necessary content. Niagara's pharmacists can coordinate local training workshops if needed. Additionally, including techniques for different age groups (e.g., administering pertussis booster to a teenager vs. giving a vaccine to an infant, though infants likely remain with pediatricians) could be considered, but since pharmacists won't routinely vaccinate very young children under the current proposal, focus will be on adult and adolescent vaccine technique.

3. Documentation and Reporting: A critical aspect of vaccination is documenting doses given and informing the broader health system (family doctors, public health immunization registry) to keep records complete. Ontario has the Digital Health Immunization Repository (DHIR) linked with CANImmunize and such; ideally pharmacists should have a straightforward way to report administered vaccines into the provincial system. For flu and COVID, mechanisms were developed (e.g., real-time documentation via COVax system for COVID). For routine vaccines, perhaps integration with the provincial Panorama system or a similar immunization database should be implemented. If not integrated, pharmacists should ensure to notify family physicians when they give certain vaccines (through automated fax or secure messaging). The College might standardize a **vaccine record form** that pharmacists fill and offer to patients and/or send to the doctor. The Ministry should leverage existing tech: for example, the DHIR has a consumer-facing portal (Yellow Card online) – pharmacists could update that if given access. It would reduce duplication and help avoid scenarios where someone gets double-vaccinated or misses a dose because of miscommunication.

4. Logistics and Workflow: Pharmacies need to prepare for handling a larger variety of vaccines. This includes storage considerations (some vaccines like the new RSV or shingles need refrigeration between 2–8°C, which is standard, but space might be an issue if volume is large). Pharmacists might need to invest in larger or second fridges if expecting a lot of stock. They also must manage **cold chain** carefully – which they do already under public health guidelines. The Ministry and OCP should emphasize adherence to cold chain protocols, perhaps offering updated guidance for the new vaccines and what to do in case of excursions, etc., to ensure no potency loss.

The workflow for technicians administering will vary by store, but generally, the pharmacist will still oversee patient screening. In a busy pharmacy, they may need to schedule dedicated vaccine clinic times or have a float pharmacist if anticipating high demand (like in fall when flu, COVID boosters, and RSV for seniors may all coincide). Planning for potential **seasonal surges** is important – e.g., come autumn 2025, pharmacies might simultaneously be offering flu, COVID booster, RSV, etc. Are staffing plans in place? One suggestion is that the Ministry could consider grants or incentives for pharmacies that extend hours for immunization clinics or hold community outreach events, to encourage maximum uptake during those times.

5. Coordination with Public Health: Niagara Region Public Health and other local public health units should be looped in and actively coordinate with pharmacies. For example, if a new adult RSV vaccine campaign is launched, public health can help by directing eligible patients to pharmacies in addition to their clinics. Conversely, if pharmacies see trends (e.g., many adults coming in requesting a vaccine that isn't publicly funded yet), they can communicate that to public health to inform policy. Establishing a **liaison** or regular communication channel between pharmacy representatives (like PANP or pharmacy leaders) and public health immunization program managers in Niagara will smooth out any issues (like supply distribution, messaging alignment, etc.). Niagara public health already works with pharmacies for flu distribution; expanding that collaboration to other vaccines will be beneficial.

6. Public Communication and Confidence: Just as with minor ailments, a strong public information component is needed when vaccine scope expands. The Ministry of Health should update its materials (like the “fact sheet” on who can give what vaccines) to include pharmacists for the new ones. Public Health should announce that “You can get your pertussis or shingles shot at local pharmacies now” in their communications. A public awareness campaign highlighting the convenience of pharmacy vaccination for these additional diseases will drive uptake. It's also important to convey safety: some segments of the public may wonder “Is it okay to get these shots at a pharmacy instead of my doctor's office?” The answer is yes, and messaging should reinforce that pharmacists and technicians are highly trained in immunization and that the same safety and monitoring protocols are followed.

Sharing stories or testimonials could help – e.g., a Niagara senior who got their shingles vaccine at a pharmacy could talk about how easy and reassuring it was. Emphasizing how this saves time and protects them could motivate others. Visual materials (posters, social media) showing pharmacists vaccinating community members (with permission) might also normalize it.

7. Safety Monitoring: With more vaccines given in pharmacies, there should be a plan for **monitoring adverse events following immunization (AEFI)**. Pharmacists already are required to report any serious or unexpected AEFIs to the local medical officer of health. This will continue, and OCP should remind pharmacists of their reporting obligations for the new vaccines too. In Niagara, the public health unit typically collects AEFI reports and investigates. Pharmacists should ensure they have the forms and know the process. If an AEFI occurs at the pharmacy (like anaphylaxis, which is extremely rare), pharmacists and

techs are trained to handle it with epinephrine and call emergency services. The current requirements of observing patients ~15 minutes post-vaccination will continue for all vaccines (some might be 5 minutes for certain ones, but generally 15). The presence of trained technicians doesn't change that – they too can monitor, but a pharmacist should be on-site to handle any emergency.

One new aspect is if RSV or others are new, we may be on lookout for particular side effects patterns. Pharmacists should be updated on what to watch for (e.g., injection site reactions, etc.) and counsel patients appropriately so they know what's normal vs. not. For example, "If you experience a high fever after this vaccine, contact your doctor or us."

8. Alignment Across Practice Settings: Similar to minor ailments, consider hospital or clinic pharmacists. Hospital pharmacists sometimes run outpatient clinics (like for travel medicine or immunization of patients before certain therapies). If hospital policy allows, pharmacists in those settings should likewise be enabled to vaccinate without a physician order for these expanded categories. It might require hospital administrative changes or orders from their P&T committees, but aligning all practice settings ensures consistent application of scope. For instance, a pharmacist in an oncology clinic could directly give a pneumococcal vaccine to a chemo patient without needing an extra order if the regulations and hospital rules permit. That said, this may be beyond OCP's immediate purview but is worth encouraging through communication with hospital pharmacy leadership.

By addressing these implementation details, Ontario can ensure that expanded pharmacist vaccination authority is rolled out **safely, efficiently, and with maximum impact**. We must remember the lessons from previous expansions – it's crucial to prepare the operational side (training, reporting, supply) and inform the public, so that these new freedoms for pharmacists translate into tangible increases in immunization and improved public health outcomes.

Administration of Injectable Medications: Enhancing Treatment Accessibility

Case for Pharmacist Administration of Injectable Therapies (Buprenorphine and Beyond)

An important facet of the expanded scope proposal is to allow pharmacists to administer certain **injectable medications**, beyond just vaccines. The primary example cited is **injectable partial opioid agonists** like **buprenorphine (Sublocade®)** for opioid use disorder, but the broader goal is to include any appropriate medications (e.g., long-acting injectables for various conditions) that pharmacists could administer to patients. PANP strongly supports this move as it addresses critical gaps in patient care and aligns Ontario with best practices in other provinces.

Opioid Crisis and Buprenorphine Access: Ontario, including the Niagara region, continues to grapple with an opioid overdose crisis. Effective treatment for opioid use disorder (OUD), such as buprenorphine (a long-acting injectable form is available as **Sublocade®, given monthly**) can be life-saving by reducing cravings

and preventing withdrawal. However, access to Sublocade in practice has been limited – currently, it must be administered by a physician or nurse in a clinic setting. For many patients, especially those in smaller communities or with chaotic lifestyles, making it to a clinic every month is a barrier. Pharmacists, with their convenient locations and frequent patient interactions, are well-positioned to **bridge that gap**.

Notably, most provinces in Canada *already* allow pharmacists to inject medications like buprenorphine. According to OPA's findings, Ontario and Quebec are outliers in *not* permitting this ³⁶ ³. It means patients in Ontario might have to travel or face wait times for appointments that those in, say, Alberta or Nova Scotia do not. By authorizing pharmacists to administer Sublocade, Ontario can rapidly expand the number of access points for OUD treatment – potentially every pharmacy with an injection-trained pharmacist could become a site of administration. This is vital for Niagara, where opioid-related emergencies are high (with EMS responding to ~64 suspected overdoses per month in 2025 ⁴). We have communities like St. Catharines, Welland, and Niagara Falls where opioid addiction is a serious public health issue, but also smaller towns where there may be no nearby addiction clinic. A patient in Fort Erie, for example, might have to go to Niagara Falls to get their injection at a clinic now; if local pharmacists can administer it, that lowers a barrier and likely keeps more patients on therapy consistently.

Patient Outcomes: The benefits in outcomes from Sublocade are remarkable – a study showed patients on long-acting buprenorphine had significantly fewer overdose events than those on daily treatments ³⁷ ³⁸. In Timmins, Ontario, introducing rapid access to Sublocade in hospital led to a **30% drop in overdose deaths** and over 70% of those patients continuing treatment after discharge ³⁸ ³⁹. These numbers are compelling. If Niagara could replicate even a fraction of that success by making Sublocade more accessible through pharmacies, we could save lives in our community. Many pharmacists in Niagara have personally encountered customers struggling with opioid dependence (through methadone dispensing or naloxone kit distribution), and they are eager to play a bigger role in their recovery by administering maintenance treatments like buprenorphine injections.

Pharmacist Training and Capability: Pharmacists in Ontario already receive injection training that covers **intramuscular and subcutaneous injections**, and they regularly administer injections (flu shots are IM; insulin shots can be SC; travel vaccines can be either). Sublocade is given as a monthly subcutaneous abdominal injection. There is nothing technically novel or more difficult about administering Sublocade compared to, say, a depot contraceptive injection or a B12 shot, which pharmacists are allowed to give. As OPA noted, pharmacists' injection training covers the routes needed for buprenorphine ⁴⁰ ⁴¹. Therefore, pharmacists have the *skills* to do this safely, including the ability to manage any injection site reactions or adverse outcomes (which for buprenorphine are rare and usually mild; the main risk is perhaps injection site pain or a nodule).

Some pharmacists in Ontario have even found workarounds to help patients: a number of community pharmacists currently provide administration of Sublocade via medical directives or collaborative practice agreements with physicians ⁴². This shows both pharmacist willingness and a current inefficiency – they're doing it, but with extra red tape. Formally expanding the scope to allow it outright will cut that unnecessary administrative burden on both prescribers and pharmacists ⁴³ ⁴⁴. It legitimizes and standardizes the practice across the province. Additionally, allowing **pharmacy technicians** to inject (under supervision) as per earlier discussion could also apply here in the future to further scale capacity – for now, focusing on pharmacists is fine, but the principle of more hands available stands.

Better Use of Healthcare Resources: When pharmacists can handle the technical task of injection, it frees other healthcare providers to focus on tasks requiring their specific expertise. OPA pointed out that having pharmacists inject these medications **frees up physicians' time** – instead of a patient seeing a doctor each month solely for an injection, the patient could see the pharmacist, and the physician can use that appointment slot for something else ⁴⁵ ⁴⁶ . Given the shortage of family doctors and specialists, shifting such tasks to pharmacists is a smart reallocation of system resources. Niagara has addiction physicians and clinics that are very busy; if stable patients can pick up their dose at a pharmacy and get it injected there, it may reduce bottlenecks at the clinics and allow them to focus on initiating new patients or addressing complications.

Furthermore, many patients pick up their medications from pharmacies frequently anyway (e.g., daily methadone or weekly carries). Combining the medication dispensing with administration in one stop at the pharmacy is convenient for patients and potentially increases adherence. A patient is more likely to stay on Sublocade if it's easy to get – monthly at a nearby pharmacy – rather than if they have to, say, arrange a ride to a clinic far away.

Other Injectables: While buprenorphine is the highlighted example, expanding pharmacists' injection authority should eventually encompass other medications in **Schedule 1 of O. Reg. 256/24** (which lists drugs pharmacists can administer by injection/inhalation). Currently, that list contains things like vitamin B12, insulin, hepatitis B shots, etc., which pharmacists can administer thanks to a 2023 amendment. But it's a finite list and, similar to the earlier point about drug lists for minor ailments, it can cause delays in adopting new therapies. There are a growing number of **long-acting injectable drugs** for chronic conditions (like antipsychotics for schizophrenia, biologics for autoimmune conditions, hormone therapies, etc.) where having pharmacist administration could improve patient access. For example, a new injectable cholesterol medication **inclisiran** was approved by Health Canada, but if it's not on the allowed list, pharmacists can't give it. This exact concern was raised during the consultation: a pharmacist urged that inclisiran and other new injectables be added so patients aren't facing "unnecessary barriers to care". We agree – the regulatory framework should be updated to **either remove the specific drug list (preferred)** or swiftly expand it to include such medications. It appears OCP is considering removing the list of injectable substances altogether, which would allow pharmacists to administer any drug that is prescribed and appropriate, as long as they are trained. We support this removal of the list as it will future-proof the scope and put trust in professional judgment.

If the list is removed, naturally there will be some medications that are too complex or risky for community administration (maybe ones needing monitoring or infusions), but pharmacists can use discretion and guidelines can outline which are generally suitable. Many drugs are perfectly amenable to pharmacy administration: e.g., **Prolia (denosumab)** for osteoporosis – patients currently often go to a doctor's office for this injection every 6 months; pharmacists could easily handle that. Another example is **depot medroxyprogesterone** (birth control shot) – not on current list, but if allowed, pharmacists could provide it and counsel on it, improving contraceptive access. These are things our Niagara pharmacists would readily integrate into practice if permitted, which would benefit patients (no need to wait for a doctor's appointment just for a quick injection). It also aligns with what other provinces do.

Patient Safety and Monitoring: When expanding pharmacist injections, safety is paramount. But evidence shows pharmacists maintain high safety standards for injections. Adverse events are extremely rare and manageable. Pharmacists keep emergency kits and follow protocols just like any clinic would. Additionally, for something like Sublocade, pharmacists will work in collaboration with the prescribing physician – the

injection is just one component of OUD treatment, and pharmacists will communicate and ensure the patient is stable and due for the dose. If any issue arises (e.g., patient shows signs of relapse or problems), the pharmacist can loop in the physician. In fact, having pharmacists involved might enhance safety because patients are often more in touch with pharmacists day-to-day than with doctors; pharmacists might catch adherence issues or side effects promptly.

Given that pharmacists already administer injectable medications (like travel vaccines or B12) without issue, expanding to these other medications does not significantly increase risk. It mostly involves medications that are similarly well-tolerated when used appropriately. Another angle: by improving access to treatments like Sublocade, patient outcomes improve (less illicit opioid use, for example), which indirectly improves safety at a population level.

In conclusion, allowing pharmacists to administer injectable medications – starting with buprenorphine for OUD and extending to others – is a **logical and compassionate advancement** in scope. It will leverage pharmacists' skills to address urgent health crises (opioids), improve chronic disease management (via long-acting therapies), and align practice in Ontario with that of most other jurisdictions. The next step is to ensure the system is ready for this expansion (training, protocols, etc.), which we will discuss in subsequent sections on implementation.

Pharmacist and Technician Role Expansion for Injectable Therapies

To maximize the benefit of expanded injectable therapy administration, it's important to consider the roles of not just pharmacists but also **pharmacy technicians and intern pharmacists**. The scope proposal suggests including **registered pharmacy technicians and pharmacy interns** among those who can administer injections to patients. PANP supports this inclusive approach to expanding capacity, as it mirrors how we addressed vaccine delivery and acknowledges the evolving pharmacy workforce.

Role of Pharmacy Technicians: As discussed in the vaccination context, pharmacy technicians are trained healthcare professionals capable of performing technical tasks under supervision. They have already begun administering some injections (COVID-19, flu) with great success in Ontario. Extending their authority to include **all substances that pharmacists can inject** (which presumably would be all Schedule 1 drugs if the list is removed, or at least those on an updated list) will significantly amplify the pharmacy's ability to serve patients. Technicians can handle the physical administration while pharmacists oversee the clinical assessment and follow-up.

For example, imagine a patient coming to a pharmacy for a monthly antipsychotic injection (like a depot risperidone). Under expanded scope, the pharmacist would confirm the prescription, assess that the patient is ready and appropriate to receive the dose (no contraindications, due time, etc.), then a technician could prepare and administer the injection, with the pharmacist available for any clinical questions or issues. This division of labor allows the pharmacy to handle more such patients efficiently. In Niagara's context, where mental health resources are stretched, enabling technicians to help deliver treatments like this in pharmacies could reduce pressure on psychiatric clinics or home care nurses that currently often do these injections.

Pharmacy technicians often express a desire to work to their full scope. This expansion will increase job satisfaction and utilization of their skillset, helping with **workforce retention**. Given widespread pharmacist burnout, using technicians to their maximum can alleviate some burden on pharmacists (pharmacist can

supervise multiple injections at once if techs are giving them, etc.). It's analogous to how nurses support doctors; here, techs support pharmacists.

Role of Pharmacy Interns/Students: Pharmacy interns (graduates in training under supervision) are also mentioned. It makes sense that interns, who are essentially pharmacists-in-waiting, be allowed to administer injections as part of their experiential learning and work, with a supervising pharmacist present. Many interns already do give flu shots under supervision. Formalizing their authority ensures no legal ambiguity and encourages their training to include these clinical services. It also immediately adds to the pool of injectors in pharmacies during times like flu season – interns working part-time in a pharmacy can take on injection duties under the eye of the licensed pharmacist.

Supervision and Accountability: With more personnel involved, clear guidelines are needed. Typically, a pharmacist can only supervise a reasonable number of techs/interns giving injections at one time to ensure safety. Perhaps one pharmacist can supervise one or two techs simultaneously depending on layout and circumstances. The supervising pharmacist remains **accountable** for the overall care (i.e., verifying the right drug/dose, patient counseling, handling any adverse reactions). Technicians administering will likely need to sign documentation as well (so it's recorded who administered the dose) for clarity.

Training for Technicians/Interns: While many have training, OCP might require that any pharmacy technician who will inject must have completed an approved injection training program (which they instituted for the COVID pilot). That should continue. It might also be prudent to require current CPR/first aid for techs as well if that's not already mandated when they inject (pharmacists already must). Ensuring that interns and techs are properly prepared fosters confidence among the public and other health professionals about this expanded role.

Operational Considerations: When techs and interns are involved, pharmacies might need slight workflow adjustments. For example, if a tech is giving a buprenorphine injection, the pharmacist should have a quick pre-injection check with the patient (ensuring patient is appropriate at that moment, no last-minute issues) and maybe a post-injection follow-up. But the tech can handle the bulk of the procedure. It will be up to each pharmacy to implement processes where techs alert the pharmacist if anything seems off or if patient has questions outside the tech's scope.

Scope Boundaries: While expanding injection authority to techs, we should clarify if any injections are restricted to pharmacists only. For instance, in the early days of vaccination, some jurisdictions allowed techs for certain vaccines but not others. However, given techs are trained similarly for any injection, we see no need to carve out exceptions. If a tech can competently give a flu shot, they can give a B12 shot or even a Sublocade shot (under the pharmacist's direct supervision). What matters more is the pharmacist's involvement in clinical decisions around those injections. So we imagine the regulation would list techs alongside pharmacists for administering any substance by injection. This provides maximum flexibility to pharmacies to assign tasks based on staff availability and patient load.

Collaboration with Other Healthcare Providers: It is worth communicating to physicians and nurse practitioners that pharmacy technicians (and interns) will be part of the injection workforce in pharmacies. Some prescribers may not be familiar with the role of a pharmacy tech, and might wonder who gave the injection if they see documentation. We should reassure them through outreach that any injection by a tech is done under a pharmacist's supervision and that pharmacists remain the point of contact for any clinical

discussion. Over time, as this becomes routine, it will be accepted just as nurses giving vaccines under doctor orders is accepted.

Workforce and Workflow Example: Consider a Niagara Falls pharmacy on a Monday morning: A patient comes in for their routine **Prolia** shot for osteoporosis, another arrives for a **vitamin B12** injection, and a third – a new OUD patient – is scheduled for their first Sublocade injection after induction on sublingual buprenorphine. With expanded scope, the pharmacist can handle the evaluation and clinical decision-making for all three, while a trained pharmacy technician can administer the B12 and Prolia concurrently in separate consultation rooms, and the pharmacist dedicates more time to the Sublocade patient (as it might involve more counseling and careful injection technique for the first time). If necessary, the pharmacist can directly handle Sublocade while overseeing the techs on the others, stepping in if needed. All three patients are thus served promptly and safely within a short timeframe, which would have been difficult or impossible if only one pharmacist could do all three in sequence. This efficiency benefits patient satisfaction as well.

Overall, expanding injection authority to pharmacy technicians and interns complements pharmacist scope expansion by ensuring the pharmacy **team** as a whole can deliver care effectively. It increases service capacity, particularly as more patients come to rely on pharmacies for injections. With proper training, supervision, and protocols, this team-based approach will enhance access without compromising safety or quality.

Financial Sustainability of Injection Services and Removing Barriers

Implementing the expansion of pharmacists' injectable therapy services requires attention to **financial sustainability** and elimination of any regulatory or systemic barriers that could hinder success. We address these aspects as follows:

Public Funding for Injection Services: At present, many clinical injection services provided in pharmacies (aside from vaccines) are **unfunded** by the public system. For example, if a pharmacist administers a B12 shot or a hepatitis B shot, they often charge the patient an injection fee because there's no OHIP code for it. Similarly, for something like Sublocade, currently pharmacists (if doing via medical directive) might bill the patient or an insurance if possible, since it's not a standard insured service in a pharmacy. This can create inequity – some patients can pay a fee, others cannot. We must avoid a scenario where only wealthier or insured patients benefit from pharmacists' expanded injection services, while others are left out due to cost.

PANP echoes OPA's recommendation that Ontario should establish a **publicly funded remuneration framework for pharmacist injection services**. In fact, OPA pointed out that Ontario is behind other provinces: five provinces currently provide public funding for some/all pharmacy injection services. Ontario should join them. Concretely, we suggest that an OHIP billing code or a similar mechanism be created for a "Pharmacy Injection Administration Fee" for medications (non-vaccine) administered by pharmacists. OPA proposed a fee of around **\$20 per injection** as reasonable compensation, referencing that Nova Scotia's pharmacy primary care clinics found ~14 minutes of pharmacy time per basic injection. A \$20 fee would cover the pharmacist's time for assessment, administration, documentation, and follow-up. It also signals that the service is part of the publicly insured basket of services, so pharmacists could advertise it as OHIP-covered, which would encourage uptake by patients who need it.

Equally important, public funding prevents a **two-tiered system** wherein patients who can't afford a private fee skip the service and possibly go without medication or rely on more costly alternatives (like going to an ER for an injection if they can't get it at a clinic). For example, a patient who can't pay a pharmacy injection fee for an antipsychotic might instead have to get a nurse injection visit arranged via the healthcare system at a greater overall system cost or they might miss doses. Public funding ensures *all* patients have access to the convenience of pharmacy injections, not just those who can pay. It promotes equity, which aligns with the government's goal of improving access for all.

Insurance Coverage and Billing: In absence of immediate OHIP coverage, many pharmacists currently rely on patient benefits or charge out-of-pocket. Some private insurers do cover pharmacist injection fees (especially those that started to during COVID for vaccines). We anticipate that if scope expands, private insurers might follow suit for things like allergy shots or B12 that their plans cover physician injection fees for. However, insurer coverage is variable and not guaranteed for all. Thus the push for OHIP is key. Meanwhile, in the short term, we can encourage insurers to treat pharmacist-administered injection claims similar to nurse/physician claims, so there's at least broad coverage in the interim.

Economic Case: It's worth reinforcing to policymakers that funding pharmacist injection services can be cost-saving or cost-neutral because it may shift or reduce costs elsewhere. For instance, one reason OPA recommended a \$20 fee for each injectable substance was that it's comparable to fees in other provinces like Alberta (\$20) and much lower than potential costs of alternate routes (like a home care nursing visit is more expensive, or patient complications if injection therapies are not adhered to). Also, by investing in these services, Ontario avoids the "two-tier" risk OPA highlighted, where those who can't pay a private fee might forego treatment. That could lead to bigger downstream costs (e.g., untreated opioid addiction leading to overdose, or untreated schizophrenia leading to hospitalization). So, there is a strong cost-benefit argument: a modest fee per injection to pharmacies can prevent much costlier outcomes.

Removing the Injectable Substances List: As noted, one barrier in current regulation is the enumerated list of drugs pharmacists can inject (Schedule 1 in O. Reg. 256/24). We support **removing or broadening this list** in the regulation. Instead of trying to list every medication, the regulation could simply empower pharmacists (and techs under supervision) to inject any medication that a patient has a valid prescription for, provided it is in the patient's best interest and within the pharmacist's competency to administer. This puts Ontario in line with provinces like Saskatchewan, which doesn't strictly list every drug but allows for clinical judgment. As an intermediate step, if the list isn't removed entirely, then promptly update it to include known high-need items like inclisiran, TB tests (the intradermal PPD test), etc., and include a mechanism (like giving OCP the power to add items by policy rather than needing a regulation change each time). A **flexible regulatory approach** will ensure pharmacists can immediately start providing injections for any new therapies that come along. Given how quickly new biologic drugs and depot formulations are emerging, a static list in law is not practical.

Interprofessional Relations and Liability: Some physicians or nurses might initially have reservations about pharmacists injecting medications like buprenorphine or others that traditionally were their domain. To ease this, we should clarify that the pharmacist's expansion is **collaborative, not competitive** – it's about increasing patient access. In fact, having pharmacists take on these tasks can lighten other providers' load, as discussed. Liability-wise, pharmacists already carry malpractice insurance and are accountable for the tasks they perform. There may be some need to clarify to prescribers that when they prescribe a drug, if a pharmacist is administering, the pharmacist assumes liability for the administration technique etc., as with vaccines. Possibly, some formal guidance on shared care responsibilities could reassure everyone.

Experience from other provinces suggests this has not been a major issue, but open communication channels (like notifying prescribers when an injection has been given, any issues, etc.) will maintain trust.

Pilot Programs and Phased Rollout: One way to demonstrate the value and refine the process could be to pilot the pharmacist administration of buprenorphine injections in a few key communities (maybe ones hit hard by opioid crisis like Niagara, Thunder Bay, etc.) if there's any hesitation. However, given pharmacists elsewhere are doing it, a pilot may not even be necessary beyond what's already informally happening. Still, the Ministry might gather data from an initial phase to evaluate outcomes (e.g., did more patients initiate Sublocade when pharmacists could give it? Did adherence improve? Overdose rates change?). Having metrics will help secure ongoing funding.

Supporting Infrastructure: If new billing codes or funding programs are created, ensure pharmacists are informed on how to use them. On a technical note, pharmacists may need to have their software updated or access to billing through OHIP systems (not all pharmacies bill OHIP for services besides meds currently, but they do for minor ailments now, so that infrastructure exists). Ensuring that any injection fees can be claimed easily (like through the HNS system that minor ailment claims use) will make adoption high. If it's too cumbersome, some might not bother to claim, which undermines viability.

Patient Willingness: From a patient perspective, if injection services at pharmacies are publicly funded (or at least widely covered), they'll be much more willing to utilize them. Imagine telling a patient, "You can get your monthly injection at our pharmacy, and it's covered by OHIP, so no cost to you." That's an easy sell. Versus, "You can get it here but there's a \$30 fee," – some will hesitate or decline. We want to minimize such deterrents to achieve the public health aims. And as OPA described, without funding, you risk a **"two-tiered system"** where those who can afford pay for convenience and those who cannot have to pursue less convenient or no treatment. That's not equitable health care.

Outreach and Awareness to Maximize Use: To make injection services sustainable, pharmacists need sufficient patient volume using them (so that funding covers costs and justifies the service operationally). Part of this will involve raising awareness among patients and prescribers that these services are available. If public funding is in place, it should be advertised in public health communications, and prescribers should be encouraged to utilize pharmacist administration for appropriate patients. E.g., an addictions doctor in Niagara might be more inclined to start patients on Sublocade if they know local pharmacies can administer it (and that it's easy to arrange). Similarly, family doctors could refer patients to pharmacists for injections like Prolia or vitamin D injections. This collaborative referral can help drive volume to pharmacies, making the service more entrenched.

In conclusion, addressing **financial sustainability** through public funding and slashing regulatory red tape (like fixed drug lists) will be vital to realize the potential of expanded pharmacist injection services. Ontario should view this not as an added cost, but as a strategic investment that improves care and likely yields savings by preventing costly healthcare usage and optimizing use of clinician time. Removing barriers and incentivizing use will ensure pharmacists can integrate these services smoothly and broadly, for the benefit of patients and the system.

(Next, we will examine the expansion of pharmacists' authority in laboratory testing and point-of-care testing, which complements the prescribing expansions by enabling pharmacists to gather more clinical data for decision-making.)

Enabling Laboratory and Point-of-Care Testing: Improving Diagnostic Support in Pharmacy Practice

Rationale and Readiness for Pharmacist-Led Lab Testing and POCT

An exciting area of expanded scope is authorizing pharmacists to **order laboratory tests** and to perform additional **point-of-care tests (POCTs)** to aid in clinical assessment and monitoring. This change is crucial to empowering pharmacists to fully manage certain conditions and to integrate more deeply into the healthcare diagnostic process. It addresses a current gap where pharmacists might suspect a condition or need a lab value but cannot directly obtain it. PANP strongly advocates for this expansion, given both the readiness of pharmacists to take it on and the clear benefits to patient care, particularly in timely diagnosis and treatment initiation.

Current Limitations: As it stands, Ontario pharmacists are not permitted to order lab tests like blood work or imaging. This is a significant limitation compared to other provinces – in fact, Ontario is one of only two provinces where pharmacists *lack* lab ordering authority. All other provinces either have granted this authority or are moving toward it, recognizing its value. Similarly, while pharmacists can do some POCT (e.g., blood glucose or cholesterol under certain programs, COVID rapid tests as recently allowed), their POCT scope is not explicitly broad.

Consider a scenario: a pharmacist is assessing a patient for a minor ailment, say **strep throat (acute pharyngitis)**. The gold standard for confirming a strep infection is a rapid antigen detection test (RADT) or culture. Without lab/POCT authority, a pharmacist in Ontario currently must either just treat empirically based on symptoms (which is not ideal since many sore throats are viral) or send the patient to a doctor or ER for a swab – which defeats the purpose of accessible care. Enabling pharmacists to **perform a throat swab POCT** in the pharmacy would allow them to make a more accurate diagnosis and only prescribe antibiotics when needed (and evidence shows this yields system savings by avoiding unnecessary antibiotics ⁴⁷).

Similarly, for chronic disease management or medication monitoring, pharmacists often need lab values. For instance, managing a patient on warfarin, a pharmacist would benefit from being able to order an INR blood test rather than asking the doctor to do it and waiting for results to be faxed back.

Pharmacists are indeed **ready and capable** of taking on lab testing roles. Their education includes understanding lab test indications, interpretation of common lab results, and applying results to patient management. Many pharmacists have already participated in collaborative care models where they indirectly access lab data (e.g., in hospital or primary care team settings, or through patients bringing lab results). Community pharmacists can view some patient lab data via clinical viewers (like OLIS – Ontario Laboratory Information System) if they have access or via the Digital Health Drug/Drug-Lab integration projects. So, conceptually, pharmacists dealing with lab info is not new. What's new is giving them the **agency to order** these tests when needed.

Point-of-Care Testing (POCT) Readiness: Pharmacists have been performing some POCT for years – the most common being blood glucose and lipid testing at pharmacy clinics, A1C tests for diabetes, and more recently, **COVID-19 rapid antigen and PCR tests** in pharmacies. They have proven they can meet quality standards doing these tests. Pharmacies have the infrastructure (private space, some have CLIA-waived

devices, etc.) and follow proper procedures (sanitation, calibration, documentation). For example, during the pandemic, many Niagara pharmacies became go-to places for rapid COVID testing for travel or work, reliably delivering results and reporting positives to public health as required. This experience has made both pharmacists and the public comfortable with pharmacies as sites for testing.

Scope of Potential Tests: The OCP and OPA have identified various tests that would be useful for pharmacists to do or order. For minor ailments specifically, OPA enumerated tests corresponding to the 14 new ailments (like throat swabs for pharyngitis, urine dipstick or culture for UTIs, potassium hydroxide skin prep for fungal infections, etc.). OPA agreed with OCP's recommendations for these tests. If pharmacists can either perform a POCT or send the patient to lab with an order for these tests, the accuracy of minor ailment prescribing will improve. For chronic disease, tests like A1C for diabetes, INR for anticoagulation, cholesterol panels for cardiovascular risk, or liver/kidney function for medication monitoring are key examples pharmacists could order in appropriate contexts (e.g., if managing a diabetic's medication adjustments or monitoring for a drug's toxicity).

Benefits of Lab/POCT Authority: By having this authority, pharmacists can **deliver more comprehensive care**. It essentially closes the loop where currently they might have to refer out just for a test then have the patient come back. Eliminating that bounce improves efficiency and patient experience. It also enhances patient safety – for instance, if a pharmacist suspects a patient's cough might be pneumonia, the ability to order a chest X-ray or CRP test (if that became feasible via lab) could lead to earlier identification and treatment, or conversely, avoid unnecessary antibiotics if the test is negative for bacterial infection.

From the perspective of Niagara's healthcare system, pharmacist-led testing can help **offload primary care**. Family doctors often do routine labs that take up appointments; if appropriate, pharmacists could handle some of those (with results forwarded to the family doctor as well). It also can **reduce ER visits**: for example, a patient with a mild chest infection could get a pharmacy CRP test or chest X-ray order rather than going to the ER for immediate evaluation if not severe, etc. Not that pharmacists would manage all such cases, but in borderline or follow-up scenarios this could apply.

Pharmacists' involvement in testing can also support public health surveillance. If pharmacists do strep tests, they can feed data on positive rates to public health systems. During flu season, if pharmacists run flu POCT, they can report incidence data quickly. The more distributed the testing network, the more robust our data on community illnesses, which was seen with the COVID pharmacy testing expansion.

Confidence and Controls: It's natural to consider if pharmacists will order tests responsibly. Evidence from jurisdictions like Alberta (where pharmacists can order labs) suggests they do so judiciously. Pharmacists are not going to over-order expensive tests because generally there's no financial incentive or culture of doing so – they'll order what's needed for care decisions. They also often have in mind cost to the system and patient; for instance, a pharmacist might choose a POCT in-pharmacy (perhaps at a small cost) vs a full lab if it's sufficient, to save the patient a trip and the system money. Moreover, OCP can issue guidance or criteria for certain test ordering if needed to ensure appropriateness.

Technological Integration: A big part of readiness is having access to test results. Ordering is moot if pharmacists can't see results. Therefore, integration with electronic lab systems is important. As Ontario modernizes health records, pharmacists should be given access to OLIS (Lab Information System) where they can see results of tests they ordered (and others in the record). Many hospital pharmacists and some community pharmacists in integrated settings already have OLIS access. Extending that to all pharmacists

(under proper privacy and training) is necessary. I believe currently community pharmacists can access OLIS through clinical viewers if they have a connection via a connected care program, but not all do. The Ministry should ensure that by the time pharmacists start ordering labs, they have straightforward access to those results electronically. It's not efficient to rely on fax.

Equipment and Training for POCT: For POCT, pharmacists may need to invest in certain devices (like a strep test kit, a small CBC device if one becomes available, etc.). Many already have blood glucose and lipid testing kits. Vendors would likely see a market and provide pharmacies with the needed equipment (some chain pharmacies might centrally procure and deploy them). Training to use new devices (like a molecular strep tester) would be provided by either the vendor or through CE. Pharmacists are adept at adopting new devices – during COVID, they took on nasopharyngeal swabbing with short training and used ID NOW or other PCR machines where provided. Quality assurance would be important (calibration, proficiency testing), and pharmacies can partake in existing QC programs or manufacturer recommendations.

Collaboration with Labs and Physicians: In implementing lab ordering, collaboration will be key. For example, LifeLabs or other diagnostic companies might need to be ready to accept lab requisitions signed by pharmacists. The Ministry should update the Laboratory and Specimen Collection Centre Licensing Act regulations to list pharmacists as authorized prescribers of lab tests. Similarly, radiology/imaging might not be part of initial scope but eventually could be considered (like pharmacists in some places can order an x-ray for certain conditions; the Ontario proposal mentions diagnostic imaging expansion for other professions but not yet pharmacists, so one step at a time). For whatever is allowed, coordination with those services is needed so they don't reject an order from a pharmacist due to outdated understanding.

Physicians should be looped in so they understand pharmacists may order labs to manage minor ailments or med monitoring. Ideally, the results should be shared with the patient's primary provider (with patient consent, which should be assumed for continuity). This fosters a **team approach**. For instance, if a pharmacist orders a UTI culture that comes back with a resistant organism, they might refer the patient to a doctor for further management if needed; the doctor should be able to see that culture result and know the pharmacist was involved.

Economic Aspects: Some labs might wonder about increased utilization. However, studies from other provinces have not shown a large surge in lab tests due to pharmacists. In minor ailments context, it might actually be substitutional – rather than a doctor ordering the test, the pharmacist does, so volume is similar. Also, with POCT, some tests might shift from lab to at-pharmacy quick tests, possibly reducing lab load for simple things. That being said, funding for lab tests comes from public funds (OHIP for labs). There might need to be a funding envelope or agreement that covers pharmacist-ordered tests. If a pharmacist orders a lab test under OHIP, currently that might not be paid because OHIP only recognizes physician or NP orders. So that system must be updated to pay labs for tests ordered by pharmacists. This is a policy change but doable – similar changes have been made when midwives or other practitioners got test ordering rights.

In conclusion, Ontario pharmacists are **ready** to incorporate lab tests and POCT into their practice. They have the knowledge, and many have practical experience from the pandemic or collaborative roles. The current limitation is solely regulatory. Lifting it will equip pharmacists with important tools to provide **more comprehensive, accurate, and timely care**, which will benefit patients through faster diagnoses and appropriate therapy, and help the system by easing load on other channels. The next section will detail the benefits and outcomes we anticipate from this change.

Benefits of Pharmacist-Ordered Testing for Patients and the Health System

Granting pharmacists the authority to order and conduct certain tests will confer numerous benefits, ranging from individual patient care improvements to broader system efficiencies. Below, we outline how these benefits manifest, with relevant data and examples:

1. Faster Diagnosis and Treatment: When pharmacists can directly obtain needed test results, patients can often get a **diagnosis in a single encounter**, rather than being shuttled between providers. This speed is crucial in acute minor ailments. For example, a patient with a sore throat can have a **pharmacy-run strep throat test** and know within minutes if they need antibiotics. If positive, the pharmacist can prescribe penicillin right then; if negative, they spare the patient unnecessary antibiotics and instead give advice for viral pharyngitis. This immediate test-and-treat model improves patient satisfaction (they leave with an answer and plan) and can shorten illness duration by prompt therapy. Studies support that such a model is effective: a Canadian analysis of pharmacy-based strep testing predicted Ontario could save **\$607,000-1,214,500** annually in health costs by avoiding doctor visits and ensuring proper antibiotic use. More importantly, from the patient perspective, it means less time feeling ill or contagious.

In chronic disease management, having pharmacists able to check labs means **therapy can be optimized more quickly**. For instance, a pharmacist adjusting a diabetic's insulin could order an A1C after a few months to gauge improvement and fine-tune dosing. Without that, the pharmacist might have to wait for the doctor to do it at next appointment (perhaps months later) or adjust blindly. Empirical evidence from Alberta suggests pharmacist involvement in ordering A1Cs led to better glycemic control as they could respond to results in real-time.

2. Improved Appropriateness of Therapy: By confirming diagnoses or monitoring therapy with lab data, pharmacists can ensure **more appropriate use of medications**. This improves patient outcomes and reduces waste/side effects. For instance, consider **UTIs**: up to now, Ontario pharmacists prescribing for UTIs do so based on symptoms and possibly dipstick if the patient has one. If pharmacists could order a urine culture when needed (like if it's a recurrent UTI or unusual presentation), they could tailor antibiotic choice to the culture result (or decide not to treat if culture shows contamination or no significant growth). This ensures the right antibiotic is used – which is good for the patient (higher cure rate) and for antimicrobial stewardship (reducing misuse). Cost-utility models have shown that pharmacist management of UTIs in Canada, even without lab authority, was cost-effective. Adding lab confirmation likely further enhances cost-effectiveness by preventing treatment failures or complications.

Similarly, in minor dermatological ailments, a pharmacist could do a KOH fungal microscopy or skin culture for a rash if uncertain. That might differentiate between eczema (needing steroid) and fungal infection (needing antifungal), avoiding a trial-and-error that could waste time or worsen a condition. The OCP had recommended specific tests for each proposed minor ailment, which implies that enabling those tests will make pharmacist decisions **evidence-based and accurate**. Accurate diagnosis leads to appropriate therapy, which means better outcomes and fewer follow-ups or complications.

3. Reduction in Duplicative Services and System Load: When pharmacists can manage more of a patient's episode of care including testing, it potentially reduces **duplicate visits and tests**. For instance, if a pharmacist orders a lab test that otherwise a physician would have, it's a shift rather than duplication, and possibly with fewer visits overall. A patient might avoid an extra doctor visit if the pharmacist can both test

and treat. This has a ripple effect: fewer walk-in clinic visits for simple test orders, fewer ER visits for things that could be confirmed in pharmacy.

In our local Niagara context, we've seen pressure on urgent care centres and family doctors for relatively minor testing needs (e.g., a simple UTI test or INR check). If patients know they can have these done at their pharmacy, it could offload dozens or hundreds of visits per week across the region. Our urgent care centres often see lines of patients who primarily need something like a strep test or a UTI check – tasks which could be diverted to pharmacies, leaving urgent care for more complex issues.

4. Cost Savings and Economic Benefits: As touched on, by reducing unnecessary physician or ER utilization and improving prescribing accuracy, pharmacist-led testing yields **cost savings**. For example, one study in *Canadian Pharmacists Journal* found that if pharmacists in community could perform strep testing and treat accordingly, the system could save money by avoiding complications from untreated strep or inappropriate antibiotics for viral infections ⁴⁷ (Lathia et al. 2018). Similarly, consider warfarin management: if pharmacists can do INR checks and adjust dosing in pharmacy, it might reduce severe out-of-range INR events that cause hospitalizations (bleeding or clotting episodes), which are costly. The U.K. has pharmacist-run anticoagulation clinics that have demonstrated high control rates and fewer adverse events, which equate to cost savings for the health system. We could emulate that in community pharmacies with testing ability.

Pharmacist-led management of conditions including testing has also been shown to reduce **employer costs and productivity losses**, as patients get care quicker and get back to normal life sooner. For instance, quicker strep treatment means fewer days off work. While these indirect economic benefits are harder to measure, they are meaningful at scale.

5. Enhanced Continuity and Integration of Care: When pharmacists have access to lab results, they become more integrated into the patient's continuous care loop. They can act upon results and also communicate them to others (e.g., if a pharmacist orders a cholesterol test and sees it's very high, they can both address it by starting or adjusting therapy and inform the patient's physician to ensure everyone's aware of this risk factor). This creates a **safety net** where it's less likely abnormal results fall through cracks. It also fosters a culture of teamwork – a physician might trust that the pharmacist will follow up on labs they ordered. Over time, this can lighten the physician's panel management burden; they know, for example, their diabetic patients who mainly go to the pharmacy are being regularly monitored and managed.

6. Better Chronic Disease Outcomes: There's evidence from pharmacist clinics and trials that giving pharmacists more autonomy including lab ordering leads to improved chronic disease markers. For example, the IMPACT study in Ontario (2009) in family health teams showed pharmacists ordering labs and adjusting therapy significantly improved cholesterol and blood pressure management in patients with diabetes ⁴⁸. More recently, in Alberta's community pharmacy chronic disease management programs, pharmacist ability to order A1C and adjust diabetes meds has been linked with improved A1C control at follow-up. These improvements in intermediate outcomes (like A1C, blood pressure, cholesterol) are proxies for reducing long-term complications like heart attacks, strokes, and so on. Thus, pharmacist lab authority can indirectly contribute to **lower rates of complications** and hospitalizations for chronic illness.

7. Increased Patient Trust and Utilization of Pharmacy Services: As pharmacists take on more diagnostic roles, public perception of pharmacists as healthcare providers is elevated. Patients begin to see the pharmacy as a one-stop shop for many healthcare needs, which improves their healthcare-seeking

behavior. Anecdotally, when pharmacies started offering A1C tests or flu tests, patients appreciated the convenience and often engaged more with the pharmacy for other healthcare advice too. This trust and frequent engagement can lead to better overall health management, as pharmacists can catch drug therapy problems or counsel on lifestyle more often when they see patients for tests.

8. Public Health Surveillance and Response: Pharmacist involvement in POCT has ancillary benefits for public health data. As we incorporate pharmacists' testing into reporting systems, health authorities get a more comprehensive picture of, say, strep throat prevalence or flu positivity in the community. During COVID, pharmacy antigen test data was limited but some PCR tests were integrated. For future or ongoing infectious disease monitoring, pharmacies could act as sentinel surveillance sites. For example, if pharmacists start doing Group A strep POCT widely, spikes in positives could alert health officials to potential outbreaks or antibiotic resistance patterns faster than before. Pharmacists could also assist in outbreak control – e.g., testing close contacts for certain infections promptly.

9. Empowering Patient Self-Management: When pharmacists order labs, they often take the time to explain results to patients and involve them in care planning. For instance, if a patient's lipid panel comes back high, the pharmacist might discuss diet changes in addition to medication. This education at the point of care encourages patients to take ownership of their health measures. Patients seeing improvements in lab values under pharmacist guidance (like A1C going down) may feel more motivated to continue those good behaviors, reinforcing positive feedback loops.

In summary, allowing pharmacists to harness diagnostic tools stands to significantly **improve healthcare quality and efficiency**. It leads to quicker, more accurate care for acute issues, better management of chronic conditions, prevention of complications, and more prudent resource use. Niagara residents, in particular, will benefit from the convenience and thoroughness of having their pharmacists able to test and monitor aspects of their health. For the local system, it could mean freed-up capacity in clinics and more stable management of prevalent issues like diabetes and heart disease, which are noted to be at higher rates in Niagara than provincial average ⁴⁹. These outcomes align with the government's goals of a more **integrated, efficient health system** that leverages all providers' skills – pharmacists ordering lab tests is a key piece of that integration puzzle that Ontario has been missing but is now poised to implement.

Implementation Considerations for Lab and POCT Expansion

Introducing lab test ordering and expanded POCT into pharmacy practice will require thoughtful implementation to ensure effectiveness and smooth integration with existing healthcare processes. Here are key considerations and steps for making this a success:

1. Defining the Scope of Tests: The Ministry and OCP will likely delineate which laboratory tests and POCT pharmacists are authorized to order or perform. It may start with a list (e.g., tests relevant to minor ailments: throat swabs, urine cultures, etc., plus common chronic disease labs). PANP recommends a broad approach but phased if needed. Initially, a focus on tests supporting minor ailments and medication management could be appropriate – such as: - Microbiology tests: throat swab RADT, urine dipstick and culture, wound swabs for minor infections, etc. - Common blood tests: A1C, fasting glucose, lipid panel, INR, CBC and basic chemistries if monitoring certain meds, CRP for infections (some countries use pharmacist CRP POCT for distinguishing bacterial vs viral infection in primary care), TSH for adjusting hypothyroid meds, etc. - Diagnostic imaging is not likely included at first (as government proposals didn't mention pharmacists for imaging yet), so we can exclude that for now.

Over time, the scope can widen based on demonstrated competence and needs.

2. Regulatory and Legal Adjustments: Amendments are needed to legislation/regulations to recognize pharmacists as authorized to order lab tests (so labs get paid) and to perform certain controlled acts in testing (for example, taking a throat swab or finger prick is generally fine, but taking a blood draw from a vein is a controlled act of phlebotomy – pharmacists will probably not do venipuncture themselves in community, rather they'd give patient a requisition to go to a lab). So, likely pharmacists will do point-of-care fingerstick tests (e.g., glucometer) but not full blood draws. If at some point they might do certain sample collections (like a throat swab or nasal swab), that might require an exemption or listing in the regulation as allowed for pharmacists.

Also, OCP should update practice standards to include guidance on lab ordering – including documenting rationale for tests, communicating results to patients and other providers, and follow-up responsibilities.

3. Integration with Lab Systems: A crucial piece is enabling pharmacists to use provincial lab ordering and result systems. Ideally, pharmacists would have access to electronic lab ordering platforms (like the systems doctors use to send orders electronically to labs). If electronic integration isn't immediate, a paper/fax requisition that labs accept would suffice initially. OCP and the lab licensing authority (Ontario's Lab Accreditation body) should collaborate to update lab requisition forms or electronic portals to include "Pharmacist" as a practitioner type. Each pharmacist would need some identifier (likely their license number) on the requisition for traceability.

For results, **ensuring pharmacists can receive results promptly** is vital. It might be via fax initially, or if integrated, via the same digital health record the pharmacist can view. The best scenario is pharmacists get connected to Ontario's eHealth Viewer or any future single patient record system. Perhaps give them access to Health Report Manager or other systems so labs can route results to them electronically.

4. Billing and Remuneration: When pharmacists order lab tests, the lab needs to get paid. Under OHIP, labs are paid per test done, billed through OHIP with the ordering practitioner's billing number or identifier. If pharmacists become recognized practitioners, they might need to get an OHIP billing number (like how NPs have one). Alternatively, the lab claim could just use a generic code indicating a pharmacist order. The Ministry must clarify this so labs aren't left in confusion. Labs might be concerned about increased volume – but if tests are clinically justified, that's part of primary care cost. Possibly budget reallocation from other services (like fewer doctor visits might offset lab costs, etc.) will cover this.

Also, if pharmacists perform the test themselves (POCT in pharmacy), in some cases they might charge for that service. For example, currently some pharmacies offer A1C tests privately for a fee. If the province wants to formalize POCT in pharmacy as part of funded care for certain things (like a strep test for minor ailment prescribing), they might consider covering that similarly to how they cover assessment fees. In Saskatchewan, for instance, the government covers pharmacists for conducting strep tests as part of their minor ailment program. Ontario could add a small fee for performing certain POCT (like \$10 for doing a strep test), which would be a **wise investment** given the overall savings. If not initially, maybe pilot it via a program or have patients pay but ideally reimburse them through drug plans or so.

5. Training and Quality Assurance: Pharmacists will need continuing education on lab test ordering and interpretation to ensure competency. Many pharmacists already have a good baseline from their education and any added certifications (like Certified Diabetes Educators are used to ordering/reading labs in

collaboration). But OCP could roll out some training modules focusing on how to integrate lab tests into practice appropriately, case studies on using lab results for decision-making, etc.

For POCT, ensure pharmacists and technicians performing tests are trained on that device. They should follow the manufacturer's quality control schedule, maintain logs, and participate in proficiency testing if available (some jurisdictions have pharmacy POCT quality programs; Ontario could adopt guidelines from, say, the Institute for Quality Management in Healthcare (IQMH) which oversees lab quality in Ontario, to extend to pharmacy settings).

6. Protocols for Abnormal Results: Implementing lab authority means pharmacists must have protocols for handling results, especially significantly abnormal ones. For example, if a pharmacist orders a CBC and it comes back with critically low hemoglobin, they should have a process: contact the patient, refer to ER or physician as needed, etc. Similarly, any critical lab values labs usually flag (like high potassium, etc.) – labs might need to know to also call the pharmacist if they would normally call a doctor for a critical result. This requires listing pharmacist contact info clearly on requisitions and maybe educating labs that yes, they should reach out to the pharmacist in those cases. OCP can provide pharmacists with guidelines on when to urgently refer based on certain lab findings.

7. Collaboration and Communication with Physicians: Rolling this out smoothly will require messaging to physicians that pharmacist lab ordering is to complement care, not to cut them out. Encouraging communication is key. For example, a best practice could be: whenever a pharmacist orders a lab test on a patient who has a primary provider, they could send a courtesy notification to that provider (if patient consents) like "Your patient Jane Doe had an A1C test today ordered by Pharmacist X as part of diabetes medication management. Result was Y." This might be laborious if done manually, but even periodic summary updates or co-managing via shared EMR in FHT settings can work. Over time, trust builds and providers will be fine with it, especially if they see improved outcomes and less workload on them.

8. IT and Workflow in Pharmacy: Pharmacies will need to adapt workflows. Possibly designating someone to manage incoming lab results (like check fax daily or web portal) and flagging the pharmacist for review. Documenting results in the pharmacy's patient profile systems is crucial (so that information is on hand for future decisions). Pharmacy software vendors might enhance their systems to have a lab results module for pharmacists to input or receive data, which would be great.

For POCT, pharmacies should allocate space and time for performing tests. For instance, a throat swab POCT might require a 10-minute consult slot. Workflows might combine that with the prescribing service seamlessly: schedule a minor ailment assessment with an extra few minutes for performing the test within it.

9. Privacy and Data Management: Handling lab results means handling sensitive personal health information. Pharmacists are already health information custodians under PHIPA and used to confidentiality. But they should ensure things like lab faxes aren't left in open view, results are stored securely, etc. If using electronic systems, maintain proper login security. Possibly OCP might suggest that pharmacists keep lab requisitions and results on file for a certain period as part of patient records, just as doctors do. All that is within normal practice but should be underscored.

10. Gradual Rollout and Evaluation: It might be prudent to implement lab ordering in phases – e.g., start with a select set of tests, gather data on usage and outcomes, then expand. Or possibly pilot in certain

pharmacy settings like those integrated in Family Health Teams to iron out the process, then roll to all community pharmacies. However, given other provinces have done it, Ontario can learn from them and possibly skip lengthy pilots. But an evaluation plan would be wise: track how often pharmacists order labs, which tests, results (maybe), interventions made from results, and any issues. This can help adjust practice guidelines and show the value being delivered (like demonstrating that pharmacists ordering an A1C led to med change and improvement, etc.).

11. Public Awareness: Finally, letting the public know they can get certain tests through pharmacies is important. Many people might not realize they could get a strep test at a pharmacy once allowed, and still go to a clinic out of habit. A communications effort (posters: "Strep throat? We can test and treat at YourPharmacy") will help uptake. Patients already trust pharmacists for medication advice; extending that trust to testing services is likely, but public messaging can accelerate acceptance.

By methodically addressing these implementation factors – regulatory changes, system integration, training, collaboration – Ontario can unlock the full potential of pharmacist-directed lab testing and POCT. Doing so will cement pharmacists' role as **accessible clinical providers** who can not only treat but also appropriately investigate health conditions, leading to better patient care continuum.

Strengthening Professional Capacity and Sustainability in Expanded Scope

Expanding pharmacists' scope of practice across prescribing, injecting, and testing is a transformative change that will bring significant benefits – but it also adds responsibilities and workload for pharmacy professionals. To ensure this expansion is successful and sustainable in the long term, we must address the support structures, resources, and systemic adjustments needed to **empower pharmacists and pharmacy technicians** without overburdening them. The well-being of the pharmacy workforce is paramount; a burnt-out or overstretched workforce cannot deliver optimal patient care. This section discusses measures to strengthen professional capacity, including training, staffing, and infrastructure, as well as strategies to sustain the expanded services financially and operationally.

Supporting Pharmacy Professionals Through Training and Resources

Comprehensive Training Programs: Pharmacists and technicians will require ongoing training to keep skills sharp and stay current with their expanded roles. While initial education covers much of the foundation, targeted continuing education will be needed for new areas. We recommend creating structured training modules for: - **Minor Ailment Prescribing:** Focused refreshers on clinical assessment, red flag identification, and protocol-driven care for each new ailment. Perhaps a certification program or micro-credential in minor ailments management. - **Injection Administration (Advanced):** Even though injection training exists, offering advanced sessions on administering specific medications like Sublocade (e.g., injection technique for subcutaneous abdominal injections) would boost confidence. Also, training technicians thoroughly. - **Laboratory Test Utilization:** Workshops or online courses on interpreting common lab results, decision thresholds for intervention, and hands-on training for any new POCT devices.

- **Clinical Decision-Making and Triage:** Expanded scope often requires split-second decisions on whether to treat or refer. Additional training on patient triage, managing uncertainty, and risk assessment will help pharmacists feel comfortable operating more independently.

Professional bodies like PANP, OPA, and educational institutions (University at Buffalo School of Pharmacy has been involved in Niagara area projects, or Canadian university pharmacy programs) can collaborate to develop these training programs. Ideally, some of this training should be **publicly or employer-funded** to encourage uptake – investing in training is investing in better care. Ontario could consider funding a one-time CE fund for pharmacies to get their staff up to speed (some provinces did something similar when introducing minor ailments).

Access to Clinical Guidelines and Decision Support Tools: Pharmacists should be equipped with the latest **evidence-based guidelines** for each area of expanded scope. For instance, providing a centralized digital repository of clinical practice guidelines for all minor ailments, immunization schedules, injectable medication protocols, and lab test interpretation charts. Much of this exists (e.g., by CFPC, CPS, or hospital guidelines) – it's about collating and ensuring pharmacists have quick access. Integrating such decision support into pharmacy management software would be ideal: e.g., when prescribing for insomnia, a pop-up of recommended algorithms or dose ranges appears. Vendors should be engaged to incorporate these tools. Also, simple checklists or templates can reduce cognitive load – for example, a minor ailments assessment form or a lab monitoring schedule template for certain drugs.

Mentorship and Knowledge Sharing: Especially in the early phase, pharmacists would benefit from sharing experiences and case discussions. PANP could facilitate a regional **peer support network or mentorship program** where pharmacists who have more experience in a domain (say, one who piloted buprenorphine injections or who works in a family health team) can mentor community pharmacists newly doing it. Regular meetings (virtual or local meet-ups) to discuss cases, challenges, and solutions can build confidence and consistency. This camaraderie can also combat feelings of isolation or overwhelm. It creates a community of practice rallying around expanded scope – making it feel like a shared professional movement, not an individual burden.

Enhancing Technician Roles in Workflow: As technicians take on more tasks (giving vaccines, maybe managing POCT processes, assisting with documentation), pharmacies should optimize workflows to utilize them fully. This may mean **updating standard operating procedures** to delegate appropriate tasks to techs – for example, a technician might handle the intake and initial triage questions for a minor ailment consult (freeing pharmacist time), or manage the scheduling and preparation for injection clinics. Providing additional training to technicians in patient communication and minor ailment triage can enable them to do these front-line tasks effectively. Ultimately, by empowering technicians, pharmacists can focus on the clinical cognitive tasks that truly require their expertise.

Addressing Staffing and Workload

The expansion will undoubtedly increase pharmacy service volume. While many pharmacists are excited to practice at a higher level, there is concern about workload, as seen in some consultation comments where pharmacists feared more responsibilities without extra support would exacerbate burnout ⁵⁰ ⁵¹ . To avoid this, strategies include:

Adequate Staffing Ratios: Encouraging or incentivizing pharmacies to have sufficient pharmacist and technician staffing when offering expanded services. In practice, that might mean scheduling an additional pharmacist or relief staff on days where many clinical services are booked, or ensuring overlap of shifts so that one pharmacist can cover dispensing while another handles clinical work. The government or employers might consider funding programs or wage supports to hire more staff as needed. For instance, in Nova Scotia's Pharmacy Primary Care Clinics, government funding allowed hiring extra staff to backfill dispensing duties. A similar model (even part-time) could be considered here – perhaps a **transitional funding** for pharmacies to hire a clinical pharmacist a few hours a week to build minor ailments and injection services until they become self-sustaining through fees.

Workflow Innovation: Pharmacies should integrate new technologies and workflow systems to handle routine tasks more efficiently, freeing pharmacist time for clinical care. This can include: - More use of automation in dispensing (like tech-check-tech or robotics for filling scripts, where allowed) to reduce pharmacist dispensing burden. - Appointment systems to manage service flow, rather than everything being walk-in. If patients book times for minor ailment consults or shots, it allows better distribution of workload through the day. - Utilizing technicians and assistants to the fullest (as described, they could do more data entry, vitals, basic education, so the pharmacist's time with patient is focused on assessment and decision). - Possibly integrating virtual care where appropriate – e.g., follow-ups for a minor ailment could be done by phone or secure messaging by the pharmacist instead of in-person to save patient and pharmacist time.

Monitoring Workload and Burnout Indicators: The pharmacy profession, with support from associations and possibly the College, should actively monitor the impact of expanded services on workload and stress levels. As noted, a CPhA survey indicated risk of burnout dropping slightly from 92% to 79% from 2022 to 2023, but still extremely high ⁵² ⁵ . We need to ensure expanded scope doesn't reverse those gains. Regular surveys or feedback channels could be set up where pharmacists can report if they feel overwhelmed or if certain tasks are too time-consuming. Based on this feedback, adjustments can be made – like adjusting fee schedules to allow pharmacies to hire help, or revising certain documentation requirements to be less onerous.

Promoting a Collaborative Practice Environment: It's important that expanded scope doesn't mean pharmacists just do more alone – it should foster collaboration with others (physicians, nurses, etc.), which can actually *reduce* stress through shared care. For example, establishing clear pathways with local clinics (like if pharmacist does X test, clinic will take referrals for Y cases) ensures pharmacists aren't bearing everything. It also helps them feel supported because they know if something goes beyond their scope, a partner provider will pick it up (and not admonish them for stepping on toes). Creating these interprofessional linkages – perhaps through the Ontario Health Teams (OHT) framework – will share responsibilities more evenly across professionals.

Financial and Operational Sustainability

Remuneration Alignment: We have touched on funding for specific services (minor ailment fees, injection fees, etc.). Ensuring these fees are not static forever is key – they should be reviewed periodically relative to cost-of-living and service complexity. OPA pointed out that previous funding models (e.g., MedsCheck) didn't account for inflation or complexity changes, leading to viability issues. We recommend the Ministry to build in mechanisms such as annual adjustments or tiered fees if service demands extra work (for example, maybe a slightly higher fee for a more complex minor ailment like insomnia which might take longer than

treating athlete's foot). That way services remain financially viable to offer, and pharmacies can justify staffing accordingly.

Incentives for Underserved Areas: Niagara has urban centers but also rural communities and areas with high needs. Perhaps consider targeted incentives for pharmacies in high-need or underserved areas to deliver expanded scope services. This could be a bonus or grant for setting up a consultation room, or an extra per-service fee in rural postal codes to encourage uptake there. This ensures equity across regions – not just big city pharmacies providing these services.

Utilizing Technology for Efficiency: Over the next few years, technology should be leveraged to streamline expanded scope: - **Digital documentation:** If pharmacists could chart directly into a shared EMR or a secure cloud system instead of paper, it saves time and ensures others can view it. There are moves to integrate pharmacist documentation (like minor ailment assessments) into hospital records via viewers, which should continue. - **AI or clinical decision support:** Perhaps in the future, AI-driven tools might help pharmacists filter relevant patient data or suggest possible diagnoses or monitoring parameters, speeding up the cognitive process. For now, even simple decision support systems as mentioned would help. - **Scheduling systems:** Many pharmacies are adopting online booking for vaccines. Extend that for minor ailment consults, lab test appointments, etc. It not only helps plan staff but also automates reminders to patients, which improves follow-up adherence (like reminding a patient to come get their next injection or repeat lab in 3 months – something that could otherwise be missed and add to pharmacist workload of chasing patients).

Workforce Pipeline: As scope expands, pharmacy as a career may become more attractive (due to increased job satisfaction from doing more clinical work). We should harness that to attract new talent to Niagara and elsewhere. Collaborating with pharmacy schools to ensure new grads have ample training in these expanded roles will produce a workforce ready to hit the ground running. Also, perhaps advocating for increased enrollment in pharmacy programs or bridging programs for international pharmacists could help meet increased service demand. Locally, Brock University or other institutions might be interested in partnering on training or residencies focusing on expanded scope, which can help recruit pharmacists to practice in the region with these skills.

Monitoring Outcomes and Making Adjustments: Sustainability also depends on proving success. By setting up metrics to monitor patient outcomes (like control of chronic conditions, reduced hospital visits, patient satisfaction) and operational metrics (service volumes, wait times for service), stakeholders can identify if additional resources are needed or if any aspect isn't working as intended. For example, if data showed pharmacists ordering labs significantly improved blood pressure control in a population, that success can justify continued funding and possibly expansion. Conversely, if one type of service is underutilized (say, few pharmacists are doing a certain injection due to complexity), that flags an area to investigate (maybe more training needed, or maybe shift strategy). Continuous quality improvement cycles should be built in at the system level.

Professional Well-being Initiatives: Recognizing that expanded scope means a period of change and potential stress, it's worth implementing well-being measures. The College or associations could provide resources on time management in the new scope context, or even mental health support. Encouraging pharmacies to allow proper breaks, limit overtime, etc., is important (some consultation comments noted pharmacists not even getting a lunch break as is – that must be addressed through better staffing and possibly labor regulations). A sustainable model values the practitioner's health too. Perhaps OCP and PANP

can lobby for or create programs to support pharmacy owners in making environment improvements that reduce burnout (like closed-door hours for paperwork, employing relief floaters to cover breaks, etc.).

In essence, the motto should be: **take care of the providers who take care of patients**. This expansion is a marathon, not a sprint. By investing in training, appropriate staffing, smart funding, and health workforce well-being, Ontario will ensure that expanded scope is not only implemented but maintained as a high-quality, high-impact part of our health system. Niagara's pharmacists, in particular, are enthusiastic but will need these supports to continue delivering exceptional care to our community under their new broadened roles.

Public and Professional Awareness, Communication, and Change Management

As the scope of pharmacy practice expands, effective **communication and awareness** strategies will be critical to ensure that both the public and other healthcare professionals understand and embrace these changes. Proper communication will drive utilization of new services by the public, facilitate smooth collaboration among providers, and help manage any misconceptions or resistance. Additionally, aligning expectations through awareness campaigns will be key to successful implementation. In this section, we outline strategies for raising awareness and fostering acceptance of expanded scope services, addressing both public education and professional relationship management.

Public Awareness and Education

Informing the Public of New Services: A robust public awareness campaign should accompany the roll-out of expanded scope authorizations. Many Ontarians may not be immediately aware that pharmacists can now prescribe for more ailments, give more vaccines, or order lab tests. The government, in partnership with pharmacy organizations, should use multiple channels to disseminate this information: - **Media Campaigns:** Utilize local and provincial media (newspaper articles, TV news segments, radio spots) to highlight the expanded role of pharmacists. For example, a human-interest story in the *St. Catharines Standard* about a Niagara pharmacist who helped a patient with a minor ailment or gave a life-saving injection would resonate ⁵³ ⁵⁴ . Short informative segments on TV (like CHCH or YourTV Niagara) can show pharmacists doing these new tasks. - **Digital/Social Media:** The Ministry of Health and organizations like OCP/OPA/PANP should push targeted social media content explaining in plain language what services are now available at pharmacies. For instance, a series of infographic posts: "Did you know? Your pharmacist can now test and treat strep throat" or "Pharmacists can now give you the shingles vaccine – closer to home." Leger Marketing data suggests many Canadians support expanded pharmacist roles ⁵⁵ ; we can leverage that positivity by reinforcing how it benefits them ("faster care, no appointment needed", etc.). - **In-Store Signage:** Pharmacies themselves should display signage and brochures about their expanded services. A clear sign saying "We can prescribe for these minor ailments" with a list, or "Ask us about injections and tests we offer." Many pharmacies did this for the initial minor ailments launch and should update with new info. The OCP can provide standardized materials to ensure consistent messaging and credible look. - **Community Outreach:** Pharmacists can present at community events, health fairs, seniors' centres, etc., describing their new services. Niagara's public libraries or community health centers could host info sessions with a pharmacist speaker. Particularly for seniors (who might not use social media as much), hearing directly that they can get, say, their pneumococcal shot at the pharmacy will encourage uptake. - **Leverage Trust in Pharmacists:** Pharmacists consistently rank among the most trusted

professionals. That trust is an asset – messages should emphasize that these expanded services are a natural extension of the care pharmacists already provide. For example: "Your trusted pharmacist can now do even more to keep you healthy." Testimonials or endorsements from patients who've had positive experiences with pharmacist care (like minor ailments prescribing) can also build confidence.

Managing Public Expectations: It's important to set appropriate expectations to avoid frustration or misunderstanding. Public messaging should clarify: - **Scope Limits:** For instance, list which conditions pharmacists can handle and gently note which they cannot (so people know when an issue is beyond the pharmacist's scope and should still see a doctor). The minor ailments program usually comes with a list; updating and sharing that is key. - **Appointments vs Walk-ins:** If services are by appointment, say so; if walk-in is available but may have wait, advise patients of best times or to call ahead. Educating patients to perhaps schedule non-urgent consults will help manage workflow. - **Fees or OHIP coverage:** Clearly communicate which services are covered by OHIP or other funding (e.g., minor ailment assessments are OHIP-funded – "just bring your health card"). If any services might have a private fee (depending on final funding decisions, e.g., a travel vaccine injection fee), be upfront so patients aren't surprised. Fortunately, in our vision much will be publicly funded, but clarity is vital. - **Collaboration with Doctors:** Reassure the public that pharmacists work in tandem with physicians and will refer to doctors when a condition is more serious or outside scope. This prevents any perception that pharmacists are replacing doctors – instead, they complement them. Also, if someone is very attached to their GP, they should hear that these pharmacy services are just another option if they want faster access, not an obligation. - **Quality and Safety Emphasis:** Public materials should emphasize that pharmacists and technicians have specialized training for these services and are regulated professionals following strict standards. For example, note the extra training pharmacists undergo to prescribe or the injection training techs receive, to bolster public confidence in these new roles.

Professional Awareness and Collaboration

Engaging Other Healthcare Providers: It's equally crucial to communicate with physicians, nurses, and other healthcare professionals about the expanded pharmacist scope. They need to understand what pharmacists can do now, how it helps patients, and how it can lighten their loads so they see it as a positive development (not as competition or risk). - **Official Notifications:** The Ministry or College should send out letters or bulletins to professional associations like the OMA (Ontario Medical Association), RNAO (Registered Nurses' Association of Ontario), and others detailing the changes. These should highlight the regulatory changes, effective dates, and outline the training pharmacists have for these tasks, addressing any potential concerns head-on (like "Pharmacists prescribing is guided by evidence-based protocols and documented in shared systems..."). - **Joint Statements:** Ideally, have endorsements or supportive statements from health system leaders. For instance, if local hospital or public health officials (like Niagara Health's CEO or Niagara's Medical Officer of Health) publicly voice support for pharmacists' expanded role, that sets a collaborative tone. In fact, Niagara Health's CEO Lynn Guerriero has advocated for innovative primary care solutions ⁵⁶ ²⁵ – she or others might be willing to say pharmacists stepping up is part of that solution. - **Collaboration Protocols:** Develop and disseminate **collaboration guidelines:** for example, how pharmacists will share information with physicians (like sending a note after prescribing for a minor ailment for a mutual patient). Clarify that pharmacists will not be diagnosing beyond minor ailments, etc., to reassure. Possibly provide sample communication templates. - **Personal Outreach:** Pharmacists might individually reach out to local clinics and physicians to say "Hey, just so you know, we can do these services now. Here's how we plan to work with you." Building one-on-one relationships can ease any tension. Offering to share care or take referrals for appropriate things can flip perception – doctors might actually

utilize pharmacists to handle minor issues or vaccine updates for their overflow. For instance, a family doctor might tell their patient to see the pharmacist for their next B12 shot or to handle their wart treatment instead of waiting 2 weeks for the clinic – if they know the pharmacist can do it. - **Addressing Concerns:** Some professionals may worry about fragmentation of care or patient safety. We should address this directly. Emphasize that pharmacists will document and communicate, that their scope expansion comes with guidelines to ensure continuity (e.g., recommending patients inform their family doctor of any prescriptions they got at the pharmacy, which ideally the pharmacist also does via system). Show evidence from other provinces that expanded scope did not increase adverse events – if anything, improved access improved outcomes. Also mention that there's no intent for pharmacists to tackle complex diagnoses – they stick to clearly defined minor ailments or protocolized tasks.

Interprofessional Education: Perhaps create opportunities for physicians and pharmacists to learn together about how expanded scope will work. For example, invite local physicians to a PANP meeting or vice versa to discuss and align on processes. This fosters mutual understanding and trust.

Public-Professional Joint Messaging: In some cases, a unified message to patients from both doctors and pharmacists can be powerful. For example, if family physicians start including a note in their clinic messages or on-hold phone systems like "Did you know your pharmacist can now help you with common ailments like UTIs or eczema? Ask them for help if we aren't available quickly," it normalizes usage of pharmacy services. Some progressive clinics might do that if they're supportive. Similarly, public health units can incorporate pharmacy service info into their communications (e.g., when promoting flu shots, explicitly mention pharmacists as providers – which they already do to some extent – now extend that to other vaccines and minor ailment programs).

Monitoring Relationships: As expanded scope rolls out, OCP or Ministry should monitor feedback from other professionals. If any friction points emerge (e.g., some physicians complaining about communication or certain cases), proactively address them through updated guidance or direct outreach to clarify misunderstandings. Historically, these scopes become accepted with time, but initial period may need careful relationship management.

Change Management and Continual Promotion

Expanding scope is also a **change management** exercise within the pharmacy profession itself. Pharmacists need to adapt their mindset from primarily dispensers to medication managers and clinical providers (many already have, but some may need encouragement). Key actions: - **Celebrate Successes:** Share success stories of how expanded scope helped patients, and how pharmacists managed it well, both within the profession and to the public. For example, if a Niagara pharmacist's minor ailment intervention prevented an ER visit, highlight that (with permission and privacy respected). Internally, that boosts pharmacist morale and externally, it builds public trust. - **Address Work Culture:** Encourage pharmacies to allow pharmacists the time to provide these services thoroughly (not rushing a consult in between 10 other tasks). This might mean convincing management of the long-term value – which comes from showing these services also can be revenue-generating or at least patient-retaining, not just an "extra cost". - **Patient Feedback:** Solicit patient feedback on their experiences with expanded services. If positive, use that in promotions ("99% of patients served by their pharmacist for minor ailments would do it again", etc.); if constructive, use it to refine process. - **Ongoing Public Education:** Public awareness isn't a one-and-done. It should be ongoing. Over time, as new things get added (say, if next year pharmacists are allowed to prescribe for birth control or to manage chronic conditions more, etc.), each step needs communication.

Keep messaging consistent: pharmacists are becoming more integrated, here to help, part of your health team.

With strong public and professional awareness efforts, we expect expanded scope services to be rapidly accepted and utilized. Niagara is a region with many older adults and unattached patients; thus, effective communication could lead to especially high uptake here, easing system pressures that have been widely reported ⁵⁶. Already, initial minor ailments and vaccination expansions have been deemed “a huge success” by provincial leaders ⁵⁷ ⁵⁸. By continuing to communicate the benefits, we can maintain and grow that momentum, ensuring that this independent voice of PANP in support of the changes resonates both with the community we serve and the colleagues we partner with.

Scope Alignment Across All Practice Settings and System Integration

As pharmacists’ scope of practice expands in community settings, it is vital to ensure alignment and integration across **all practice settings** – including hospital pharmacies, long-term care, primary care teams, and others – so that pharmacists throughout the health system can practice to their full scope and patients can benefit from consistent services. Additionally, expanded scope should go hand-in-hand with improved health system integration, particularly digital integration (health records, e-prescribing) and collaborative care models. This will maximize the impact of expanded services and prevent fragmentation. In this section, we discuss the importance of uniform scope application, cross-setting collaboration, and enhancements in digital health integration.

Aligning Pharmacist Scope in Various Settings

Hospital and Clinical Pharmacist Scope: Currently, regulatory changes primarily impact pharmacists in the community (where prescribing and such is most needed for direct patient access). However, hospital pharmacists and those in other specialized settings should also be empowered with similar authorities where relevant. For example, a hospital pharmacist on a ward technically doesn’t have independent prescribing rights under O. Reg. 256/24 (except under delegation/team protocols) – yet their counterparts in the community now do for minor ailments. While hospital pharmacists work in a different model (often making recommendations to physicians), enabling a consistent scope across environments could enhance efficiency. For instance, a hospital pharmacist on an internal medicine floor could independently prescribe a needed vaccine or adjust a medication under their scope, saving physician time. Similarly, hospital pharmacists often manage inpatient warfarin dosing; giving them formal authority aligns with what community pharmacists will do for INR management in future.

In practice, many hospital policies allow pharmacist-managed protocols (i.e., they functionally prescribe under medical directives). Recognizing and formalizing these roles by regulation or hospital credentialing fosters respect and consistency. Hospitals could adopt expanded scope gradually: e.g., allow their pharmacists to prescribe minor ailment treatments on discharge (like continue a UTI antibiotic or order a needed lab before discharge, etc.). This ensures continuity – a patient leaving hospital with a minor condition doesn’t need a separate doctor order if pharmacist can handle it.

Long-Term Care (LTC) Settings: As OPA noted, pharmacy services in long-term care haven’t benefited from minor ailments expansion because the billing mechanism (OHIP) doesn’t readily apply in LTC. Yet LTC

residents could greatly benefit – they often have minor conditions (like fungal skin infections or insomnia) that could be treated promptly by consultant pharmacists rather than waiting for physician rounds. We should explore adapting funding models or permission for pharmacists in LTC to use expanded scope. Perhaps allow LTC clinical pharmacists to prescribe for minor ailments and have those assessments covered through their service agreements or a separate billing code. That might require negotiation with Ministry of Long-Term Care or so, but should be pursued. It aligns with better care for residents and easing physician burden in LTC (where doctor visits are infrequent).

Primary Care Teams (FHTs, OHTs): Pharmacists in Family Health Teams (FHTs) in Ontario already have somewhat broader scope under collaborative agreements. Many are already ordering labs and adjusting meds under medical directives. Ensuring that the regulatory expansions also benefit them (or at least acknowledging them) is key. Perhaps OCP can clarify that these expanded authorities also apply to pharmacists working in family health teams – they might not need to rely on directives for certain things anymore. FHT pharmacists could start minor ailment prescribing clinics for unattached patients or high-need communities, complementing what community pharmacies do. As Ontario Health Teams develop, pharmacists (both community and those embedded in teams) should coordinate efforts so all patients of the OHT have access to expanded services, regardless of which door they enter.

Consistent Standards: Aligning scope across settings also means aligning standards of practice. For instance, a blister-pack medication review done by a community pharmacist vs a hospital pharmacist doing a discharge med reconciliation – if both have prescribing authority for continuity, they should follow consistent documentation standards. OCP can unify guidance across practice sectors so everyone is on the same page (literally, potentially using the same forms or electronic systems for notes that can be shared).

Digital Health Integration and Information Sharing

Electronic Health Records (EHR) Integration: Expanded pharmacist activities (prescriptions, test orders, immunizations) generate important patient data. To avoid silos, integrating pharmacy records with broader EHRs is crucial. Steps to do this include: - **Pharmacy access to provincial EHR** (ConnectingOntario/ClinicalViewer): Many pharmacies still don't have direct access to these viewers (some do through special projects). Ideally, all pharmacists should have read/write access appropriate to their scope. For write: ensure pharmacist-generated records (like a minor ailment prescription or a lab result they ordered) become part of the patient's central record so any provider can see. This may involve linking pharmacy software to EHR or using provincial documentation portals. - **E-Prescribing (PrescribeIT):** Ontario is rolling out PrescribeIT for doctor to pharmacy e-scripts. We should incorporate pharmacist prescribing into that system. E.g., if a pharmacist prescribes an antibiotic, it should be logged maybe through PrescribeIT or dispensed and recorded such that it's visible to others. Right now, a pharmacist's own prescription might just show in the pharmacy system but not necessarily on a provincial drug profile unless it goes through ODB or the patient's shared record. Perhaps the Drug Information System (if any, like the Digital Health Drug Repository) should capture pharmacist prescriptions too. As OPA notes, PrescribeIT currently charges pharmacies a small fee per transaction, which could disincentivize adoption by pharmacies. If pharmacy prescribing is to integrate, addressing such costs (maybe waiving them or subsidizing them) is wise so pharmacies use these digital tools.

- **Lab System Connectivity:** Ensure pharmacists can send orders electronically to labs and receive results digitally, as earlier described. This integration prevents delays and miscommunication (fax issues). It also means these lab results can populate a central record accessible by others.

- **Immunization Records:** We should fully integrate pharmacist-delivered immunizations into the provincial repository (Panorama or new COVax system evolving). Already, pharmacies input flu shots into DHIR via billing claims which update to clinical viewers; just ensure new vaccines get similarly reported. For example, if pharmacists start giving shingles and it's publicly funded, have a mechanism to transmit that record to the digital Yellow Card. Possibly adapt the COVax solution used for COVID to a broader immunization recording tool for pharmacies.
- **Patient Health Apps:** As patients take more control, linking pharmacy-provided services to patient apps could be beneficial. For instance, if a pharmacist orders a lab test, the result could go to the patient's MyChart or PocketHealth so they see it too. This keeps the patient in the loop. Similarly, if a pharmacist prescribes something, the patient's medication list in their app should update. It's all part of connected care.

Data Analytics and Evaluation: With integration, we can use data to evaluate expanded scope impact. For example, track how many pharmacist prescriptions, what conditions, outcomes etc. Government and OCP should plan to collect and analyze such data (maybe via anonymous aggregated data from claims, lab orders, etc.) to refine programs and demonstrate value.

Privacy and Consent Management: Integration must respect privacy laws. But PHIPA allows sharing within circle of care; once pharmacists are recognized as such for these conditions, they qualify. We might need to update some consents, for example, a family doctor's office might need to list pharmacists as part of care team if they regularly share info. Educating the public that their health information will be shared appropriately between providers for their benefit is part of awareness (and how it is safeguarded). Cases where patients opt-out of sharing should be rare but process should exist (like if someone says they don't want pharmacist seeing their labs, fine, but then pharmacist can't fully manage them, which we'd explain). Most will see the benefit.

Collaborative Care Models and Agreements

Ontario Health Teams (OHTs): The philosophy of OHTs is integrated care. Expanded pharmacy services fit well into OHT goals of timely access and reduced hospital usage. OHTs should formally incorporate community pharmacists as partners. Some OHTs in Ontario have already engaged pharmacies (like COVID vax rollout). For Niagara's OHT, they could set up structured referral pathways: e.g., a local urgent care could refer minor cases to pharmacies; or the OHT could create a central triage line that directs patients to pharmacy or clinic appropriately (taking advantage of new pharmacy capabilities).

As OPA suggested, a formal **pharmacy agreement** with the Ministry could solidify the commitment to integration. This might outline how pharmacy services will be funded and evolve, and ensure they're part of system planning (for example, including pharmacies in system resilience planning – e.g., immunization campaigns, chronic disease management strategies).

SCOPE (Seamless Care Optimizing Patient Experience) Program: Niagara is already involved in a SCOPE program linking primary care providers to hospital resources ¹⁰. Perhaps pharmacists could be added to the SCOPE network as a resource or referral endpoint (for minor ailments, medication management, etc.). Also SCOPE has nurse navigators that could refer patients to pharmacy if appropriate after triage. Interweaving pharmacists into such integrated programs would maximize their usage.

Harmonizing Policy Across Sectors: We should advocate for consistent policies. For instance, if a pharmacist in a hospital is adjusting insulin, it should be recognized like an outpatient pharmacist adjusting insulin. Government or institutional policies might need an update so that one environment's restrictions don't impede another's progress. Another example: The ability to bill for services is currently only for community pharmacists via ODB/HNS. If a hospital outpatient clinic pharmacist sees a referred patient for a minor ailment, there's no mechanism for them to bill OHIP. Should we extend billing privileges to those pharmacists or have alternate funding? Probably alternate – e.g., pay them via hospital budget or have them direct patient to community pharmacy for that. It's a nuance, but aligning these pieces will avoid patients falling into cracks (like "the pharmacist at clinic could help me but couldn't officially prescribe because of how that setting works" – fix that).

Continuous Communication Channels: It would help to maintain open channels among professional groups to address issues in real time. For instance, a local Niagara interdisciplinary committee (including pharmacists, physicians, nurses) meeting occasionally to troubleshoot any integration issues – maybe under the OHT's umbrella – would help iron out wrinkles quickly and foster mutual understanding.

Scope Evolution Management: Alignment also means as one setting expands scope further, others should catch up. For example, if in future pharmacists get authority to manage some chronic diseases (like renewing and adjusting medications for stable conditions), community might do it first but ideally hospital and primary care pharmacists follow. Plan for those next steps with all stakeholders.

In summary, integration and alignment are about ensuring expanded scope doesn't operate in isolation but rather becomes a **seamless part of the healthcare system**. Patients should experience it as simply improved service and access, not as disconnected bits of care. Niagara is well-poised to demonstrate this integration – with active collaboration between Niagara Health, Niagara Region Public Health, and community providers, we can create a model where pharmacists truly function as part of a network of care. This will lead to a stronger health system that leverages pharmacists' full expertise and delivers **equitable, high-quality care** across all settings for all Ontarians.

Conclusion

The Pharmacists Association of the Niagara Peninsula (PANP) is grateful for the opportunity to contribute our perspective to the Ontario College of Pharmacists' Expanded Scope of Practice consultation. In this submission, we have articulated a comprehensive and evidence-based case for expanding pharmacists' roles in managing minor ailments, administering a broader range of medications and vaccines, conducting point-of-care testing, and ordering laboratory investigations – all while emphasizing the necessary supports and collaborative frameworks to ensure success.

A Vision for Integrated, Patient-Centred Care: The overarching theme of our recommendations is that expanding pharmacists' scope is not an end in itself, but a means to **strengthen patient care, access, and outcomes**. It is about allowing highly trained pharmacy professionals to fully apply their expertise in medication management and primary care, thereby filling gaps in our strained healthcare system. We envision a near future in Niagara and across Ontario where: - A mother with a sick child can promptly receive a strep throat test and treatment plan from her local pharmacist, avoiding an ER visit and returning home with peace of mind. - A senior in Fort Erie can walk into a pharmacy to get their routine pneumonia or shingles vaccine from a trusted technician, instead of waiting months for a doctor's appointment or traveling to a public clinic. - An individual struggling with opioid dependence in St. Catharines can receive

their monthly buprenorphine injection at the pharmacy down the street, maintaining their recovery with convenience and dignity. - A busy working professional in Niagara Falls can have their pharmacist order and interpret a cholesterol test, then counsel them on starting therapy and lifestyle changes, in coordination with their family doctor. - A long-term care resident with a minor infection can be assessed and treated by a consultant pharmacist the same day, rather than enduring discomfort until the next physician round.

These vignettes exemplify **patient-centric improvements** that expanded pharmacist scope will bring about – many of which are already being realized in provinces that have moved ahead on these fronts. Ontario, once a leader in pharmacy practice change, has an opportunity to regain momentum and achieve new heights of healthcare innovation.

Supporting the Health System and Workforce: Our submission also underscored that expanded scope must be accompanied by supportive measures: - **Public funding** for new services (minor ailment assessments, injection administration, etc.) is essential to ensure equitable access and sustainability. We urge the Ministry to implement appropriate remuneration as an integral part of scope expansion, following the lead of other provinces. - **Investments in pharmacy human resources** – through training, staffing, and technology – will pay dividends in better care. Burnout is a real concern ⁵; by addressing workload and providing resources, we can enable pharmacists to thrive in their expanded roles, not be overburdened by them. PANP is committed to working with stakeholders to facilitate training programs, mentorship, and the sharing of best practices to help pharmacists across Niagara and Ontario confidently embrace their new scope. - **Collaboration and communication** must be the bedrock of implementation. We have highlighted the importance of integrating pharmacists into the broader healthcare team (for example, through OHTs and shared electronic records). When pharmacists, physicians, nurses, and other providers collaborate and communicate transparently, patients experience seamless care and all providers practice at their best. Early signs are encouraging – many physician leaders and healthcare organizations support leveraging pharmacists to improve access ⁵⁷. We must build on that by establishing clear protocols and mutual respect across professions. - **Ongoing evaluation and quality improvement** will ensure the expanded services truly deliver on their promise. We recommend tracking outcome metrics (such as reductions in ER visits for minor ailments, immunization rate improvements, or control of chronic disease indicators) and soliciting feedback from patients and providers. This will allow mid-course adjustments and demonstrate the value of pharmacists' contributions to the system. Where barriers or unintended consequences arise, they should be swiftly addressed through the collaborative governance of the College, Ministry, and professional associations.

Local Impact – Niagara's Readiness: Throughout this report, we have infused local Niagara context and data – from our region's physician shortages and aging population to the proactive efforts of Niagara pharmacists in innovating practice. The Niagara Peninsula, with its mix of urban and rural communities and its engaged healthcare stakeholders, can serve as a **microcosm** of how expanded scope can benefit Ontarians. Our challenges – such as 155,000 residents without a family doctor and high chronic disease rates ⁴⁹ – are exactly the kinds of pressures expanded pharmacy services can alleviate. And our strengths – a near-100% pharmacy participation in new programs ¹¹, strong interprofessional relationships, and a community-focused pharmacy network (e.g., the Boggio Pharmacies, who have multiple locations across Niagara ⁹) – position Niagara to be a leader in implementation. PANP members stand ready to work with our local hospitals, public health unit, family health teams, and community organizations to roll out these services efficiently and effectively. We anticipate that Niagara can yield compelling success stories and data that inspire other regions and reinforce the case for these changes.

Empowering Pharmacy Technicians and the Pharmacy Team: We want to particularly acknowledge the role of pharmacy technicians in this expanded scope landscape. Allowing technicians to administer vaccines and injections and to play a greater role in technical aspects of care is not only prudent from a workload perspective, but it also recognizes their growing expertise and contributions. This is a positive step for the pharmacy profession's evolution into a true **team-based clinical practice**, and PANP supports continued expansion of technician responsibilities under appropriate supervision.

Equitable Access and Patient Choice: Expanded scope is fundamentally about increasing **access to care**. It gives patients more choices on how and where to receive care for certain needs. Importantly, it does so in an equitable way – pharmacies are ubiquitously distributed and often open extended hours, making them accessible to many who face barriers to traditional care settings. By integrating these expanded services into the publicly funded system, we ensure that convenience does not come at an extra cost to patients, thus avoiding any two-tier implications. Instead, we harness pharmacies as an accessible, publicly accountable channel for delivering primary care and preventative services. The end result should be that **all Ontarians – whether in Niagara or Nipigon – can rely on their pharmacists as front-line healthcare providers** for everyday health concerns.

A Collaborative Path Forward: PANP reaffirms its commitment to collaborating with the Ontario College of Pharmacists, the Ontario Pharmacists Association, the Ministry of Health, and all other stakeholders in the implementation of these expanded scope initiatives. Our association may be regional, but our perspective encompasses broad system benefits. We will continue to lend the Niagara region's voice and experience as a constructive partner in policy development and roll-out efforts. We believe our region can serve as a model for how to implement changes efficiently, measure their impact, and iterate for improvement.

In closing, the expansion of pharmacists' scope of practice represents a **pivotal opportunity** to improve healthcare delivery in Ontario. It is a response born out of necessity – to address provider shortages, increase capacity, and reduce system delays – but it is also a forward-looking strategy to make better use of the rich skills of pharmacy professionals. The recommendations and viewpoints detailed in this submission align with those of the Ontario Pharmacists Association on key positions, but we trust we have added a unique PANP perspective, colored by local data, local stories, and a local vision of success.

By implementing these changes with care, support, and collaboration, Ontario can achieve a win-win-win: **patients win** with enhanced access and outcomes, **pharmacists win** with a more fulfilling scope and recognition of their value, and the **health system wins** with improved efficiency and capacity. Together, let us proceed with confidence to unlock the full potential of pharmacy practice for the benefit of the people of Niagara and all of Ontario.

PANP appreciates your time and consideration of our submission. We are optimistic that with collective effort, the expanded scope of practice for pharmacists will be a cornerstone in building a more resilient, accessible, and patient-focused healthcare system in our province.

References

1. Ontario Pharmacists Association (OPA). *Submission to OCP on Expanded Scope of Practice – November 21, 2025*. (Pages 4–5, 25–26) – Highlights pharmacists' demonstrated readiness and competence in minor ailments and vaccinations.

2. Ontario College of Pharmacists (OCP). *Public Consultation on Expanded Scope of Practice*. (Findings and comments) – Provides statistics on minor ailment program uptake and proposed minor ailment test recommendations ¹¹ .
3. Niagara Independent. "Addressing Niagara Region's doctor shortage" (March 22, 2024) – Reports that ~30% of Niagara residents lack a family physician, amounting to roughly 155,000 people, with 81 additional family doctors needed.
4. NiagarNow (The Lake Report). "Code Grey: Region needs 91 more doctors" (April 12, 2023) – Details Niagara's primary care gaps: 477,000 population with only 255 family doctors serving ~322,000 residents (67%), leaving ~155,000 without a doctor. Notes high senior population (35% in NOTL) increasing care complexity.
5. Niagara Health News. "Primary care is the path forward" – Opinion by NH CEO Lynn Guerriero (May 2, 2025) stressing primary care gaps in Fort Erie and Port Colborne (over 21,000 without a PCP) and need for new integrated solutions ⁵⁶ ⁶ .
6. Waterloo News. "Pharmacists gain more prescribing power for minor ailments" (Oct 11, 2023) – Provides data from Ministry of Health: 302,503 pharmacist minor ailment assessments Jan–June 2023; 87% of pharmacies participated ¹¹ . Lists proposed 14 new ailments and context for expansion ⁵⁹ ⁶⁰ .
7. Niagara Independent. "Ontario adds six more common ailments pharmacists can treat" (Oct 3, 2023) – Notes 89% of pharmacies participated in minor ailments program since Jan 2023; over 400,000 assessments provided by pharmacists in first nine months ⁵⁴ ¹³ . Quotes Health Minister on improved access and OPA CEO on program's success ¹⁶ ⁵⁸ .
8. OPA Media Release (via Daisy Wai, MPP). "Ontario Taking Next Steps to Improve Health-Care Access" (Sept 17, 2025) – Announces proposed scope expansions: list of 14 minor ailments, additional vaccines (RSV, Tdap, shingles, etc.), pharmacist injection of Sublocade, and POCT for strep. Quick facts: since Jan 2023, >1.8 million assessments with ~100% of pharmacies participating. Contains supportive quotes from OPA and Neighbourhood Pharmacies CEOs.
9. Auditor General of Ontario. *Annual Report 2023 – Emergency Departments Audit*. – Provides statistic that less urgent/non-urgent cases accounted for ~23% (1.29 million) of Ontario ED visits in 2022/23 ⁷ , underscoring potential impact of diverting minor ailments to pharmacies.
10. Canadian Pharmacists Journal (Lathia et al. 2018). "Cost-minimization analysis of pharmacy-based POCT for strep throat." – Found Ontario could save an estimated \$607,000 to \$1.214 million annually by implementing pharmacy strep testing, due to reduced physician visits and appropriate antibiotic use.
11. OPA Background Data. – Reports that pharmacist minor ailment interventions in first year (403,143 UTI/conjunctivitis cases) yielded an estimated \$17.3–71.3 million health system savings by avoiding higher-cost care and complications.

12. OPA Submission (Expanded Scope). – Recommends publicly funded injection service fees to prevent two-tier access; notes five provinces fund pharmacy injection services and suggests a \$20 fee per injection. Also highlights that lack of funding creates inequity where those unable to pay may not receive care.
13. Canadian Foundation for Pharmacy. "Expanded scope plus business smarts equals success" (June 16, 2023) – Cites CPhA 2022 survey: 90% of pharmacy professionals at risk of burnout (down to 79% in 2023) ⁵, with inadequate staffing impacting mental health ⁶¹. Emphasizes need for support as scope increases. Also notes 182,932 minor ailment claims in first 4 months of 2023, demonstrating uptake ⁶².
14. Niagara Region Opioid Statistics (2025) – From Jan–Oct 2025, Niagara EMS responded to 641 suspected opioid overdoses (~64 per month) ⁴. Shows urgent local need for improved OUD treatment access (e.g., Sublocade injections in pharmacies).
15. Canadian Affairs. "Opioid addiction medication saves lives – why has uptake been slow?" (Mar 10, 2025) – Describes Sublocade's benefits: significantly fewer overdoses vs daily meds ³⁷ ³⁸. Timmins program cut overdose deaths ~30% after introducing rapid Sublocade access ³⁸. Highlights need for financial incentives and easier access to improve uptake ⁶³ ⁶⁴ – making case for pharmacist administration to expand access.
16. Waterloo News / OCP Advisory Group Info (2023) – OCP Board approved list of expanded minor ailments including lab test recommendations (e.g., recommending which tests support each ailment) ¹⁴. Ontario remains 1 of only 2 provinces where pharmacists can't order labs, indicating a gap to be closed for parity.
17. OPA Submission – Emphasizes enabling lab/POCT authority to support safe prescribing for in-scope conditions and notes all other provinces have or are adding pharmacist lab ordering. Cites that integrating digital health (e.g., e-prescribing) is needed and current cost barriers (e.g., PrescribeIT fees) shouldn't impede uptake.
18. Neighbourhood Pharmacies Association Quote (2025) – CEO Sandra Hanna stated that expanding pharmacists' ability to prescribe, test, and vaccinate "will give Ontarians faster, more convenient access to care... and strengthen the health system for everyone", underscoring broad support for integration of pharmacy services.
19. Niagara Needs Primary Care Op-Ed (Niagara Health, Apr 5, 2024) – Projects 4 million Ontarians without a family doctor by 2026 and identifies Niagara's high senior population and chronic disease rates ²⁵ ⁴⁹. Advocates team-based care and collaboration – expanded pharmacy scope fits into this recommended paradigm shift in primary care delivery.
20. Niagara Independent. "Ontario adds six ailments..." – Mentions that after initial 13 ailments and +6 in Oct 2023 (total 19), pharmacists had performed >400,000 assessments, reflecting public uptake ⁵⁸. Also quotes Deputy Premier Sylvia Jones praising pharmacist prescribing as a "huge success" and noting Ontario now a leader in convenient care through pharmacies ¹⁶ ⁵⁷, signaling government recognition of pharmacists' contributions.

1 Influenza vaccination in community pharmacy: A cross-sectional ...

<https://journals.sagepub.com/doi/abs/10.1177/17151635241240464>

2 5 50 61 62 Expanded scope plus business smarts equals success - Canadian Foundation for Pharmacy

<https://cfpnet.ca/expanded-scope-plus-business-smarts-equals-success/>

3 24 27 28 29 30 31 32 33 34 35 36 40 41 42 43 44 45 46 47

Ontario Pharmacists Association (OPA). *Submission to OCP on Expanded Scope of Practice – November 21, 2025.*

4 Opioid Usage - Statistics in Niagara

https://www.niagararegion.ca/living/health_wellness/alc-sub-abuse/drugs/opioids.aspx

6 56 Primary care is the path forward - Niagara Health News, Updates & Publications

<https://www.niagarahealth.on.ca/site/news/2025/05/02/primary-care-is-the-path-forward>

7 Emergency Departments

https://www.auditor.on.ca/en/content/annualreports/arreports/en23/AR_emergencydepts_en23.pdf

8 9 Managing Minor Ailments – Boggio Family of Pharmacies

<https://www.boggios.com/managing-minor-ailments/>

10 20 21 25 26 49 Niagara needs to double down on primary care - Niagara Health News, Updates & Publications

<https://www.niagarahealth.on.ca/site/news/2024/04/05/niagara-needs-to-double-down-on-primary-care>

11 14 15 18 59 60 Q and A with the experts: Pharmacists gain more prescribing power for minor ailments | Waterloo News | University of Waterloo

<https://uwaterloo.ca/news/media/q-and-experts-pharmacists-gain-more-prescribing-power-minor>

12 13 16 53 54 57 58 The Niagara Independent

<https://niagaraindependent.ca/ontario-adds-six-more-common-ailments-to-list-of-conditions-pharmacists-can-treat/>

17 The Top 5 Minor Ailments and Pharmacist Management in Ontario

<https://pmc.ncbi.nlm.nih.gov/articles/PMC11627696/>

19 Impact of Pharmacists Prescribing Minor Ailments in Ontario

<https://theeconomist.com/impact-of-pharmacists-prescribing-minor-ailments-in-ontario-increasing-access-and-shifting-care-patterns/>

22 23 Pharmacists prescribing for minor ailments will save health-care ...

<https://uwaterloo.ca/news/media/pharmacists-prescribing-minor-ailments-will-save-health-care>

37 38 39 63 64 This opioid addiction medication saves lives. So why has uptake been slow? - Canadian Affairs

<https://www.canadianaffairs.news/2025/03/10/opioid-addiction-medication-saves-lives-so-why-has-uptake-been-slow/>

48 51 52 National survey shows mental health of pharmacy professionals has ...

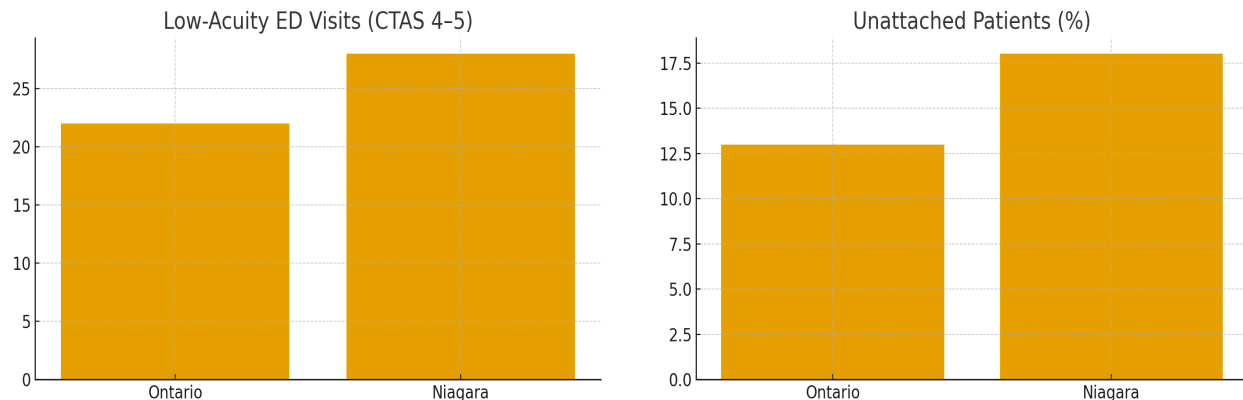
<https://www.pharmacists.ca/news-events/news/national-survey-shows-mental-health-of-pharmacy-professionals-has-improved-but-more-support-and-investments-needed-to-address-continued-challenges/>

55 Recognizing Pharmacists' Expanding Role in Canadian Healthcare

<https://leger360.com/market-intelligence-pharmacists-expanding-role-in-canadian-healthcare/>

APPENDIX: VISUALISATIONS

Low-Acuity Emergency Department Utilization & Primary Care Unattachment Rates



Low-Acuity Emergency Department Utilization Explanation:

This figure compares the proportion of low-acuity emergency department visits (CTAS 4–5) between the Ontario average (22%) and Niagara (28%). The 6-percentage-point difference translates into thousands of avoidable ED encounters each year. CTAS 4–5 visits include minor infections, uncomplicated respiratory symptoms, mild dermatologic issues, conjunctivitis, and other clinical presentations explicitly identified as minor ailments suitable for pharmacist management. In the context of the PANP submission, this graphic demonstrates that Niagara’s EDs are disproportionately burdened with low-acuity cases due to primary care shortages and lack of timely access. Expanding pharmacist scope directly redirects these patients to community pharmacies—improving ED flow, reducing wait times, and ensuring that urgent resources remain available for high-acuity care. This visualization reinforces the argument that expanded pharmacist prescribing and POCT are not merely optional enhancements—they are critical system interventions for regions like Niagara, where ED overcrowding is persistent and worsening.

Canadian Institute for Health Information. (2023). Emergency department trends in Canada. <https://www.cihi.ca/>

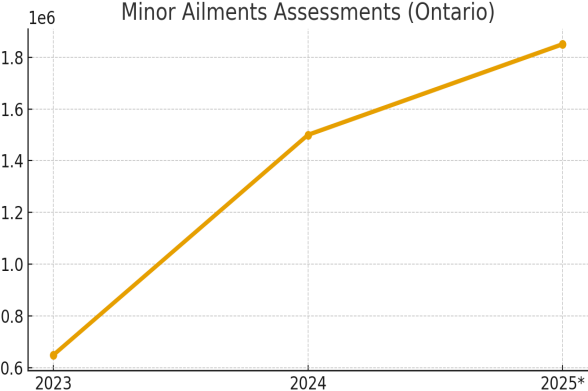
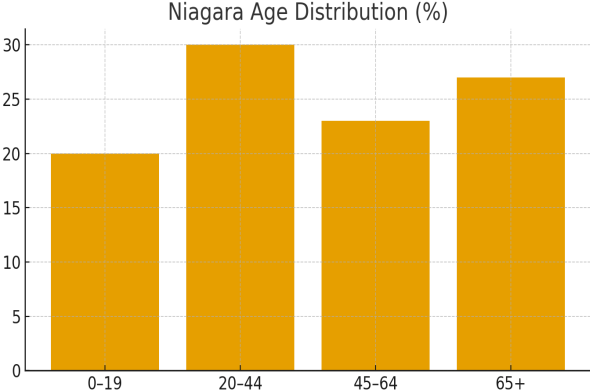
Primary Care Unattachment Rates Explanation:

This chart compares the proportion of residents without a primary care provider—13% provincially and 18% in Niagara. That 5-percentage-point gap equals approximately 58,000 to 62,000 Niagara residents who are medically unattached. Unattached patients experience significantly worse health outcomes, higher emergency department reliance, and delays in chronic disease management. For the purposes of the PANP expanded scope submission, this figure underscores that pharmacists are often the only timely point of care available to unattached individuals. Expanded authority for minor ailments, diagnostic testing, vaccinations, and therapeutic injections is therefore especially impactful in Niagara.

Because unattached patients lack continuity of care, pharmacist ability to assess, diagnose, and treat minor conditions fills a critical gap and reduces system fragmentation. This graphic directly supports PANP's argument that expanded scope is a health-equity imperative in the region.

Health Quality Ontario. (2024). Primary care access and attachment in Ontario. <https://www.hqo.ca/>

Demographic Pressure in Niagara & Growth in Pharmacist Minor Ailment Assessments



Demographic Pressure in Niagara Explanation:

This figure illustrates Niagara’s age distribution, showing a significantly older demographic profile relative to the province. Seniors (age 65+) represent 27% of Niagara’s population—far above Ontario’s average. Older adults require more frequent medication management, more routine vaccinations, more monitoring for chronic illness, and faster access to treatment for minor but potentially complicating infections. In the context of the PANP submission, this age structure reinforces why expanded pharmacy scope is crucial in Niagara. Pharmacists already serve as the most accessible healthcare providers for seniors, many of whom struggle with mobility, transportation, or the lack of a family physician. An older population also generates higher demand for POCT (e.g., strep, UTI, HbA1c), vaccine administration, and rapid prescribing for minor ailments. This visual highlights the demographic pressure that expanded pharmacist practice is designed to address.

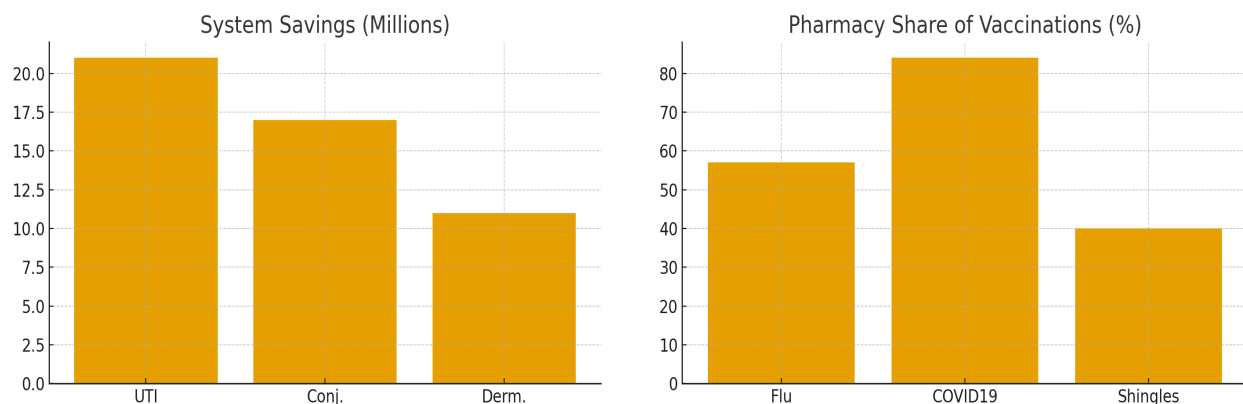
Statistics Canada. (2024). Demographic estimates by census division. <https://www.statcan.gc.ca/>

Growth in Pharmacist Minor Ailment Assessments Explanation:

This chart shows the rapid increase in pharmacist-led minor ailment assessments across Ontario—from approximately 650,000 in 2023 to 1.5 million in 2024, with projections exceeding 1.85 million in 2025. This upward trajectory demonstrates several important points: patient trust in pharmacists, the scalability of pharmacist-delivered care, and the effectiveness of decentralized access points like community pharmacies. For the purposes of the PANP submission, this trend is crucial because it confirms real-world success: pharmacists have already proven capable of safely handling large volumes of clinical assessments. Expanding the list of assessable conditions, removing restrictive prescribing lists, and enhancing diagnostic authority will further strengthen this system. Niagara, with its overburdened EDs and large unattached population, stands to benefit even more from this expansion.

Ontario Ministry of Health. (2025). Minor ailments prescribing utilization statistics.

Estimated System Savings & Pharmacy Contribution to Vaccination Programs



Estimated System Savings Explanation:

This figure estimates system savings associated with pharmacist-led management of minor ailments, with specific examples (UTI, conjunctivitis, dermatitis) ranging from \$11 million to \$21 million per condition nationally. These savings come from reduced ED visits, fewer walk-in clinic encounters, earlier treatment, and improved antimicrobial stewardship. For the PANP expanded scope submission, this visual supports the argument that investing in pharmacist authority is fiscally responsible. Ontario's strained healthcare system requires interventions that reduce costs while improving patient outcomes. Pharmacist-led care is a rare example of a service that simultaneously saves money, reduces physician workload, improves patient satisfaction, and increases access to timely care—especially in regions like Niagara.

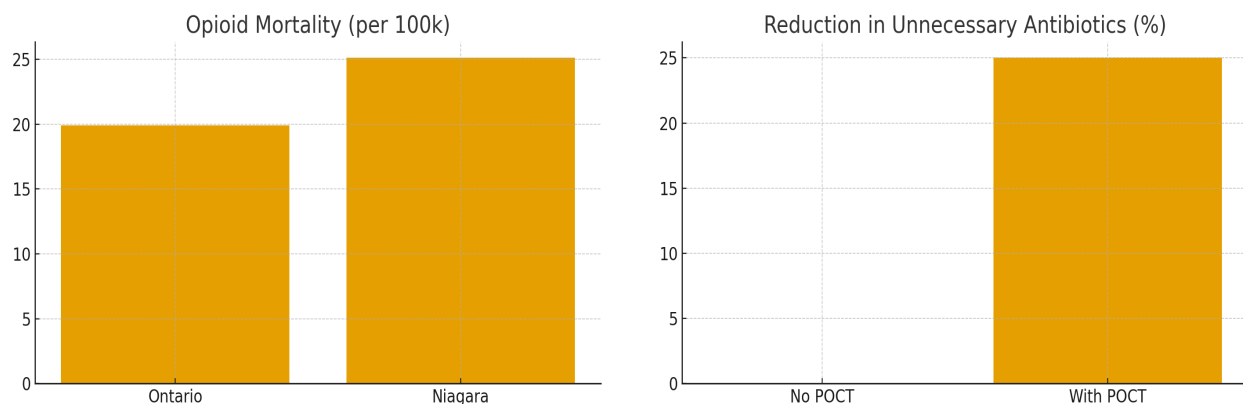
Canadian Pharmacists Journal. (2023). Health economic evaluation of pharmacist-led minor ailment management.

Pharmacy Contribution to Vaccination Programs Explanation:

This figure shows the percentage of key vaccinations administered in pharmacies: 57% of adult influenza doses, 84% of COVID-19 doses during peak period, and 40% of shingles vaccines. These numbers highlight that pharmacies are already the primary immunization channel for adults in Ontario. For PANP's submission, this visual demonstrates that pharmacists have the infrastructure, workflow capacity, and public trust necessary to expand to all Health Canada approved vaccines and remove unnecessary age restrictions. Given Niagara's older demographic and high chronic disease burden, expanded vaccine authority would greatly increase coverage, reduce disease transmission, and lessen the burden on public health units and primary care providers.

Public Health Ontario. (2024). Immunization coverage report for Ontario.

Opioid Mortality in Niagara & POCT Impact on Antibiotic Stewardship



Opioid Mortality in Niagara Explanation:

This chart compares opioid mortality rates between Ontario (19.9 per 100,000) and Niagara (25.1 per 100,000). Niagara’s rate places it among the hardest-hit regions in the province. The impact is particularly severe in St. Catharines, Niagara Falls, and Fort Erie. In the context of the PANP submission, this figure is essential evidence for expanding pharmacist authority to administer injectable formulations of buprenorphine and other opioid agonist therapies. Pharmacists are already central to harm reduction, but current restrictions limit their ability to deliver life-saving long-acting treatments. This visual demonstrates the urgency for that change.

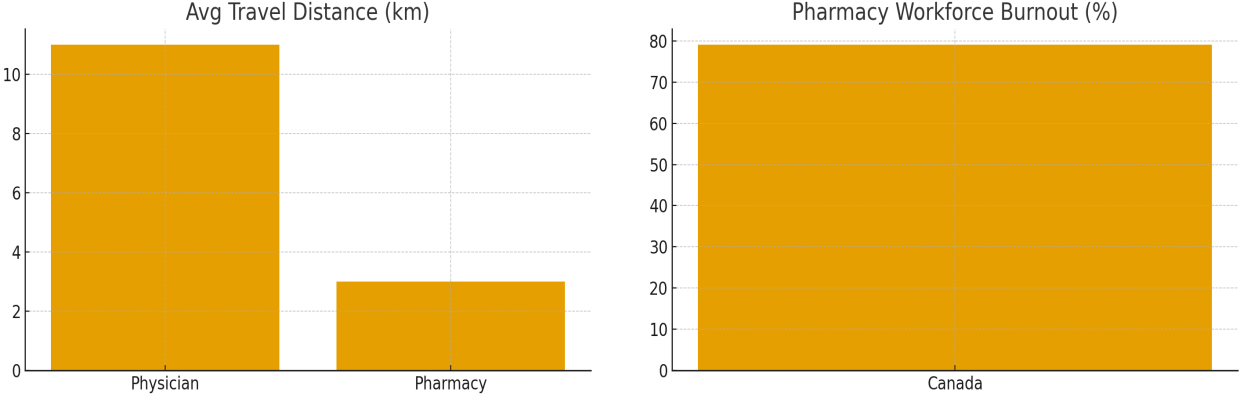
Public Health Ontario. (2024). Interactive opioid toxicity dashboard.

POCT Impact on Antibiotic Stewardship Explanation:

This figure displays the reduction of unnecessary antibiotic use—approximately 25%—when point-of-care testing (POCT) such as rapid strep tests is used in community settings. This directly supports expanded pharmacist authority to order and perform POCT, improving antimicrobial stewardship and reducing downstream complications. For PANP’s submission, this visual reinforces that pharmacists can provide high-value diagnostic interventions that improve care quality, reduce inappropriate prescribing, and mitigate antimicrobial resistance—one of the most pressing public health challenges in Ontario.

National Institute for Health and Care Excellence. (2023). POCT and antimicrobial stewardship evidence review.

Rural Access Advantage & Pharmacy Workforce Burnout



Rural Access Advantage Explanation:

This figure compares average travel distance to physician offices (11 km) versus pharmacies (3 km) in rural Niagara municipalities. The dramatic difference highlights why pharmacies are the true access point for care in rural and transportation-limited communities such as Wainfleet, West Lincoln, Pelham, and areas of Lincoln. For expanded scope, this demonstrates that pharmacists serve populations who otherwise face long delays and travel burdens for basic care. Enabling pharmacists to manage minor ailments, provide POCT, and administer injections ensures timely treatment for patients who cannot easily access physicians.

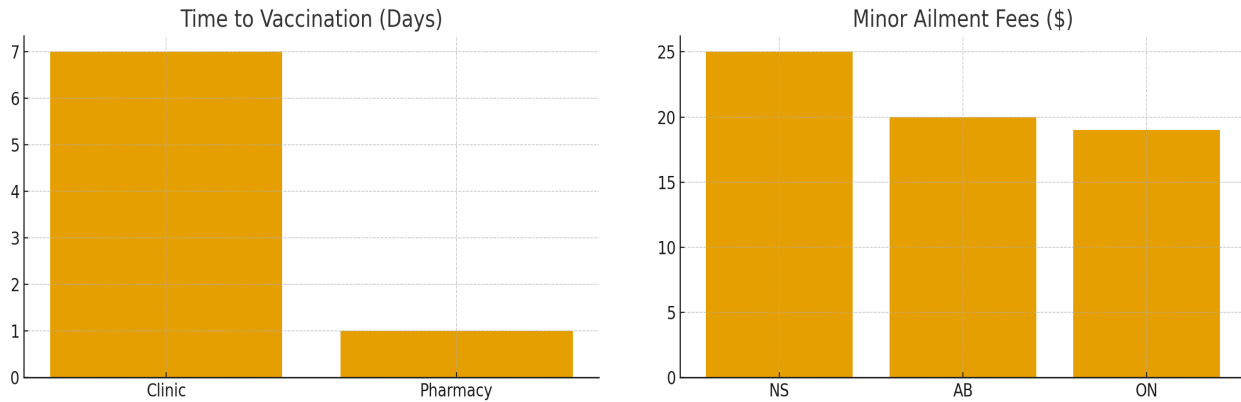
Niagara Region. (2024). Rural transportation and health access analysis.

Pharmacy Workforce Burnout Explanation:

This figure highlights burnout levels in the pharmacy workforce, with national surveys indicating approximately 79% of pharmacists and technicians reporting symptoms of professional burnout. In the context of expanded scope, this provides evidence for the necessity of enabling pharmacy technicians to assume clinical support roles (such as vaccine administration) to alleviate workflow strain. For PANP’s submission, this visual reinforces the argument that sustainable implementation requires workforce redistribution—not simply adding responsibilities to pharmacists.

Canadian Pharmacists Association. (2023). Workforce wellness and burnout survey.

Vaccination Efficiency Comparison & Remuneration Comparison Across Provinces



Vaccination Efficiency Comparison Explanation:

This figure compares time to vaccination between clinics (average 7 days) and pharmacies (average 1 day). This demonstrates faster access through pharmacy-based vaccination. In Niagara—where older adults make up a large population segment and where mobility or transportation barriers delay care—this efficiency gain is especially important. For PANP’s submission, this visual illustrates why expanded vaccine authority should be granted without drug- or age-specific limitations.

Canadian Immunization Research Network. (2023). Vaccination workflow optimization study.

Remuneration Comparison Across Provinces Explanation:

This figure compares pharmacist remuneration for minor ailments services: Nova Scotia (\$25), Alberta (\$20), and Ontario (\$19). Ontario’s fee is the lowest despite higher patient volumes, higher system pressure, and higher complexity in regions like Niagara. For PANP’s submission, this underscores the importance of sustainable funding to ensure expanded scope can be maintained without compromising pharmacy viability or workforce wellbeing.

Government of Alberta & Nova Scotia Health. (2024). Pharmacist fee schedule comparison.