



Members Present:

Doug Kipp, Chair, District 4
Bev Harris, Vice-Chair, District 2
Agnes Fridl Poljak, District 1
Blair Tymchuk, District 3
Bob Craigie, District 5
Anar Dossa, District 6
Jerry Casanova, District 7
Bal Dhillon, District 8
Kris Gustavson, Government Appointee
Jeremy Walden, Government Appointee
Jeff Slater, Government Appointee

Member Regrets:

Ryan Hoag, Government Appointee

Staff Present:

Bob Nakagawa, Registrar
Suzanne Solven, Deputy Registrar
Ashifa Keshavji - Director, Practice Reviews and Competency
Cam Egli, Director – Hospital Pharmacy Practice and Technology
Doreen Leong, Director – Community Pharmacy Practice and Registration
Mykle Ludvigsen, Director – Public Accountability and Engagement
Mike Stonefield, Chief Operating Officer – Office Operations and Business
Pina Naccarato, Executive Assistant to the Registrar (Minute-taker)
Lori Tanaka, Executive Assistant to the Deputy Registrar (Presentation facilitator)

Note: Reference and background material mentioned within is provided in attached appendices accordingly

1.0 WELCOME & CALL TO ORDER

Chair Doug Kipp called the meeting to order at 9:03 am

- Chair introduced UBC student, Aaron Sihota, Pharmacy Undergrad Society President as an invited guest at the meeting.
- Chair asked if there were any conflicts for Board members with items on the agenda; J. Slater stated he had a conflict of interest on item 4.4 of the agenda; therefore he would abstain from voting and leave the room during the discussion.

2.0 CONFIRMATION OF AGENDA – JUNE 21, 2013

Chair Doug Kipp called for any additional agenda items; two additional items were requested as follows:

- Jeff Slater requested an addition to thank Bal Dhillon, District 8 Board member, for the tour she provided him of the Fraser Health Pharmacy Drug Distribution Centre in Langley facility



- Chair Doug Kipp granted immediate permission to do so; Jeff Slater thanked Bal Dhillon for an informative and productive tour.
- Bob Craigue requested that updates on Elections and Oregon Survey be added.
 - Chair noted these additions as 6.2 and 11.0.1 respectively.

It was MOVED (J. Slater), SECONDED (K. Gustavson) and **CARRIED** that the Board:

Approve the Agenda for the June 21, 2013 Board Meeting as amended.

2.1 BOARD EVALUATION FORM FEEDBACK

- Feedback from the April 19, 2013 Board Evaluation Form was provided for information.

3.0 APPROVAL OF APRIL 19, 2013 MINUTES

It was MOVED (B. Craigue), SECONDED (J. Casanova) and **CARRIED** that the Board:

Approve the April 19, 2013 Board Meeting Minutes as presented.

3.1 BUSINESS ARISING FROM MINUTES

- Bob Nakagawa reviewed the business arising from the minutes as circulated.
 - He reported that staff reviews these items on a weekly basis to ensure that all Board direction is followed.

4.0 CHAIR'S REPORT

- Chair Doug Kipp reviewed his report as circulated. (Attached - Appendix 1)
 - He also advised that he and Vice Chair Bev Harris are in regular contact with the Registrar, and are kept updated at least every two weeks.

4.1 REGISTRAR'S REPORT

- Bob Nakagawa reviewed his report as circulated. (Attached - Appendix 2)
 - Also provided an updates on:
 - Medical marijuana
 - Use of abbreviations – concern that the abbreviations are being used and confused in the community – information was disseminated in our newsletter as well as in that of the College of Physicians and Surgeons.



It was MOVED (K. Gustavson), SECONDED (B. Harris) and **CARRIED** that the Board:

Approve the following motion from the April 19, 2013 Board meeting be taken from the table: "That the Board approve that staff plan for the June or September Board meeting be held in (location), with a reception for local leaders to be held in conjunction."

*Original motion was MOVED (B. Tymchuk) and SECONDED (A. Dossa)

It was MOVED (B. Tymchuk), SECONDED (A. Dossa) and **DEFEATED** that the Board:

Approve that staff plan for the June or September Board meeting be held in (location), with a reception for local leaders to be held in conjunction.

4.2 QUALITY ASSURANCE: PDAP UPDATE PRESENTATION

- Bob Craigue, in his capacity as QAC Chair, along with Ashifa Keshavji presented an update. (Attached - Appendix 3)

4.3 NAPRA UPDATE

- Report by Bob Craigue was circulated. (Attached - Appendix 4)
 - Update: IPG Gateway enrolment is anticipated to be at 1500 candidates by 2015
 - Pharmacists have been taken off the Citizen and Immigration Canada's list of eligible professions.

4.4 INQUIRY COMMITTEE APPOINTMENTS

* Jeff Slater left the meeting for this agenda item due to a conflict of interest.

It was MOVED (J. Walden), SECONDED (B. Dhillon) and **CARRIED** that the Board:

Appoint the following people to the Inquiry Committee effective immediately with terms expiring as noted:

John Hope – April 30, 2015

Cynthia Widder – April 30, 2015

Liz Zhang – April 30, 2015

Nancy Slater (P) – April 30, 2014

5.0 GRANT REQUEST PRESENTATION: PROMOTING INNOVATION IN COMMUNITY PHARMACY THROUGH PRECISION THERAPY

- As presented by Corey Nislow, PhD, see attached (Appendix 5).



It was MOVED (B. Craigue), SECONDED (K. Gustavson) and CARRIED that the Board:

Approve the request for funding from UBC'S Associate Professor, Corey Nislow, Sequencing Centre, Faculty of Pharmaceutical Sciences, in the amount of \$200,000 in support of the proposal entitled "Promoting Innovation in Community Pharmacy Practice Through Precision Therapy".

- B. Tymchuk voted against
- It was noted that the final total including UBC overhead, will be greater than \$200,000.

6.0 FEBRUARY 15, 2013 BOARD RESOLUTION RE: BYLAW CHANGES

It was MOVED (A. Dossa), SECONDED (J. Walden) and CARRIED that the Board:

Rescinds the resolution of February 15, 2013 to repeal and replace the bylaws under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act as submitted in Appendix 8.

6.1 PODSA/HPA BYLAWS – INCENTIVE PROHIBITIONS

- As presented by Suzanne Solven, see attached (Appendix 6)

It was MOVED (B. Tymchuk), SECONDED (J. Casanova) and CARRIED that the Board:

Directs the Registrar to complete the drafting of bylaws consistent with Option 2 – Implement Proposed Full Prohibition of Incentives as previously posted with the addition of the following exclusions:

- *schedule 3 drugs, except on a prescription from a practitioner;*
- *providing free or discounted parking to patients who are obtaining a Schedule 1 or Schedule 2 drug;*
- *providing free or discounted delivery services to patients who are obtaining a Schedule 1 or Schedule 2 drug,*
- *permitting patients or patients' representatives to pay for Schedule 1 or Schedule 2 drugs using major credit cards that are linked to incentives like points, loyalty points or rewards, except where, directly or indirectly, the incentives are awarded specifically for the purchase of a Schedule 1 or Schedule 2 drug.*

6.2 BOARD ELECTIONS UPDATE

- Bob Nakagawa explained that the implementation of the electronic voting process was being held up with the bylaw changes; therefore, elections this year will be conducted manually, as in the past.



7.0 HEALTH CANADA PRESENTATIONS: SCOPE OF WORK

- As presented by Jacqueline Oddi, Inspector, Regional Compliance Officer, Controlled Substances Program Compliance & Enforcement Directorate, Regions & Programs Bureau, see attached (Appendix 7).

7.1 METHADONE

7.1.1 PPP-66 Methadone Maintenance Treatment – Policy & Policy Guide Update

- As presented by Suzanne Solven, see attached (Appendix 8)

7.1.2 Methadone Prescription Form

- As presented by Suzanne Solven, see attached (Appendix 9)

It was MOVED (B. Harris), SECONDED (A. Poljak) and **CARRIED** that the Board:

Approve the revised methadone controlled prescription form as presented.

7.1.3 New PPP-71 Home Delivery of Methadone Maintenance Treatment

- As presented by Suzanne Solven, see attached (Appendix 10)

It was MOVED (J. Slater), SECONDED (J. Walden) and **CARRIED** that the Board:

Approve Professional Practice Policy #71 – Home Delivery of Methadone for Maintenance Treatment as amended.

7.2 GRANTS

It was MOVED (K. Gustavson), SECONDED (A. Dossa) and **CARRIED** that the Board:

Approve the UBC Faculty of Pharmaceutical Sciences – Office of Experiential Education \$4000 grant to assist in funding the annual pharmacist preceptor workshop.

It was MOVED (J. Casanova), SECONDED (A. Dossa) and **CARRIED** that the Board:

Approve \$2500 grant to assist in funding HRO joint project of review of Health Professions Review Board processes and outcomes.



8.0 STRATEGIC UPDATE

8.0.1 Subcommittee Updates:

Standards, as presented by Jeremy Walden, see attached (Appendix 11).

Technology, as presented by Jeff Slater, see attached (Appendix 12).

Scope of Practice, as presented by Bal Dhillon, see attached (Appendix 13)

Public Expectations, as presented by Anar Dossa, see attached (Appendix 14)

Interdisciplinary Relationships, as presented by Kris Gustavson, see attached (Appendix 15)

8.1 BOARD SELF EVALUATION

- As presented by Kris Gustavson, see attached (Appendix 16)

It was MOVED (A. Dossa), SECONDED (J. Slater) and **CARRIED** that the Board:

Approve the Board Self Evaluation Task Group's recommendation for a pilot test in Fall 2013 following revisions to the tool over the summer.

- Note: deadline for Board feedback is August 31, 2013

9.0 COMPOUNDING GUIDELINES PRESENTATION: OVERVIEW OF THE COMPOUNDING PROCESS IN CANADA

- As presented by Sebastian Denison, RPh, BSc (Pharm), BSc (Microbiology/Chem), see attached background material (Appendix 17).

10.0 AUDIT 2012/2013 FISCAL YEAR

- As presented by Mike Stonefield, see attached (Appendix 18)

10.0.1 Key Messages from the Auditor Report

10.0.2 Approval of 2012/13 Audited Statements

It was MOVED (J. Slater), SECONDED (B. Harris) and **CARRIED** that the Board:

Approve the audited financial statements for the fiscal year 2012/13 as presented.

10.1 FIRST QUARTER (Q1) AND LATEST ESTIMATE FOR FULL YEAR (LE1) FINANCIALS FOR THE 2013/2014 FISCAL YEAR



11.0 ENGAGEMENT & COMMUNICATIONS STRATEGY & ROADSHOW UPDATE

- As presented by Mykle Ludvigsen, see attached (Appendix 19).

11.0.1 Oregon Survey

- Registrar has been working with the CORE group from UBC and College COO to finalize a contract
- The College has retained written permission from Oregon to use their survey
- It will be a web-based survey that will be posted for a long time to give registrants a chance to all contribute.
- Registrants will receive a customized link to the survey.
- The target is late August to have the survey posted and ideally results available in November for a Board presentation; if not then the presentation will be at the February 2014 Board meeting.

11.1 JUNE 21, 2013 BOARD HIGHLIGHTS HEADLINES

- As presented by Mykle Ludvigsen,

It was MOVED (J. Slater), SECONDED (B. Harris) and **CARRIED** that the Board:

Approve the Board Highlights for June 21, 2013 as presented.

12.0 BOARD EVALUATION

12.1 HOUSEKEEPING INFORMATION 2013 & EXPENSE FORM

The College of Pharmacists of British Columbia Board Meeting scheduled June 21, 2013 concluded at 3:07 pm.



4.0 Chair's Report

INFORMATION ONLY:

or

DECISION REQUIRED:

Chair's Report

Since the last meeting of the Board, I've been active as your chair, mostly through regular conversations with the registrar and vice chair. We continue to have calls every few weeks to discuss a wide range of College issues including:

- PDAP, inducements, Board agenda and various college issues.
- In addition, I attended the CPhA AGM with the Vice Chair and Registrar



4.1 Registrar's Report

INFORMATION ONLY:

or

DECISION REQUIRED:

Registrar's Report

- Attended the Laal discipline hearing
- Hosted conversations and strategic planning sessions (AKA The Roadshow) with Mykle Ludvigsen in Burnaby, Victoria, Prince George, Kelowna and Langley. These were useful engagements to connect with the pharmacists and technicians. While in town for the Roadshows, we visited several pharmacies, representing a wide variety of practices. Small and large, specialized and general, hospital and community. Everyone I spoke with was appreciative of the opportunity to connect. It was a good opportunity to see the practice in the real world and for me as Registrar, to reach out.
- Discussion with Dean Pro Tem Riggs about new happenings and opportunities for collaboration between the College and the Faculty
- Discussions with NAPRA and Health Canada about compounding and manufacturing requirements in Canada, as a result of the recent events in New England and Toronto.
- Regular meetings with the ADM Pharmaceutical Services Division and other Ministry officials.
- Discussions with Loyalty One re: Inducements and our process
- Attended the National Association of Boards of Pharmacy AGM
- Attended meetings of the Inquiry Committee, Joint Venture, BC Pharmacy conference, and APEG BC.
- Presented to the graduating class of 2013 at the Dean's reception
- Attended the BCPhA and CPhA conferences
- Participated in the annual meeting of Health Canada with the Registrars to discuss a variety of topics
- Participated in various development activities with the staff to support and advance a positive work environment
- Discussions with CPhA about the College supporting pharmacists' participation in the ADAPT program



COLLEGE OF PHARMACISTS
OF BRITISH COLUMBIA

Professional Development and Assessment Program (PDAP)

Update Presentation

Ashifa Keshavji, Director

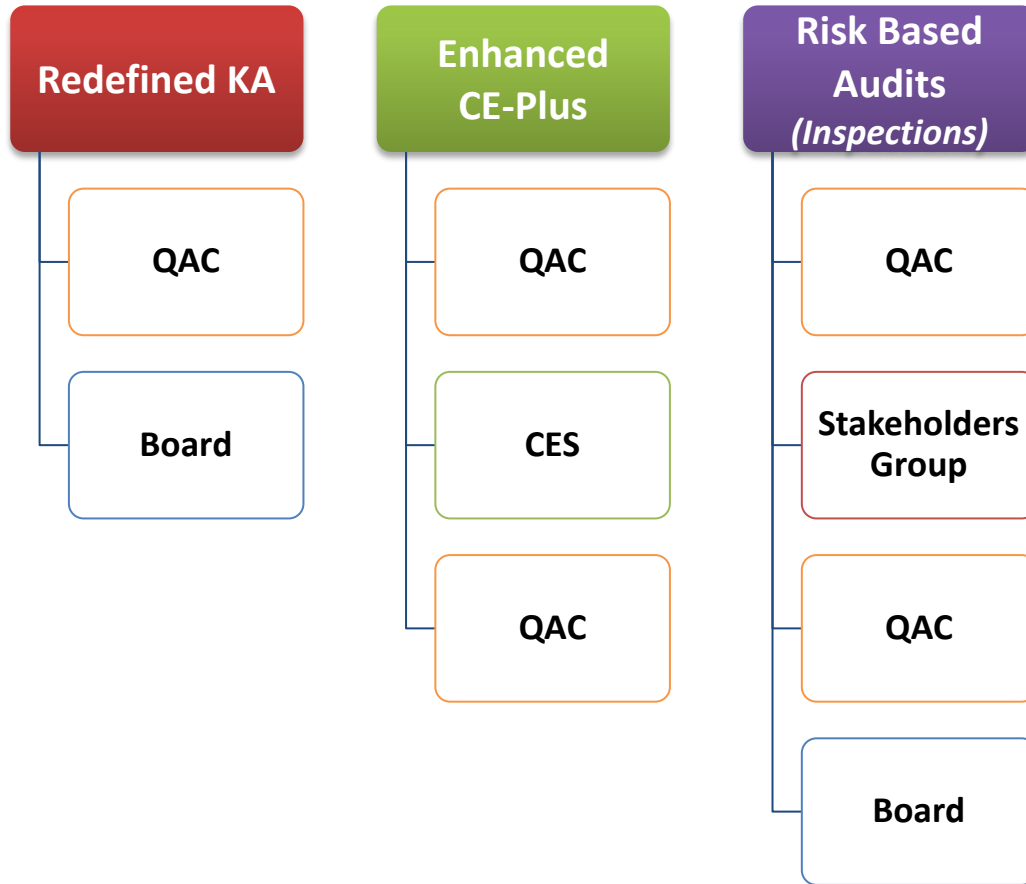
Bob Craigue, QAC Chair

Board Meeting

June 21, 2013



Board Direction



QAC Action Plan

Redefined KA

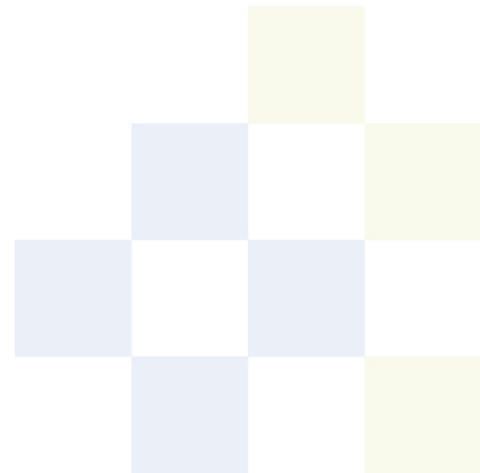
- Continue to administer KA for return to practice applicants

Enhanced CE

- Develop recommendations to provide direction to the CE Plus Subcommittee for review

Risk Based Audits (Inspections)

- Creation of a stakeholder working group
- CPBC Staff to explore other sources of information



Enhanced CE

CE –Plus Subcommittee Report – Action Items

1. Mandate specific continuing professional development programs
 2. Incorporate requirement for accredited CE
 3. Ensure CE-Plus requirements are simple and straight forward
 4. Update UBC CE Programs
-



Enhanced CE

CE –Plus Subcommittee Report – Tabled Items

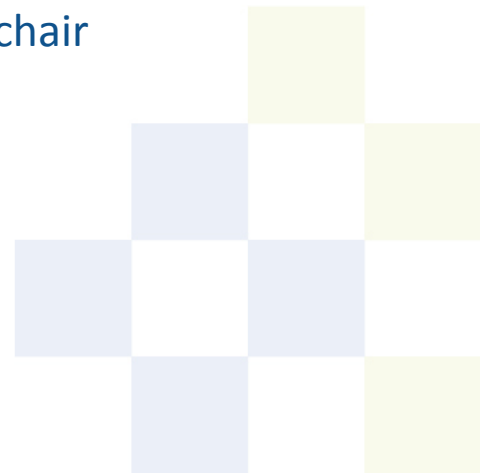
1. Require % of CE to be live programs vs. Distance education
 2. Biennial Submission
 3. Reassess CE-Plus process (resource materials, self assessment, learning records)
 4. Assess resource and staffing implications of enhanced CE-Plus initiatives
-



Risk Based Inspections

Stakeholder Group

- **Mandate:** How to identify pharmacies/pharmacists who may present a risk (to the public) and to determine potential inspection methodologies.
- **Participants:**
 - Quality assurance Committee Chair
 - Residential Care Advisory Committee Vice-chair
 - Hospital Pharmacy Advisory Committee Chair
 - Community Pharmacy Advisory committee Vice- chair
 - Inspector, Community and Hospital Pharmacy
 - Complaints Resolution Investigator
 - 2 community pharmacy residents.



Risk Based Inspections

1. Potential risk factors related to a
PRACTITIONER

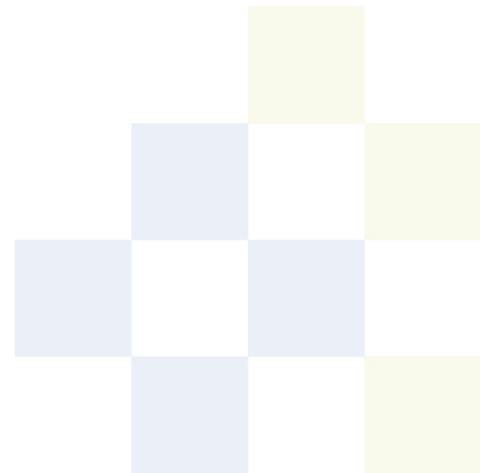
2. Potential risk factors related to a
PRACTICE

3. Potential Methodologies for
Inspections



College Staff

- PharmaNet data
- Complaints/inquiry/discipline process data
- Environmental scan of best practices from other provinces
- Registrant and Public Engagement
- Costing of Potential Models

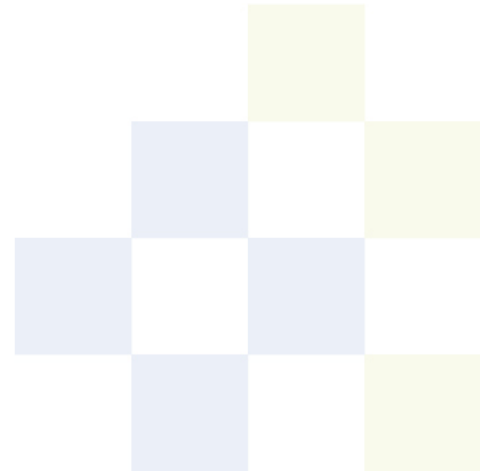


QAC Next Steps

- July 2013 - QAC Teleconference – review environmental scan, costing, identify feasible options for further development
- August 2013 - QAC Teleconference to review draft report and inspection models for approval
- September 2013 – QAC Presentation to Board for approval of new inspection process
- October 2013 – Feb 2014 – Development of new inspection process (tools, staff, training)
- March 2014 – implementation of new inspection process



Timeline





COLLEGE OF PHARMACISTS
OF BRITISH COLUMBIA

Questions?





4.3 NAPRA Update

INFORMATION ONLY:

or

DECISION REQUIRED:

NAPRA Update

The issue of the revised scope of practice for Pharmacists and a similar document for Technicians led to long discussions and it ended up being referred back to the individual Colleges for review. Bob Nakagawa will provide the Board with these two documents for Board comments and I urge you to read them and comment if you have issues. Remember that these will become the new standard for entry to practice and therefore have significant consequence.

The Auditor recommended that NAPRA create an Audit Committee, but they decided at this time to continue with the Executive Committee performing this function.

NAPRA expects to get a major boost to its budget from 2 areas over the next few years. The first area is from technicians using the Bridging Program. NAPRA has an educational program gleaned from the provinces that presently have techs, Alberta, BC, and Ontario, and they intend to charge educational bodies such as schools and universities \$400 per student that uses all 4 programs leading to Technician licensing. They anticipate 2000 assistants transitioning to technician status this year and 8000 in each following year. I reminded them that BC's experience was that we were way behind on technician transitions in community pharmacy and stated that their numbers were unrealistic. Only time will tell.

IPGs are the other source NAPRA is looking for new revenues. They are expecting \$68,750 in IPG revenues this year and \$420,750 in 2014. They couldn't put numbers to these immediately, but they will send them to me when available. What that means is that BC will be flooded with new IPG's in the future and should prepare themselves for falling pharmacist wages unless the flow is restricted. As we all know, the whole world wants to be Canadian. Bob Nakagawa is on the IPG Steering Committee and is your contact person.

As always NAPRA meetings are painful, as consensus comes by talking issues to death and changing people's minds by exhaustion as well as reasoned arguments. Even so, I find the meetings very valuable for both its look at the national scene as well as building relations among the provinces. It also gives us a window on what is happening in the US with NABP which is often a precursor to problem areas that will develop in Canada. I nominated Bob Nakagawa to a NABP committee, and if he is chosen, he will make a valuable contribution.

Reducing Adverse Drug Reactions caused by 2nd Generation Antipsychotics (ReADRes):

Promoting Innovative Pharmacy Practice
through Precision Therapy

Corey Nislow, Ph.D.

June 21, 2013



THE UNIVERSITY OF BRITISH COLUMBIA
PHARMACEUTICAL
SCIENCES

Our Team

**Mark
Kunzli**

RPh, ExecMBA

**Ron
Reid**

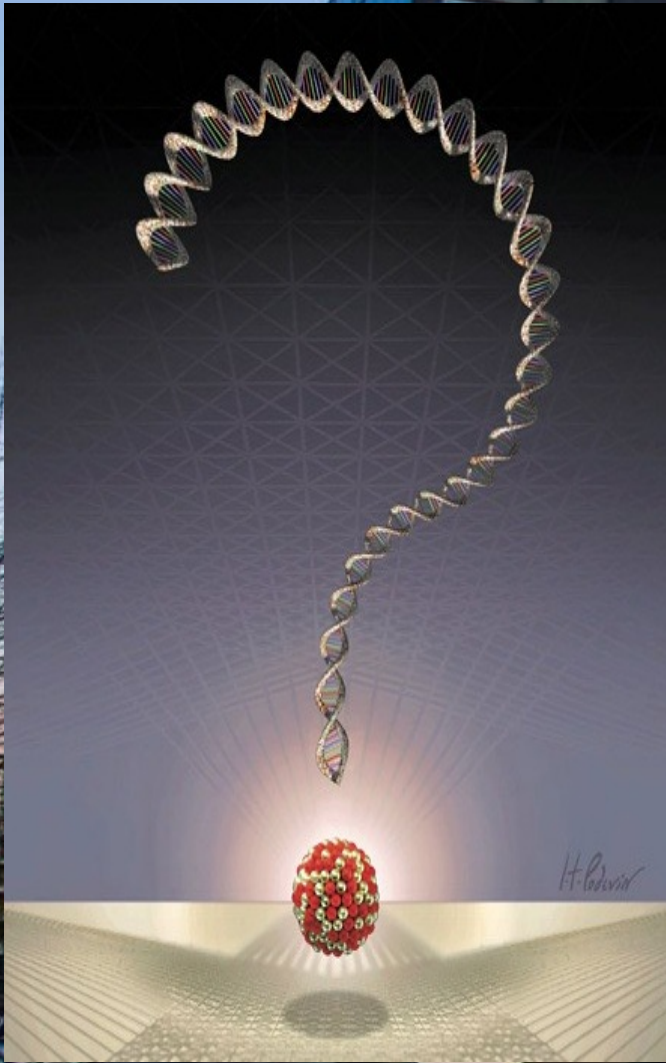
PhD

Corey Nislow

PhD



One-time cost, lifetime amortization



Genomics allows for truly personalized medicine



Pharmacists are ideally situated between patient and physician



Sequencing today will answer the questions of tomorrow

Opportunity Costs and Considerations:

We know we don't know

What are the costs of not doing anything?

- ADRs are not an endpoint; addressing them is the beginning of effective therapeutic outcome (untreated individuals)
- The direct costs of ADRs can be forecast, but without understanding their causes, the indirect costs cannot
- Sequencing can be implemented in stages, allowing for interim assessment and refinement

Project Proposal

ReADRes:

Reducing Adverse Drug Reactions caused by
2nd Generation Atypical Antipsychotics

Second Generation Antipsychotics (SGAs):

Broadly prescribed, poorly understood

- No atypical antipsychotic has been approved for any indication in children

- **FDA probes deaths of two patients on Lilly schizophrenia drug**
2011: 240,000 prescriptions for risperidone in children 12 and under

By Ransdell Pierson

(Reuters) - The U.S. Food and Drug Administration is investigating the cases of two individuals who died after injections with Eli Lilly and Co.'s long-acting treatment for schizophrenia, Zyprexa Relprevv.

- Both patients died three to four days after receiving "an appropriate dose" of the medicine, and both had very high blood levels of the drug, the agency said on Tuesday.

The medicine's package insert carries a prominent "black box" warning of risk from post-injection delirium syndrome (PIDS), a serious condition in which the drug enters the blood too quickly following an injection, causing greatly elevated levels of the drug in the bloodstream. High doses of the drug can cause delirium, cardiopulmonary arrest, heart rhythm problems, sedation and coma, the FDA said.

muscular tics

Enabling Precision SGA Therapy

- Understanding ADRs is crucial to understanding how to treat
- Healthcare requires greater knowledge of the implications of SGA treatment
- Pharmacists require education to apply genomic information to the use of SGAs (and more)



UBC Pharmaceutical Sciences Sequencing Centre

- First (and only) in North America dedicated to pharmaceutical science research
- Illumina hiSeq 2500
- Illumina miSeq
- Extensive automation



Province-wide Outreach

- Build upon existing network of pharmacies and pharmacists
- Infrastructure and training available throughout BC

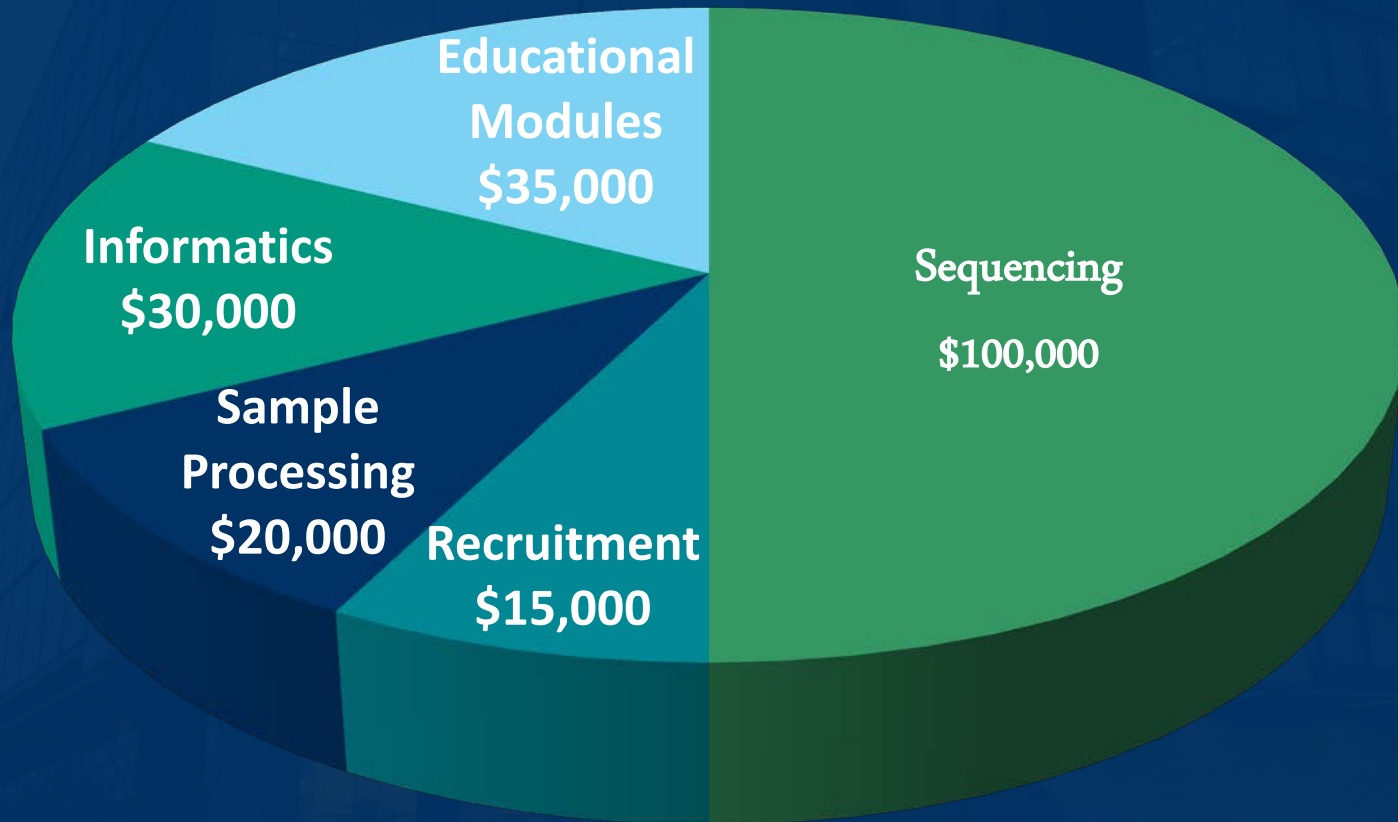
Project Deliverables

- Standard Operating Procedures for assessing SGAs and genomic tests
- Saliva sample protocol for DNA analysis
- Syllabus of pharmacogenomic CE modules
- Detailed preliminary study to build upon
- 200 full exomes from patients on SGAs

Pharmacovigilance in Practice

- Pharmacist-driven “Phase IV” trials
- Network allows for data collection at “time zero”
 - ie. Fanapt (iloperidone)
- Iterative approach
 - One time collection, ongoing interpretation

Operating Budget - \$200,000



Evolving the Profession of Pharmacy

and become the profession of 'why' and 'how'
'what' and 'when'



We hope you join us!

- BC Mental Health & Addictions Research Institute
 - Alasdair Barr
 - Ric Procyshyn
- BC Generations Project
 - John Spinelli
- Analysis of Severe ADRs
 - Steven Johnson Syndrome
 - Toxic Epidermal Necrolysis
- NASA/NSBRI
 - Yeast Microgravity
- Million Veterans Project



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Safe and Effective Pharmacy Care



BC GENERATIONS PROJECT

Your time today builds a healthier tomorrow.



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**COLLEGE OF PHARMACISTS OF BC
DECISION REQUIRED**

6.1: PODSA Bylaws Incentive Prohibitions

EXECUTIVE SUMMARY:

The Registrar of the College of Pharmacists of BC (CPBC) requested information and potential options for consideration by the Board to determine how to proceed with the incentive/loyalty program prohibition drafted for the College bylaws in 2012. The proposed incentive/loyalty program prohibition was removed by the Board from the set of bylaws approved at the February 2013 Board meeting, based on feedback received during the public comment period.

BACKGROUND:

“Incentives and loyalty programs encompass a range of mechanisms and strategies designed to encourage consumers to make certain choices including: changing their pharmacy, remaining with their current pharmacy, selecting particular pharmacy products or obtaining products or services on certain days. Incentives include programs, promises, or rewards that create an incentive for a patient to procure goods or services from a specific pharmacy.”¹

Results from an environmental scan of Canadian regulatory body prohibition legislation/policies, surveys on this issue, research, feedback and legal opinions obtained are summarized in the tables below. Detailed information obtained during the environmental scan is provided in the appendices.

Table A – Canadian Pharmacy Regulatory Body Prohibition legislation/policy (note: detail in Appendix A)

Jurisdiction / Implementation Year	Description of Prohibition
Alberta (2013)	<i>Prohibition Pending</i> ² <ul style="list-style-type: none"> - Prohibits provision or redemption of incentives for professional pharmacy products or services. - Does not prohibit free or discounted parking, free pharmacy services or products offered on compassionate grounds or payment for services or products using credit cards linked to incentives like points, loyalty points or rewards. Refer to Appendix D for draft regulatory provision.
Manitoba (2010)	Prohibits the provision of additional incentives over and above the usual amount of points, loyalty points or rewards for prescription drugs ³ .
Ontario (2004) & Prince Edward Island (2010)	<ul style="list-style-type: none"> - Prohibits incentives on prescription medications and professional pharmacy services and the redemption of points or awards to purchase medications. - Does not prohibit reimbursement of parking charges for patients providing the reimbursements are not advertised and does not prohibit the use of credit cards linked to awards programs to purchase prescription medications or professional services.
Quebec (2008)	Prohibits advertising that promotes consumption of medications; advertising of a discount, rebate, gift, trading stamp, bonus or other benefit of a similar nature for the purchase of a medication.
Newfoundland and Labrador (1999)	Prohibits any advertising that may be capable of interfering with the public's freedom of choice of a pharmacy or advertising of incentives related to the sale or distribution of prescription drugs.

¹ https://pharmacists.ab.ca/Content_Files/Files/InducementHighlights.pdf

² https://pharmacists.ab.ca/Content_Files/Files/Inducements_paper_apr18.pdf

³ <http://edmonton.ctvnews.ca/alberta-college-of-pharmacists-may-ban-rewards-programs-in-pharmacies-1.1051448>

Table B – Incentives/Loyalty Program Surveys (note: detail in Appendix B)

Organization and Year of Survey, Research or Feedback - Key Points
<p>Canadian Pharmacy Association (CPhA), 2005 CPhA Members: Most pharmacists employed in pharmacies with loyalty programs support the program and do not believe that the programs affect the public’s view of pharmacists. Pharmacists not employed in pharmacies with loyalty programs do not support the program and believe these programs have a negative impact on public perception of pharmacists. Most pharmacists regardless of where they work believe that loyalty programs effect when a patient fills their prescriptions.</p>
<p>Alberta College of Pharmacists (ACP), 2012 ACP Members: Survey of 1700 pharmacists, 75% of pharmacists surveyed⁴ voted in favour of prohibiting points programs.</p>
<p>College of Pharmacists of BC (CPBC), 2012 CPBC Members and the Public: 13,689 responses were received; 98% were in response to the proposed prohibition of loyalty programs; the majority of respondents were opposed to the prohibition. Safeway: Do not support prohibition, is unnecessary and unlawful, is not supported by evidence; is too broad, difficult to interpret and restricts trade and patient choice. Pacific Blue Cross (PBC): Support prohibition of loyalty programs for prescription drug purchases; see Appendix E for PBC data.</p>
<p>Saskatchewan College of Pharmacists (SCP), 2006 SCP Members and the Public: Provision of a reward program had minimal impact on the public perception of the pharmacists and minimal impact on how a patient chooses a pharmacy; hours of pharmacy operation and the friendliness of the staff had a greater impact on patient choice.</p>
<p>Manitoba Society of Pharmacists (MSP), 2005 MSP Members: Most members agreed that loyalty points should be awarded for the purchase prescription medications and should not be provided when a 3rd party payor pays for the medication. Most members felt more prescriptions were filled on ‘bonus days’. Some felt that they had insufficient time to counsel patients during a bonus day. About half knew of patients who postponed filling a prescription until a bonus day even if they would miss medication doses and almost all felt that loyalty bonus offerings should not be time limited offers to purchase prescription medications.</p>

Table C – Legal Opinion (note: detail in Appendix C)

Organization	Legal Opinion – Key Points	Legal Reference
CPBC 2012	CPBC Board has received legal opinions that outlined prohibition challenges from a legal perspective.	Distributed previously – not included in this briefing note.
Manitoba Society of Pharmacists (MSP) 2007 “Proposed Regulatory Provision, Section 73”	Legal analysis ⁵ of MSP’s Proposed Prohibition. - Not required for any legitimate patient care issue; - Would not withstand a Court challenge under <i>The Canadian Charter of Rights & Freedoms</i> ; - Is a restraint on trade, not connected to protection of the public, and is beyond the jurisdiction of self-governing professions to regulate. - No evidence of any harm or risk to patient care. - Lack of evidence of complaints, discipline proceedings or court cases. - No risk to public "over-buying" prescription drugs as a valid prescription is required. - The wide variety of incentives would make it difficult and unfair to draw distinctions between the incentive types. - Price Waterhouse Coopers 2009 Issue and Options	Supreme Court of Canada statement: - Is unlawful to deny a business freedom of expression through advertising, providing that advertising is not irresponsible or misleading. - Irresponsible or misleading promotion is addressed via pre-existing federal and provincial laws governing unlawful trade practices or misleading advertising. There is no need to prohibit legitimate incentive designed to reward customer loyalty. - A regulation aimed at maintaining a high standard of professionalism or ethics, or the ‘protection of the public’ cannot be used as a shield to disallow a right of an individual or a business to communicate responsibly to the public. Refer to Appendix B for MSP Analysis report and footnote below for MSP 2009 Position Statement ⁷ .

⁴ https://pharmacists.ab.ca/Content_Files/Files/InducementHighlights.pdf

⁵ http://www.msp.mb.ca/files/proposed_regulatory_prohibition_on_legitimate_inducements.pdf

DISCUSSION:

The College has received anecdotal evidence of the negative impact to pharmaceutical care of incentive/loyalty programs; examples include pharmacist reports of patients who fill prescriptions more frequently than required, patients who continue to refill expensive medications after they have stopped therapy to acquire points, patients who postpone prescription fills until bonus days, significantly higher number of dispenses on bonus days, patient use of multiple pharmacies or increased number of requests to transfer prescriptions to accumulate loyalty points, increased incidence of multiple or partial patient histories maintained at more than one pharmacy and increased patient demand for pharmacists to explain loyalty programs reduces the time available for pharmacist to provide effective patient counseling regarding medication therapies.

The Alberta College of Pharmacists has done significant research in this area and recently published (April 18, 2013) a paper “Incentive for Drugs and Professional Services, A Basis for Prohibition” which provides a synopsis of the issue, professional concerns and a position on the regulatory body role. Appendix E

The College Board has indicated previously its desire to prohibit loyalty and incentive programs but removed the prohibition from the set of bylaws approved at the February 2013 Board meeting, based on feedback received during the public comment period.

The Registrar is now seeking direction from the Board on how they wish to proceed.

OPTIONS

Option 1 – Respond to Public and Stakeholder Feedback

The options 1(A) and 1(B) are responsive to concerns regarding the broad scope of the original proposed prohibition which banned incentives to secure prescriptions or “in relation to the provision of the practice of pharmacy as defined in Section 25.8 of the *Health Professions Act*”. This definition included the full scope of practice of the pharmacist ie. compounding and dispensing drugs as well as identifying and assessing drug related problems (medication management), promoting health and preventing disease, and injection authority.

Option 1(A) – Implement Incentive Prohibition for Dispensing of Schedule 1 & Schedule 2 drugs

This option limits the prohibition on incentives to the dispensing of Schedule 1 and Schedule 2 drugs only. As the medication experts, the pharmacy profession has expressed the most concern about incentives linked to the filling of prescription orders and the resultant problems associated with this action. Therefore this option is responsive to the comments received during the public comment period, but also takes into account responsible action for the profession. Incentives would be permitted on other areas of pharmacy practice as defined within the pharmacist scope.

See proposed draft bylaws – Appendix F

(Note: *Health Professions Act* Bylaws, Schedule A, Conflict of Interest Standards, Standard 1 would need to be repealed).

⁷ http://www.msp.mb.ca/PDF/Bill41_PharmaceuticalAct_PositionStatement.pdf

⁶ http://napra.ca/Content_Files/Files/Bill_41_Regulations_PWCAAnalysis_Issue9_Inducements_Sept_10_2009_FINAL.pdf

Option 1(B) - Collaborate with stakeholders to identify a “middle ground” prohibition

Bylaws *could include* combinations of prohibitions. The following are just examples of what could be included for discussion with stakeholders: prohibition on transfer of prescriptions; allow loyalty programs to encourage patient to stay at one pharmacy but place limits on bonus days; prohibiting incentives on Schedule 1 drugs only. Draft bylaws below are provided as a sample of what they could look like for some of the examples noted above:

- PODSA Bylaws Part 1 – Definitions: “**incentive**” means money, gifts, discounts, rebates, refunds, customer loyalty schemes, coupons, goods, rewards and other prescribed things
- PODSA Bylaws Part 3 – Responsibilities of Pharmacy Managers, Owners and Directors:
 - *Ensure that no incentives are provided to the patient or the patient’s representative to obtain prescription transfers of Schedule 1 and/or*
 - *Ensure that any incentive provided to the patient or the patient’s representative to obtain a Schedule 1 drug is provided in a consistent manner and prohibits promotional changes*
- (Note: *Health Professions Act* Bylaws, Schedule A, Conflict of Interest Standards, Standard 1 would need to be repealed).
- HPA Bylaws Schedule F Part 1 – Prohibition on the Provision of Incentives
 - *No registrant shall provide or distribute or be a party to the provision or distribution of any incentive to a patient or patient’s representative for obtaining a Schedule 1 or Schedule 2 drug.*
 - *The above section does not prohibit registrants from:*
 - *providing free or discounted parking to patients who are obtaining a Schedule 1 or Schedule 2 drug,*
 - *providing free or discounted delivery services to patients who are obtaining a Schedule 1 or Schedule 2 drug,*
 - *permitting patient’s or patients representatives to pay for Schedule 1 or Schedule 2 drugs using major credit cards that are linked to incentives like points, loyalty points or rewards, except where, directly or indirectly, the incentives are awarded specifically for the purchase of a Schedule 1 or Schedule 2 drug.*

Option 2 – Implement Proposed Full Prohibition of Incentives as previously posted

This option would be to approve and submit to government the full prohibition on incentives for the pharmacists full scope of practice as defined in the HPA as previously posted (with minor modifications/updates as highlighted in green).

See Appendix G:

(Note: *Health Professions Act* Bylaws, Schedule A, Conflict of Interest Standards, Standard 1 would need to be repealed).

Option 3 – Status Quo

Maintain prohibition that currently exists in the *Health Professions Act* Bylaws, Schedule A, Conflict of Interest Standards.

Standard 1: Registrants Protect and Promote the Best Interests of their Patients in Achieving Their Chosen Health Outcome

Guidelines for Application:

- b) Registrants must not offer loyalty or incentive programs that are contrary to the patient’s best interests.

(Note: *Puts onus on registrants rather than owners/directors*)

APPENDIX A

Canadian Pharmacy Regulatory Body Prohibition Legislation/Policy Details by Jurisdiction

Jurisdiction	Prohibition Date, Description and Supporting Legislation or
<p>Alberta</p>	<p>Prohibition Date: 31, 2013</p> <p>Description: Prohibits provision, distribution or participation to provide or distribute any incentive that may be used to obtain Schedule 1 and Schedule 2 drugs, blood products and professional pharmacy services⁸, such as: cash, gifts, points, loyalty points, coupons, discounts, goods, rewards and similar schemes which can be redeemed for a gift or other benefit.</p> <p>Does not prohibit:</p> <ol style="list-style-type: none"> a. Free or discounted parking to patients receiving professional products or professional services from a licensed pharmacy; b. Free professional services or professional products on compassionate grounds; c. Free or discounted delivery services of professional products or professional services; d. Establishing the price for a professional product or professional service; e. Permitting payment for professional products or professional services by using major credit cards that are linked to incentive like points, loyalty points or rewards, except where, directly or indirectly, the incentives are awarded specifically for the purchase of professional products or professional services. <p>Supporting Legislation and Standards of Practice: <i>Code of Ethics</i>⁹ “The Code of Ethics forms part of the law that governs the practice of pharmacy and the operation of pharmacies. “</p> <p>“Principle 1 – Hold the well-being of each patient to be my primary consideration 13. Do not provide rewards or incentives that have the potential to cause harm to a patient.”</p> <p>Standards of Practice for Pharmacies “Standard 1 – A licensee must ensure the licensed pharmacy operates in accordance with the law.</p> <p>Application of Standard 1 1.1 A licensee must ensure that the licensed pharmacy operates in accordance with the law that governs pharmacy operations, drug distribution, the practice of pharmacists and the practice of pharmacy technicians, including, but not limited to: ...c) the Alberta College of Pharmacists Code of Ethics;”</p>

⁸ Professional services as defined in Section 3 of Schedule 19 to the Health Professions Act, <http://www.qp.alberta.ca/documents/Acts/h07.pdf>

⁹ https://pharmacists.ab.ca/Content_Files/Files/CodeofEthics_2011.pdf

Appendix A (cont)

Jurisdiction	Prohibition Date, Description and Supporting Legislation or Policy
<p>Manitoba</p>	<p>Prohibition Date: Oct 8, 2010</p> <p>Description: May provide the usual amount of points, loyalty points or rewards for prescription drugs, additional incentives are not permitted. on the transfer of prescriptions.</p> <p>Supporting Regulation: Pharmaceutical Regulation Policy Document¹⁰ <i>“Section 73 Incentive With the exception of the retail sale of a drug not pursuant to a prescription, a member or owner must not offer or provide any promotion or event that would provide a patient, or his or her agent, increase in the usual amount of points, loyalty points or rewards in the course of performing any activity described under section 2(1) of the Act.”</i></p>
<p>Ontario</p>	<p>Prohibition Date: July 1, 2004</p> <p>Description: Prohibits incentives on prescription medications and professional pharmacy services and the redemption of points to purchase medications.</p> <p>Does not prohibit: The use of credit cards linked to awards programs to purchase prescription medications or professional services or reimbursement of parking charges for patients filling a prescription as long as the reimbursement is not advertised.</p> <p>Supporting Policy: “Loyalty Program Policy”¹¹</p> <ol style="list-style-type: none"> a. Bonus points, loyalty points or air miles may not be awarded on prescriptions, prescription services, or other professional services related to the practice of pharmacy. b. Points may not be redeemed, or used to purchase prescriptions. c. Prescriptions, prescription services, or other professional pharmacy services may be paid by a major credit card that is linked to awards, loyalty points or air miles through special agreements with financial institutions, except where directly or indirectly, a special gift, bonus, or other incentive is offered for prescriptions, prescription services or other professional pharmacy services. d. This policy does not affect the College’s current position respecting pharmacies and parking charges. Pharmacies that reimburse parking charges (for a client who is having a prescription filled) are not in violation of current regulations (professional misconduct), as long as such reimbursement is not advertised.”

¹⁰ http://www.msp.mb.ca/files/section_73%281%29.pdf

¹¹ <http://www.ocpinfo.com/client/ocp/OCPHome.nsf/web/Loyalty+Program+Policy>

Appendix A (con't)

Jurisdiction	Prohibition Date, Description and Supporting Legislation or Policy
Quebec	<p>Prohibition Date: 2008</p> <p>Description: Prohibits advertising that promotes consumption of medications, i.e. advertising of a discount, rebate, gift, trading stamp, bonus or other benefit of a similar nature for the purchase of a medication.</p> <p>Supporting Legislation: <i>Quebec Code of Ethics for Pharmacists</i>¹² "Chapter 7 – Advertising, Section 98 No advertising by pharmacists or on their behalf may promote the consumption of medications; any advertising of a discount, rebate, gift, trading stamp, bonus or other benefit of a similar nature applicable to the purchase of a medication contravenes that requirement."</p>
Newfoundland and Labrador	<p>Prohibition Date: September 1999</p> <p>Description: Prohibits any advertising that may be capable of interfering with the public's freedom of choice of a pharmacy or advertising of incentives related to the sale or distribution of prescription drugs.</p> <p>Supporting Standards of Practice: <i>"Advertising in Community Pharmacies</i>¹³ - Section 5. Prohibitions A pharmacist or pharmacy shall not:</p> <ol style="list-style-type: none"> 1. Distribute to any practitioner prescription pads or any other matter having the name of the pharmacist or pharmacy thereon, for use by a practitioner in issuing a prescription to be dispensed by a pharmacist, 2. Give anything of value to another person for recommending the pharmacist's or pharmacy's services (This clause does not apply to the payment of costs or advertising), 3. Engage in any advertising that may be capable of interfering with the public's freedom of choice of a pharmacy, or 4. Engage in any advertising that offers incentives of any kind related to the sale or distribution of prescription drugs."

¹² http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=3&file=/P_10/P10R7_A.HTM

¹³ http://www.nljb.ca/Documents/Standards_Policies_Guidelines/SOPP-Advertising-September1999.pdf

Appendix A (con't)

Jurisdiction	Prohibition Date and Description
<p>Prince Edward Island</p>	<p>Prohibition Date: April 2012</p> <p>Description: Prohibits incentives for prescriptions, prescription services, or other professional services related to the practice of pharmacy and the redemption of points for the purchase of prescriptions.</p> <p>Does not prohibit: The use of credit cards linked to awards programs to purchase prescription medications or professional services or reimbursement of parking charges for patients filling a prescription providing the reimbursement is not advertised.</p> <p>Supporting Policy: <i>“Policy¹⁴ on Loyalty Points Programs</i></p> <ol style="list-style-type: none"> <i>1. Bonus points, loyalty points or air miles may not be awarded on prescriptions, prescription services, or other professional services related to the practice of pharmacy in Prince Edward Island.</i> <i>2. Points may not be redeemed, or used as legal tender, for the purchase of prescriptions.</i> <i>3. Prescriptions, prescription services, or other professional pharmacy services may be paid by a major credit card that is linked to awards, loyalty points or air miles through special arrangements with financial institutions, except where directly or indirectly, a special gift, coupon, bonus or other incentive is offered for prescriptions, prescription services or other professional pharmacy services in relation to prescription or prescription services.</i> <i>4. This policy does not prevent pharmacies from reimbursing parking charges (for a client who is having a prescription filled). They would not be in violation of current regulations (professional misconduct), as long as such reimbursement is not advertised.”</i>
<p>Saskatchewan</p> <p>New Brunswick</p> <p>Nova Scotia</p> <p>Northwest Territories</p> <p>Yukon</p> <p>Nunavut</p>	<p>Loyalty programs are not prohibited.</p>

¹⁴ <http://pei.in1touch.org/uploaded/68/web/pdf/Advertising%20-%20Loyalty%20Programs%20Policy%20April%202012.pdf>

APPENDIX B – Incentive/Loyalty Program Surveys

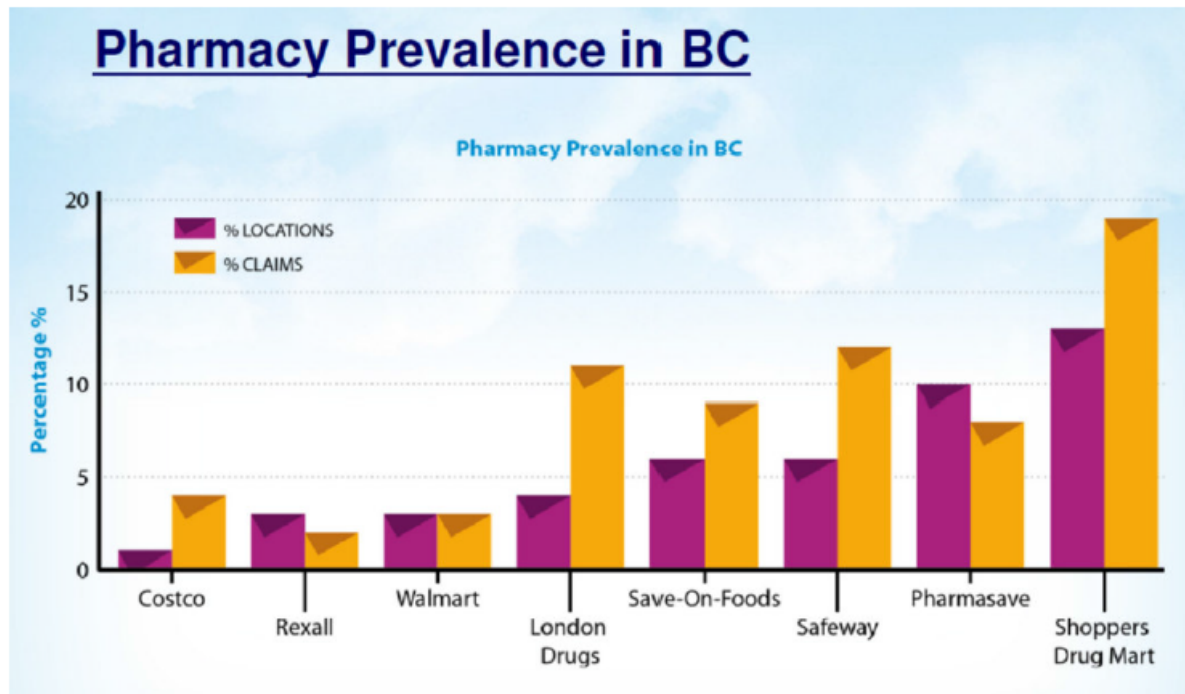
Organization and Year	Respondent Type, Survey / Research / Feedback Key Points
<p>Canadian Pharmacy Association (CPhA) 2005</p>	<p>CPhA Members:</p> <ol style="list-style-type: none"> 1. 65% of members working in pharmacies with loyalty programs support loyalty programs, while 23% not working in pharmacies with loyalty programs support loyalty programs 2. 60% believe that loyalty points programs affect when patients fill their prescriptions 3. Nearly 70% of members working in pharmacies with loyalty programs believe that the programs have no effect on the public's view of pharmacists as health professionals. 4. 70% of members working in pharmacies without loyalty programs believe these programs have a negative impact on public perception of pharmacists.
<p>Alberta College of Pharmacists (ACP) 2012</p>	<p>ACP Members:</p> <p>Research methods: web survey of 1,703 registered pharmacists and pharmacy technicians, focus groups with frequent pharmacy users, two online discussions with pharmacists to probe identified survey issue and one-on-one interviews with pharmacy stakeholders and representatives of other health professions. 75% of pharmacists surveyed voted in favour of prohibiting points programs.</p>
<p>College of Pharmacists of BC (CPBC) 2012</p>	<p>CPBC Members and the Public:</p> <p>The number of responses received during the public comment period was unprecedented at 13,689. 98% of responses were regarding the proposed prohibition of loyalty programs; the majority of respondents were opposed to the proposed changes.</p> <p>Safeway:</p> <p>The proposed prohibition is unnecessary and unlawful, that it seeks to interfere with the right of pharmacies and patients to participate in voluntary programs, it is not supported by evidence; it is unreasonably broad, will be difficult to interpret and restricts trade and patient choice.</p> <p>Pacific Blue Cross:</p> <p>Issued a letter of support to the CPBC in support of a bylaw prohibiting provision of loyalty points by pharmacies for prescription drug purchases. PBC provided data which suggests that loyalty programs influence prescription filling patterns. Refer to Appendix E.</p>

APPENDIX B (con't)

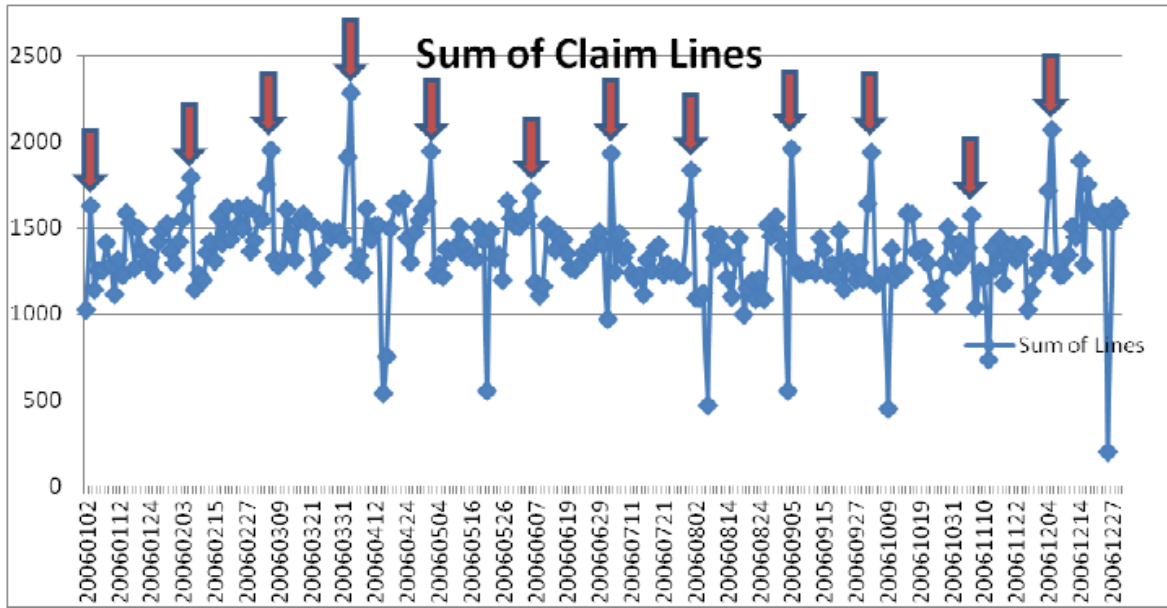
Organization and Year	Respondent Type, Survey / Research / Feedback Key Points
<p>Saskatchewan College of Pharmacists (SCP) 2006</p>	<p>SCP Members and the Public: The research study goals attempted to identify the public's perceptions of pharmacists. The research project included focus groups and a telephone survey which produced results that are statistically accurate to +/- 5%, 19 times out of 20. Public participants were asked to respond on a scale of 1 to 5 (1 = no influence and 5 = a lot of influence), on a variety of questions.</p> <p>Survey results:</p> <ol style="list-style-type: none"> 1) Whether or not the store has a reward program had minimal impact on the perception of the pharmacists (2.1) 2) Whether or not the pharmacy store had a rewards program had minimal impact on how the decision to choose which pharmacy to use was made (2.7); the hours of operation (4.1) and the friendliness of the staff (4.3) had a greater impact.
<p>Manitoba Society of Pharmacists (MSP) 2005</p>	<p>MSP Members:</p> <ol style="list-style-type: none"> 1) 74% completely agree that loyalty programs should not provide benefits in with respect to the purchase of prescription medications 2) 84% completely agree that loyalty programs should not provide benefits to a patient when a 3rd party payor pays for prescription medications 3) 88% of members employed at a pharmacy with a loyalty program felt that an increase in prescriptions filled occurred on "bonus days"; 54% estimated a 25% or higher increase. 4) 21% indicated that either always/most times an additional pharmacist assists with an increase in prescription volume during bonus days 5) 18% indicated they never have adequate time to counsel each patient during a bonus day 6) 47% were aware of patients who wait for a bonus day to fill their prescription even if they will be without their medication for a period of time 7) 92% completely agree that "bonus days" associated with loyalty programs should not provide time limited increased benefits for the purchase of prescription medications

APPENDIX B – Incentive/Loyalty Program Surveys

Pacific Blue Cross Claims Data



Chain Store	Rolling Year Ending October 2012				Year 2011			
	% Claims	Average Disp Fee	Rank	Change in Fee	% Claims	Average Disp Fee	Rank	Change in Fee
Costco	4.17%	\$4.42	1	0.49%	3.55%	\$4.40	1	-0.04%
Pacific Compounding Pharmacy**	0.38%	\$8.98	2	11.03%	0.30%	\$8.09	2	0.00%
London Drugs	10.69%	\$9.39	3	0.43%	10.93%	\$9.35	3	7.48%
Medicine Shoppe	2.06%	\$9.63	4	1.39%	2.09%	\$9.50	5	7.53%
The Antidote Pharmacy**	0.64%	\$9.70	5	2.37%	0.58%	\$9.48	4	0.00%
Save-On-Foods	7.30%	\$9.82	6	2.87%	7.50%	\$9.55	7	8.54%
Pricesmart Foods Pharmacy**	1.76%	\$9.85	7	2.48%	1.44%	\$9.61	10	0.00%
Drugstore Pharmacy	5.68%	\$9.85	8	2.78%	5.32%	\$9.58	8	9.75%
Overwaitea Pharmacy	0.32%	\$9.92	9	3.42%	0.40%	\$9.60	9	7.33%
Walmart	3.06%	\$10.06	10	3.38%	3.04%	\$9.73	11	13.37%
Thrifty Foods Pharmacy**	0.56%	\$10.19	11	2.18%	0.53%	\$9.98	12	0.00%
Paragon Pharmacy**	0.60%	\$10.29	12	-1.20%	0.53%	\$10.42	17	0.00%
All Other Stores	18.26%	\$10.31	13	2.11%	16.86%	\$10.09	14	0.00%
Safeway	11.88%	\$10.41	14	2.78%	12.09%	\$10.13	15	10.38%
Rexall	2.50%	\$10.44	15	3.97%	2.40%	\$10.04	13	6.29%
Shoppers Drug Mart	19.28%	\$10.48	16	1.10%	19.40%	\$10.36	16	2.68%
Central Drugs**	0.37%	\$10.79	17	2.97%	0.38%	\$10.48	18	0.00%
People's Drug Mart	2.66%	\$10.95	18	3.07%	2.79%	\$10.62	19	7.70%
Pharmasave	7.81%	\$10.99	19	1.96%	8.11%	\$10.78	20	6.59%
Zellers*					1.77%	\$9.53	6	9.79%
Northam Drugs Ltd***								
* Most Zellers stores closed May 2012								
** 6 stores split from All Other Stores in 2011								
*** Part of Shoppers Drug Mart since 2006								
Total for all Chains	100.00%	\$9.98		1.67%	98.23%	\$9.82		6.64%
Max Dispensing Fee Allowed by Pharmacare (At year End):		\$10.00				\$10.00		
Increases in Max Allowed Dispensing Fee:					July:	\$0.40		



Red arrows represent the days when bonus reward points were offered at this pharmacy chain

APPENDIX C – Legal Opinions

Organization	Legal Opinion	Legal / Legislative Reference	Outcome
College of Pharmacists of BC (2012)	The CPBC Board has received previous legal opinions that outlined challenges with the prohibition from a legal perspective.	Details to be provided during a Board meeting.	
Manitoba Society of Pharmacists (MSP) (2007) “Proposed Regulatory Provision, Section 73”	<p>Bob Sokalski, LLB report following analysis of MSP’s Proposed Regulatory Prohibition on Incentives¹⁵.</p> <p>Key report points:</p> <ul style="list-style-type: none"> - The proposed prohibition: <ul style="list-style-type: none"> o not required for any legitimate patient care issue; o would not withstand a court challenge Court challenge... based on jurisdiction, or the rights to freedom of expression under <i>The Canadian Charter of Rights and Freedoms</i>; o is in effect a restraint on trade, not connected to the protection of the public, and is beyond the jurisdiction of self-governing professions to regulate. - There is no evidence of any harm or risk to patient care resulting from loyalty programs. - There is a lack of evidence of complaints, discipline proceedings or court cases regarding loyalty programs; - There is no risk to public "over-buying" prescription drugs to obtain loyalty program benefits as the purchase of prescription drugs require a valid prescription. - Incentives vary from loyalty points, diabetes meters, free delivery or parking to free coffee; it would be difficult and unfair to try to draw distinctions between the incentive types. 	<p>The report states;</p> <ul style="list-style-type: none"> - The Supreme Court of Canada has stated that it is unlawful to deny a business freedom of expression through advertising, providing that advertising is not irresponsible or misleading. - Irresponsible or misleading promotion is addressed via pre-existing federal and provincial laws governing unlawful trade practices or misleading advertising. There is no need to prohibit legitimate incentive designed to reward customer loyalty. - Based on a review of relevant case law, a regulation aimed at maintaining a high standard of professionalism or ethics, or the ‘protection of the public’ cannot be used as a shield to disallow a right of an individual or a business to communicate responsibly to the public. 	<p>In 2010 MSP implemented a regulation that appears to exclude prescription drugs from loyalty programs¹⁶.</p> <p>Refer to Appendix D for Bob Sokalski’s 2007 report and Appendix B for MSP 2009 Position Statement.</p>

¹⁵ http://www.msp.mb.ca/files/proposed_regulatory_prohibition_on_legitimate_inducements.pdf

¹⁶ http://www.msp.mb.ca/files/section_73%281%29.pdf

APPENDIX C – Legal Opinions

Analysis of Proposed Regulatory Prohibition on Legitimate Inducements Bob Sokalski, Pitblado LLP-2007¹⁷

For information purposes, an analysis of Proposed Regulatory Provision, Section 73 has been carried out and the results of that analysis are now provided.

As will be seen in this analysis, the proposed prohibition is not one that is required for any legitimate patient care issue nor, is it one that could withstand a Court challenge either based on jurisdiction, or the rights to freedom of expression under The Canadian Charter of Rights and Freedoms.

In short, the proposed prohibition ought not to be included in the Pharmacy Regulations because the prohibition would do nothing towards the public interest and would be contrary to the laws that apply to these types of Regulations.

To be quite clear, the general purpose of pharmacy regulations is to afford protection to the public in a patient care setting. The question to ask is whether inducements harm the public; not whether the removal of inducements could harm the public. The simple fact is that there is no harm to the public from inducements. This is not a patient care issue and therefore has no place in the proposed pharmacy regulations. In fact, inducements are clearly a benefit to the public insofar as they promote loyalty, which pharmacists generally endorse as a positive factor in patient care.

There is virtually no evidence of complaints or discipline proceedings regarding inducements, nor are there any Court cases dealing with inducements in a pharmacy setting. Simply put, inducements are not a problem and have not proven to be an issue in regards to patient care or professional conduct matters.

Attached to this analysis is a review of survey information from the Manitoba Pharmaceutical Association, the New Brunswick Pharmaceutical Society, the Saskatchewan College of Pharmacists, the Manitoba Society of Pharmacists, and from the Ratiopharm CFP Report on Pharmacy Services: Consumers' Perception of Pharmacy. The New Brunswick and Saskatchewan survey results demonstrate that incentive programs have little influence over customers' pharmacy choices. Conversely professionalism had a much stronger influence. Thus, the profession can feel confident that their high standards for patient care are not threatened by commercial incentives for patients to maintain loyalty. Most pharmacists view loyalty as an attribute and the CFP Report recites statistics confirming the loyalty trend. The incentive programs under siege are interchangeably described as "loyalty programs". Customers are thus rewarded for loyalty - one would think a laudable result given the consensus among pharmacists that loyalty is preferable to frequent changes in pharmacy choices by customers.

Proposed Regulatory Provision, s. 73

Inducements

73 With the exception of the retail sale of a drug, a member or owner may not offer to provide a patient or their agent any of the following in the course of performing any activity described under section 2(1) of the Act:

- (a) a gift;*
- (b) a rebate;*
- (c) a bonus;*
- (d) points, loyalty points or rewards, which can be redeemed for a gift or other benefit; or*
- (e) any other inducement of a similar nature.*

Analysis

¹⁷ http://www.msp.mb.ca/files/proposed_regulatory_prohibition_on_legitimate_inducements.pdf

- *Based on the commentary provided with the proposed changes, this section would prohibit pharmacy owners or members from offering any type of loyalty program, such as air miles, to customers who purchase prescription drugs.*
- *There is no evidence of any harm or risk to patient care resulting from loyalty programs.*
- *The proposed prohibition is an unacceptable attempt to interfere with the marketing some retailers/pharmacies choose to use to build their business, while leaving other marketing initiatives alone. Whether a business decides to deliver a prescription to a customer's door, or give that same customer air miles, points or coupons redeemable on non-prescription items is a business decision - it has no bearing on the regulation of the profession, unless it involved false or exploitative advertising which would be prohibited in any event under pre-existing provincial trade practice legislation and federal competition law.*
- *This provision is in effect a restraint on trade, not in any way connected to the protection of the public, and restraint of trade is not what self-governing professions are empowered to regulate.*
- *The purpose of The Pharmaceutical Act and its regulations is the self-governance of the profession in order to protect the safety of the public. A customer can only purchase drugs (that are not GTC) with a valid prescription so there is no risk to the public of "over-buying" prescription drugs in order to obtain some loyalty program benefit.*
- *Even if pharmacists at some point are able to issue prescriptions, the pharmacists would still be bound to limit the amount prescribed. No ethical pharmacist would over-prescribe to allow a patient to take advantage of a loyalty program - therefore, there is no risk to the public on this front.*
- *Many have already noted that inducements come in many forms. One pharmacy may offer free parking, coffee, snacks, delivery, postage and promotional material. Another pharmacy may provide rent-free premises to nearby physicians in return for promotion of their pharmacy. Yet others may provide information packages, clinics, points, miles, dietician consultations, diabetic meters and sampling. These are all forms of inducement and it would be unworkable, unmanageable and unfair to try and parse or draw distinctions among these various forms of inducement. The prohibition on inducements will inevitably lead to the risk of discriminatory treatment among various pharmacies who choose to employ different forms of inducement. One way to resolve this inevitable dilemma is to place an absolute prohibition on any form of inducement regardless of how large or how small. Certain inducement programs involve loyalty rewards amounting to fractions of a cent, far less than the value or cost of free delivery, free parking, free coffee and similar forms of inducement. Where can a reasonable line be drawn? Simply put, it cannot be drawn. To venture down the road of prohibiting inducements must logically require that virtually all forms of inducement are prohibited.*
- *The Alberta College of Pharmacists, when faced with the prospect of being invited to prohibit all forms of inducement instead elected to prohibit none.*
- *To attempt to prohibit some forms of inducement under a Regulation designed for the protection of the safety of the public would be regressive and out-of-step with modern economic reality. In addition to the practical problems that make the proposed prohibition unfair and unrealistic, the proposed prohibition would not be able to withstand a legal challenge because this is not a matter of patient safety but purely and simply an economic matter that would be outside of the jurisdiction of the governing legislation and in addition, would be contrary to the rights to freedom of expression enshrined in The Canadian Charter of Rights and Freedoms.*
- *The proposed prohibition at its heart, is a restriction on **both** the right to offer an economic benefit and the right to advertise that benefit to potential customers. Similar restrictions on the right to*

inform the public and promote a business have been found to be unconstitutional by the Supreme Court of Canada and other jurisdictions.

- *The Supreme Court of Canada has stated that it is unlawful to deny a business freedom of expression through advertising, as long as that advertising is not irresponsible or misleading. If a promotion is irresponsible or misleading, there are pre-existing federal and provincial laws governing unlawful trade practices or misleading advertising. Thus, there is no need for pharmacists to venture into this area by prohibiting legitimate inducement designed to reward customer loyalty.*
- *Because commercial expression is protected under the Charter, "commercial enterprises have the constitutional right to engage in activities to inform and promote", - the orderly operation of our market economy depends on businesses and consumers having access to abundant and diverse information.*
- *In a case involving dentists who had participated in an advertising campaign, the Court said that a regulation that restricted both the manner and content of advertising was unconstitutional, in that it restricted the dentists' right to free expression and the public's interest in obtaining the information, under section 2(b) of the Charter. Since this case was decided in 1990, Courts have found other regulatory provisions that severely restrict advertising by professionals are not lawful.*
- *Therefore, based on a review of the relevant case law, a regulation aimed at maintaining a high standard of professionalism or ethics, or the "protection of the public" cannot be used as a **shield** to disallow a right of an individual or a business to communicate responsibly to the public. A blanket prohibition on advertising is not supportable at law. A prohibition on advertising that allows for some forms of advertising is also not supportable at law, unless it can be shown that the advertising is misleading or irresponsible.*
- *There is nothing about rewarding loyalty points or air miles (or advertising the same), on prescriptions that could constitute misleading or irresponsible advertising - unless the business did not deliver what it promised, and if so, provincial trade practice restrictions and federal restrictions prohibiting misleading advertising provide the required remedies.*
- *The analysis of the Manitoba survey results reveals two primary concerns:
 - bonus days; and
 - loyalty rewards on government subsidized purchases.*
- *The issue surrounding "bonus days" is easily addressed by pharmacists exercising appropriate professional judgment, or alternatively by expanding the "bonus days" to longer periods for loyalty rewards, or beyond that, eliminating the time limits or restrictions.*
- *The loyalty rewards on government subsidized purchases is a matter that comes under the jurisdiction of the Pharmacare Program. If the government considers this a legitimate area of concern, it can be addressed in the same way that it has restricted the use of coupons for subsidized purchases. In short, this is not the subject matter of professional regulations; rather, it falls under the jurisdiction of the province in relation to its subsidy of prescription drug cost assistance.*
- *In other jurisdictions across Canada, we were not able to locate any legislative prohibition against a pharmacist offering loyalty points or air miles on prescriptions, although there are a number of jurisdictions that have policies in place that limit whether points or air miles can be awarded (Ontario) on prescriptions, or whether a pharmacy can advertise that points will be awarded (P.E.I.). In other words, in P.E.I., loyalty points can be provided to customers as a reward for their loyalty on prescription items, but the pharmacies cannot advertise this fact pursuant to this policy. In Newfoundland and Labrador, incentives are not permitted by policy, but this policy is being reviewed*

at the present time because it has been brought forward on a number of occasions that the policy is not supportable at law. It should be noted that policies in of themselves do not have the force of law, and, we believe none of these policies would be upheld if challenged in a Court.

- *Practical Consideration: Because loyalty programs have been in existence for many years, and because many pharmacies have embraced loyalty programs on a national scale with an investment of significant amounts of capital, it would be very surprising if the proposed prohibition was not challenged in Court. In terms of jurisdiction and freedom of expression under the Charter, such a challenge would likely be successful based on the Supreme Court of Canada decisions to date. What does that mean for pharmacists in Manitoba? Simply put, Court action on this proposed prohibition is likely inevitable and the outcome is bound to sustain any challenge to the proposed prohibition on inducements based on jurisdictional arguments, and based on the Charter right to freedom of commercial expression. The substantial cost of contesting those challenges will inevitably be borne by pharmacists in Manitoba. Thus, in view of these legal issues, would it not make more sense to dedicate those financial resources to patient care issues that are much more deserving of the attention of pharmacists in Manitoba.*

Appendix D – Alberta College of Pharmacists – References



DRAFT Regulatory Provision – circulated for discussion
Feedback due by Dec. 3, 2012

Prohibition on the provision of inducements

1. In this regulatory provision
 - (a) "licensee" means a clinical pharmacist who holds a license issued under the *Pharmacy and Drug Act*;
 - (b) "regulated member" means
 - (i) a clinical pharmacist,
 - (ii) a courtesy pharmacist,
 - (iii) a provisional pharmacist,
 - (iv) student pharmacist,
 - (v) a pharmacy technician,
 - (vi) a courtesy pharmacy technician, and
 - (vii) a provisional pharmacy technician;
 - (c) "professional products" means
 - (i) Schedule 1 and Schedule 2 drugs as defined in the *Pharmacy and Drug Act*, and
 - (ii) blood products;
 - (d) "professional services" means
 - (i) the practice of pharmacists as described in section 3(1) of Schedule 19 to the *Health Professions Act*, and
 - (ii) the practice of pharmacy technicians as described in section 3(2) of Schedule 19 to the *Health Professions Act*; and
 - (e) "proprietor" has the same meaning as in the *Pharmacy and Drug Act*.
2. No regulated member, licensee or proprietor shall provide or distribute or be a party to the provision or distribution of any inducement to a patient or patient's agent for obtaining a professional product from a licensed pharmacy or a professional service from a regulated member, including cash, gifts, points, loyalty points, coupons, discounts, goods, rewards and similar schemes which can be redeemed for a gift or other benefit.
3. Section 2 does not prohibit regulated members, licensees or proprietors from:
 - a. providing free or discounted parking to patients who are receiving professional products or professional services from a licensed pharmacy;
 - b. providing free professional services or professional products on compassionate grounds;
 - c. providing free or discounted delivery services in respect of professional products or professional services;
 - d. establishing the price for a professional product or professional service;
 - e. permitting patients or patients' agents to pay for professional products or professional services by using major credit cards that are linked to inducements like points, loyalty points or rewards, except where, directly or indirectly, the inducements are awarded specifically for the purchase of professional products or professional services.
4. Guideline 13 of Article 1¹ of the Code of Ethics is repealed.

¹ Guideline 13 to Article 1 of the Code of Ethics reads:

13. Do not provide rewards or incentives that have the potential to cause harm to a patient.
It will be replaced by the proposed regulatory provision.

EMBARGOED UNTIL APRIL 18, 2013

Inducements for Drugs and Professional Services

A Basis for a Prohibition

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A note about pharmacy technicians

Offering inducements for drugs and professional services negatively impacts pharmacy technicians as well as pharmacists. However, because only pharmacists may assess a patient and the appropriateness of a prescription, and thus are the arbiters of the patient's drug therapy, the impact is greater for pharmacists. Because of this, and to allow for easier reading, this paper speaks only of pharmacists.

Understanding at a Glance

Issue Statement

It is not acceptable for pharmacists and pharmacy technicians to offer individuals inducements conditional on them being provided drugs, blood products or professional services. Inducements cloud decisions that should be based solely on the best healthcare.

Providing inducements in conjunction with drugs, blood products or a professional service is disruptive to:

- impartial decision-making,
- the coordination and continuity of care, and
- the effective operation of health teams and Alberta's health system.

Pharmacy Inducements Provided

- Inducements are provided in return for having a Schedule 1 or 2 drug dispensed or an immunization administered
- Inducements are provided for the total cost of drugs and professional services; not the amount that patients pay
- Bonus inducements are provided to transfer prescriptions to another pharmacy
- Bonus inducements are provided in return for prescriptions being dispensed during time-limited periods

Patient Behaviours Observed

The following patterns of patient behaviour have been observed:

- delays in filling prescriptions (*disrupts adherence to treatment, may compromise health outcomes*)
- requests to process prescriptions earlier than indicated (*negatively impacts pharmacist availability, creates conflict between pharmacist/patient and possibly pharmacist/prescriber*)
- requests for larger quantities of medication (*contributes to waste and potentially cost*)
- transferring of prescriptions from pharmacy to pharmacy (*disrupts continuity of care, introduces potential safety concerns*)
- distribution of prescriptions and care amongst different pharmacies to optimize inducement rewards (*disrupts coordination of care, introduces potential safety concerns*)
- have prescriptions dispensed at one pharmacy that offers rewards, but contact a pharmacist at a different pharmacy to obtain advice on using it (*disrupts coordination of care, negatively impacts pharmacist availability*)

Systemic Concerns

- Calls into question integrity of the pharmacy profession
- Disrupts relationships between patients, pharmacists, and other health team members
- Disrupts coordination and continuity of care
- Potential to negatively impact treatment goals and health outcomes
- Potential to contribute to medication waste
- Inducements cost the health system; they are an opportunity cost that should be reallocated to improve access and care

Proposed Prohibition

Prohibit pharmacists, pharmacy technicians and pharmacy proprietors from providing or being party to the provision of an inducement conditional on being provided a Schedule 1 drug, a Schedule 2 drug, blood product or a professional service from a pharmacist or pharmacy technician.

Drugs means any Schedule 1 or Schedule 2 product (primarily prescription drugs), not Schedule 3 drugs, health care aids or devices.

Inducement means any consideration including, but not limited to, cash, gifts, points, loyalty points, rewards, coupons, time-restricted discounts, goods, memberships, prizes and similar offerings which can be redeemed for a gift or other benefit.

Professional service means any service provided pursuant to Sections 3(1) and 3(2) of Schedule 19 of the *Health Professions Act*, but does not include the provision of Schedule 3 drugs or the provision of health aids and devices.

Executive Summary

Defining the issue

Providing inducements¹ in conjunction with drugs, blood products or a professional pharmacy service creates potential conflict of interest situations for both pharmacists and patients and clouds decisions that should be based solely on the best healthcare. It is disruptive to:

- The patient’s focus on health,
- Impartial decision-making by pharmacists,
- The coordination and continuity of care, and
- The effective operation of health teams and Alberta’s health system.

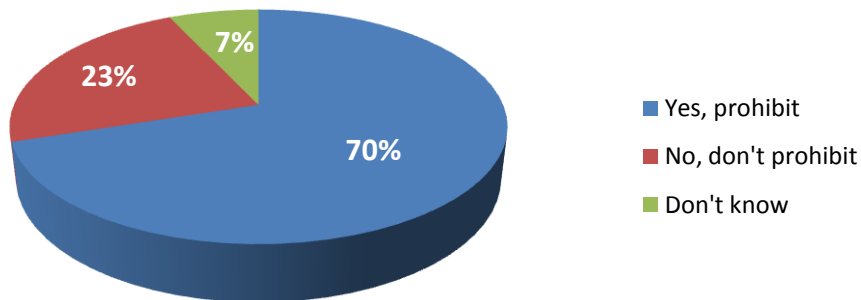
What is the college’s role in this?

The Alberta College of Pharmacists regulates pharmacy in Alberta. Our job is to protect the health of Albertans and the integrity of pharmacy. We do this by registering pharmacists and pharmacy technicians, licensing pharmacies, and setting ethical and practice standards.

We must carry out our activities and govern our registrants in a manner that protects and serves the public interest. Protecting and serving the public interest is not only about public safety or public wishes. It includes ensuring that the profession maintains its integrity and removing impediments to cooperative practice with other health professionals. It is about ensuring an environment for both patients and practitioners that does not detract from quality patient care.

Our registrants want a prohibition on inducements; 70% of surveyed pharmacists, pharmacy technicians, and pharmacy interns and students agree with prohibiting inducements in relation to the sale of prescription drugs and pharmacy services.²

Registrant support for a prohibition



Together with our registrants, the college believes inducements are detrimental to the integrity of the pharmacist profession, inter-professional cooperation, and quality patient care.

¹ **Inducement** means any consideration including, but not limited to, cash, gifts, points, loyalty points, rewards, coupons, time-restricted discounts, goods, memberships, prizes and similar offerings which can be redeemed for a gift or other benefit.

² Calder Bateman/Leger Marketing, *Survey of ACP Registrants*, Fall 2012

Why look at this issue now?

Pharmacists' role has rapidly evolved in the last twenty years from being a purveyor of drugs to being a patient care manager and coordinator of drug therapy. This role change has increased pharmacists' duty of care to patients and the need for close collaboration with other healthcare professionals. The role change is also instrumental in ensuring Albertans have better access to care. The importance of pharmacists' healthcare role cannot be fettered or conflicted by inducements.

In recent years, the college has also observed increases in the quantities and frequency of inducements, and the targeting of vulnerable populations.

- Most registrants (60%) believe inducements target certain populations – in particular seniors and low income Albertans – and that it is inappropriate to do so.³

Why a prohibition?

We, and pharmacists as health professionals, cannot condone programs that call into question the integrity of the profession, lead patients to make unhealthy choices, and result in the misuse of health resources.

Eliminating inducements for drugs, blood products and professional pharmacy services is about ensuring a practice environment where:

- Care decisions are made based solely on the best healthcare;
- Pharmacists practice on the basis of the highest ethical standards applicable to health professionals; and
- Outside influences, real and perceived, are removed from patient-professional relationships.

"I'll never forget the lady that came in with shingles. It was getting very close to her eye (which could have permanently affected her vision), but she didn't want to fill her prescription for two days because she wanted to earn a bonus offer."
- pharmacist experience shared during research session

It does not matter if inducements are one-time or long-term offers. It does not matter if some or all of the costs are paid by the patient or by a third party. The end result is the same: when healthcare decisions are based on anything except the best healthcare, the issues become clouded, integrity and objectivity are called into question, vulnerable individuals are targeted, healthcare relationships are disrupted, and the health system's ability to achieve desired outcomes is diminished.

Therefore, the college proposes prohibiting pharmacists, pharmacy technicians and pharmacy proprietors from providing or being party to the provision of an inducement to an individual conditional on the individual being provided a Schedule 1 drug, a Schedule 2 drug,⁴ blood product or a professional service⁵ from a pharmacist or pharmacy technician.

The prohibition will apply equally to all pharmacists, pharmacy technicians and pharmacies in Alberta and will only apply to drugs, blood products and professional pharmacy services. It will not apply to Schedule 3 drugs, health aids and devices, or others sales within pharmacies.

³ Calder Bateman/Leger Marketing, *Survey of ACP Registrants*, Sept. 2012

⁴ Schedule 1: Drugs that require a prescription as a condition of sale.

Schedule 2: Drugs that are available only from the pharmacist and without a prescription. There is no opportunity for patient self-selection.

⁵ A service within the practice of pharmacists and pharmacy technicians as defined in Section 3 of Schedule 19 to the *Health Professions Act*. The prohibition is not proposed to apply to Schedule 3 drugs, health care aids and devices.

1. An Overview of Inducements and Pharmacy in Alberta

Inducements defined

In general, an inducement is anything that may persuade an individual to act in a particular way. The inducement is meant to *push* an individual to make a decision or change, or to behave differently.⁶

Inducements include programs, promises or rewards that are provided to an individual on the condition that the individual purchases a Schedule 1 drug, a Schedule 2 drug or a blood product from a particular pharmacy or uses a particular professional service. Inducements are designed to encourage patients to change their behavior based on a program, promise or reward, not what is the best or preferred healthcare choice. Inducements in pharmacy were first encountered in the form of coupons; more recently they have been identified with loyalty programs (such as Air Miles, Aeroplan or Shoppers Optimum programs). However, inducements encompass a range of incentives designed to alter individuals' choice of access to care, and the treatment and professional services they receive as a result of the conditions associated with the inducement. The types of activities that fall within inducements range from providing cash to patients for prescriptions to providing benefits via coupons to sophisticated loyalty programs.

From a healthcare perspective, inducements encompass more than collecting points for economic rewards. They have psychological meaning for the consumer, and can directly influence a consumer's behaviour and choice of pharmacy.

Inducements offered on the condition that an individual purchase a Schedule 1 or 2 drug or blood product or use a particular professional service cloud decisions that should be based solely on health outcomes and create tension and disruption in relationships.

The pharmacy inducements climate in Alberta

In pharmacy in Alberta today, inducements can be provided in return for having a Schedule 1 or 2 drug dispensed or an injection administered. These are professional services which may only be provided by the pharmacist.

Inducements can be provided for the total cost of drugs and professional services, not just the portion paid by the patient.

Bonus inducements can be provided for transferring prescriptions to another pharmacy. They can also be provided in return for prescriptions being dispensed during time-limited periods.

Pharmacies, or third parties (such as Air Miles or Aeroplan) that are affiliated with the pharmacies, have a direct relationship with the consumer and are the direct beneficiaries of the loyalty generated by the program. Generally, the consumer of a product or service is the direct beneficiary of the rewards provided by the loyalty program.

"I have had some patients drop off a prescription at one pharmacy, have that pharmacy put the prescription on file, only then go to another pharmacy so they get inducements for transferring the prescription. What a waste of professional resources!"
- pharmacist focus group participant

⁶ Canadian Oxford Dictionary (1998)

Inducement programs are typically established and directed by the pharmacy ownership (e.g., the owner or corporate office), but it is the pharmacists and pharmacy technicians who interact with the individuals receiving the inducements, thus pharmacists become the administrators and providers of programs over which they often have no decision-making role or control. In fact, the inducements are provided conditionally on the drugs and services that they provide.

The evolving role of pharmacists

A key reason that inducements need to be prohibited in pharmacy practice is that the relationship between pharmacists and patients has changed fundamentally and will continue to change in a manner that has pharmacists playing a greater role in patients' primary healthcare. Over the past twenty years, pharmacists have moved beyond being purveyors of drugs to being professional managers of drug therapy.

While dispensing drugs remains a key part of pharmacy practice, the role of pharmacists is moving beyond this. Pharmacists are shifting their focus to the delivery of professional pharmacy services such as medication management, administering injections and prescribing drugs. In so doing, pharmacists are assuming more significant roles as essential health professionals who form part of a patient's care team. This developing role as an integral part of a patient's healthcare team is central to the effectiveness of pharmacists and pharmacy technicians in the modern healthcare environment.

Pharmacists take full responsibility for care decisions they make and require long-term relationships with patients and their other healthcare providers to provide the continuity implied by the changes in their responsibilities.

As pharmacists provide primary care and manage chronic disease, they play a vital part in coordinating patients' drug therapy and make critical decisions about patients' care. This role includes changing treatments, initiating new treatments, and sometimes stopping treatments. Sometimes the appropriate intervention of a pharmacist is to *not* provide a prescription drug. The professional service associated with these decisions is invaluable, despite the conflict that the inducement offered is only available if a drug is dispensed.

Inducements that are conditional on a drug being dispensed or a professional service being provided drive patient demands and undermine the pharmacist's ability to effectively counsel a course of treatment. In this context, inducements also have the potential to undermine the credibility and integrity of pharmacists from the perspective of other members of the healthcare team, who are not compelled by corporate policy to provide inducements in exchange for a patient purchasing a particular form of treatment.

- There are almost 4500 pharmacists in Alberta. As of March 28, 2013, Alberta had:
 - 2081 pharmacists authorized to administer vaccinations, and
 - 229 authorized to prescribe.
- Pharmacists are now paid for services in addition to dispensing (see Appendix 1 for details).
- The interaction of the pharmacist with a patient today is more than a transaction based on dispensing and selling a drug.

2. The Dual Role Between Consumer and Patient

When an individual seeks a healthcare service the individual assumes two roles: the *consumer* (primarily driven by economic interest) and the *patient* (primarily driven by health concerns). Depending on the risk involved in the decision to obtain the service, the patient role may have more influence than the consumer role, and vice versa.

A key challenge with inducements is that the consumer role is often brought into conflict with the patient role. Patients are placed in a position where competing interests (in the form of psychological or economic rewards) undermine the integrity and trust of the health-based patient-pharmacist relationship. Therefore, it is important to understand these two roles.

a. Consumer role

Consumers buy for a variety of reasons and can be influenced in their purchase decisions by a number of factors. Marketers understand that purchase decisions can be complex and have studied consumers to determine the best way to influence them to make specific purchases. Within the consumer decision-making process there are many opportunities to use inducements to influence purchase decisions.

The decision to purchase any product or service can be broken down into a five-step process.⁷ In turn, each step of the decision-making process can be influenced by a number of factors and the context of each purchase decision is important. When marketing products and services, a business considers the entire decision-making process in order to influence purchase decisions. This decision-making model is particularly useful when considering a purchase that might require more information or thought, such as drugs and professional pharmacy services.

i. *The consumer purchase decision-making process*

- *Need or problem recognition.* The consumer determines there is a purchase need or problem to be solved. The need can be recognized independently, or it can be influenced by marketing messages.
- *Information gathering* is the next step in purchase decisions. If the problem is relatively simple, the information search will be short or non-existent. However, when the problem is complex, the information search can be extensive. Healthcare concerns are often complex, and chronic diseases even more so. Healthcare is a rich and growing marketplace for products and services. Direct-to-consumer advertising of drugs in the United States demonstrates this (and its influence is felt in Canada).

Marketing in healthcare is fraught with issues related to the reliability and integrity of the information provided. Consumers of healthcare products need objective professionals who can help them navigate conflicting and changing sources of information. If the professional that provides the professional guidance is driven by profit-making or pressured to promote specific consumer benefits, it may be difficult for the professional to provide unbiased information or for the patient to have confidence in the information.

⁷ Sandhusen, Richard L; Marketing. (2000)

- At the *alternative evaluation stage*, a consumer takes the information the consumer has gathered and evaluates it against a number of important criteria. For example, cost, service, location of the place of purchase, the reputation of the business or various attributes of the product. Each of these criteria, and their weighting, is individual and personal. The availability of an inducement would be considered in this evaluation.
- Following the *purchase decision*, the final step is the *post-purchase evaluation*. Inducements can provide a cost-purchase psychological benefit in the post-purchase evaluation. For example, the perception of the high cost of a prescription can be softened with an offer of a reward for the amount of money spent.

ii. Psychological and economic impact of inducements on consumers

Inducements provide value to consumers economically as well as psychologically. When consumers redeem their points or coupons for rewards they realize the *economic value* of the program and this in turn further reinforces purchasing behaviour.⁸

In addition, a consumer will assign *psychological meaning* to an inducement program. When a consumer signs up for an inducement program there is a psychological anticipation of the collection of points and the subsequent ability to obtain the rewards.⁹ Consumers even go so far as to describe “a high” associated with the collection of points.¹⁰ Forty-three percent of Canadians get a rush from accumulating reward points, while 48 percent say it affects their shopping behaviour.

Inducement programs modify consumer behaviour. It is interesting to note that 78 percent of Canadian consumers report that they shop strategically to accumulate points, and 35 percent of consumers have driven beyond a nearby retailer to get to one where they can earn points.¹¹ Consumers with a higher personal income are more likely to acknowledge that inducement programs influence their buying behaviour.

While programs benefit both the pharmacy (economically) and the consumer (economically and psychologically), these programs actually impair the patient-pharmacist relationship when the weighting a consumer places on the value of an inducement is higher than the value the consumer places on the advice given by their pharmacist or the continuity of their relationship with the pharmacist.

iii. Consumer participation in inducement programs

Canada has the largest percentage of citizens who participate in loyalty-based inducement programs.¹² In 2012, 94 percent of Canadians reported being a member of at least one loyalty program.¹³ On average, Canadians belong to 6.4 loyalty programs.

⁸ Szczepanska & Gawron (2011), *Loyalty Programs Effectiveness*, Foundations of Management, Vol. 3 No. 2

⁹ Szczepanska & Gawron (2011), *Loyalty Programs Effectiveness*, Foundations of Management, Vol. 3 No. 2

¹⁰ Davies, Kyle & Daniel, Rob (2011) *Maritz Insight Report*

¹¹ Davies, Kyle & Daniel, Rob (2012) *Maritz Insight Report*

¹² Davies, Kyle & Daniel, Rob (2011) *Maritz Insight Report*

¹³ Davies, Kyle & Daniel, Rob (2012) *Maritz Insight Report*

Three of the top five loyalty programs in Canada - Air Miles, Shoppers Optimum, and Aeroplan - are offered by pharmacies. The most popular loyalty programs in Canada¹⁴ based on the percentage of Canadians enrolled are as follows:

- Air Miles* (79 percent)
- Canadian Tire Money (56 percent)
- HBC Rewards (56 percent)
- Shoppers Optimum (54 percent)
- Aeroplan (44 percent)

b. Patient role

Inducements are powerful marketing tools. It is apparent inducements influence the buying behaviour of patients seeking pharmacy products or services.

Obviously, the consumer/patient is one individual. However, there are some unique attributes to a patient role in the purchase decision-making framework. These attributes include the vulnerability of certain types of consumers.

College registrants have observed that certain populations are currently targeted with inducements, identifying seniors and the elderly, Albertans with lower incomes, those on social assistance, those with drug plans or insurance coverage, those who take expensive medications, and mental health patients, as targeted groups.

These diverse groups all have contact with the health system and with pharmacists. From a public protection perspective, the marketing messages associated with inducements, particularly in a pharmacy setting, may be directed to these more vulnerable patient populations and they would be particularly susceptible to targeted market inducements.

78% of surveyed registrants feel it is not appropriate to target a population with inducements.

60% of surveyed registrants believe inducements target certain populations – in particular seniors and low income individuals.

Calder Bateman/Leger Marketing survey findings, Sept. 2012

c. Healthcare purchases vs. consumer purchases

In this discussion, not only do we have to keep in mind the differences between the role of consumers and the role of patients, but also the differences between healthcare purchases and consumer purchases. Healthcare products and services, including professional pharmacy services, are different from other consumer purchases.

- As seen in the purchase decision-making model, all purchases involve an information gathering phase. The difficulty with healthcare information is that the patient is an important modifier of the context in which that information is provided. While most disease conditions have predictable courses, each patient will experience a disease differently due to a host of factors. In healthcare, mass-produced information must be individualized for each patient's particular situation. **Patients must be able to trust that their pharmacist is providing unbiased information, free from pressure that**

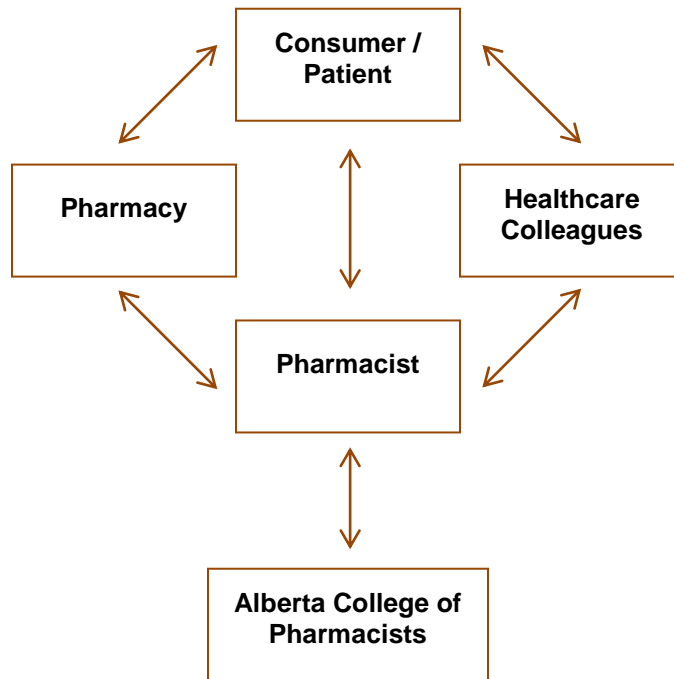
¹⁴ Kubas Primedia (2011), *Major Markets Retail Survey*

inducements may have on recommendations about appropriate medication therapy. Even the perception of bias is detrimental to informed decision-making.

- The decision to purchase a pharmaceutical product or service is a high-risk purchase. There is potential risk in terms of appropriateness of a drug choice, interactions between drugs, side effects of drugs and individual healthcare needs. A pharmacist who is familiar with an individual's health concerns and drug therapy needs can mitigate these risks. **Patients, especially those who may be vulnerable or disadvantaged, should not feel forced to choose between their economic needs and their health needs when selecting a pharmacist, pharmacy, or drug therapy.**
- Inducements are being used more frequently for a growing range of professional services, beyond drug products. When prescribing a drug, administering an injection, or reviewing medication therapy, a pharmacist is called upon to assess the needs of a patient and determine the appropriateness of the service or product. Providing the inducement conditional on a patient receiving a pre-determined drug or professional service conflicts with the responsibility of the pharmacist to first assess the patient and determine whether the drug or professional service is appropriate for the patient. **Pharmacists need to be able to deliver professional services and make assessments in the best interests of the patient, without feeling pressured by what may be conflicting interests of a pharmacy's inducement program.**
- From the perspective of professional standards of practice, pharmacists must be able to exercise independence in their judgment. **Pharmacists must be free from pressure from consumers, who only receive the inducements if they receive the drugs, blood products or professional services.**

3. How Inducements Disrupt Relationships

The major relationship in which inducements are used is between a consumer and a pharmacy. However, it is most often the pharmacist who deals directly with the patient in these transactions. Therefore, the relationships between a pharmacist and a pharmacy, a pharmacist and the Alberta College of Pharmacists, a pharmacist and other healthcare colleagues, and ultimately between a pharmacist and a patient are all affected by the use of inducements.



We'll take a closer look at the impact of inducements on each of these relationships.

a. The pharmacist-patient relationship

As the role of pharmacists shifts from a purveyor of drugs to a coordinator of drug therapy, the fundamental relationship between pharmacists and patients has changed. Pharmacists take full responsibility for care decisions they make and thus require long-term relationships with patients to provide the continuity implied by the changes in responsibilities.

The challenge with the use of inducements in this environment is that the consumer role can override the patient role. **Patients should not be placed in a position where they must choose between an economic benefit and what is best for their health. When the desire for a reward conflicts with professional advice and care, it can place the patient at risk.**

College registrants have relayed several experiences and instances where inducements have interfered with the patient-pharmacist relationship. For example:

- Patients transferring one or two expensive medications to a different pharmacy to obtain inducements at that pharmacy, thus creating incomplete patient records at two pharmacies.

- Patients obtaining medications at several different pharmacies to maximize their inducements, without the knowledge of the pharmacists. This led to the patient experiencing adverse effects resulting from the interactions of the medications. (Electronic health records are not yet robust enough to prevent these situations.)
- Patients filling their prescription at one pharmacy that offers rewards, but contacting a pharmacist at a different pharmacy, whom they felt was more knowledgeable, to ask about the medication and obtain advice on using it.
- Patients making choices about drug therapy and other health decisions based on the inducement available, rather than on the professional advice of the pharmacist.

“Patients don’t have complete profiles, which inhibits my ability to provide professional service and advice, checking for interactions...”
 - pharmacist focus group participant

The patient-pharmacist relationship needs to be rooted in integrity and trust. **Patients should select their pharmacist based on the pharmacist's knowledge and quality of care, not based on inducements. Patients and pharmacists should be able to make health decisions free from competing economic and psychological influences.**

Pharmacists must assess the appropriateness of the prescription when dispensing, even if the initial assessment and prescribing was done by another healthcare professional. The pharmacist’s assessment may identify that a patient does not need drug or professional service prescribed and therefore the patient may not qualify for the inducement that the patient will anticipate receiving. In this situation, inducements create conflict between the patient and consumer roles, and between the patient and the pharmacist.

When the therapy the pharmacist believes is in the patient’s best interest reduces or eliminates inducements for the patient, it creates conflict between the pharmacist and the patient and is counterproductive to health-based decision making.

b. The pharmacist-pharmacy relationship

Pharmacists play a unique role in healthcare as they are amongst the only health professionals to work extensively in retail settings. While this is a boon for patient access to care, it is proving a hindrance for the evolution of the profession in modern healthcare because components of the retail process, like inducements, are now hampering practitioners from realizing their full potential as healthcare professionals.

With the expansion of pharmacists’ role has come a change in the pharmacist-pharmacy dynamic. When the role of the pharmacist was focused on dispensing medications, the pharmacist was largely engaged in a *retail practice*. Now, as they take on expanded responsibilities, pharmacists are undertaking *professional practices in retail environments*. This distinction is important, and underlies a conflict between pharmacists and pharmacies around inducements, particularly when the pharmacist is an employee of the retail employer.

To put the magnitude of the conflict in context, let's look at the numbers. There are just over 1000 community pharmacies in Alberta and they employ approximately 4000 of Alberta's 4500 pharmacists.¹⁵ The majority of these pharmacies offer inducements.

As part of the 2012 inducements survey, registrants were asked, "Do you believe inducements and loyalty programs in relation to the sale of prescription drugs and pharmacy services should be prohibited?"

Again, the registrant call for a prohibition was confirmed: 70% said yes to a prohibition. Of responding registrants who work at a pharmacy which currently offers some kind of inducement or loyalty program, 65% said yes to a prohibition.

Inducements have long been used by pharmacies to increase the number of prescriptions filled. In recent years, pharmacies have been increasing the value of the inducements awarded. Even if a patient is satisfied with the service at their current pharmacy, they may find the increased rewards at another difficult to refuse.

The issue of pharmacist autonomy in an employer-employee relationship can be difficult to negotiate when the power dynamic favours the employer. Indeed, college registrants have pointed to instances where the inducements offered by their employer have created conflicts for the pharmacist. For example:

- Inducements take time away from pharmacists' that should be spent providing patient care.
 - Patients are less interested in learning about the medication they are taking, and instead focus their discussions with the pharmacist on the rewards associated with the purchase.
 - The pharmacist's time is consumed with administrative concerns about inducement programs.
 - The pharmacist is taken away from helping other patients to deal with customers' issue with inducements.
- Pharmacists are overwhelmed on special "transfer promotions" wherein high volumes of patients transfer their prescriptions between pharmacies to take advantage of an inducement such as "bonus points". The time and attention to patient care is compromised when pharmacists and pharmacy technicians are forced to deal with the higher than normal prescription volumes.
- Pharmacists struggle with the ethical dilemma of delivering professional services for which inducements are rewarded. It is inappropriate for pharmacists to provide cash to patients in exchange for professional services; the provision of inducements, which can be converted into cash and gifts, is in the eyes of many pharmacists tantamount to the same unethical practice.

"Time is taken away from pharmaceutical care in order to explain incentives or lack of certain rewards."
- registrant survey participant

Pharmacists are caught between meeting the expectations of their retail employers, dealing with consumers focused on the inducement offered by the employer, delivering professional pharmacy services in the best interests of their patients, and observing ethical guidelines.

Inducements thereby worsen the tensions inherent in the modern pharmacist-pharmacy relationship, and interfere with the patient-pharmacist relationship.

¹⁵ ACP registrant database, Jan. 14, 2013

c. The pharmacist-other healthcare providers relationship

As the role of pharmacists has expanded, the relationship between pharmacists and other healthcare professionals has changed significantly as well. Team-based care has taken on a larger role than ever before in the management of patients in the health system. This team-based care and the role of the pharmacist in it will expand in a health system that faces increasing demands with fewer resources.

However, inducements negatively impact healthcare teams and patients. When a patient transfers pharmacies or uses multiple pharmacies to chase inducements, the patient’s relationship with the pharmacist is not the only one affected. It also impacts the relationships between the pharmacist and the other members of the patient’s healthcare team. It takes time to establish a complete patient history, mutual therapy goals, and lines of communication among team members who often practice in different locations and see the patient over differing periods of time. If team members are constantly changed or only have access to portions of a patient’s medical and care history, it makes it extremely difficult for them to work together effectively and ensure continuity of care.

With formalized teams, such as those being created in Primary Care Networks and Family Care Clinics, inducements are creating another kind of tension. Pharmacists, doctors, nurses and other allied professionals are concerned that pharmacists are the only members of the team who can offer inducements.¹⁶

For team members to work together most effectively and maximize health outcomes for patients, it is important that there be no question that pharmacists are objective healthcare professionals who are valued by patients for their expertise, not their ability to provide inducements. Accordingly, pharmacists must be subject to similar rules of conduct that prevent the possibility or perception that pharmacy services are being accessed or recommended for any reason other than the health of the patient. This means implementing a prohibition on inducements in pharmacy practice, similar to the prohibitions in place for other health professionals.

“Please, put pharmacists on the same level as other healthcare professionals we collaborate with!”
- pharmacist focus group participant

Inducements given for drugs and professional pharmacy services undermine the coordination, communication and trust required among health team members. If teams can’t function properly, this compromises the health system’s ability to achieve outcomes that would benefit Albertans, including the delivery of better integrated care and the expansion of team-based care in delivering primary health services.

¹⁶ In Alberta, physicians, dentists and physiotherapists all have some type of inducement prohibition in place.

Ontario, Newfoundland, PEI, and Quebec prohibit inducements on prescription drugs. BC prohibits inducements on all drugs and pharmacy services covered by PharmaCare, the provincial coverage plan. Manitoba prohibits inducements to transfer prescriptions.

d. The pharmacist-regulator relationship

The Alberta College of Pharmacists is the regulatory body for pharmacy in Alberta. Our job is to serve and protect the public interest and the profession’s integrity. For the last century, the college has set and maintained high pharmacist qualifications and practice standards.

To discuss the relationship between a pharmacist and the college, it is important to understand the college’s responsibilities to individual pharmacists and to the profession as a whole.

i. The college’s role with pharmacists

Pharmacists are first and foremost health professionals. Professionals are generally understood to hold themselves to higher standards in terms of:

- A duty to serve a client, to put the clients interest ahead of the professional’s own interests
- Professional ethics and behaviour
- Work ethic and quality
- Maintenance of competence throughout their career
- Confidentiality of information from a client and maintenance of trust relationship
- Holding a positive attitude towards the profession
- A high degree of collegiality among the members of the profession

The college’s Code of Ethics sets out our professional expectations, specifying that, “The responsibility that comes with being an essential health resource is significant. As professionals, pharmacists and pharmacy technicians are challenged and expected to abide by a higher standard of conduct.”

As pharmacists have evolved from purveyors of medication to essential members of the team of health professionals that serve the health needs of patients, it has become even more crucial that pharmacists hold themselves, and are seen to be held, to a high standard of professionalism. **The use of inducements in pharmacy practice undermines pharmacists’ reputation as trusted, objective health professionals.**

Moreover, college registrants have said that inducements further reinforce the public’s view of pharmacists as “pill counters” in a business context, rather than as health professionals. This view limits the expansion of pharmacists’ responsibilities and the potential to improve Albertans’ access to primary care services. **A compromised view of pharmacists due to use of inducements diminishes efforts to improve healthcare access for Albertans.**

78% of surveyed registrants felt that the use of inducements has a negative impact on pharmacists’ view of their own profession.

Two-thirds of respondents (67%) felt that inducements negatively impact the public’s view of pharmacists.

Calder Bateman/Leger Marketing survey findings, Sept. 2012

ii. The college’s role with the profession

The Alberta College of Pharmacists’ role in leading the pharmacist profession includes shepherding appropriate legislation. As the profession has changed, we have seen to it that the legislative framework governing the conduct of pharmacists reflects the expanded role

and responsibilities of pharmacists and ensures safe, appropriate and effective care for all patients.

Today's patient-centric practice is mirrored in the college's expectations of pharmacists, as set out in the Code of Ethics and Standards of Practice. The Standards include such requirements as the maintenance of patient records, private and semi-private consultation areas, and patient follow-up for drug management.

The Code of Ethics compels pharmacists to do more than cooperate, and actually "demonstrate responsibility for self and other health professionals" (Principle 11) by "challeng[ing] the judgment of colleagues and other health or social care professions if [they] have reason to believe that their decisions could compromise the safety or care of others." This statement makes it clear that pharmacists have autonomy for their practice and their decision-making. Principle 12: *Nurture the Profession* tells pharmacists to maintain professional relationships with colleagues and other healthcare professions.

Pharmacists' autonomous decision-making and the ability to successfully collaborate with other health professionals will be continually challenged as long as their integrity and objectivity is called into question because of their association with inducements.

e. The patient-insurer relationship

Consumers do not always pay for their drugs and professional services. Third-party insurance plans, whether government-, corporate-, or privately funded, may pay for a portion or all of the cost of the drugs and professional services provided. Insurance premiums paid by the individual consumer are usually much less than the payments made for pharmaceuticals on their behalf.

In essence, third-party insurance plans are supplementing the consumer, while the consumer reaps the rewards from the inducements. This poses an interesting ethical dilemma: should patients/consumers receive benefits or rewards for products or services for which they do not pay?

This dynamic also influences patient behaviour, undermining the patient-pharmacist relationship, creating potential risks to patients' health, and creating opportunity costs that should be reallocated to improve access and care.

College registrants have relayed several experiences of patients making questionable and unhealthy choices in order to take advantage of inducements. For example:

- Patients who have delayed getting their medication and interrupted drug therapy to capitalize on a forthcoming inducement campaign.
- Patients who have discarded their medication supply to justify a refill and take advantage of an inducement offer (e.g., refilling on a "bonus points" day).
- Patients who have repeatedly filled small prescription amounts, rather than obtaining the supply recommended by the health professional, so that the total cost (and hence total rewards) are higher.

College registrants have noted that in many cases, patients have little or no incentive to stop engaging in these behaviours. In cases where patients only pay a small co-payment (and where the

third-party insurer pays the balance), the value on which awards are calculated is substantially greater than what the individual has paid.

Offering an inducement can make the purchase of an expensive product more desirable because of the anticipated reward to be gained from the purchase.¹⁷

A system in which patients chase inducements creates higher costs for the government and insurance companies, resulting in higher costs for insurance plan members and taxpayers.

Without inducements influencing their choices, patients would not be tempted to behave in ways that cost the health system. Prohibiting inducements will reduce medication waste, reduce costs to the health system, and bolster relationships among patients, their pharmacists and other health team members that are important to patients' ongoing care.

¹⁷ There is also evidence that inducements can soften price competition as the consumer's focus moves away from the actual price of the product or service to the amount of the reward available with a purchase. [See Kim, B., Shi, M. & Srinivasan, K. (2001), *Rewards Programs and Tacit Collusion*, Marketing Science, Vol. 20, No. 2, pp. 99-120]

Conclusion

There are a number of reasons to consider prohibiting inducements offered in conjunction with drugs and professional pharmacy services in Alberta now.

- The scope of pharmacists' practice is expanding to include additional responsibilities for medication management. The number of pharmacists obtaining authorization to independently prescribe medications and administer injections is increasing steadily in Alberta.
- Pharmacists are increasingly working as part of healthcare teams.
- Pharmacists are paid for professional pharmacy services in addition to dispensing.
- There now needs to be a different type of professional relationship between a pharmacist and a patient. The interaction of the pharmacist with a patient today is more than a transaction based on dispensing medication. The pharmacist has an increased responsibility for the ongoing healthcare of their patients.
- In recent years, there have been increases in the quantities and frequency of inducements, and the targeting of vulnerable populations.
- Within the context of the current role of pharmacists, the use of inducements in pharmacy negatively impacts the integrity and trust of the patient-pharmacist relationship, and negatively impacts the reputation of the profession.
- Inducements create a fundamental conflict in patients, between their desire to seek economic and psychological rewards versus following the professional health knowledge and advice of their pharmacist.
- The shift of pharmacists' primary responsibility from retailing drugs to delivering professional practices has, in retail environments, generated a new dynamic between pharmacist employees and their retail employers. Inducements exacerbate conflicts between pharmacist employees, who need to make unbiased professional judgments in the best interests of the patient, and their retail employers, who have financial interests in offering the inducement.
- Inducements can drive individuals to access pharmacy services in ways that are not health-rational, jeopardizing their continuity of care and driving up costs to the health system, governments, insurance companies and taxpayers.

From our perspective, and that of our registrants, the use of inducements in relation to drugs, blood products and professional pharmacy services should be prohibited. Without such action, the effects of inducements risk undermining the health system's ability to achieve desired outcomes such as integrated delivery of care; expansion of team-based delivery of primary health services; improved service access for Albertans through the expansion of scopes of practice; efficient allocation of limited health resources; and improved health for Albertans.

Prohibiting inducements that are provided conditionally on obtaining Schedule 1 and Schedule 2 drugs, blood products and professional pharmacy services will:

- **enhance the ability of patients to focus on their healthcare,**
- **support pharmacists in providing that care as part of the healthcare team, and**
- **ensure that scarce health resources are targeted on patient care.**

Appendix 1 – A Timeline of the Evolution of Pharmacist Practice in Alberta

- Before 1994, the role of the profession was that of “purveyor of medication.” The *Alberta Pharmaceutical Association Act* and Regulations, Code of Ethics, and Principles of Good Pharmacy Practice guided the profession, and were largely focused on this limited role of dispensing.
 - The focus of the Act was not on the pharmacist and the relationship to the patient, but rather on the pharmacy and activities practiced under the traditional role of the pharmacist.
 - The Code of Ethics almost exclusively focused on the dispensing role of pharmacists, buying and selling prescriptions, return of medication, and packaging and labelling. While there was a statement regarding the necessity of keeping a patient record, the contents of the record were to include only drug-related information, a requirement used primarily for facilitating refills of prescriptions and for billing auditing purposes.
- The Principles of Good Pharmacy Practice – the Pharmacist (May 1993), prepared in anticipation of a new *Pharmaceutical Profession Act*, formalized the pharmacist’s focus on patient care, rather than the medication. Section 5.2.1 of this document stipulated that a pharmacist must “place a patient’s welfare first.”

This document also introduced the role of the pharmacist in “patient-oriented pharmacy services”, such as ensuring appropriateness of the prescription, the right to refuse to dispense a prescription, monitoring of drug therapy, evaluation of a patient’s medication profile for clinically significant problems, and an intervention role if necessary to prevent drug misuse and abuse. The pharmacist was now required to take steps to intervene in drug therapy when in the “pharmacist’s professional opinion the prescriber’s therapy is not in the best interests of the patient.”

- After 1994, there was a move towards enhancing the role of pharmacists in providing counselling to the public and providing drug information. The *Pharmaceutical Profession Act* and Regulations, the Code of Ethics, the Standards of Pharmaceutical Practice, and The Pharmacist guidelines provided the framework for setting expectations for the role and responsibilities of the pharmacist in Alberta.
- In 2000, the Alberta Pharmaceutical Association underwent a name change to the Alberta College of Pharmacists and exclusively focused on professional self-regulation responsibilities. The Alberta Pharmacists’ Association was created as a separate entity from the college to address the economics and the wellbeing of pharmacists and pharmacies.
- By 2007, the profession and its governing legislation had solidified the pharmacist as a healthcare professional, a member of a team of professionals providing care to patients, with far more autonomy in decision-making about their professional responsibilities. Pharmacists were now expected to manage drug therapy, to provide continuity of care for patients and to offer a much larger range of services including prescribing and administration of injections.
- On July 1, 2011, amendments to the Pharmacists Profession Regulation came into effect to include pharmacy technicians as a new health profession to be regulated by the Alberta College of Pharmacists. The regulation of this new group of professionals further enables an expanded role for pharmacists in direct patient care.

- In July 2012, the provincial government recognized the pharmacists' expanded scope and their role in primary care with a new reimbursement program. The payment model has expanded from fees for dispensing to now include fees for direct pharmacist services such as:
 - Comprehensive Annual Care Plans – Albertans living with multiple chronic diseases are supported by pharmacists through assessment, care plan development and ongoing monitoring.
 - Standard Medication Management Assessments – Pharmacists conduct medication reviews and develop care plans for patients with at least one chronic disease and on at least four continuous medications.
 - Assessments of a Patient's Prescription for Purposes of Renewal, Adaption
 - Administration of Drugs by Injection.
 - Patient Assessments by Pharmacists with Additional Prescribing Authority (APA).
 - Assessments of a Patient who has an Urgent Medication Requirement – this service enables the care of Albertans who are experiencing an emergency need for a medication as defined in Standard 13 of the Standards of Practice for Pharmacists and Pharmacy Technicians.
 - Refusals to Fill a Prescription – this service will prevent the misuse and abuse of prescription medications by supporting pharmacists' decisions to refuse to fill in situations of overuse/abuse, poly-pharmacy/multi-doctoring and falsified or altered prescriptions.¹⁸

¹⁸ The Capsule, The Alberta Pharmacists' Association, March 28, 2012

Appendix 2 –Pharmacists’ Expanded Role

Every practising pharmacist you meet in Alberta is a licensed health professional. They must:

- complete four to five years of university education in pharmacy
- pass the national qualifying exams and a provincial jurisprudence exam
- be registered with the Alberta College of Pharmacists
- continually update their learning each year
- follow all legal requirements necessary to operate as an Alberta pharmacist including professional conduct rules, patient care and confidentiality laws, standards of practice, and a code of ethics

Your pharmacist can:

- prevent drug interactions and allergic reactions
- help you with over-the-counter medications
- provide you with information on how to properly take your drugs
- give you advice on non-prescription and natural health products, e.g., herbal remedies
- develop comprehensive annual care plans – Albertans living with multiple chronic diseases are supported by pharmacists through assessment, care plan development and ongoing monitoring
- conduct standard medication management assessments – pharmacists conduct medication reviews and develop care plans for patients with at least one chronic disease and on at least four continuous medications
- renew prescriptions when appropriate
- administer drugs by injection (if authorized)
- prescribe medications (if they have received additional prescribing authority)
- offer assistance with your weight-loss or stop-smoking goals
- monitor and help manage chronic conditions such as diabetes, asthma, or high blood pressure
- follow up with you to monitor your response to your medicine and to provide additional support in using your drugs properly

Your pharmacist cannot:

- replace your doctor or other members of your healthcare team. Regular checkups and consultations with your doctor, dentist, and other health professionals are an important part of maintaining your health.
- read your mind. Good healthcare relies on good communication. Your pharmacist can only do what is best for you, and what is safe, by knowing your complete health history, your lifestyle, and your current health condition.

Health Professions Act – BYLAWS

SCHEDULE F

PART 1 - Community Pharmacy Standards of Practice

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11. Pharmacist/Patient Consultation
12. Schedule II and III Drugs
13. Sole Pharmacy Services Provider
14. Prohibition on the Provision of Incentives

Application		
1.		This Part applies to all registrants providing pharmacy services in a community pharmacy.
Definitions		
2.		In this Part:
		<p>“community pharmacy” has the same meaning as in section 1 of the bylaws of the college under the <i>Pharmacy Operations and Drug Scheduling Act</i>; “medication management” has the same meaning as in section 2, Schedule F, Part 5 of the bylaws of the College under the <i>Health Professions Act</i>;</p> <p>“incentive” includes money, gifts, discounts, rebates, refunds, customer loyalty schemes, coupons, goods, rewards and any other things approved by the Board from time to time.</p> <p>“personal health number” means a unique numerical lifetime identifier used in the specific identification of an individual patient who has any interaction with the BC health system;</p> <p>“prescription copy” means a copy of a prescription given to a patient by a registrant for information purposes only;</p> <p>“prescription transfer” means the transfer via direct communication from a registrant to another registrant of all remaining refill authorizations for a particular prescription to a requesting community pharmacy;</p> <p>“refill” means verbal or written approval from a practitioner authorizing a registrant to dispense additional quantities of drug(s) pursuant to a prescription;</p> <p>“renewal” means authorization by a full pharmacist to dispense additional quantities of drug(s) pursuant to a previously dispensed prescription, in accordance with section 25.92 of the <i>Act</i>;</p> <p>“Residential Care Facilities and Homes Standards of Practice” means the standards, limits and conditions for practice established in Part 3 of this Schedule.</p>
Patient Choice		
3.		Registrants, owners and directors must not enter into agreements with patients, patient’s representatives, practitioners, corporations, partnerships, or any other person or entity, that limit a patient’s choice of pharmacy, except as required or permitted under the bylaws.
Pharmacy Assistants		
4.		A registrant may delegate technical functions relating to the operation of the community pharmacy to a pharmacy assistant if the registrant

		directly supervises the pharmacy assistant and implements procedures, checks and controls to ensure the accurate and safe delivery of community pharmacy services.
Prescription		
5.	(1)	A registrant must ensure that a prescription is authentic.
	(2)	<p>Upon receipt from the practitioner, a prescription must include the following information:</p> <ul style="list-style-type: none"> (a) the date the prescription was written; (b) the name and address of the patient; (c) the name of the drug or ingredients and strength if applicable; (d) the quantity of the drug for controlled drug substances; (e) the quantity of the drug or the calculated quantity based on the directions and duration of use (f) the dosage instructions including the frequency, interval or maximum daily dose; (g) refill authorization if applicable, including number of refills; (h) the practitioner’s name, the practitioner’s college registration identification number for prescriptions on the Controlled Prescription Program and the practitioner’s signature for all prescriptions. (i)
	(3)	For the purpose of subsection (4), “prescription” includes a new prescription, a refill, a renewal or a balance owing.
	(4)	<p>At the time of dispensing, a prescription must include the following additional information:</p> <ul style="list-style-type: none"> (a) the prescription number; (b) the date on which the prescription was dispensed; (c) the manufacturer’s drug identification number or the brand name of the product dispensed; (d) the quantity dispensed; (e) the written or electronic identification of each registrant and pharmacy assistant involved in each step of the dispensing process; (f) the written or electronic confirmation and identification of the registrant who

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		<ul style="list-style-type: none"> (i) reviewed the personal health information stored in the PharmaNet database, (ii) reviewed the drug usage evaluation messages (DUE) from the PharmaNet database, and (iii) performed the final check including when dispensing a balance owing. <p>(g) the practitioner’s college registration identification number.</p>
	(5)	<p>A full pharmacist must</p> <ul style="list-style-type: none"> (a) review prescriptions for completeness and appropriateness with respect to the drug, dosage, route and frequency of administration, (b) review patient personal health information for potential drug interactions, allergies, therapeutic duplications and any other potential problems, (c) consult with patients concerning the patient’s drug history and other personal health information, (d) consult with practitioners with respect to a patient’s drug therapy, when necessary unless s.25.92(2) of the <i>Act</i> applies, and (e) follow-up on suspected adverse drug reactions.
	(6)	A registrant may receive verbal prescription authorizations directly from a practitioner or from a practitioner’s recorded voice message.
	(7)	A registrant must make a written or electronic record of a verbal authorization, and include his or her written or electronic signature or initial.
	(8)	A registrant must not dispense a prescription issued for more than one patient.
	(9)	<p>For refill authorizations, a registrant</p> <ul style="list-style-type: none"> (a) may <ul style="list-style-type: none"> (i) accept a refill authorization for Schedule I drugs from a practitioner’s agent if confident the agent consulted the practitioner and accurately conveyed the practitioner’s direction, (ii) retain the current prescription number for a quantity change if the software system is capable of retaining a record of the quantity dispensed on each previous occasion, and

		<ul style="list-style-type: none"> (iii) document the refill authorization on the original prescription if <ul style="list-style-type: none"> (A) a computerized transaction log is maintained, or (B) a new prescription number is assigned, and (b) must <ul style="list-style-type: none"> (i) cancel any unused refill authorizations remaining on any previous prescription if a patient presents a new prescription for a previously dispensed drug, (ii) advise the other pharmacy of the new prescription if unused refills are at another pharmacy, and (iii) create a new prescription number if a renewal authorization involves a different drug identification number, practitioner or directions for use.
	(10)	<p>If a full pharmacist authorizes a prescription renewal, he or she must</p> <ul style="list-style-type: none"> (a) create a written or electronic record, (b) assign a new prescription number, and (c) use his or her college identification number in the practitioner field on PharmaNet.
Transmission by Facsimile		
6.	(1)	<p>Prescription authorizations may be received by facsimile from a practitioner to a pharmacy, if</p> <ul style="list-style-type: none"> (a) the prescription is sent only to a pharmacy of the patient's choice, (b) the facsimile equipment is located within a secure area to protect the confidentiality of the prescription information, and (c) in addition to the requirements of section 5(2), the prescription includes <ul style="list-style-type: none"> (i) the practitioner's telephone number, facsimile number and unique identifier if applicable, (ii) the time and date of transmission, and (iii) the name and fax number of the pharmacy intended to receive the transmission.
	(2)	<p>Prescription refill authorization requests may be transmitted by facsimile from a pharmacy to a practitioner, if the pharmacy submits refill requests on a form that includes space for</p>

		<ul style="list-style-type: none"> (a) the information set out in section 5(2), (b) the name, address and telephone number of the pharmacy, and (c) the practitioner's name, date and time of transmission from the practitioner to the pharmacy.
	(3)	A registrant must not dispense a prescription authorization received by facsimile transmission for a drug referred to on the Controlled Prescription Program Drug List.
	(4)	<p>Prescription transfers may be completed by facsimile transmission if</p> <ul style="list-style-type: none"> (a) the transferring registrant includes his or her name and the address of the pharmacy with the information required in section 7(4), and (b) the name of the registrant receiving the transfer is known and recorded on the document to be faxed.
Prescription Copy and Transfer		
7.	(1)	If requested to do so, a registrant must provide a copy of the prescription to the patient or the patient's representative, or to another registrant.
	(2)	<p>A prescription copy must contain</p> <ul style="list-style-type: none"> (a) the name and address of the patient, (b) the name of the practitioner, (c) the name, strength, quantity and directions for use of the drug, (d) the dates of the first and last dispensing of the prescription, (e) the name and address of the community pharmacy, (f) the number of authorized refills remaining, (g) the date the original prescription was written, (h) the signature of the registrant supplying it, and (i) an indication that it is a copy.
	(3.1)	<p>Upon request, a registrant must transfer to a pharmacy licenced in Canada a prescription for a drug if</p> <ul style="list-style-type: none"> (a) the drug does not contain a controlled drug substance except as provided in subsection (3.2), and (b) the transfer occurs between a registrant and another registrant or an equivalent of a registrant in another Canadian

		jurisdiction
	(3.2)	<p>Upon request, a pharmacist must transfer to a pharmacy licenced in Canada a prescription for a drug if</p> <ul style="list-style-type: none"> (a) the drug contains a benzodiazepine, (b) the prescription has not been transferred previously, and (c) the transfer occurs between a pharmacist and another pharmacist or an equivalent of a pharmacist in another Canadian jurisdiction.
	(4)	<p>A registrant who transfers a prescription to another registrant under subsection (3) must</p> <ul style="list-style-type: none"> (a) enter on the patient record <ul style="list-style-type: none"> (i) the date of the transfer, (ii) the registrant's identification, (iii) identification of the community pharmacy to which the prescription was transferred, and (iv) identification of the person to whom the prescription was transferred, and (v) the prescribing date of the prescription (b) transfer all prescription information listed in subsection (2) (a) to (g).
	(5)	A registrant must make prescriptions available for review and copying by authorized inspectors of Health Canada.
Prescription Label		
8.	(1)	All drugs dispensed pursuant to a prescription or a full pharmacist-initiated adaptation must be labeled.
	(2)	<p>The label for all prescription drugs must include</p> <ul style="list-style-type: none"> (a) the name, address and telephone number of the pharmacy, (b) the prescription number and dispensing date, (c) the full name of the patient, (d) the name of the practitioner, (e) the quantity and strength of the drug, (f) the practitioner's directions for use, and

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		(g) any other information required by good pharmacy practice.
	(3)	For a single-entity product, the label must include (a) the generic name, and (b) at least one of (i) the brand name, (ii) the manufacturer's name, or (iii) the drug identification number.
	(4)	For a multiple-entity product, the label must include (a) the brand name, or (b) all active ingredients, and at least one of (i) the manufacturer's name, or (ii) the drug identification number.
	(5)	For a compounded preparation, the label must include all active ingredients.
	(6)	If a drug container is too small to accommodate a full label in accordance with subsection (2), (a) a trimmed prescription label must be attached to the small container, (b) the label must include (i) the prescription number, (ii) the dispensing date, (iii) the full name of the patient, and (iv) the name of the drug, and (c) the complete prescription label must be attached to a larger container and the patient must be advised to keep the small container inside the large container.
	(7)	All required label information must be in English, but may contain directions for use in the patient's language following the English directions.
Dispensing		
9.	(1)	A registrant may adjust the quantity of drug to be dispensed if

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		<ul style="list-style-type: none"> (a) a patient requests a smaller amount, (b) a manufacturer’s unit-of-use standard of package size does not match the prescribed quantity, (c) the quantity prescribed exceeds the amount covered by the patient’s drug plan, or (d) a trial prescription quantity is authorized by the patient.
	(2)	<p>A full pharmacist may adjust the quantity of drug to be dispensed, if</p> <ul style="list-style-type: none"> (a) he or she consults with a practitioner and documents the result of the consultation, and (b) if <ul style="list-style-type: none"> (i) a poor compliance history is evident on the patient record, (ii) drug misuse is suspected, or (iii) the safety of the patient is in question due to the potential for overdose.
	(3)	If a registrant doubts the authenticity of a prescription, the registrant may refuse to dispense the drug.
	(4)	<p>All drugs must be dispensed in a container that is certified as child-resistant unless</p> <ul style="list-style-type: none"> (a) the practitioner, the patient or the patient’s representative directs otherwise, (b) in the registrant’s judgment, it is not advisable to use a child-resistant container, (c) a child-resistant package is not suitable because of the physical form of the drug or the manufacturer’s packaging is designed to improve patient compliance, or (d) child-resistant packaging is unavailable.
	(5)	A registrant must not dispense a prescription more than one year from the prescribing date, except for oral contraceptives which may be dispensed for up to two years.
Patient Record		
10.	(1)	<p>A patient record must be prepared and kept current for each patient for whom:</p> <ul style="list-style-type: none"> (a) a Schedule I drug is dispensed,

		<p>(b) medication management is provided, or</p> <p>(c) both.</p>
	(2)	<p>The patient record must include</p> <p>(a) the patient’s full name,</p> <p>(b) the patient’s personal health number,</p> <p>(c) the patient’s address,</p> <p>(d) the patient’s telephone number,</p> <p>(e) the patient’s date of birth,</p> <p>(f) the patient’s gender,</p> <p>(g) the patient’s allergies, adverse drug reactions and intolerances, and the date the information was collected,</p> <p>(h) the patient’s clinical conditions, if available,</p> <p>(i) the date the drug is dispensed,</p> <p>(j) the prescription number,</p> <p>(k) the generic name, strength and dosage form of the drug,</p> <p>(l) the drug identification number,</p> <p>(m) the quantity of drug dispensed,</p> <p>(n) the intended duration of therapy, specified in days,</p> <p>(o) the date and reason for discontinuation of therapy,</p> <p>(p) the directions to the patient,</p> <p>(q) the identification of the prescribing practitioner,</p> <p>(r) special instructions from the practitioner to the registrant,</p> <p>(s) past and present prescribed drug therapy including the drug name, strength, dosage, frequency, duration and effectiveness of therapy,</p> <p>(t) compliance with the prescribed drug regimen, and</p> <p>(u) Schedule II and III drug use if available.</p>
	(3)	<p>A full pharmacist must review the patient’s personal health information stored on the PharmaNet database before dispensing a drug, providing medication management or both, and take appropriate action with respect to</p> <p>(a) appropriateness of drug therapy,</p>

		<ul style="list-style-type: none"> (b) drug interactions, (c) allergies, adverse drug reactions and intolerances, (d) therapeutic duplication, (e) correct dosage, route, frequency and duration of administration and dosage form, (f) contraindicated drugs, (g) degree of compliance, and (h) any other potential drug therapy problems.
Pharmacist/Patient Consultation		
11.	(1)	A full, limited, or student pharmacist must provide verbal patient consultation to the patient at the time of dispensing for all new and refill prescriptions. in accordance with subsection (3) and must document the identification of the pharmacist who performed the consultation, by written or electronic means.
	(2)	Patient consultation for all new and refill prescriptions must occur in person if practical, or by telephone, and must respect the patient's right to privacy.
	(3)	<p>Subject to subsection (6), a full, limited or student pharmacist must engage in direct consultation with a patient or the patient's representative regarding a Schedule I drug, and must</p> <ul style="list-style-type: none"> (a) confirm the identity of the patient, (b) identify the name and strength of drug being dispensed, (c) identify the purpose of the drug, (d) provide directions for use of the drug including the frequency, duration and route of therapy, (e) discuss common adverse effects, drug and food interactions and therapeutic contraindications that may be encountered, including their avoidance, and the actions required if they occur, (f) discuss storage requirements, (g) provide prescription refill information, (h) provide information regarding <ul style="list-style-type: none"> (i) how to monitor the response to therapy, (ii) expected therapeutic outcomes,

		<p>(iii) action to be taken in the event of a missed dose, and</p> <p>(iv) when to seek medical attention, and</p> <p>(i) provide other information unique to the specific drug or patient.</p>
	(4)	If a drug therapy problem is identified during full pharmacist/patient consultation, the full, limited or student pharmacist must take appropriate action to resolve and for Schedule I drugs, document the problem.
	(5)	If an adverse drug reaction as defined by Health Canada is identified, a full, limited or student pharmacist must notify the patient's practitioner, make an appropriate entry on the PharmaNet record and report the reaction to the appropriate department of Health Canada.
	(6)	A full, limited or student pharmacist must use reasonable means to comply with subsections (1), (2) and (3) for patients or the patient's representatives who have language or communication difficulties.
Schedule II and III Drugs		
12.	(1)	A registrant must not attribute a new prescription or refill for a Schedule II or Schedule III drug to a practitioner without the authorization of the practitioner.
	(2)	If a patient purchases a Schedule II drug, a full, limited or student pharmacist must counsel the patient regarding the selection and use of the drug.
	(3)	A full pharmacist must be available for consultation with a patient who wishes to select a Schedule III drug.
Sole Pharmacy Services Provider		
13.		<p>The manager of a pharmacy may enter into an agreement with another person to be the sole provider of pharmacy services in a premise or part of a premise, if</p> <p>(a) pharmacy services are provided in a manner that is consistent with the <i>Residential Care Facilities and Homes Standards of Practice</i>,</p> <p>(b) patient therapeutic outcomes are monitored to enhance patient safety, and</p> <p>(c) appropriate provision has been made for safe and effective distribution, administration and control of drugs.</p>
Prohibition on the Provision of Incentives		
14.	(1)	No registrant shall provide or distribute or be a party to the provision

		<p>or distribution of any incentive to a patient or patient's representative for obtaining a Schedule 1 or Schedule 2 drug.</p>
	<p>(2)</p>	<p>Section (1) does not prohibit registrants from:</p> <ul style="list-style-type: none"> (a) providing free or discounted parking to patients who are obtaining a Schedule 1 or Schedule 2 drug, (b) providing free or discounted delivery services to patients who are obtaining a Schedule 1 or Schedule 2 drug, (c) permitting patient's or patients representatives to pay for Schedule 1 or Schedule 2 drugs using major credit cards that are linked to incentives like points, loyalty points or rewards, except where, directly or indirectly, the incentives are awarded specifically for the purchase of a Schedule 1 or Schedule 2 drug.

Pharmacy Operations and Drug Scheduling Act - BYLAWS

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Definitions	
1.	In these bylaws:
	“ Act ” means the <i>Pharmacy Operations and Drug Scheduling Act</i> ;
	“ community pharmacy ” means a pharmacy licensed to sell or dispense drugs to the public and includes a telepharmacy central site but does not include telepharmacy remote site;
	“ Community Pharmacy Standards of Practice ” means the standards, limits and conditions for practice established under section 19 (1) (k) of the <i>Health Professions Act</i> respecting community pharmacies;
	“ controlled drug substance ” means a drug which includes a substance listed in Schedule I, II, III, IV or V of the <i>Controlled Drugs and Substances Act (Canada)</i> ;
	“ controlled prescription program ” means a program approved by the board, to prevent prescription forgery and reduce inappropriate prescribing of drugs;
	“ dispensary ” means the area of a community pharmacy that contains Schedule I and II drugs;
	“ health authority ” means

	(a) a regional health board designated under the <i>Health Authorities Act</i> , or (b) the Provincial Health Services Authority;
	“ hospital ” has the same meaning as in section 1 of the <i>Hospital Act</i> ;
	“ hospital pharmacy ” means a pharmacy licensed to operate in or for a hospital;
	“ hospital pharmacy remote site ” means a location, not staffed by registrants, outside the hospital premises used for the provision of pharmacy services which is dependent upon support and administrative services from the hospital pharmacy;
	“ hospital pharmacy satellite ” means a physically separate area, staffed by registrants, on or outside the hospital premises used for the provision of pharmacy services which is dependent upon support and administrative services from the hospital pharmacy;
	“ Hospital Pharmacy Standards of Practice ” means the standards, limits and conditions for practice established under section 19 (1) (k) of the <i>Health Professions Act</i> respecting hospital pharmacies;
	“ incentive ” has the same meaning as in Schedule F Part 1 of the bylaws of the College under the <i>Health Professions Act</i>
	“ medication ” has the same meaning as “drug”;
	“ medication management ” has the same meaning as in section 2, Schedule F, Part 5 of the bylaws of the College under the <i>Health Professions Act</i> ;
	“ outsource prescription processing ” means to request another pharmacy to prepare or process a prescription drug order;
	“ patient ” includes a patient’s representative;
	“ patient’s representative ” has the same meaning as in section 64 of the bylaws of the college under the <i>Health Professions Act</i> ;
	“ pharmacy assistant ” has the same meaning as “support person”;
	“ pharmacy education site ” means a pharmacy <ul style="list-style-type: none"> (a) that has Schedule I, II and III drugs, but no controlled drug substances, (b) that is licensed solely for the purpose of pharmacy education, and (c) from which pharmacy services are not provided to any person;
	“ pharmacy technician ” has the same meaning as in section 1 of the bylaws of the college under the <i>Health Professions Act</i> ;
	“ pharmacy services ” has the same meaning as in section 1 of the bylaws of the college under the <i>Health Professions Act</i> ;
	“ prescription drug ” means a drug referred to in a prescription;
	“ professional products area ” means the area of a community pharmacy that contains Schedule III drugs;
	“ professional service area ” means the area of a community pharmacy that contains

	Schedule II drugs;
	“Residential Care Facilities and Homes Standards of Practice” means the standards, limits and conditions for practice established under section 19 (1) (k) of the <i>Health Professions Act</i> respecting residential care facilities and homes;
	“telepharmacy” means the practice of pharmacy utilizing telecommunication technology between the telepharmacy central site and telepharmacy remote site;
	“telepharmacy central site” means a pharmacy from which a full pharmacist practices pharmacy and provides direct supervision to a telepharmacy remote site
	“telepharmacy remote site” means a pharmacy providing pharmacy services to the public, or in or for a hospital, (a) without a full pharmacist present, (b) in a rural and remote community, and (c) under the supervision and direction of a full pharmacist at a central pharmacy site.
PART I - All Pharmacies	
Application of Part	
2.	Except as provided in Section 22, this Part applies to all pharmacies except pharmacy education sites.
Responsibilities of Pharmacy Managers, Owners and Directors	
3.	(1) A full pharmacist must be the manager of a pharmacy (a) A pharmacy must not be open for business unless a manager is appointed. (b) An owner or director must notify the registrar in writing of the appointment and any change of manager within 2 business days. (c) A pharmacy manager must notify the registrar in writing at least 2 days prior to ceasing to be the pharmacy’s manager. (d) A full pharmacist may not act as manager of more than one pharmacy location, unless the pharmacy of which the full pharmacist is manager is: (i) a telepharmacy remote site, (ii) a hospital pharmacy satellite, or (iii) a hospital pharmacy remote site.
	(2) A manager must do all of the following: (a) actively participate in the day-to-day management of the pharmacy; (b) confirm that the staff members who represent themselves as registrants are registrants;

		<ul style="list-style-type: none"> (c) notify the registrar in writing of the appointments and resignations of registrants as they occur; (d) cooperate with inspectors acting under section 17 of the <i>Act</i> or sections 28 or 29 of the <i>Health Professions Act</i>; (e) ensure that registrant and pharmacy assistant staff levels are commensurate with the workload volume and patient care requirements at all times; (f) ensure that new information directed to the pharmacy pertaining to drugs, devices and drug diversion is immediately accessible to registrants and pharmacy assistants; (g) establish policies and procedures to specify the duties to be performed by registrants and pharmacy assistants; (h) establish procedures for <ul style="list-style-type: none"> (i) inventory management, (ii) product selection, and (iii) proper destruction of unusable drugs and devices; (i) ensure that all records related to the purchase and receipt of controlled drug substances are signed by a full pharmacist; (j) ensure appropriate security and storage of all Schedule I, II, and III drugs and controlled drug substances for all aspects of pharmacy practice including operation of the pharmacy without a registrant present; (k) ensure there is a written drug recall procedure in place for pharmacy inventory; (l) ensure that all steps in the drug recall procedure are documented, if the procedure is initiated; (m) ensure that each individual working in the pharmacy wears a badge that clearly identifies the individual's registrant class or other status; (n) ensure that confidentiality is maintained with respect to all pharmacy and patient records in accordance with all applicable legislation; (o) make reasonable security arrangements in respect of unauthorized access, collection, use, disclosure or disposal of personal information kept on the pharmacy premises; (p) notify the registrar as soon as possible in the event that he or she will be absent from the pharmacy for more than eight weeks; (q) ensure the correct and consistent use of the community pharmacy operating name as it appears on the community pharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising and stationery; (r) ensure that appropriate security is in place for the premises and staff generally;
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		<p>(s) in the event of a pharmacy closure</p> <ul style="list-style-type: none"> (i) notify the registrar in writing at least thirty business days before the effective date of the closure , (ii) post in a prominent location, for at least ninety days after closure, on the exterior of the building in which the pharmacy is located, information to identify the pharmacy that will be in possession of the prescription and patient records, (iii) remove or obliterate all exterior and interior signs, advertisements, and websites containing the words “pharmacy, drug store, drug department, drugs, medicines, drug sundries, druggist, apothecary or chemist”. (iv) provide for the safe transfer and appropriate storage of all Schedule I, II, and III drugs and controlled drug substances, either to another pharmacy or returned to a drug wholesaler, (v) advise the registrar in writing of the disposition of all drugs and prescription records within 7 days of closure, (vi) provide the registrar with a copy of the return invoice and any other documentation sent to Health Canada in respect of the destruction of all controlled drug substances, and (vii) arrange for the safe transfer of the prescriptions and patient records to another pharmacy. <p>(s.1) in the event of a pharmacy relocation/renovation,</p> <ul style="list-style-type: none"> (i) notify the registrar in writing at least fifty business days before the effective date of a proposed relocation/renovation, (ii) post in a prominent location, for at least ninety days after relocation, on the exterior of the building in which the pharmacy was located, information to identify the new location of the pharmacy, and (iii) provide for the safe transfer and appropriate storage of all Schedule I, II, and III drugs and controlled drug substances, <p>(t) ensure sample medications are dispensed in accordance with the requirements in the Drug Schedules Regulation;</p> <p>(u) advise the registrar if the pharmacy is providing pharmacy services over the internet, and provide to the registrar the internet address of every website operated or used by the pharmacy;</p> <p>(v) ensure the pharmacy contains the reference material and equipment approved by the board from time to time;</p> <p>(w) require all registrants, owners, managers, directors, pharmaceutical representatives, pharmacy assistants and computer software programmers or technicians who will access the in-pharmacy computer</p>
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		<p>system to sign an undertaking in a form approved by the registrar to maintain the confidentiality of patient record information;</p> <p>(x) retain the undertakings referred to in paragraph (w) in the pharmacy for 3 years after employment or any contract for services has ended;</p> <p>(y) be informed of the emergency preparedness plan in the area of the pharmacy that he or she manages and be aware of his or her responsibilities in conjunction with that plan,</p> <p>(z) ensure that no incentives are provided to the patient or the patient's representative to obtain prescription orders of Schedule 1 and Schedule 2 drugs.</p>
	(3)	Owners and directors must comply with subsection (2)(d), (e), (j), (n), (o), (q) (r), (s), (u), (v), (w), (x) and (z) except that subsections (2)(j), s(v), s(vi), s(vii), do not apply to a non-dispensing pharmacy.
	(4)	An owner must ensure that the requirements to obtain a pharmacy licence under the <i>Act</i> are met at all times; including but not limited to the completion of Forms 1, 4, 5 and 6, as applicable.
	(5)	For the purpose of subsection (2)(s), a pharmacy closure includes a suspension of the pharmacy licence for a period greater than 30 days, unless otherwise directed by the registrar.
	(6)	Owners, directors, and managers must ensure that the requirements in section 29 and 30 are met at all times.
Sale and Disposal of Drugs		
4.	(1)	Schedule I, II, and III drugs and controlled drug substances must only be sold or dispensed from a pharmacy.
	(2)	A registrant must not sell or dispense a quantity of drug that will not be used completely prior to the manufacturer's expiry date, if used according to the directions on the label.
	(3)	If the manufacturer's expiry date states the month and year but not the date, the expiry date is the last day of the month indicated.
	(4)	Every registrant must protect from loss, theft or unlawful sale or dispensing of all Schedule I, II, and III drugs and controlled drug substances in or from the pharmacy.
	(5)	Every registrant must ensure that drugs and devices are maintained within appropriate temperature, light, and humidity standards in accordance with the policy approved by the board.
	(6)	<p>A registrant must not sell, dispense, dispose of or transfer a Schedule I drug except</p> <p>(a) on the prescription or order of a practitioner,</p> <p>(b) to transfer drug inventory to a pharmacy for the purpose of providing an</p>

		<p>emergency supply of the drug required to fill a prescription or to provide expired drugs to a pharmacy education site.</p> <p>(c) to transfer drug inventory to or from an entity operating within a health authority solely for the purposes of the health authority,</p> <p>(d) by return to the manufacturer or wholesaler of the drug, or</p> <p>(e) for destruction, in accordance with the policy approved by the board.</p>
	(7)	<p>Drugs included in the controlled prescription program must not be sold or dispensed unless</p> <p>(a) the registrant has received the prescription on the prescription form approved by both the board and the College of Physicians and Surgeons of British Columbia, and</p> <p>(b) the prescription form is signed by the patient or the patient's representative upon receipt of the dispensed drug.</p>
	(8)	<p>A new prescription from a practitioner is required each time a drug is dispensed, except for</p> <p>(a) a part-fill,</p> <p>(b) a prescription authorizing repeats,</p> <p>(c) a full pharmacist-initiated renewal or adaptation, or</p> <p>(d) an emergency supply for continuity of care.</p>
	(9)	<p>Subsection (7) does not apply to prescriptions written for</p> <p>(a) residents of a facility or home subject to the requirements of the <i>Residential Care Facilities and Homes Standards of Practice</i>, or</p> <p>(b) patients admitted to a hospital.</p>
Drug Procurement/Inventory Management		
5.	(1)	<p>A full pharmacist may authorize the purchase of Schedule I, II, or III drugs or controlled drug substances only from</p> <p>(a) a wholesaler or manufacturer licensed to operate in Canada, or</p> <p>(b) a registrant at another pharmacy for the purpose of providing an emergency supply of drug required to fill a prescription.</p>
	(2)	<p>A registrant must record a transfer of drugs that occurs for any reason other than for the purpose of dispensing in accordance with a practitioner's prescription.</p>
	(3)	<p>All drug shipments must be delivered unopened to the pharmacy or a secure storage area.</p>
	(4)	<p>Non-usable and expired drugs must be stored in a separate area of the</p>

		pharmacy or a secure storage area until final disposal or transfer to a pharmacy education site.
	(5)	A full pharmacist must not purchase Schedule I, II and III drugs and controlled drug substances unless they are for sale or dispensing in or from a pharmacy.
Sterile Products and Hazardous Drugs		
6.	(1)	Sterile products must be prepared and distributed in an environment that is in accordance with the policies approved by the board from time to time.
	(2)	Hazardous drugs must be handled, prepared and distributed in accordance with the policies approved by the board from time to time.
Interchangeable Drugs		
7.		When acting under section 25.91 of the <i>Health Professions Act</i> , a full pharmacist must determine interchangeability of drugs by reference to Health Canada's Declaration of Equivalence, indicated by the identification of a Canadian Reference Product in a Notice of Compliance for a generic drug.
Returned Drugs		
8.		No registrant may accept for return to stock or reuse any drug previously dispensed except in accordance with section 10(3) of the <i>Residential Care Facilities and Homes Standards of Practice</i> or section 4(3) of the <i>Hospital Pharmacy Standards of Practice</i> .
Records		
9.	(1)	All prescriptions, patient records, invoices and documentation in respect of the purchase, receipt or transfer of Schedule I, II and III drugs and controlled drug substances must be retained for a period of not less than three years from the date <ul style="list-style-type: none"> (a) a drug referred to in a prescription was last dispensed, or (b) an invoice was received for pharmacy stock.
	(2)	Registrants, pharmacy assistants, managers, directors, and owners must not, for commercial purposes, disclose or permit the disclosure of information or an abstract of information obtained from a prescription or patient record which would permit the identity of the patient or practitioner to be determined.
	(3)	Despite subsection (1), a registrant must not destroy prescriptions, patient records, invoices or documentation until the completion of any audit or investigation currently underway for which the registrant has received notice.
Pharmacy Licences		
10.	(1)	The following classes of pharmacy licences are established: <ul style="list-style-type: none"> (a) a community pharmacy;

		<ul style="list-style-type: none"> (b) a hospital pharmacy; (c) a telepharmacy remote site; (d) a telepharmacy central site; (e) a hospital pharmacy satellite; (f) a hospital pharmacy remote site; and (g) a pharmacy education site;
	(2)	<p>An applicant for a pharmacy licence in subsection (1)(a) and (g), must submit the following to the registrar:</p> <ul style="list-style-type: none"> (a) a completed application in Form 1, 2 or 3 where applicable; (b) a diagram to scale of 1/4 inch equals 1 foot, of the entrances of the pharmacy and the preparation, dispensing, consulting, storage, professional services, professional products, and packaging areas; (c) the applicable fee set out in Schedule “A”; (d) for a community pharmacy, proof in a form satisfactory to the registrar that the municipality in which the pharmacy is located has issued a business licence for the pharmacy to the pharmacy’s owner or manager.
	(3)	<p>The registrar may renew a pharmacy licence upon receipt of the following:</p> <ul style="list-style-type: none"> (a) a completed application in Form 4, 5 or 6, as applicable; and (b) the applicable fee set out in Schedule “A”.
	(4)	<p>A pharmacy’s manager must submit to the registrar, in writing, any proposed pharmacy design changes or structural renovations together with a new pharmacy diagram for approval before the commencement of construction or other related activities.</p>
	(5)	<p>If a pharmacy will be closed temporarily for up to 14 consecutive days, the pharmacy’s manager must</p> <ul style="list-style-type: none"> (a) obtain the approval of the registrar, (b) notify patients and the public of the closure at least 30 days prior to the start of the closure, and (c) make arrangements for emergency access to the pharmacy’s hard copy patient records.
	(6)	<p>A pharmacy located in a hospital which dispenses drugs to staff, out-patients or the public and which is not owned or operated by a health authority, must be licenced as a community pharmacy.</p>

PART II – Community Pharmacies

Community Pharmacy Manager – Quality Management		
11.		<p>A community pharmacy's manager must develop, document and implement an ongoing quality management program that includes a written or electronic policy and procedure manual that</p> <ul style="list-style-type: none"> (a) maintains and enforces policies and procedures to comply with legislation applicable to the operation of a community pharmacy, (b) monitors staff performance, equipment, facilities and adherence to the <i>Community Pharmacy Standards of Practice</i>, and (c) includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies.
Community Pharmacy Premises		
12.	(1)	<p>In locations where a community pharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy's manager must ensure that</p> <ul style="list-style-type: none"> (a) the professional products area extends not more than 25 feet from the perimeter of the dispensary and is visually distinctive from the remaining areas of the premises by signage, and (b) a sign reading "Medication Information" is clearly displayed to identify a consultation area or counter at which a member of the public can obtain a full pharmacist's advice, and (c) the professional services area products are inaccessible for self-service by the public.
	(2)	<p>The dispensary area of a community pharmacy must</p> <ul style="list-style-type: none"> (a) be at least 160 square feet, (b) be inaccessible to the public by means of gates or doors across all entrances, (c) include a dispensing counter with at least 30 square feet of clear working space, in addition to service counters, (d) contain adequate shelf and storage space, (e) contain a double stainless steel sink with hot and cold running water, and (f) contain an adequate stock of drugs to provide full dispensing services.
	(3)	<p>In all new and renovated community pharmacies, an appropriate area must be provided for patient consultation that</p> <ul style="list-style-type: none"> (a) ensures privacy and is conducive to confidential communication, and (b) includes, but is not limited to, one of the following: <ul style="list-style-type: none"> (i) a private consultation room;

		(ii) a semiprivate area with suitable barriers.
	(4)	All new and renovated community pharmacies must have a separate and distinct area consisting of at least 40 square feet reserved as secure storage space.
Operation Without a Full Pharmacist		
13.	(1)	Except as provided in subsection (2), a community pharmacy must not be open to the public unless a full pharmacist is present.
	(2)	<p>A community pharmacy that does not have a telepharmacy remote site licence may operate without a full pharmacist present if all the following requirements are met:</p> <ul style="list-style-type: none"> (a) the registrar is notified of the hours during which a full pharmacist is not present; (b) a security system prevents the public, pharmacy assistants and other non-pharmacy staff from accessing the dispensary, the professional service area and the professional products area; (c) a pharmacy technician is present and ensures that the pharmacy is not open to the public; (d) Schedule I, II, and III drugs and controlled drug substances in a secure storage area are inaccessible to pharmacy assistants, other non-pharmacy staff and the public; (e) dispensed prescriptions waiting for pickup may be kept outside the dispensary if they are inaccessible, secure and invisible to the public and the requirements of section 11 of the <i>Community Pharmacy Standards of Practice</i> have been met; (f) the hours when a full pharmacist is on duty are posted.
	(3)	<p>If the requirements of subsection (2) are met, the following activities may be performed at a community pharmacy by anyone who is not a registrant:</p> <ul style="list-style-type: none"> (a) requests for prescriptions, orders for Schedule II and III drugs and telephone requests from patients to order a certain prescription may be placed in the dispensary area by dropping them through a slot in the barrier; (b) orders from drug wholesalers, containing Schedule I, II and III drugs, may be received but must be kept secure and remain unopened.
Outsource Prescription Processing		
14.	(1)	<p>A community pharmacy may outsource prescription processing if</p> <ul style="list-style-type: none"> (a) all locations involved in the outsourcing are community pharmacies in British Columbia, (b) all prescriptions dispensed are labeled and include an identifiable code

		that provides a complete audit trail for the dispensed drug, and (c) a notice is posted informing patients that the preparation of their prescription may be outsourced to another pharmacy.
	(2)	The manager of an outsourcing community pharmacy must ensure that all applicable standards of practice are met in processing prescriptions at all locations involved in the outsourcing.
	(3)	In this section, “community pharmacy” includes a hospital pharmacy.
PART III – Hospital Pharmacies		
Hospital Pharmacy Manager – Quality Management		
15.	(1)	A hospital pharmacy’s manager must develop, document and implement an ongoing quality management program that includes a written or electronic policy and procedure manual that: (a) maintains and enforces policies and procedures to comply with legislation applicable to the operation of a hospital pharmacy, (b) monitors staff performance, equipment, facilities and adherence to the <i>Hospital Pharmacy Standards of Practice</i> , (c) includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies, (d) documents periodic audits of the drug distribution process, (e) includes a process to review patient-oriented recommendations, (f) includes a process that reviews a full pharmacist’s documentation notes in the hospital’s medical records, (g) includes a process to evaluate drug use, and (h) regularly updates policies and procedures for drug use control and patient-oriented pharmacy services in collaboration with the medical and nursing staff and appropriate committees.
	(2)	If sample drugs are used within a hospital, the hospital pharmacy’s manager must ensure that the pharmacy oversees the procurement, storage and distribution of all sample drugs.
	(3)	Section 3(2)(q) does not apply to a hospital pharmacy manager.
Drug Distribution		
16.	(1)	A hospital pharmacy manager must establish a drug distribution system that (a) provides drugs in identified dosage units ready for administration whenever possible and practical, (b) removes all expired, contaminated, and recalled drugs from the inventory

		<p>of the hospital and its associated hospital pharmacy satellites, telepharmacy remote sites and hospital pharmacy remote sites,</p> <p>(c) provides a method of recording drugs at the time of administration, and</p> <p>(d) eliminates or reduces the need to maintain ward stock.</p>
	(2)	A unit dose, monitored dose, multiple pouch packaging or individual patient prescription drug distribution system must be used for dispensing drugs.
	(3)	Drugs must be stored in conditions that protect their integrity, stability and sterility or in accordance with policies approved by the board from time to time,
After Hours Service		
17.	(1)	<p>If continuous pharmacy services are not provided in a hospital, the hospital pharmacy's manager must ensure that urgently needed drugs and patient-oriented pharmacy services are available at all times by</p> <p>(a) providing a cabinet which must</p> <ul style="list-style-type: none"> (i) be a locked cabinet or other secure enclosure located outside of the hospital pharmacy, to which only authorized persons may obtain access, (ii) be stocked with a minimum supply of drugs most commonly required for urgent use, (iii) not contain controlled drug substances unless they are provided by an automated dispensing system, (iv) contain drugs that are packaged to ensure integrity of the drug and labeled with the drug name, strength, quantity, expiry date and lot number, and (v) include a log in which drug withdrawals are documented, and <p>(b) arranging for a full pharmacist to be available for consultation on an on-call basis.</p>
	(2)	When a hospital pharmacy or hospital pharmacy satellite is closed, the premises must be equipped with a security system that will detect unauthorized entry.
PART IV – Telepharmacy		
Telepharmacy Services		
18.	(1)	The registrar may authorize a community pharmacy or hospital pharmacy to provide telepharmacy services, upon receipt of a completed application in Form 2 and if satisfied that the requirements of this section will be met.
	(2)	Telepharmacy services may only be provided in or through pharmacies

		authorized under this Part to provide telepharmacy services.
	(3)	A telepharmacy remote site must be under the direct supervision of a full pharmacist at the central pharmacy site.
	(4)	A telepharmacy remote site must be under the responsibility of the manager of the central pharmacy site.
	(5)	The <i>Community Pharmacy Standards of Practice</i> apply to a telepharmacy remote site, unless it is located in, or providing pharmacy services for, a hospital in which case the <i>Hospital Pharmacy Standards of Practice</i> apply.
	(6)	Full pharmacists at a central pharmacy site must comply with section 11 of the <i>Community Pharmacy Standards of Practice</i> by using video and audio links.
	(7)	A sign must be posted at the dispensary counter of a telepharmacy remote site advising patients and staff when the site is operating in telepharmacy mode.
	(8)	A telepharmacy remote site must not remain open and prescriptions must not be dispensed if <ul style="list-style-type: none"> (a) an interruption in data, video or audio link occurs, (b) a pharmacy technician is not on duty at the telepharmacy remote site, or (c) a full pharmacist is not on duty at the central pharmacy site.
	(9)	Prescriptions dispensed at a telepharmacy remote site must be distinguishable from a prescription dispensed at the central pharmacy site and include a unique label and a unique identifier for the prescription.
	(10)	The manager of a central pharmacy site must <ul style="list-style-type: none"> (a) inspect and audit each affiliated telepharmacy remote site at least 3 times each year, (b) make a written record of all inspections and audits, and (c) provide a copy of a record described in paragraph (b) to the college on request.
	(11)	There must be a policy and procedure manual which describes the specific telepharmacy operations that are in place to ensure the safe and effective distribution of pharmacy products and delivery of pharmaceutical care.
PART V – Hospital Pharmacy Remote Site		
Definitions		
19.		In this Part: “base pharmacy” means a hospital pharmacy that provides pharmacy services to a hospital pharmacy remote site.

		<p>“healthcare provider” means a registrant of a designated health profession pursuant to the <i>Health Professions Act</i> authorized to provide pharmacy services within a hospital pharmacy remote site.</p>
<p>Hospital Pharmacy Remote Site Manager</p>		
20.		<p>Hospital Pharmacy Remote Site Manager</p> <ol style="list-style-type: none"> (1) The provisions of Section 3(2)(a), (d), (f), (h), (i), (j), (k), (l), (o) (p), (r), (s), (t), and (y) apply to a hospital pharmacy remote site manager. (2) The pharmacy manager at the base pharmacy is the manager of the hospital pharmacy remote site. (3) A hospital pharmacy remote site manager must: <ol style="list-style-type: none"> (a) inspect and audit the hospital pharmacy remote site at the site location at least once every 6 months; (b) document all inspections and audits; (c) develop, maintain and enforce policies and procedures <ol style="list-style-type: none"> (i) to comply with legislation applicable to the operation of a hospital pharmacy remote site; (ii) to restrict access to a hospital pharmacy remote site to healthcare providers of the facility; and (iii) for drug distribution in collaboration with healthcare providers in accordance with the policy approved by the board. (d) provide a list of drugs available in the hospital pharmacy remote site to health care providers of the facility, (e) ensure drugs stocked in the hospital pharmacy remote site are labelled with the expiry date and manufacturer lot number, (f) develop a documentation system that: <ol style="list-style-type: none"> (i) tracks and records the type and quantity of drugs transferred to the hospital pharmacy remote site, (ii) identifies the pharmacy staff stocking and supplying drugs to the hospital pharmacy remote site, (iii) identifies the health care provider or pharmacy staff receiving drugs at the hospital pharmacy remote site, (iv) identifies the health care provider dispensing drugs from the hospital pharmacy remote site.
<p>Hospital Pharmacy Remote Site Premises</p>		
21.		<p>A hospital pharmacy remote site must:</p> <ol style="list-style-type: none"> (1) be located in a controlled and monitored area, outside of public access and away from public view, and (2) be locked or located in a locked area when not in use,
<p>PART VI – Pharmacy Education Sites</p>		
<p>Pharmacy Education Site Manager</p>		
22.	(1)	<p>The provisions of Section 3(2)(a), (d), (h), (j), (p), (r), (s), (v) and (vi) and 10(1)(i), 10(2), 10(5), and 10(6) apply to a pharmacy education site manager.</p>
	(2)	<p>A full pharmacist must be the manager of a pharmacy education site that</p>

		provides pharmacist education.
	(3)	A full pharmacist or pharmacy technician must be the manager of a pharmacy education site that provides pharmacy technician education.
	(4)	A pharmacy education site manager must ensure that only registrants, instructors and students registered in a program listed in Schedule C are present in the pharmacy education site.
	(5)	A pharmacy education site manager must ensure that documentation in respect of the purchase, receipt or transfer of Schedule I, II and III drugs is created and retained for a period of not less than 3 years from the date the drugs were received by the pharmacy education site.
	(6)	A pharmacy education site manager must ensure that drugs are disposed of in accordance with Section 4(6)(e).
PART VIIIX – PharmaNet		
Application of Part		
23.		This Part applies to every pharmacy that connects to PharmaNet.
Definitions		
24.		In this Part:
		“ database ” means those portions of the provincial computerized pharmacy network and database referred to in section 13 of the <i>Act</i> ;
		“ electronic prescription ” means a prescription transcribed by electronic means, evidenced by an electronic signature only using prescribed information management technology under the <i>Pharmaceutical Services Act</i> ;
		“ electronic signature ” means a signature in an electronic form that a pharmacist or practitioner has created to sign an electronic prescription;
		“ in-pharmacy computer system ” means the computer hardware and software utilized to support pharmacy services in a pharmacy;
		“ patient keyword ” means an optional confidential pass code selected by the patient which limits access to the patient’s PharmaNet record until the pass code is provided to the registrant;
		“ PharmaNet patient record ” means the patient record described in section 11(2) of the <i>Community Pharmacy Standards of Practice</i> and in the PharmaNet Professional and Software Compliance Standards as the “patient profile”;
		“ PharmaNet Professional and Software Compliance Standards ” means the document provided by the Ministry of Health Services specifying the requirements of an in-pharmacy computer system to connect to PharmaNet;
		“ terminal ” means any electronic device connected to a computer system,

		which allows input or display of information contained within that computer system.
Operation of PharmaNet		
25.	(1)	A pharmacy licensed pursuant to Section 10(1)(a) must connect to the PharmaNet System and be equipped with the following: <ul style="list-style-type: none"> (a) an in-pharmacy computer system which meets the requirements set out in the current PharmaNet Professional and Software Compliance Standards; (b) a terminal that is capable of accessing and displaying patient records, located in an area of the pharmacy which <ul style="list-style-type: none"> (i) is only accessible to registrants and pharmacy assistants, (ii) is under the direct supervision of a registrant, and (iii) does not allow information to be visible to the public, unless intended to display information to a specific patient; (c) the computer software upgrades necessary to comply with changes to the PharmaNet Professional and Software Compliance Standards.
	(2)	If a pharmacy licensed pursuant to Section 10(1)(e) or (g) connects to the PharmaNet system it must comply with subsections (a) to (c).
Data Collection, Transmission of and Access to PharmaNet Data		
26.	(1)	A registrant must enter the prescription information and transmit it to PharmaNet at the time of dispensing and keep the PharmaNet patient record current.
	(2)	A registrant may collect and transmit patient record information to PharmaNet or access a patient's PharmaNet record only <ul style="list-style-type: none"> (a) to dispense a drug, (b) to provide patient consultation, (c) to evaluate a patient's drug usage, or (d) to provide medication management services.
	(3)	A registrant may collect and transmit patient record information to PharmaNet or access a patient's PharmaNet record only for the purposes of claims adjudication and payment by an insurer.
	(4)	A registrant must revise information in the PharmaNet database pertaining to corrected billings for prescriptions billed to the patient or a payment agency other than PharmaCare and record the reason for the revision within 90 days of the original entry on PharmaNet.
	(5)	A registrant must reverse information in the PharmaNet database, for any

		drug that is not released to the patient or the patient's representative, and record the reason for the reversal no later than 30 days from the date of the original entry of the prescription information in PharmaNet.
	(6)	If a registrant is unable to comply with the deadlines in subsections (4) or (5), he or she must provide the information required to make the correction to the college as soon as possible thereafter.
	(7)	At the request of the patient, a registrant must establish, delete or change the patient keyword.
	(8)	Where a patient or patient's representative requests an alteration to be made to the PharmaNet information, the registrant must <ul style="list-style-type: none"> (a) correct the information, or (b) if the registrant refuses to alter the information, he or she must inform the person requesting the change of his or her right to request correction under the <i>Personal Information Protection Act</i>.
Confidentiality		
27.		A registrant must take reasonable steps to confirm the identity of a patient, patient's representative, registrant or practitioner before providing any pharmacy service, including but not limited to <ul style="list-style-type: none"> (a) establishing a patient record, (b) updating a patient's clinical information, (c) providing a printout of an in-pharmacy or requesting a PharmaNet patient record, (d) establishing, deleting, or changing a patient keyword, (e) viewing a patient record, (f) answering questions regarding the existence and content of a patient record, (g) correcting information, and (h) disclosing relevant patient record information to another registrant for the purpose of dispensing a drug or device, and/or for the purpose of monitoring drug use.
Electronic Prescription		
28.	(1)	A registrant may dispense an electronic prescription only in accordance with these bylaws.

PART XVIII – Marketing and Advertising		
Definitions		
29.		<p>In this Part:</p> <p>"advertisement" means the use of space or time in a public medium, or the use of a commercial publication such as a brochure or handbill, to communicate with the general public, or a segment thereof, for the purpose of promoting professional services or enhancing the image of the advertiser;</p> <p>"marketing" includes</p> <p>(a) an advertisement,</p> <p>(b) any publication or communication in any medium with any patient, prospective patient or the public generally in the nature of an advertisement, promotional activity or material, a listing in a directory, a public appearance or any other means by which professional services are promoted, and</p> <p>(c) contact with a prospective client initiated by or under the direction of a registrant.</p>
Marketing and Advertising		
30.	(1)	When advertising pharmacy services that are required by legislation, the statement, "Required in all British Columbia Pharmacies", must accompany the advertising and must be of the same size and prominence as all other print in the advertising.
	(2)	<p>Schedule I drug price advertising is restricted to</p> <p>(a) the proprietary (brand) name, if any, for the drug and/or the device,</p> <p>(b) the drug product's generic name and the manufacturer's name,</p> <p>(c) the dosage form and strength,</p> <p>(d) total price for a specific number of dosage units or quantity of the drug product, and</p> <p>(e) the phrase "only available by prescription".</p>
	(3)	Where Schedule I drug price advertising includes direct or indirect reference to a professional fee charged, the total prescription price must also be incorporated into the advertisement, and both figures must be featured equally.
	(4)	Schedule I drug price advertising must not include any reference to the safety, effectiveness or indications for use of the advertised prescription drug products or compare the fees charged by the registrant with those charged by another registrant.

	(5)	<p>Any marketing undertaken or authorized by a registrant in respect of his or her professional services must not be</p> <ul style="list-style-type: none"> (a) false, (b) inaccurate, (c) reasonably expected to mislead the public, or unverifiable.
	(6)	<p>Marketing violates subsection (5) if it</p> <ul style="list-style-type: none"> (a) is calculated or likely to take advantage of the weakened state, either physical, mental or emotional, of the recipient or intended recipient, (b) is likely to create in the mind of the recipient or intended recipient an unjustified expectation about the results which the registrant can achieve, (c) implies that the registrant can obtain results <ul style="list-style-type: none"> (i) not achievable by other registrants, (ii) by improperly influencing a public body or official, or any corporation, agency or person having any interest in the welfare of the recipient, (iii) by any other improper means, or (iv) compares the quality of services provided with those provided by another registrant, or a person authorized to provide health care services under another enactment, or another health profession.
	(7)	<p>The home page of any pharmacy that advertises on a website must clearly show</p> <ul style="list-style-type: none"> (a) the pharmacy licence number issued by the college, (b) the contact information for the college, (c) a notice to patients that complaints of a registrant's professional conduct or pharmacy practice issues may be reported to the college, (d) the pharmacy name, (e) the community pharmacy name where the pharmacy is physically located (f) the physical location of the pharmacy operation and street address of the community pharmacy, (g) the pharmacy telephone number, and (h) the name of the pharmacy's manager.
		<ul style="list-style-type: none"> (i) a notice to patients that customer service complaints or inquiries may be reported to the community pharmacy

Health Professions Act – BYLAWS

SCHEDULE F

PART 1 - Community Pharmacy Standards of Practice

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- 14. Prohibition on the Provision of Incentives**

Application		
1.		This Part applies to all registrants providing pharmacy services in a community pharmacy.
Definitions		
2.		In this Part:
		<p>“community pharmacy” has the same meaning as in section 1 of the bylaws of the college under the <i>Pharmacy Operations and Drug Scheduling Act</i>; “medication management” has the same meaning as in section 2, Schedule F, Part 5 of the bylaws of the College under the <i>Health Professions Act</i>;</p> <p>“incentive” includes money, gifts, discounts, rebates, refunds, customer loyalty schemes, coupons, goods, rewards and any other things approved by the Board from time to time.</p> <p>“personal health number” means a unique numerical lifetime identifier used in the specific identification of an individual patient who has any interaction with the BC health system;</p> <p>“prescription copy” means a copy of a prescription given to a patient by a registrant for information purposes only;</p> <p>“prescription transfer” means the transfer via direct communication from a registrant to another registrant of all remaining refill authorizations for a particular prescription to a requesting community pharmacy;</p> <p>“refill” means verbal or written approval from a practitioner authorizing a registrant to dispense additional quantities of drug(s) pursuant to a prescription;</p> <p>“renewal” means authorization by a full pharmacist to dispense additional quantities of drug(s) pursuant to a previously dispensed prescription, in accordance with section 25.92 of the <i>Act</i>;</p> <p>“Residential Care Facilities and Homes Standards of Practice” means the standards, limits and conditions for practice established in Part 3 of this Schedule.</p>
Patient Choice		
3.		Registrants, owners and directors must not enter into agreements with patients, patient’s representatives, practitioners, corporations, partnerships, or any other person or entity, that limit a patient’s choice of pharmacy, except as required or permitted under the bylaws.
Pharmacy Assistants		
4.		A registrant may delegate technical functions relating to the operation of the community pharmacy to a pharmacy assistant if the registrant

		directly supervises the pharmacy assistant and implements procedures, checks and controls to ensure the accurate and safe delivery of community pharmacy services.
Prescription		
5.	(1)	A registrant must ensure that a prescription is authentic.
	(2)	<p>Upon receipt from the practitioner, a prescription must include the following information:</p> <ul style="list-style-type: none"> (a) the date the prescription was written; (b) the name and address of the patient; (c) the name of the drug or ingredients and strength if applicable; (d) the quantity of the drug for controlled drug substances; (e) the quantity of the drug or the calculated quantity based on the directions and duration of use (f) the dosage instructions including the frequency, interval or maximum daily dose; (g) refill authorization if applicable, including number of refills; (h) the practitioner’s name, the practitioner’s college registration identification number for prescriptions on the Controlled Prescription Program and the practitioner’s signature for all prescriptions. (i)
	(3)	For the purpose of subsection (4), “prescription” includes a new prescription, a refill, a renewal or a balance owing.
	(4)	<p>At the time of dispensing, a prescription must include the following additional information:</p> <ul style="list-style-type: none"> (a) the prescription number; (b) the date on which the prescription was dispensed; (c) the manufacturer’s drug identification number or the brand name of the product dispensed; (d) the quantity dispensed; (e) the written or electronic identification of each registrant and pharmacy assistant involved in each step of the dispensing process; (f) the written or electronic confirmation and identification of the registrant who

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		<ul style="list-style-type: none"> (i) reviewed the personal health information stored in the PharmaNet database, (ii) reviewed the drug usage evaluation messages (DUE) from the PharmaNet database, and (iii) performed the final check including when dispensing a balance owing. <p>(g) the practitioner’s college registration identification number.</p>
	(5)	<p>A full pharmacist must</p> <ul style="list-style-type: none"> (a) review prescriptions for completeness and appropriateness with respect to the drug, dosage, route and frequency of administration, (b) review patient personal health information for potential drug interactions, allergies, therapeutic duplications and any other potential problems, (c) consult with patients concerning the patient’s drug history and other personal health information, (d) consult with practitioners with respect to a patient’s drug therapy, when necessary unless s.25.92(2) of the <i>Act</i> applies, and (e) follow-up on suspected adverse drug reactions.
	(6)	A registrant may receive verbal prescription authorizations directly from a practitioner or from a practitioner’s recorded voice message.
	(7)	A registrant must make a written or electronic record of a verbal authorization, and include his or her written or electronic signature or initial.
	(8)	A registrant must not dispense a prescription issued for more than one patient.
	(9)	<p>For refill authorizations, a registrant</p> <ul style="list-style-type: none"> (a) may <ul style="list-style-type: none"> (i) accept a refill authorization for Schedule I drugs from a practitioner’s agent if confident the agent consulted the practitioner and accurately conveyed the practitioner’s direction, (ii) retain the current prescription number for a quantity change if the software system is capable of retaining a record of the quantity dispensed on each previous occasion, and

		<ul style="list-style-type: none"> (iii) document the refill authorization on the original prescription if <ul style="list-style-type: none"> (A) a computerized transaction log is maintained, or (B) a new prescription number is assigned, and (b) must <ul style="list-style-type: none"> (i) cancel any unused refill authorizations remaining on any previous prescription if a patient presents a new prescription for a previously dispensed drug, (ii) advise the other pharmacy of the new prescription if unused refills are at another pharmacy, and (iii) create a new prescription number if a renewal authorization involves a different drug identification number, practitioner or directions for use.
	(10)	<p>If a full pharmacist authorizes a prescription renewal, he or she must</p> <ul style="list-style-type: none"> (a) create a written or electronic record, (b) assign a new prescription number, and (c) use his or her college identification number in the practitioner field on PharmaNet.
Transmission by Facsimile		
6.	(1)	<p>Prescription authorizations may be received by facsimile from a practitioner to a pharmacy, if</p> <ul style="list-style-type: none"> (a) the prescription is sent only to a pharmacy of the patient's choice, (b) the facsimile equipment is located within a secure area to protect the confidentiality of the prescription information, and (c) in addition to the requirements of section 5(2), the prescription includes <ul style="list-style-type: none"> (i) the practitioner's telephone number, facsimile number and unique identifier if applicable, (ii) the time and date of transmission, and (iii) the name and fax number of the pharmacy intended to receive the transmission.
	(2)	<p>Prescription refill authorization requests may be transmitted by facsimile from a pharmacy to a practitioner, if the pharmacy submits refill requests on a form that includes space for</p>

		<ul style="list-style-type: none"> (a) the information set out in section 5(2), (b) the name, address and telephone number of the pharmacy, and (c) the practitioner's name, date and time of transmission from the practitioner to the pharmacy.
	(3)	A registrant must not dispense a prescription authorization received by facsimile transmission for a drug referred to on the Controlled Prescription Program Drug List.
	(4)	<p>Prescription transfers may be completed by facsimile transmission if</p> <ul style="list-style-type: none"> (a) the transferring registrant includes his or her name and the address of the pharmacy with the information required in section 7(4), and (b) the name of the registrant receiving the transfer is known and recorded on the document to be faxed.
Prescription Copy and Transfer		
7.	(1)	If requested to do so, a registrant must provide a copy of the prescription to the patient or the patient's representative, or to another registrant.
	(2)	<p>A prescription copy must contain</p> <ul style="list-style-type: none"> (a) the name and address of the patient, (b) the name of the practitioner, (c) the name, strength, quantity and directions for use of the drug, (d) the dates of the first and last dispensing of the prescription, (e) the name and address of the community pharmacy, (f) the number of authorized refills remaining, (g) the date the original prescription was written, (h) the signature of the registrant supplying it, and (i) an indication that it is a copy.
	(3.1)	<p>Upon request, a registrant must transfer to a pharmacy licenced in Canada a prescription for a drug if</p> <ul style="list-style-type: none"> (a) the drug does not contain a controlled drug substance except as provided in subsection (3.2), and (b) the transfer occurs between a registrant and another registrant or an equivalent of a registrant in another Canadian

		jurisdiction
	(3.2)	<p>Upon request, a pharmacist must transfer to a pharmacy licenced in Canada a prescription for a drug if</p> <ul style="list-style-type: none"> (a) the drug contains a benzodiazepine, (b) the prescription has not been transferred previously, and (c) the transfer occurs between a pharmacist and another pharmacist or an equivalent of a pharmacist in another Canadian jurisdiction.
	(4)	<p>A registrant who transfers a prescription to another registrant under subsection (3) must</p> <ul style="list-style-type: none"> (a) enter on the patient record <ul style="list-style-type: none"> (i) the date of the transfer, (ii) the registrant's identification, (iii) identification of the community pharmacy to which the prescription was transferred, and (iv) identification of the person to whom the prescription was transferred, and (v) the prescribing date of the prescription (b) transfer all prescription information listed in subsection (2) (a) to (g).
	(5)	A registrant must make prescriptions available for review and copying by authorized inspectors of Health Canada.
Prescription Label		
8.	(1)	All drugs dispensed pursuant to a prescription or a full pharmacist-initiated adaptation must be labeled.
	(2)	<p>The label for all prescription drugs must include</p> <ul style="list-style-type: none"> (a) the name, address and telephone number of the pharmacy, (b) the prescription number and dispensing date, (c) the full name of the patient, (d) the name of the practitioner, (e) the quantity and strength of the drug, (f) the practitioner's directions for use, and

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		(g) any other information required by good pharmacy practice.
	(3)	For a single-entity product, the label must include (a) the generic name, and (b) at least one of (i) the brand name, (ii) the manufacturer's name, or (iii) the drug identification number.
	(4)	For a multiple-entity product, the label must include (a) the brand name, or (b) all active ingredients, and at least one of (i) the manufacturer's name, or (ii) the drug identification number.
	(5)	For a compounded preparation, the label must include all active ingredients.
	(6)	If a drug container is too small to accommodate a full label in accordance with subsection (2), (a) a trimmed prescription label must be attached to the small container, (b) the label must include (i) the prescription number, (ii) the dispensing date, (iii) the full name of the patient, and (iv) the name of the drug, and (c) the complete prescription label must be attached to a larger container and the patient must be advised to keep the small container inside the large container.
	(7)	All required label information must be in English, but may contain directions for use in the patient's language following the English directions.
Dispensing		
9.	(1)	A registrant may adjust the quantity of drug to be dispensed if

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		<ul style="list-style-type: none"> (a) a patient requests a smaller amount, (b) a manufacturer's unit-of-use standard of package size does not match the prescribed quantity, (c) the quantity prescribed exceeds the amount covered by the patient's drug plan, or (d) a trial prescription quantity is authorized by the patient.
	(2)	<p>A full pharmacist may adjust the quantity of drug to be dispensed, if</p> <ul style="list-style-type: none"> (a) he or she consults with a practitioner and documents the result of the consultation, and (b) if <ul style="list-style-type: none"> (i) a poor compliance history is evident on the patient record, (ii) drug misuse is suspected, or (iii) the safety of the patient is in question due to the potential for overdose.
	(3)	If a registrant doubts the authenticity of a prescription, the registrant may refuse to dispense the drug.
	(4)	<p>All drugs must be dispensed in a container that is certified as child-resistant unless</p> <ul style="list-style-type: none"> (a) the practitioner, the patient or the patient's representative directs otherwise, (b) in the registrant's judgment, it is not advisable to use a child-resistant container, (c) a child-resistant package is not suitable because of the physical form of the drug or the manufacturer's packaging is designed to improve patient compliance, or (d) child-resistant packaging is unavailable.
	(5)	A registrant must not dispense a prescription more than one year from the prescribing date, except for oral contraceptives which may be dispensed for up to two years.
Patient Record		
10.	(1)	<p>A patient record must be prepared and kept current for each patient for whom:</p> <ul style="list-style-type: none"> (a) a Schedule I drug is dispensed,

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		<p>(b) medication management is provided, or</p> <p>(c) both.</p>
	(2)	<p>The patient record must include</p> <p>(a) the patient’s full name,</p> <p>(b) the patient’s personal health number,</p> <p>(c) the patient’s address,</p> <p>(d) the patient’s telephone number,</p> <p>(e) the patient’s date of birth,</p> <p>(f) the patient’s gender,</p> <p>(g) the patient’s allergies, adverse drug reactions and intolerances, and the date the information was collected,</p> <p>(h) the patient’s clinical conditions, if available,</p> <p>(i) the date the drug is dispensed,</p> <p>(j) the prescription number,</p> <p>(k) the generic name, strength and dosage form of the drug,</p> <p>(l) the drug identification number,</p> <p>(m) the quantity of drug dispensed,</p> <p>(n) the intended duration of therapy, specified in days,</p> <p>(o) the date and reason for discontinuation of therapy,</p> <p>(p) the directions to the patient,</p> <p>(q) the identification of the prescribing practitioner,</p> <p>(r) special instructions from the practitioner to the registrant,</p> <p>(s) past and present prescribed drug therapy including the drug name, strength, dosage, frequency, duration and effectiveness of therapy,</p> <p>(t) compliance with the prescribed drug regimen, and</p> <p>(u) Schedule II and III drug use if available.</p>
	(3)	<p>A full pharmacist must review the patient’s personal health information stored on the PharmaNet database before dispensing a drug, providing medication management or both, and take appropriate action with respect to</p> <p>(a) appropriateness of drug therapy,</p>

		<ul style="list-style-type: none"> (b) drug interactions, (c) allergies, adverse drug reactions and intolerances, (d) therapeutic duplication, (e) correct dosage, route, frequency and duration of administration and dosage form, (f) contraindicated drugs, (g) degree of compliance, and (h) any other potential drug therapy problems.
Pharmacist/Patient Consultation		
11.	(1)	A full, limited, or student pharmacist must provide verbal patient consultation to the patient at the time of dispensing for all new and refill prescriptions. in accordance with subsection (3) and must document the identification of the pharmacist who performed the consultation, by written or electronic means.
	(2)	Patient consultation for all new and refill prescriptions must occur in person if practical, or by telephone, and must respect the patient's right to privacy.
	(3)	<p>Subject to subsection (6), a full, limited or student pharmacist must engage in direct consultation with a patient or the patient's representative regarding a Schedule I drug, and must</p> <ul style="list-style-type: none"> (a) confirm the identity of the patient, (b) identify the name and strength of drug being dispensed, (c) identify the purpose of the drug, (d) provide directions for use of the drug including the frequency, duration and route of therapy, (e) discuss common adverse effects, drug and food interactions and therapeutic contraindications that may be encountered, including their avoidance, and the actions required if they occur, (f) discuss storage requirements, (g) provide prescription refill information, (h) provide information regarding <ul style="list-style-type: none"> (i) how to monitor the response to therapy, (ii) expected therapeutic outcomes,

		<p>(iii) action to be taken in the event of a missed dose, and</p> <p>(iv) when to seek medical attention, and</p> <p>(i) provide other information unique to the specific drug or patient.</p>
	(4)	If a drug therapy problem is identified during full pharmacist/patient consultation, the full, limited or student pharmacist must take appropriate action to resolve and for Schedule I drugs, document the problem.
	(5)	If an adverse drug reaction as defined by Health Canada is identified, a full, limited or student pharmacist must notify the patient's practitioner, make an appropriate entry on the PharmaNet record and report the reaction to the appropriate department of Health Canada.
	(6)	A full, limited or student pharmacist must use reasonable means to comply with subsections (1), (2) and (3) for patients or the patient's representatives who have language or communication difficulties.
Schedule II and III Drugs		
12.	(1)	A registrant must not attribute a new prescription or refill for a Schedule II or Schedule III drug to a practitioner without the authorization of the practitioner.
	(2)	If a patient purchases a Schedule II drug, a full, limited or student pharmacist must counsel the patient regarding the selection and use of the drug.
	(3)	A full pharmacist must be available for consultation with a patient who wishes to select a Schedule III drug.
Sole Pharmacy Services Provider		
13.		<p>The manager of a pharmacy may enter into an agreement with another person to be the sole provider of pharmacy services in a premise or part of a premise, if</p> <p>(a) pharmacy services are provided in a manner that is consistent with the <i>Residential Care Facilities and Homes Standards of Practice</i>,</p> <p>(b) patient therapeutic outcomes are monitored to enhance patient safety, and</p> <p>(c) appropriate provision has been made for safe and effective distribution, administration and control of drugs.</p>
Prohibition on the Provision of Incentives		
14.	(1)	No registrant shall provide or distribute or be a party to the provision

		<p>or distribution of any incentive to a patient or patient's representative for obtaining a prescription order or in relation to the provision of the practice of pharmacy as defined in section 25.8 of the <i>Health Professions Act</i>.</p>
	<p>(2)</p>	<p>Section (1) does not prohibit registrants from:</p> <ul style="list-style-type: none"> (a) providing free or discounted parking to patients who are obtaining a prescription order or in relation to the provision of the practice of pharmacy as defined in section 25.8 of the <i>Health Professions Act</i>. (b) providing free or discounted delivery services to patients who are obtaining a prescription order or in relation to the provision of the practice of pharmacy as defined in section 25.8 of the <i>Health Professions Act</i>. (c) permitting patient's or patients representatives to pay for a prescription order or in relation to the provision of the practice of pharmacy as defined in section 25.8 of the <i>Health Professions Act</i>. using major credit cards that are linked to incentives like points, loyalty points or rewards, except where, directly or indirectly, the incentives are awarded specifically for the purchase of a prescription order of the practice of pharmacy.

Pharmacy Operations and Drug Scheduling Act - BYLAWS

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Definitions	
1.	In these bylaws:
	“ Act ” means the <i>Pharmacy Operations and Drug Scheduling Act</i> ;
	“ community pharmacy ” means a pharmacy licensed to sell or dispense drugs to the public and includes a telepharmacy central site but does not include telepharmacy remote site;
	“ Community Pharmacy Standards of Practice ” means the standards, limits and conditions for practice established under section 19 (1) (k) of the <i>Health Professions Act</i> respecting community pharmacies;
	“ controlled drug substance ” means a drug which includes a substance listed in Schedule I, II, III, IV or V of the <i>Controlled Drugs and Substances Act (Canada)</i> ;
	“ controlled prescription program ” means a program approved by the board, to prevent prescription forgery and reduce inappropriate prescribing of drugs;
	“ dispensary ” means the area of a community pharmacy that contains Schedule I and II drugs;
	“ health authority ” means

	(a) a regional health board designated under the <i>Health Authorities Act</i> , or (b) the Provincial Health Services Authority;
	“ hospital ” has the same meaning as in section 1 of the <i>Hospital Act</i> ;
	“ hospital pharmacy ” means a pharmacy licensed to operate in or for a hospital;
	“ hospital pharmacy remote site ” means a location, not staffed by registrants, outside the hospital premises used for the provision of pharmacy services which is dependent upon support and administrative services from the hospital pharmacy;
	“ hospital pharmacy satellite ” means a physically separate area, staffed by registrants, on or outside the hospital premises used for the provision of pharmacy services which is dependent upon support and administrative services from the hospital pharmacy;
	“ Hospital Pharmacy Standards of Practice ” means the standards, limits and conditions for practice established under section 19 (1) (k) of the <i>Health Professions Act</i> respecting hospital pharmacies;
	“ incentive ” has the same meaning as in Schedule F Part 1 of the bylaws of the College under the <i>Health Professions Act</i>
	“ medication ” has the same meaning as “drug”;
	“ medication management ” has the same meaning as in section 2, Schedule F, Part 5 of the bylaws of the College under the <i>Health Professions Act</i> ;
	“ outsource prescription processing ” means to request another pharmacy to prepare or process a prescription drug order;
	“ patient ” includes a patient’s representative;
	“ patient’s representative ” has the same meaning as in section 64 of the bylaws of the college under the <i>Health Professions Act</i> ;
	“ pharmacy assistant ” has the same meaning as “support person”;
	“ pharmacy education site ” means a pharmacy <ul style="list-style-type: none"> (a) that has Schedule I, II and III drugs, but no controlled drug substances, (b) that is licensed solely for the purpose of pharmacy education, and (c) from which pharmacy services are not provided to any person;
	“ pharmacy technician ” has the same meaning as in section 1 of the bylaws of the college under the <i>Health Professions Act</i> ;
	“ pharmacy services ” has the same meaning as in section 1 of the bylaws of the college under the <i>Health Professions Act</i> ;
	“ prescription drug ” means a drug referred to in a prescription;
	“ professional products area ” means the area of a community pharmacy that contains Schedule III drugs;
	“ professional service area ” means the area of a community pharmacy that contains

	Schedule II drugs;
	“Residential Care Facilities and Homes Standards of Practice” means the standards, limits and conditions for practice established under section 19 (1) (k) of the <i>Health Professions Act</i> respecting residential care facilities and homes;
	“telepharmacy” means the practice of pharmacy utilizing telecommunication technology between the telepharmacy central site and telepharmacy remote site;
	“telepharmacy central site” means a pharmacy from which a full pharmacist practices pharmacy and provides direct supervision to a telepharmacy remote site
	“telepharmacy remote site” means a pharmacy providing pharmacy services to the public, or in or for a hospital, (a) without a full pharmacist present, (b) in a rural and remote community, and (c) under the supervision and direction of a full pharmacist at a central pharmacy site.
PART I - All Pharmacies	
Application of Part	
2.	Except as provided in Section 22, this Part applies to all pharmacies except pharmacy education sites.
Responsibilities of Pharmacy Managers, Owners and Directors	
3.	<p>(1) A full pharmacist must be the manager of a pharmacy</p> <p>(a) A pharmacy must not be open for business unless a manager is appointed.</p> <p>(b) An owner or director must notify the registrar in writing of the appointment and any change of manager within 2 business days.</p> <p>(c) A pharmacy manager must notify the registrar in writing at least 2 days prior to ceasing to be the pharmacy’s manager.</p> <p>(d) A full pharmacist may not act as manager of more than one pharmacy location, unless the pharmacy of which the full pharmacist is manager is:</p> <p>(i) a telepharmacy remote site,</p> <p>(ii) a hospital pharmacy satellite, or</p> <p>(iii) a hospital pharmacy remote site.</p>
	<p>(2) A manager must do all of the following:</p> <p>(a) actively participate in the day-to-day management of the pharmacy;</p> <p>(b) confirm that the staff members who represent themselves as registrants are registrants;</p>

		<ul style="list-style-type: none"> (c) notify the registrar in writing of the appointments and resignations of registrants as they occur; (d) cooperate with inspectors acting under section 17 of the <i>Act</i> or sections 28 or 29 of the <i>Health Professions Act</i>; (e) ensure that registrant and pharmacy assistant staff levels are commensurate with the workload volume and patient care requirements at all times; (f) ensure that new information directed to the pharmacy pertaining to drugs, devices and drug diversion is immediately accessible to registrants and pharmacy assistants; (g) establish policies and procedures to specify the duties to be performed by registrants and pharmacy assistants; (h) establish procedures for <ul style="list-style-type: none"> (i) inventory management, (ii) product selection, and (iii) proper destruction of unusable drugs and devices; (i) ensure that all records related to the purchase and receipt of controlled drug substances are signed by a full pharmacist; (j) ensure appropriate security and storage of all Schedule I, II, and III drugs and controlled drug substances for all aspects of pharmacy practice including operation of the pharmacy without a registrant present; (k) ensure there is a written drug recall procedure in place for pharmacy inventory; (l) ensure that all steps in the drug recall procedure are documented, if the procedure is initiated; (m) ensure that each individual working in the pharmacy wears a badge that clearly identifies the individual's registrant class or other status; (n) ensure that confidentiality is maintained with respect to all pharmacy and patient records in accordance with all applicable legislation; (o) make reasonable security arrangements in respect of unauthorized access, collection, use, disclosure or disposal of personal information kept on the pharmacy premises; (p) notify the registrar as soon as possible in the event that he or she will be absent from the pharmacy for more than eight weeks; (q) ensure the correct and consistent use of the community pharmacy operating name as it appears on the community pharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising and stationery; (r) ensure that appropriate security is in place for the premises and staff generally;
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		<p>(s) in the event of a pharmacy closure</p> <ul style="list-style-type: none"> (i) notify the registrar in writing at least thirty business days before the effective date of the closure , (ii) post in a prominent location, for at least ninety days after closure, on the exterior of the building in which the pharmacy is located, information to identify the pharmacy that will be in possession of the prescription and patient records, (iii) remove or obliterate all exterior and interior signs, advertisements, and websites containing the words “pharmacy, drug store, drug department, drugs, medicines, drug sundries, druggist, apothecary or chemist”. (iv) provide for the safe transfer and appropriate storage of all Schedule I, II, and III drugs and controlled drug substances, either to another pharmacy or returned to a drug wholesaler, (v) advise the registrar in writing of the disposition of all drugs and prescription records within 7 days of closure, (vi) provide the registrar with a copy of the return invoice and any other documentation sent to Health Canada in respect of the destruction of all controlled drug substances, and (vii) arrange for the safe transfer of the prescriptions and patient records to another pharmacy. <p>(s.1) in the event of a pharmacy relocation/renovation,</p> <ul style="list-style-type: none"> (i) notify the registrar in writing at least fifty business days before the effective date of a proposed relocation/renovation, (ii) post in a prominent location, for at least ninety days after relocation, on the exterior of the building in which the pharmacy was located, information to identify the new location of the pharmacy, and (iii) provide for the safe transfer and appropriate storage of all Schedule I, II, and III drugs and controlled drug substances, <p>(t) ensure sample medications are dispensed in accordance with the requirements in the Drug Schedules Regulation;</p> <p>(u) advise the registrar if the pharmacy is providing pharmacy services over the internet, and provide to the registrar the internet address of every website operated or used by the pharmacy;</p> <p>(v) ensure the pharmacy contains the reference material and equipment approved by the board from time to time;</p> <p>(w) require all registrants, owners, managers, directors, pharmaceutical representatives, pharmacy assistants and computer software programmers or technicians who will access the in-pharmacy computer</p>
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		<p>system to sign an undertaking in a form approved by the registrar to maintain the confidentiality of patient record information;</p> <p>(x) retain the undertakings referred to in paragraph (w) in the pharmacy for 3 years after employment or any contract for services has ended;</p> <p>(y) be informed of the emergency preparedness plan in the area of the pharmacy that he or she manages and be aware of his or her responsibilities in conjunction with that plan,</p> <p>(z) ensure that no incentives are provided to the patient or the patient's representative to obtain prescription orders or in relation to the provision of the practice of pharmacy as defined in section 25.8 of the <i>Health Professions Act</i> to secure prescriptions.</p>
	(3)	Owners and directors must comply with subsection (2)(d), (e), (j), (n), (o), (q) (r), (s), (u), (v), (w), (x) and (z) except that subsections (2)(j), s(v), s(vi), s(vii), do not apply to a non-dispensing pharmacy.
	(4)	An owner must ensure that the requirements to obtain a pharmacy licence under the <i>Act</i> are met at all times; including but not limited to the completion of Forms 1, 4, 5 and 6, as applicable.
	(5)	For the purpose of subsection (2)(s), a pharmacy closure includes a suspension of the pharmacy licence for a period greater than 30 days, unless otherwise directed by the registrar.
	(6)	Owners, directors, and managers must ensure that the requirements in section 29 and 30 are met at all times.
Sale and Disposal of Drugs		
4.	(1)	Schedule I, II, and III drugs and controlled drug substances must only be sold or dispensed from a pharmacy.
	(2)	A registrant must not sell or dispense a quantity of drug that will not be used completely prior to the manufacturer's expiry date, if used according to the directions on the label.
	(3)	If the manufacturer's expiry date states the month and year but not the date, the expiry date is the last day of the month indicated.
	(4)	Every registrant must protect from loss, theft or unlawful sale or dispensing of all Schedule I, II, and III drugs and controlled drug substances in or from the pharmacy.
	(5)	Every registrant must ensure that drugs and devices are maintained within appropriate temperature, light, and humidity standards in accordance with the policy approved by the board.
	(6)	A registrant must not sell, dispense, dispose of or transfer a Schedule I drug except <p>(a) on the prescription or order of a practitioner,</p>

		<p>(b) to transfer drug inventory to a pharmacy for the purpose of providing an emergency supply of the drug required to fill a prescription or to provide expired drugs to a pharmacy education site.</p> <p>(c) to transfer drug inventory to or from an entity operating within a health authority solely for the purposes of the health authority,</p> <p>(d) by return to the manufacturer or wholesaler of the drug, or</p> <p>(e) for destruction, in accordance with the policy approved by the board.</p>
	(7)	<p>Drugs included in the controlled prescription program must not be sold or dispensed unless</p> <p>(a) the registrant has received the prescription on the prescription form approved by both the board and the College of Physicians and Surgeons of British Columbia, and</p> <p>(b) the prescription form is signed by the patient or the patient's representative upon receipt of the dispensed drug.</p>
	(8)	<p>A new prescription from a practitioner is required each time a drug is dispensed, except for</p> <p>(a) a part-fill,</p> <p>(b) a prescription authorizing repeats,</p> <p>(c) a full pharmacist-initiated renewal or adaptation, or</p> <p>(d) an emergency supply for continuity of care.</p>
	(9)	<p>Subsection (7) does not apply to prescriptions written for</p> <p>(a) residents of a facility or home subject to the requirements of the <i>Residential Care Facilities and Homes Standards of Practice</i>, or</p> <p>(b) patients admitted to a hospital.</p>
Drug Procurement/Inventory Management		
5.	(1)	<p>A full pharmacist may authorize the purchase of Schedule I, II, or III drugs or controlled drug substances only from</p> <p>(a) a wholesaler or manufacturer licensed to operate in Canada, or</p> <p>(b) a registrant at another pharmacy for the purpose of providing an emergency supply of drug required to fill a prescription.</p>
	(2)	<p>A registrant must record a transfer of drugs that occurs for any reason other than for the purpose of dispensing in accordance with a practitioner's prescription.</p>
	(3)	<p>All drug shipments must be delivered unopened to the pharmacy or a secure storage area.</p>

	(4)	Non-usable and expired drugs must be stored in a separate area of the pharmacy or a secure storage area until final disposal or transfer to a pharmacy education site.
	(5)	A full pharmacist must not purchase Schedule I, II and III drugs and controlled drug substances unless they are for sale or dispensing in or from a pharmacy.
Sterile Products and Hazardous Drugs		
6.	(1)	Sterile products must be prepared and distributed in an environment that is in accordance with the policies approved by the board from time to time.
	(2)	Hazardous drugs must be handled, prepared and distributed in accordance with the policies approved by the board from time to time.
Interchangeable Drugs		
7.		When acting under section 25.91 of the <i>Health Professions Act</i> , a full pharmacist must determine interchangeability of drugs by reference to Health Canada's Declaration of Equivalence, indicated by the identification of a Canadian Reference Product in a Notice of Compliance for a generic drug.
Returned Drugs		
8.		No registrant may accept for return to stock or reuse any drug previously dispensed except in accordance with section 10(3) of the <i>Residential Care Facilities and Homes Standards of Practice</i> or section 4(3) of the <i>Hospital Pharmacy Standards of Practice</i> .
Records		
9.	(1)	All prescriptions, patient records, invoices and documentation in respect of the purchase, receipt or transfer of Schedule I, II and III drugs and controlled drug substances must be retained for a period of not less than three years from the date (a) a drug referred to in a prescription was last dispensed, or (b) an invoice was received for pharmacy stock.
	(2)	Registrants, pharmacy assistants, managers, directors, and owners must not, for commercial purposes, disclose or permit the disclosure of information or an abstract of information obtained from a prescription or patient record which would permit the identity of the patient or practitioner to be determined.
	(3)	Despite subsection (1), a registrant must not destroy prescriptions, patient records, invoices or documentation until the completion of any audit or investigation currently underway for which the registrant has received notice.
Pharmacy Licences		
10.	(1)	The following classes of pharmacy licences are established:

		<ul style="list-style-type: none"> (a) a community pharmacy; (b) a hospital pharmacy; (c) a telepharmacy remote site; (d) a telepharmacy central site; (e) a hospital pharmacy satellite; (f) a hospital pharmacy remote site; and (g) a pharmacy education site;
	(2)	<p>An applicant for a pharmacy licence in subsection (1)(a) and (g), must submit the following to the registrar:</p> <ul style="list-style-type: none"> (a) a completed application in Form 1, 2 or 3 where applicable; (b) a diagram to scale of 1/4 inch equals 1 foot, of the entrances of the pharmacy and the preparation, dispensing, consulting, storage, professional services, professional products, and packaging areas; (c) the applicable fee set out in Schedule “A”; (d) for a community pharmacy, proof in a form satisfactory to the registrar that the municipality in which the pharmacy is located has issued a business licence for the pharmacy to the pharmacy’s owner or manager.
	(3)	<p>The registrar may renew a pharmacy licence upon receipt of the following:</p> <ul style="list-style-type: none"> (a) a completed application in Form 4, 5 or 6, as applicable; and (b) the applicable fee set out in Schedule “A”.
	(4)	<p>A pharmacy’s manager must submit to the registrar, in writing, any proposed pharmacy design changes or structural renovations together with a new pharmacy diagram for approval before the commencement of construction or other related activities.</p>
	(5)	<p>If a pharmacy will be closed temporarily for up to 14 consecutive days, the pharmacy’s manager must</p> <ul style="list-style-type: none"> (a) obtain the approval of the registrar, (b) notify patients and the public of the closure at least 30 days prior to the start of the closure, and (c) make arrangements for emergency access to the pharmacy’s hard copy patient records.
	(6)	<p>A pharmacy located in a hospital which dispenses drugs to staff, out-patients or the public and which is not owned or operated by a health authority, must be licenced as a community pharmacy.</p>

PART II – Community Pharmacies		
Community Pharmacy Manager – Quality Management		
11.		<p>A community pharmacy’s manager must develop, document and implement an ongoing quality management program that includes a written or electronic policy and procedure manual that</p> <ul style="list-style-type: none"> (a) maintains and enforces policies and procedures to comply with legislation applicable to the operation of a community pharmacy, (b) monitors staff performance, equipment, facilities and adherence to the <i>Community Pharmacy Standards of Practice</i>, and (c) includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies.
Community Pharmacy Premises		
12.	(1)	<p>In locations where a community pharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy’s manager must ensure that</p> <ul style="list-style-type: none"> (a) the professional products area extends not more than 25 feet from the perimeter of the dispensary and is visually distinctive from the remaining areas of the premises by signage, and (b) a sign reading “Medication Information” is clearly displayed to identify a consultation area or counter at which a member of the public can obtain a full pharmacist’s advice, and (c) the professional services area products are inaccessible for self-service by the public.
	(2)	<p>The dispensary area of a community pharmacy must</p> <ul style="list-style-type: none"> (a) be at least 160 square feet, (b) be inaccessible to the public by means of gates or doors across all entrances, (c) include a dispensing counter with at least 30 square feet of clear working space, in addition to service counters, (d) contain adequate shelf and storage space, (e) contain a double stainless steel sink with hot and cold running water, and (f) contain an adequate stock of drugs to provide full dispensing services.
	(3)	<p>In all new and renovated community pharmacies, an appropriate area must be provided for patient consultation that</p> <ul style="list-style-type: none"> (a) ensures privacy and is conducive to confidential communication, and (b) includes, but is not limited to, one of the following:

		<ul style="list-style-type: none"> (i) a private consultation room; (ii) a semiprivate area with suitable barriers.
	(4)	All new and renovated community pharmacies must have a separate and distinct area consisting of at least 40 square feet reserved as secure storage space.
Operation Without a Full Pharmacist		
13.	(1)	Except as provided in subsection (2), a community pharmacy must not be open to the public unless a full pharmacist is present.
	(2)	<p>A community pharmacy that does not have a telepharmacy remote site licence may operate without a full pharmacist present if all the following requirements are met:</p> <ul style="list-style-type: none"> (a) the registrar is notified of the hours during which a full pharmacist is not present; (b) a security system prevents the public, pharmacy assistants and other non-pharmacy staff from accessing the dispensary, the professional service area and the professional products area; (c) a pharmacy technician is present and ensures that the pharmacy is not open to the public; (d) Schedule I, II, and III drugs and controlled drug substances in a secure storage area are inaccessible to pharmacy assistants, other non-pharmacy staff and the public; (e) dispensed prescriptions waiting for pickup may be kept outside the dispensary if they are inaccessible, secure and invisible to the public and the requirements of section 11 of the <i>Community Pharmacy Standards of Practice</i> have been met; (f) the hours when a full pharmacist is on duty are posted.
	(3)	<p>If the requirements of subsection (2) are met, the following activities may be performed at a community pharmacy by anyone who is not a registrant:</p> <ul style="list-style-type: none"> (a) requests for prescriptions, orders for Schedule II and III drugs and telephone requests from patients to order a certain prescription may be placed in the dispensary area by dropping them through a slot in the barrier; (b) orders from drug wholesalers, containing Schedule I, II and III drugs, may be received but must be kept secure and remain unopened.
Outsource Prescription Processing		
14.	(1)	<p>A community pharmacy may outsource prescription processing if</p> <ul style="list-style-type: none"> (a) all locations involved in the outsourcing are community pharmacies in

		British Columbia, (b) all prescriptions dispensed are labeled and include an identifiable code that provides a complete audit trail for the dispensed drug, and (c) a notice is posted informing patients that the preparation of their prescription may be outsourced to another pharmacy.
	(2)	The manager of an outsourcing community pharmacy must ensure that all applicable standards of practice are met in processing prescriptions at all locations involved in the outsourcing.
	(3)	In this section, “community pharmacy” includes a hospital pharmacy.
PART III – Hospital Pharmacies		
Hospital Pharmacy Manager – Quality Management		
15.	(1)	A hospital pharmacy’s manager must develop, document and implement an ongoing quality management program that includes a written or electronic policy and procedure manual that: (a) maintains and enforces policies and procedures to comply with legislation applicable to the operation of a hospital pharmacy, (b) monitors staff performance, equipment, facilities and adherence to the <i>Hospital Pharmacy Standards of Practice</i> , (c) includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies, (d) documents periodic audits of the drug distribution process, (e) includes a process to review patient-oriented recommendations, (f) includes a process that reviews a full pharmacist’s documentation notes in the hospital’s medical records, (g) includes a process to evaluate drug use, and (h) regularly updates policies and procedures for drug use control and patient-oriented pharmacy services in collaboration with the medical and nursing staff and appropriate committees.
	(2)	If sample drugs are used within a hospital, the hospital pharmacy’s manager must ensure that the pharmacy oversees the procurement, storage and distribution of all sample drugs.
	(3)	Section 3(2)(q) does not apply to a hospital pharmacy manager.
Drug Distribution		
16.	(1)	A hospital pharmacy manager must establish a drug distribution system that (a) provides drugs in identified dosage units ready for administration

		<p>whenever possible and practical,</p> <p>(b) removes all expired, contaminated, and recalled drugs from the inventory of the hospital and its associated hospital pharmacy satellites, telepharmacy remote sites and hospital pharmacy remote sites,</p> <p>(c) provides a method of recording drugs at the time of administration, and</p> <p>(d) eliminates or reduces the need to maintain ward stock.</p>
	(2)	A unit dose, monitored dose, multiple pouch packaging or individual patient prescription drug distribution system must be used for dispensing drugs.
	(3)	Drugs must be stored in conditions that protect their integrity, stability and sterility or in accordance with policies approved by the board from time to time,
After Hours Service		
17.	(1)	<p>If continuous pharmacy services are not provided in a hospital, the hospital pharmacy's manager must ensure that urgently needed drugs and patient-oriented pharmacy services are available at all times by</p> <p>(a) providing a cabinet which must</p> <p>(i) be a locked cabinet or other secure enclosure located outside of the hospital pharmacy, to which only authorized persons may obtain access,</p> <p>(ii) be stocked with a minimum supply of drugs most commonly required for urgent use,</p> <p>(iii) not contain controlled drug substances unless they are provided by an automated dispensing system,</p> <p>(iv) contain drugs that are packaged to ensure integrity of the drug and labeled with the drug name, strength, quantity, expiry date and lot number, and</p> <p>(v) include a log in which drug withdrawals are documented, and</p> <p>(b) arranging for a full pharmacist to be available for consultation on an on-call basis.</p>
	(2)	When a hospital pharmacy or hospital pharmacy satellite is closed, the premises must be equipped with a security system that will detect unauthorized entry.
PART IV – Telepharmacy		
Telepharmacy Services		
18.	(1)	The registrar may authorize a community pharmacy or hospital pharmacy to provide telepharmacy services, upon receipt of a completed application in Form 2 and if satisfied that the requirements of this section will be met.

	(2)	Telepharmacy services may only be provided in or through pharmacies authorized under this Part to provide telepharmacy services.
	(3)	A telepharmacy remote site must be under the direct supervision of a full pharmacist at the central pharmacy site.
	(4)	A telepharmacy remote site must be under the responsibility of the manager of the central pharmacy site.
	(5)	The <i>Community Pharmacy Standards of Practice</i> apply to a telepharmacy remote site, unless it is located in, or providing pharmacy services for, a hospital in which case the <i>Hospital Pharmacy Standards of Practice</i> apply.
	(6)	Full pharmacists at a central pharmacy site must comply with section 11 of the <i>Community Pharmacy Standards of Practice</i> by using video and audio links.
	(7)	A sign must be posted at the dispensary counter of a telepharmacy remote site advising patients and staff when the site is operating in telepharmacy mode.
	(8)	A telepharmacy remote site must not remain open and prescriptions must not be dispensed if (a) an interruption in data, video or audio link occurs, (b) a pharmacy technician is not on duty at the telepharmacy remote site, or (c) a full pharmacist is not on duty at the central pharmacy site.
	(9)	Prescriptions dispensed at a telepharmacy remote site must be distinguishable from a prescription dispensed at the central pharmacy site and include a unique label and a unique identifier for the prescription.
	(10)	The manager of a central pharmacy site must (a) inspect and audit each affiliated telepharmacy remote site at least 3 times each year, (b) make a written record of all inspections and audits, and (c) provide a copy of a record described in paragraph (b) to the college on request.
	(11)	There must be a policy and procedure manual which describes the specific telepharmacy operations that are in place to ensure the safe and effective distribution of pharmacy products and delivery of pharmaceutical care.
PART V – Hospital Pharmacy Remote Site		
Definitions		
19.		In this Part: “base pharmacy” means a hospital pharmacy that provides pharmacy services to a hospital pharmacy remote site.

		<p>“healthcare provider” means a registrant of a designated health profession pursuant to the <i>Health Professions Act</i> authorized to provide pharmacy services within a hospital pharmacy remote site.</p>
Hospital Pharmacy Remote Site Manager		
20.		<p>Hospital Pharmacy Remote Site Manager</p> <p>(1) The provisions of Section 3(2)(a), (d), (f), (h), (i), (j), (k), (l), (o) (p), (r), (s), (t), and (y) apply to a hospital pharmacy remote site manager.</p> <p>(2) The pharmacy manager at the base pharmacy is the manager of the hospital pharmacy remote site.</p> <p>(3) A hospital pharmacy remote site manager must:</p> <p>(a) inspect and audit the hospital pharmacy remote site at the site location at least once every 6 months;</p> <p>(b) document all inspections and audits;</p> <p>(c) develop, maintain and enforce policies and procedures</p> <p>(i) to comply with legislation applicable to the operation of a hospital pharmacy remote site;</p> <p>(ii) to restrict access to a hospital pharmacy remote site to healthcare providers of the facility; and</p> <p>(iii) for drug distribution in collaboration with healthcare providers in accordance with the policy approved by the board.</p> <p>(d) provide a list of drugs available in the hospital pharmacy remote site to health care providers of the facility,</p> <p>(e) ensure drugs stocked in the hospital pharmacy remote site are labelled with the expiry date and manufacturer lot number,</p> <p>(f) develop a documentation system that:</p> <p>(i) tracks and records the type and quantity of drugs transferred to the hospital pharmacy remote site,</p> <p>(ii) identifies the pharmacy staff stocking and supplying drugs to the hospital pharmacy remote site,</p> <p>(iii) identifies the health care provider or pharmacy staff receiving drugs at the hospital pharmacy remote site,</p> <p>(iv) identifies the health care provider dispensing drugs from the hospital pharmacy remote site.</p>
Hospital Pharmacy Remote Site Premises		
21.		<p>A hospital pharmacy remote site must:</p> <p>(1) be located in a controlled and monitored area, outside of public access and away from public view, and</p> <p>(2) be locked or located in a locked area when not in use,</p>
PART VI – Pharmacy Education Sites		
Pharmacy Education Site Manager		
22.	(1)	<p>The provisions of Section 3(2)(a), (d), (h), (j), (p), (r), (s), (v) and (vi) and 10(1)(i), 10(2), 10(5), and 10(6) apply to a pharmacy education site manager.</p>

	(2)	A full pharmacist must be the manager of a pharmacy education site that provides pharmacist education.
	(3)	A full pharmacist or pharmacy technician must be the manager of a pharmacy education site that provides pharmacy technician education.
	(4)	A pharmacy education site manager must ensure that only registrants, instructors and students registered in a program listed in Schedule C are present in the pharmacy education site.
	(5)	A pharmacy education site manager must ensure that documentation in respect of the purchase, receipt or transfer of Schedule I, II and III drugs is created and retained for a period of not less than 3 years from the date the drugs were received by the pharmacy education site.
	(6)	A pharmacy education site manager must ensure that drugs are disposed of in accordance with Section 4(6)(e).
PART VIIX – PharmaNet		
Application of Part		
23.		This Part applies to every pharmacy that connects to PharmaNet.
Definitions		
24.		In this Part:
		“database” means those portions of the provincial computerized pharmacy network and database referred to in section 13 of the <i>Act</i> ;
		“electronic prescription” means a prescription transcribed by electronic means, evidenced by an electronic signature only using prescribed information management technology under the <i>Pharmaceutical Services Act</i> ;
		“electronic signature” means a signature in an electronic form that a pharmacist or practitioner has created to sign an electronic prescription;
		“in-pharmacy computer system” means the computer hardware and software utilized to support pharmacy services in a pharmacy;
		“patient keyword” means an optional confidential pass code selected by the patient which limits access to the patient’s PharmaNet record until the pass code is provided to the registrant;
		“PharmaNet patient record” means the patient record described in section 11(2) of the <i>Community Pharmacy Standards of Practice</i> and in the PharmaNet Professional and Software Compliance Standards as the “patient profile”;
		“PharmaNet Professional and Software Compliance Standards” means the document provided by the Ministry of Health Services specifying the requirements of an in-pharmacy computer system to connect to PharmaNet;

		<p>“terminal” means any electronic device connected to a computer system, which allows input or display of information contained within that computer system.</p>
<p>Operation of PharmaNet</p>		
25.	(1)	<p>A pharmacy licensed pursuant to Section 10(1)(a) must connect to the PharmaNet System and be equipped with the following:</p> <ul style="list-style-type: none"> (a) an in-pharmacy computer system which meets the requirements set out in the current PharmaNet Professional and Software Compliance Standards; (b) a terminal that is capable of accessing and displaying patient records, located in an area of the pharmacy which <ul style="list-style-type: none"> (i) is only accessible to registrants and pharmacy assistants, (ii) is under the direct supervision of a registrant, and (iii) does not allow information to be visible to the public, unless intended to display information to a specific patient; (c) the computer software upgrades necessary to comply with changes to the PharmaNet Professional and Software Compliance Standards.
	(2)	<p>If a pharmacy licensed pursuant to Section 10(1)(e) or (g) connects to the PharmaNet system it must comply with subsections (a) to (c).</p>
<p>Data Collection, Transmission of and Access to PharmaNet Data</p>		
26.	(1)	<p>A registrant must enter the prescription information and transmit it to PharmaNet at the time of dispensing and keep the PharmaNet patient record current.</p>
	(2)	<p>A registrant may collect and transmit patient record information to PharmaNet or access a patient’s PharmaNet record only</p> <ul style="list-style-type: none"> (a) to dispense a drug, (b) to provide patient consultation, (c) to evaluate a patient’s drug usage, or (d) to provide medication management services.
	(3)	<p>A registrant may collect and transmit patient record information to PharmaNet or access a patient’s PharmaNet record only for the purposes of claims adjudication and payment by an insurer.</p>
	(4)	<p>A registrant must revise information in the PharmaNet database pertaining to corrected billings for prescriptions billed to the patient or a payment agency other than PharmaCare and record the reason for the revision within 90 days of the original entry on PharmaNet.</p>

	(5)	A registrant must reverse information in the PharmaNet database, for any drug that is not released to the patient or the patient's representative, and record the reason for the reversal no later than 30 days from the date of the original entry of the prescription information in PharmaNet.
	(6)	If a registrant is unable to comply with the deadlines in subsections (4) or (5), he or she must provide the information required to make the correction to the college as soon as possible thereafter.
	(7)	At the request of the patient, a registrant must establish, delete or change the patient keyword.
	(8)	Where a patient or patient's representative requests an alteration to be made to the PharmaNet information, the registrant must <ul style="list-style-type: none"> (a) correct the information, or (b) if the registrant refuses to alter the information, he or she must inform the person requesting the change of his or her right to request correction under the <i>Personal Information Protection Act</i>.
Confidentiality		
27.		A registrant must take reasonable steps to confirm the identity of a patient, patient's representative, registrant or practitioner before providing any pharmacy service, including but not limited to <ul style="list-style-type: none"> (a) establishing a patient record, (b) updating a patient's clinical information, (c) providing a printout of an in-pharmacy or requesting a PharmaNet patient record, (d) establishing, deleting, or changing a patient keyword, (e) viewing a patient record, (f) answering questions regarding the existence and content of a patient record, (g) correcting information, and (h) disclosing relevant patient record information to another registrant for the purpose of dispensing a drug or device, and/or for the purpose of monitoring drug use.
Electronic Prescription		
28.	(1)	A registrant may dispense an electronic prescription only in accordance with these bylaws.

PART XVIII – Marketing and Advertising		
Definitions		
29.		<p>In this Part:</p> <p>"advertisement" means the use of space or time in a public medium, or the use of a commercial publication such as a brochure or handbill, to communicate with the general public, or a segment thereof, for the purpose of promoting professional services or enhancing the image of the advertiser;</p> <p>"marketing" includes</p> <p>(a) an advertisement,</p> <p>(b) any publication or communication in any medium with any patient, prospective patient or the public generally in the nature of an advertisement, promotional activity or material, a listing in a directory, a public appearance or any other means by which professional services are promoted, and</p> <p>(c) contact with a prospective client initiated by or under the direction of a registrant.</p>
Marketing and Advertising		
30.	(1)	When advertising pharmacy services that are required by legislation, the statement, "Required in all British Columbia Pharmacies", must accompany the advertising and must be of the same size and prominence as all other print in the advertising.
	(2)	<p>Schedule I drug price advertising is restricted to</p> <p>(a) the proprietary (brand) name, if any, for the drug and/or the device,</p> <p>(b) the drug product's generic name and the manufacturer's name,</p> <p>(c) the dosage form and strength,</p> <p>(d) total price for a specific number of dosage units or quantity of the drug product, and</p> <p>(e) the phrase "only available by prescription".</p>
	(3)	Where Schedule I drug price advertising includes direct or indirect reference to a professional fee charged, the total prescription price must also be incorporated into the advertisement, and both figures must be featured equally.
	(4)	Schedule I drug price advertising must not include any reference to the safety, effectiveness or indications for use of the advertised prescription drug products or compare the fees charged by the registrant with those charged by another registrant.

	(5)	<p>Any marketing undertaken or authorized by a registrant in respect of his or her professional services must not be</p> <ul style="list-style-type: none"> (a) false, (b) inaccurate, (c) reasonably expected to mislead the public, or unverifiable.
	(6)	<p>Marketing violates subsection (5) if it</p> <ul style="list-style-type: none"> (a) is calculated or likely to take advantage of the weakened state, either physical, mental or emotional, of the recipient or intended recipient, (b) is likely to create in the mind of the recipient or intended recipient an unjustified expectation about the results which the registrant can achieve, (c) implies that the registrant can obtain results <ul style="list-style-type: none"> (i) not achievable by other registrants, (ii) by improperly influencing a public body or official, or any corporation, agency or person having any interest in the welfare of the recipient, (iii) by any other improper means, or (iv) compares the quality of services provided with those provided by another registrant, or a person authorized to provide health care services under another enactment, or another health profession.
	(7)	<p>The home page of any pharmacy that advertises on a website must clearly show</p> <ul style="list-style-type: none"> (a) the pharmacy licence number issued by the college, (b) the contact information for the college, (c) a notice to patients that complaints of a registrant's professional conduct or pharmacy practice issues may be reported to the college, (d) the pharmacy name, (e) the community pharmacy name where the pharmacy is physically located (f) the physical location of the pharmacy operation and street address of the community pharmacy, (g) the pharmacy telephone number, and (h) the name of the pharmacy's manager.
		<ul style="list-style-type: none"> (i) a notice to patients that customer service complaints or inquiries may be reported to the community pharmacy



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sécurité... notre priorité.*

Controlled Substances Program (CSP)

Health Canada

Friday, June 21, 2013



Canada

CSP Organization



Atlantic/Quebec Region

- 1 Regional Manager in Quebec
- 1 Inspector in Atlantic
- 4 Inspectors in Quebec

Ontario/Nunavut Region

- 1 Regional Manager in Ontario
- 5 Inspectors in Ontario

Western Canada Region (Alberta, British Columbia, Manitoba, Saskatchewan, and Yukon)

- 1 Regional Manager in British Columbia
- 1 Inspector in Manitoba
- 2 Inspectors in Alberta
- 2 Inspectors in British Columbia



Substances regulated under the *Controlled Drugs and Substances Act (CDSA)*:

- **Benzodiazepines and other targeted substances**
i.e. Diazepam, Lorazepam, etc.
- **Chemical precursors (including Class A and B precursors)**
i.e. Acetone, Potassium permanganate, Ephedrine, etc.
- **Controlled drugs**
i.e. Barbiturates, Amphetamines, etc.
- **Industrial hemp**
- **Medical Marihuana**
- **Narcotics**
i.e. Oxycodone, Morphine, etc.
- **Restricted drugs**
i.e. LSD, MDMA, etc.



Sections 30 and 31 of the CDSA



Inspector's Powers

An inspector may, to ensure compliance with the regulations, at any reasonable time enter any place the inspector believes on reasonable grounds is used for the purpose of conducting the business or professional practice of **any person licensed or otherwise authorized under the regulations** to deal in a controlled substance or a precursor



Pharmacy Inspections

- All inspections are unannounced
- The scope is limited to:

Sections 30 to 49 of the *Narcotic Control Regulations*

Sections G.03.001. to G.03.017.3. of the *Food and Drug Regulations*

Sections 48 to 57 of the *Benzodiazepines and Other Targeted Substances Regulations*

Applicable circular letters

- Compliance promotion and education
- Observations and corrective actions are communicated in an exit interview and in writing



Information Sharing

The Minister shall provide in writing any factual information about a pharmacist or practitioner that has been obtained under the Act or these Regulations to the provincial professional licensing authority responsible for the registration or authorization of the person to practise their profession

(a) in the province in which the pharmacist or practitioner is registered or entitled to practise if

(i) the authority submits a written request that states the name and address of the pharmacist or practitioner , a description of the information being sought and a statement that the information is required for the purpose of assisting a lawful investigation by the authority, or

Narcotic Control Regulations (NCR) 46;

Food and Drug Regulations (FDR) G.03.017; and

Benzodiazepines and Targeted Substances Regulations (BOTSR) 81

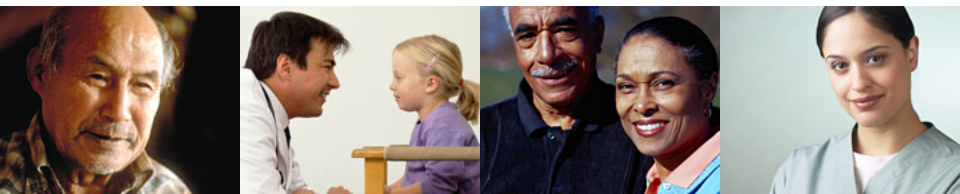


Information Sharing - Continued

- (ii) the Minister has reasonable grounds to believe that the pharmacist or practitioner has
 - (A) contravened a rule of conduct established by the authority,
 - (B) been found guilty in a court of law of a designated drug offence or of a contravention of these Regulations, or
 - (C) contravened a provision of these Regulations; or

- (b) in a province in which the pharmacist or practitioner is not registered or entitled to practise, if the authority submits to the Minister
 - (i) a written request for information that states
 - (A) the name and address of the pharmacist or practitioner, and
 - (B) a description of the information being sought, and
 - (ii) documentation that shows that the pharmacist or practitioner has applied to that authority to practise in that province

NCR 46; NCR 57; FDR G.03.017; FDR G.04.004. ; and BOTSR 81



Diversion of Controlled Substances

- Loss and theft
- Destruction
- Pilferage
- Record Keeping
- Compounding/Waste



Current Topics



Compounding Pharmacies

- Record keeping of the production process
- Policy on Manufacturing and Compounding Drug Products in Canada (POL-0051)

Internet Pharmacies

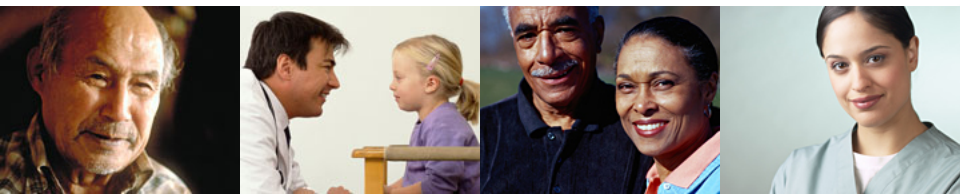
- Importation and exportation of controlled substances requires licensing and permits



Health Canada - British Columbia

For any questions related to drugs, natural health products, medical devices, controlled substances, and chemical precursors. Please contact us at:

604-666-3350





7.1.1 PPP-66 MMT – Policy & Policy Guide Update

INFORMATION ONLY:

or

DECISION REQUIRED:

Methadone Maintenance Treatment (MMT) Policy Changes

BACKGROUND:

After the approval and implementation of Professional Practice Policy 66 (PPP-66) – Methadone Maintenance Treatment in 2010 the College continues to receive significant numbers of complaints related to MMT pharmacy practice. In the 2012/13 update to the College strategic plan, an MMT action plan was identified as an objective. Included in the action plan was consultation with various stakeholders and through that process it was identified that the policy and standards required updating in several areas.

Coincidentally in the fall of 2012 the pharmaceutical manufacturer Mallinckrodt announced the imminent Health Canada approval of a commercially available 10mg/ml methadone oral solution. As a result, a joint working group was established with representatives from CPBC, the College of Physicians and Surgeons of BC (CPSBC) and the Ministry of Health - Pharmaceutical Services Division. The working group met a number of times from November 2012 to June 2013 to identify issues, requirements and timelines for consideration to implement coverage of methadone 10mg/ml oral solution effective November 1, 2013 and discontinue coverage of compounded methadone 1mg/ml solution effective December 1, 2013. In addition, the working group reviewed existing MMT policies and standards for physicians and pharmacists to ensure public safety in this transition to a concentrated oral solution 10 times the strength of the previously compounded product.

DISCUSSION:

The Board briefing package includes the policy and standard changes that are recommended following the work that was completed from the action plan as well as with the change to 10mg/ml commercially available methadone oral solution.

These draft documents are being shared with a MMT Dispensers working group (composition noted in appendix A) and a meeting is scheduled on June 10, 2013 to discuss any issues/concerns they may have. At the same time CPBC is seeking feedback from CPSBC, the Ministry of Health and an MMT patient advocacy group - Vancouver Area of Network Drug Users (VANDU). Once feedback is gained any appropriate changes will be incorporated into the documents and then the documents will be forwarded to Board members at least one week in advance of the June 2013 Board meeting.



BOARD MEETING June 21, 2013

Changes to the policy and guide are highlighted in a table that will be forwarded with the documents.

Working Group Member	Workplace
Parkash Ragsdale	BC Pharmacy Association
Geoff Cridge	Family Care Pharmacy
Harvey Chan	Omnicare Pharmacy
Amy Huang	Downtown Clinic Pharmacy
Radovan Markovich	Marmar Pharmacy
Ken Wong	London Drugs #82
Jennifer Gates-Martinez (Pharmacy Technician)	Safeway #62
Ken Lee	Overwaitea Head Office



7.1.2 Methadone Prescription Form

INFORMATION ONLY:

or

DECISION REQUIRED:

Methadone Controlled Prescription Form

BACKGROUND:

In order to facilitate changes to 10mg/ml as the standard MMT dose the *methadone controlled prescription form* has been changed. These changes have been approved by the College of Physicians and Surgeons and CPBC staff have reviewed and endorse the changes. The changes are outlined below:

Current Version	New Version
Methadone 1mg/ml	Methadone 10mg/ml (<i>this will become the new standard strength</i>)
Quantity section: ml	Quantity section: mg (<i>the 2 colleges want to convert all prescriptions to mg to decrease mistakes – physicians should be prescribing the mg strength needed, not the number of mls required.</i>)
“Void after 5 days” section (<i>this was not quite correct for methadone prescriptions if the start date was put into the sig – therefore suggested a change to remove this but indicate no refills permitted</i>)	‘No refills permitted’

Below is the excerpt from PODSA Bylaws which indicate that the CPBC Board must approve the CPP form:

- (6) Drugs included in the controlled prescription program must not be sold or dispensed unless:
- (a) the registrant has received the prescription on the prescription form approved by both the board and the College of Physicians and Surgeons of British Columbia, and
 - (b) the prescription form is signed by the patient

The draft form which outlines the changes will be forwarded to the Board one week in advance of the Board meeting, along with the other methadone related documents.

DECISIONS:

Approve the revised methadone controlled prescription form as presented.

MOCK UP ONLY / DRAFT / WORKING COPY

-----BC CONTROLLED PRESCRIPTION FORM-----

Take to pharmacy of choice

PLEASE PRINT

PERSONAL HEALTH NO.			PRESCRIBING DATE		
YEAR		MONTH		DAY	
PATIENT NAME		FIRST		INITIAL	
		LAST			
ADDRESS					
STREET					
CITY		PROVINCE		DATE OF BIRTH	
YEAR		MONTH		DAY	
Rx: DRUG NAME AND STRENGTH		METHADONE 10 mg/ml		DUE TO THE PATIENT'S IMMOBILITY, I CONFIRM DELIVERY IS REQUIRED.	
PRESCRIBER'S SIGNATURE					
QUANTITY		NUMERIC		ALPHA	
		mg		mg	
DIRECTIONS FOR USE					
METHADONE					
_____ mg/day					
START DAY: _____			LAST DAY: _____		
YYYY MM DD			YYYY MM DD		
CIRCLE ONE DWI OR CARRIES ▶ SPECIFY NUMBER OF DAYS PER WEEK OF WITNESSED INGESTION IN PHARMACY					
NUMERIC			ALPHA		
SPECIAL INSTRUCTIONS				PRESCRIBER'S SIGNATURE	
PRESCRIBER'S INFORMATION					
				CPSID	
				FOLIO	
PHARMACY USE ONLY					
RECEIVED BY: PATIENT OR AGENT SIGNATURE			SIGNATURE OF DISPENSING PHARMACIST		

PHARMACY COPY—COPYING OR DUPLICATING THIS FORM IN ANY WAY CONSTITUTES AN OFFENCE

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POLICY STATEMENT(S):

Under extraordinary circumstances, if the patient has restrictions in mobility and if the prescribing physician has provided written authorization on the prescription by signing the declaration, pharmacists may provide home delivery of methadone for maintenance. This practice is the exception to the rule and not normal practice.

Neither the pharmacy manager nor the staff pharmacist may authorize the provision of home delivery for methadone in the absence of the prescriber's authorization on the prescription.

Delivery Standards:**1. Prescribing Physician Authorization of Home Delivery**

- a. Should the prescribing physician determine that, due to the patient's immobility, delivery is required; the physician may authorize delivery by signing the declaration on the Methadone Maintenance Program, Controlled Prescription Program form.
 - i. If the pharmacist or pharmacy technician has concerns regarding the authenticity of the prescriber's signature they must contact the prescriber for verification.
 - ii. Physicians will not authorize delivery unless patient safety is assured and restrictions in mobility have been identified.
 - iii. Distance between patient home and pharmacy does not qualify as a restriction in mobility.

2. Home Delivery Schedule and Location

If delivery is authorized as noted in section 1 above, the pharmacist must meet the following delivery requirements:

- a. The pharmacist must determine whether home delivery is feasible within the services and resources the pharmacy provides. If the pharmacy does not provide delivery service – it may be appropriate to refer the patient to a pharmacy that can provide the delivery.
- b. If the pharmacy is able to provide home delivery the pharmacist must work with the patient to make appropriate arrangements for delivery. Arrangements must include:
 - iv. Address for delivery - methadone may only be delivered to a patient's home with a valid street address; delivery to a public location is not permitted.
 - i. Time for delivery.
 - ii. Procedure if patient not available at address to receive methadone delivery including communication of appropriate alternate arrangements for the patient to obtain their prescription.

Note: *it is not acceptable for the pharmacist to deliver the methadone to an alternate person or location or to leave the methadone unattended.*

3. Secure Transportation and Storage

- a. The dispensing pharmacist is responsible for securely transporting and appropriately storing methadone.
- b. Methadone must be transported directly from the dispensing pharmacy to the patient's home address; methadone may not be stored outside of the pharmacy under any circumstances.

4. Release of Methadone for Maintenance

The pharmacist must be present to:

- a. Confirm the identity of the patient.
- b. Assess the competence of the patient.

- c. Witness the release and ingestion of methadone to the patient, this responsibility cannot be delegated to a pharmacy technician or any other pharmacy support staff.
- d. Provide appropriate patient counseling.
- e. If carries are provided, the pharmacist must always witness first dose of the take-home prescription; all subsequent doses must be dispensed in child-resistant containers with explicit warning label(s).

5. Documentation

The pharmacist must:

- a. At the time of release of a methadone prescription the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific part-fill accountability log. Neither party may 'pre-sign' for future doses.
- b. Document any and all home deliveries of methadone in the patient's record.
- c. Log the home delivery with the address where the delivery was made on the methadone part-fill accountability log.
- d. Document any appropriate follow-up plan in the patient's record.
- e. File the methadone part-fill accountability log with original methadone prescription form.

BACKGROUND:

Legislation

Federal legislation does not support delivery of narcotics. The Controlled Drugs and Substances Act (CDSA) defines the transport or delivery of narcotics as trafficking, the Narcotic Control Regulations (NCR) limit the transport of narcotics to licensed dealers only.

Controlled Drugs and Substances Act

"Section 2 - Interpretation, Definitions¹

"traffic" means, in respect of a substance included in any of Schedules I to IV,
(a) to sell, administer, give, transfer, **transport**, send or **deliver** the substance"

Narcotic Control Regulations

"Section 2 - Interpretation, Definitions²

"licensed dealer" means the holder of a licence issued under section 9.2.

Dealers' Licenses and Licensed Dealers³

8. (1) Subject to these Regulations, no person *except a licensed dealer* shall produce, make, assemble, import, export, sell, provide, **transport, send or deliver a narcotic."**

Pharmacists are required to adhere to the CDSA and its regulations as well as the *Health Professions Act, Pharmacy Operations and Drug Scheduling Act* and their *Bylaws*. The College of Pharmacists and the College of Physicians and Surgeons recognize that there are extraordinary circumstances where due to temporary or permanent restrictions in mobility patients would require delivery of their methadone for maintenance to ensure best patient health outcomes and continuity of care.

¹ <http://laws-lois.justice.gc.ca/eng/acts/C-38.8/page-1.html#h-2>

² http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._1041/page-1.html#docCont

³ http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._1041/page-3.html#docCont

Board Subcommittee - STANDARDS

Monday, June 17th, 2013

Teleconference
10:00am – 10:30am

Present: Jeremy Walden, Suzanne Solven, Ashifa Keshavji, Lori Tanaka

Regrets: Blair Tymchuk, Bev Harris

The subcommittee was informed that Bob Nakagawa and Paul Sacilotto were hoping that the subcommittees could draft goals/objectives for the June Board meeting for discussion purposes.

It was noted that the Board has had several discussions regarding increasing enforcement of standards of practice, but in order to step up enforcement, the Board needs to ensure that the standards are relevant and current. Therefore, this subcommittee work will need to align with the enforcement work and identification of priorities.

Keeping that in mind, and building from the previous meeting, the following Goal and Objectives were identified:

Goal:

The College ensures that the standards of practice are current, relevant and contribute to safe and effective pharmacy care.

Objectives:

1. Develop standards of practice for pharmacy work flow.
2. Review and update (as necessary) existing standards in the following priority areas:
 - a. Review of patient profile on PharmaNet prior to dispensing
 - b. Pharmacist/patient consultation (counselling)
 - c. Narcotic reconciliation
 - d. Patient identification verification

Board Subcommittee - Technology

Members: Jerry Casanova, Kris Gustavson, Doug Kipp, Agnes Fridl Poljak, Jeff Slater, Anar Dossa

The subcommittee reviewed the results of the recent registrant consultation process. The results clearly indicated that technology has important linkages with most areas of registrant feedback; in addition to the responses provided to a technology-specific question.

Building from the results of our previous meeting coupled with the validation provided by the registrant consultation, the following Goal and Objectives were identified:

Goal:

The College ensures that current and emerging technologies are leveraged to facilitate safe and effective pharmacy care.

Objectives:

1. CPBC act as a key stakeholder in order to facilitate enhancements to the PharmaNet database such that a more complete drug history is available for clinicians, The expanded data set is to include:
 - a. the most recent list of medications administered in hospital prior to discharge,
 - b. any physician samples provided to patients,
 - c. all HIV/AIDS-related medications and
 - d. all medications used to treat cancer

2. CPBC establish/maintain a comprehensive “portal library” to be accessed via the CPBC website in order to facilitate timely access to up to date drug information for registrants.

Strategic Planning Information Gathering & Analysis
Board Subcommittee

Strategic Plan Theme – Quality of pharmacy services to optimize patient outcomes

Topic:
Scope of Practice
Context (<i>definitions, history, key stakeholders</i>):
<ul style="list-style-type: none">• Pharmacists need to be working to the full scope of their current practice and taking on advanced practice• Pharmacy practices should ensure they are incorporating pharmacy technicians into practice and utilizing them to their full scope• The skill sets required for pharmacists and pharmacy technicians for future practice, needs to be identified and planned for
Current State Analysis (<i>What is actually happening in the practice, what currently exists, available metrics, what is going well/needs to improve?</i>):
<ul style="list-style-type: none">• Pharmacists currently have within their scope of practice the ability to:<ul style="list-style-type: none">• Adapt a prescription, administer injections (vaccinations) and provide Medication Review Services• Current state:<ul style="list-style-type: none">• Adaptations (implemented January 2009) – results of study of PharmaNet data (from January 1, 2009 to January 31, 2010) & the May 2010 provincial survey from community pharmacists<ul style="list-style-type: none">• 0.17% uptake in adaptations• 78% community pharmacies and 71% of pharmacists adapted prescriptions; 29% of pharmacists did not adapt• 80% of adaptations were for prescription renewals• Injections (implemented October 2009) – results of BCPhA survey in December 2012<ul style="list-style-type: none">• 45% of BC pharmacists authorized to administer injections; 69% of community pharmacists authorized to administer injections• 4th year pharmacy students were able to apply for injection authority effective October 2012• Medication Review Services (effective April 2011)<ul style="list-style-type: none">• 3 levels of Best Possible Medication History services can be provided• Need metrics on uptake and benefit to patient outcome• Advanced Practice Pharmacists – presentation at Board Meeting April 19, 2013• Pharmacy Technicians (PT)<ul style="list-style-type: none">• Currently 332 PTs are registered of which 119 are community, 180 are hospital and 33 are other/unknown

- Need metrics on number of PTs registered but not practising as a regulated PT
- Public unaware of new healthcare professional and their scope of practice; active campaigning required
- Owners/directors need to be aware of PT potential integration into practice and benefits

Future State (*What is the ideal future state?*):

- Adaptations
 - No restrictions
 - ADAPT program funding for pharmacists; other CE courses
 - Need metrics to demonstrate benefit to patient outcome
 - Enhanced PT utilization to enable pharmacist time to provide adaptations
 - Public aware that all pharmacists able to adapt a prescription
- Injections
 - No restrictions
 - Incorporate into UBC curriculum as a mandatory course; ensures standard of practice within our scope of practice
 - Public aware that all pharmacists able to administer injections
- Medication Services Reviews (MSR)
 - Completed for every patient
 - Public aware that all pharmacists able to provide MSRs
- Pharmacy Technicians
 - Fully integrated into pharmacy practice and practising to their full scope

Gap Analysis (*Difference between current and future state, perceived issues, barriers*):

- Adaptations - barriers
 - Inadequate compensation for time spent
 - Administrative time demands (including lack of computer generated forms)
 - Complexity of restrictions on adaptations
 - Physician resistance (expected or real) – approximately 6% of prescriptions have the “Do Not Adapt” notation of which 20% of these were considered adaptable
 - Employers may put additional restrictions on what pharmacists may adapt
 - Perceived benefit: greater access for continuity of care, time savings for patient
- Injections – barriers
 - Lack of interest; personal comfort with administering injections
 - Lack of time to get the certification
 - Employer unwilling to cover training costs
 - \$10 payment does not cover time required

- Insufficient staffing, space or storage
- Perceived benefit: improved access to immunization / injections for patients
- Medication Review Services - barriers
 - Administrative time demands (including lack of computer generated forms)
 - Insufficient staff or space
 - Pharmacist confidence and knowledge, skills and abilities
 - Perceived quality of medication services review
- Pharmacy Technicians – barriers / issues
 - Understanding their full scope of practice (pharmacists and pharmacy technicians)
 - Incorporating PTs into practice and permitting them to practice to their full scope
 - Shifting responsibilities within the pharmacy practice; trust in their work
 - Developing inter and intra-professional relationships / collaboration / recognition of another healthcare professional
 - Public awareness and value to the public and the pharmacy team

Recommendations for 2014-16 Strategic Plan *(What are 2-3 reasonable initiative, which can be achieved in 3 years, which will improve the quality of pharmacy services and optimize patient outcomes? Will these require additional resources - \$/staff – yes/no/maybe):*

- **Strategic Goal:** The enhanced and expanded care and services that registrants deliver are safe and effective and aligned with the healthcare need of the public
 - **Objectives:**
 - Develop/update legislation, policy and tools to support Advanced Pharmacist Practice (APP) certification. **(Timeline: over 3 years)**
 - Develop/update legislation, policy and tools to support full scope of practice (removal of restrictions on adaptation policy and injection standards, limits and conditions; include authority for pharmacy technicians to administer injections **(Timeline: if include pharmacy technicians, may need to review certification process – within year 1)**; enable access to patient lab information)
 - Support pharmacists and pharmacy technicians to practice to their full scope (continuing education (CE), targeted CE for example to help pharmacists to feel more competent to adapt prescriptions, ADAPT program, integration of required KSA into UBC and pharmacy technician program curriculum). **(Timeline: over 3 years)**
- **Strategic Goal:** The public, government, healthcare professionals and registrants understand the role and value of the registrant
 - **Objectives:**
 - Develop an engagement strategy so stakeholders and registrants understand the role and value of pharmacists and pharmacy technicians (eg. Active campaign at the pharmacy level what a pharmacy technician and pharmacist do; post information on College website, etc). **(Timeline: over 3 years – see Bal’s PT Scope of Practice document).**
 - Develop a strategy to encourage uptake of pharmacy technicians into community pharmacy practice settings. (Note:

environmental factors such as oversupply of pharmacists and subsequent decrease in pharmacist wages may affect uptake).

Information/questions to be validated via public consultation:

- Would you apply for authorization to prescribe if pharmacists receive the authority?
- Would there be limitations in your practice that would be a barrier for prescribing? If so, what are they from both an employee and employer perspective?
- If pharmacists were authorized to administer all types of injections, would your practice setting encourage increased injection administration?
- Does your business model support or has it been changed to incorporate pharmacy technicians? If not, why not?
- Would you want the College to develop preferred practice models to support integration of pharmacy technicians?
- How many pharmacy technicians do you currently have in your practice; what is the anticipated number in the next year, next 2 years, next 3 years?
- What do you consider the most valuable asset provided by pharmacy technicians, within your practice site or with other healthcare professionals?

Board Subcommittee – PUBLIC EXPECTATIONS

Friday June 12, 2013

12:00pm – 1:00pm

Present: Anar Dossa, Mykle Ludvigsen

The subcommittee discussed that any goals and objectives should be relevant, in line with other goals and achievable within the timeline of the strategic plan. This subcommittee was established by the Board to develop possible goals and objectives that would lead to not only a better understanding of the role of the pharmacist and pharmacy technician, but also as a way of informing public expectations over what it means to be providing safe and effective pharmacy care.

It was also noted that after the adoption of the strategic plan, the College would adopt a new communications and engagement strategy that aligns with both the strategic plan and the work of the College.

Goal:

Public expectations placed on pharmacists and pharmacy technicians in optimizing health outcomes are informed by better understanding of our role, our dedication to continuous quality improvement, and our accountability to the public.

Objective:

The College will develop a strategy to raise awareness of the role of pharmacists and pharmacy technicians and the importance they place on optimizing patient health outcomes, practising based on standards, enhancing quality on a continuous basis, and delivering clinical services.

-

Board Subcommittee – INTERDISCIPLINARY RELATIONSHIPS

Thursday June 20, 2013

1:00pm – 2:00pm

Present: Kris Gustafson, Suzanne Solven, Mykle Ludvigsen

The subcommittee discussed that any goals and objectives should be relevant, in line with other goals and achievable within the timeline of the strategic plan. It was noted that the *Health Professions Act* in the *Duties and objects of a College* identifies that colleges need to promote and enhance relationships with other regulatory bodies and inter-professional collaborative practice between professions.

Keeping that in mind, and building from the previous meeting, the following Goal and Objective was identified:

Goal:

Consistent with the *Health Professions Act*, enhance communication and collaboration with other healthcare professionals in order to ensure safe and quality care.

Objective:

Create forums for regulated healthcare professionals to identify interdisciplinary opportunities for improvement.

The subcommittee then brainstormed on what some operational plan topics might develop for this objective. This brainstorming was informed by the registrant engagement report that was completed in April 2013 via a survey to registrants as well as work currently underway related to methadone maintenance (MMT) policy development.

Topic ideas for interdisciplinary forums:

- Access to lab results
- Support from other colleges eg. CPSBC
- Expanded role of pharmacists
- Interdisciplinary CE events supported by the Colleges
 - MMT education regarding new standards

DRAFT

Board Self-Evaluation

(Adapted from existing tools – Elements of governing from the College of Pharmacists Board Reference, Accreditation Canada, Health Authority & Board Governance best practice literature)

Task Group: Anar Dossa, Bal Dhillon, Kris Gustavson

Model for Improvement



Aim: Complete an annual board self-evaluation in order to:

- Reflect on individual and shared responsibilities.
- Identify different perceptions and opinions among board members.
- Point to questions that need attention.
- Use the results as a springboard for board improvement.
- Increase the level of board teamwork.
- Clarify mutual board/staff expectations.
- Demonstrate accountability as an important organizational value.
- Display credibility to internal and external audiences.

Plan: Based on the results of the evaluation, consider what can be done to improve.

Measures: “How will we know that the change is an improvement?”

Measure annually over time (longitudinally) to see trends and opportunities

Answers to this survey will be kept confidential. Individual responses will not be shared with anyone. The questions serve to assess awareness and knowledge in addition to individual views and perspectives. The information will be compiled into a report designed to address perceived gaps and create actions to improve the effectiveness of the board.

The word “College” will refer to the College of Pharmacists of BC.

The Board and Policy

A. For each statement below, please select the appropriate response.

	Completely Agree	Agree	Neutral	Disagree	Completely Disagree	Don't Know
1. Our board develops policy to enable general oversight of the operations of the College.						
2. Our board has a policy concerning conflict of interest.						
3. Our board takes steps to mitigate risk to itself and the College.						
4. As a board member, I am covered by liability insurance.						
5. Our board is guided by a code of conduct and oath of office.						
6. I am aware of the confidentiality policies of the College.						
7. I receive regular updates to my board reference manual.						
8. Our Board, in collaboration with the Registrar has scanned the environment to identify changes, threats, weaknesses and opportunities.						

Board Members and Fiduciary Responsibility

B. For each statement below, please select the appropriate response.

	Completely Agree	Agree	Neutral	Disagree	Completely Disagree	Don't Know
1. I receive the information I need about the College's finances.						
2. I understand all the financial information I receive.						
3. I feel comfortable asking questions about the budget and finance.						
4. The College has the right financial policies in place.						
5. Our board ensures for suitable internal controls and financial information systems.						
6. I am confident that the College is in good shape financially.						
7. Our board annually reviews a multi-year financial plan (2-5 years).						
8. Our board reports on its performance on an annual basis.						

The Board and its Relationship with the Registrar

C. For each statement below, please select the appropriate response.

	Completely Agree	Agree	Neutral	Disagree	Completely Disagree	Don't Know
1. Our board delegates responsibility to the Registrar and does not interfere inappropriately.						
2. Our board (or a delegated group of board members) conducts an annual performance review of the Registrar.						
3. Our board ensures the Registrar's compensation is in line with others in comparable sectors.						
4. Our board has a succession plan for the Registrar.						
5. Our board monitors the Registrar's performance regarding achievement of results/expectations of the board.						
6. In general, there is a positive and supportive day-to-day relationship between the Registrar and the board.						

How the Board Manages Itself

D. For each statement below, please select the appropriate response.

	Completely Agree	Agree	Neutral	Disagree	Completely Disagree	Don't Know
1. Our board conducts an annual self-assessment.						
2. Our board acts on the results of the self-assessment making necessary adjustments accordingly.						
3. All board members have a comprehensive orientation and reference manual.						
4. Board members understand the time commitment of being on the board.						
5. I feel that my own time is respected and well used as a board member of the College.						
6. Our board has systems in place to deal with behavioural issues and challenges.						

Board Meetings

E. For each statement below, please select the appropriate response.

	Completely Agree	Agree	Neutral	Disagree	Completely Disagree	Don't Know
1. We set and adhere to an annual meeting schedule.						
2. In advance, we establish clear agendas and time limits for each item on the agenda.						
3. I receive a board information package at least seven days in advance of each board meeting.						
4. The amount of information I receive is enough without being too detailed.						
5. At board meetings, agenda items are designed to promote discussion and involvement.						
6. Routine reports are received in writing with questions discussed at the board meeting						
7. My time is respected with meetings that begin and end of time.						
8. I find our board meetings interesting and feel that my time is well spent.						

The Board and Decision Making

F. For each statement below, please select the appropriate response.

	Completely Agree	Agree	Neutral	Disagree	Completely Disagree	Don't Know
1. I receive enough information to make informed decisions.						
2. There is sufficient time to discuss and ask questions before making a decision.						
3. Members of the board maintain solidarity with other board members in support of a decision made at a board meeting.						

Individual Board Member Effectiveness

G. For each statement below, please select the appropriate response.

	Completely Agree	Agree	Neutral	Disagree	Completely Disagree	Don't Know
1. I attend meetings almost all the time, making my commitment to the College a high priority.						
2. I am prepared for meetings (do my homework).						
3. I ask questions and contribute to board meetings.						
4. I remember to thank staff and other board members for their efforts.						
5. I believe that most other board members also take their responsibilities seriously.						

Committees and Task Forces

H. For each statement below, please select the appropriate response.

	Completely Agree	Agree	Neutral	Disagree	Completely Disagree	Don't Know
1. We have the right number & types of committees.						
2. Our committees all have clear terms of reference and carry out their responsibilities effectively.						
3. We never strike a new committee when a task force is sufficient.						
4. We use committees to do detailed work and bring recommendations to the board.						
5. My committee work is meaningful.						

Other Board Functions

I. For each statement below, please select the appropriate response.

	Completely Agree	Agree	Neutral	Disagree	Completely Disagree	Don't Know
1. I have enough data about the quality of the programs delivered by the College.						
2. The College has a clear sense of direction as evidenced by a current strategic plan.						
3. The board is meeting the College Mission: To protect the public by ensuring that College registrants provide safe and effective pharmacy care to help people achieve better health.						
4. The board is meeting its targeted goals as stated in the strategic plan.						

List 1-3 board achievements that you are most proud of:

Identify 1-3 issues or challenges that could have been managed better:

Identify at least 1 suggestion as an opportunities for the future:

Please add any further comments you have about any section in this questionnaire, or feedback you think is important in evaluating the board and its function:

COMPOUNDING IN CANADA

The New Frontier

Legislation in Canada

Policy on Compounding and Manufacturing Drugs in Canada POL-0051

http://www.hc-sc.gc.ca/dhp-mps/compl-conform/gmp-bpf/docs/pol_0051-eng.php#a7

To provide a policy framework to assist in distinguishing between compounding and manufacturing activities of drug products in Canada.

What does it cover?

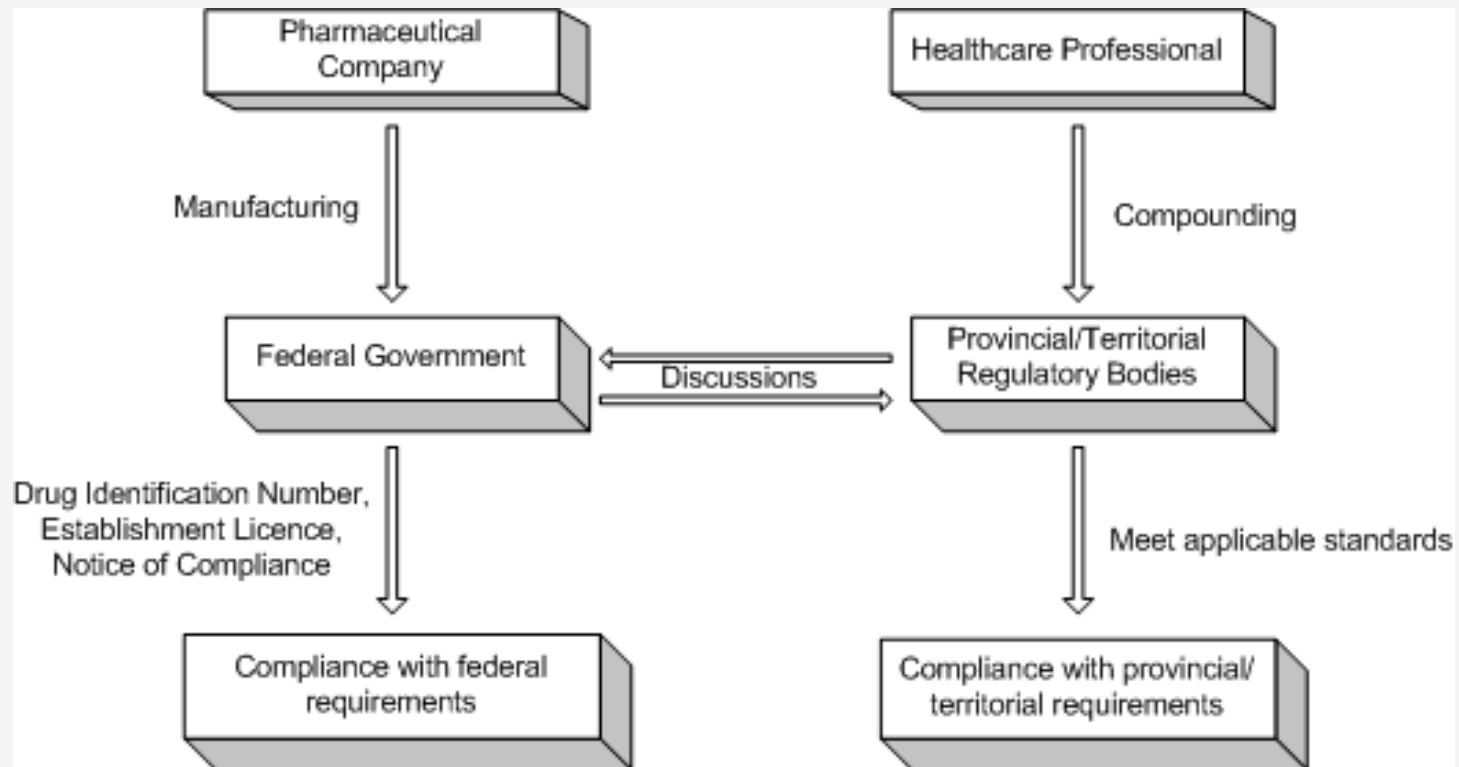
- ❑ All drugs covered in the Food and Drug Act
 - ie; Federal Schedule C,D,F,G
 - OTC's
- ❑ Does Not Cover
 - Natural Health Products
 - Cosmetics

GREAT NEWS!!!!

‘In Canada, compounding of drugs is practised primarily by pharmacists as an integral part of their profession and is regulated by the respective regulatory authorities in each province/territory.’



JURISDICTION



MANUFACTURING

- Manufacturers of drugs in dosage form must comply with the requirements of the *Food and Drugs Act* and *Food and Drug Regulations* including all associated standards and guidelines.

COMPOUNDING

- Provincial Jurisdiction
- Normal scope of practice in the province licensed in
- Responsibility of Risk!!!!

General Guiding Principles

Compounding must be a legitimate part of the practice of regulated healthcare professionals and must not be used as a means to bypass the federal drug review and approval system.

All drug compounding and manufacturing activities performed are to be regulated and fall under either the federal or the provincial/territorial jurisdiction.

The distinguishing between compounding and manufacturing activities is made on a case-by-case basis.

PATIENT



PHYSICIAN

PHARMACIST

THE TRIAD RELATIONSHIP

Limited Quantities

Therapeutic need or lack of product

Customized therapeutic solution



≠



Authorized drug

For use in Canada or listed in a **recognized Pharmacopoeia** (USP, PhEur, PhF, PhI, BP, CF, NF, Codex - *Schedule B Food and Drugs Act.*)

Compounding of Sterile Products

- Only permitted in hospitals or other practice settings where carefully established standards for the operation of clean rooms and the preparation of sterile products are in place and documented, in accordance with a recognized source.

NAPRA

Guidelines

to Pharmacy

Compounding October 2006

In February of 2004, the Importation and Compounding of Animal Drugs Task Force met to discuss several issues related to the use of compounded products in Canada. It was decided that guidelines needed to be developed in collaboration with provincial pharmacy licensing bodies to describe when it is appropriate to compound and how to compound¹. The National Association of Pharmacy Regulatory Authorities (NAPRA) made a commitment to develop such guidelines and the Compounding Guidelines Task Force (CGTF) was formed in January 2005 to complete this initiative. The CGTF, which developed these guidelines, is made up of pharmacists from across Canada (see Appendix A) experienced in the area of compounding preparations and nominated by their provincial Pharmacy Regulatory Authority. The task force recognized that compounding is an essential part of pharmacy practice and the guidelines reflect the knowledge they felt was required to prepare a safe and appropriate product.

NAPRA Compounding Guidelines Task Force Members

Carolyn Carruthers
Saskatchewan College of
Pharmacists
Kendra Day
Prince Edward Island
Pharmacy Board
Ken Dicks
Newfoundland and
Labrador Pharmacy Board
Dennis Wong
Manitoba Pharmaceutical
Association

Peter Ford
New Brunswick
Pharmaceutical Society
Rita Ozolins
Ontario College of
Pharmacists
Larry Salsman
Nova Scotia College of
Pharmacists
Larry Thorne
College of Pharmacists of
British Columbia
Mike Wolowyk
Alberta College of
Pharmacists

So, What's Next?

USP

- United States Pharmacopeia

- <http://www.usp.org/>

- As part of its commitment to providing public standards for the quality, consistency, purity, identity, and strength of all medicines, USP has developed standards for compounding. These standards help compounding practitioners adhere to widely acknowledged, scientifically sound procedures and practices, and facilitate the delivery of consistent and good-quality prepared medicines to patients

USP

- ❑ USP 795- Non-sterile
- ❑ USP 797-Sterile (Appropriate Monographs)
- ❑ USP 1160- Pharmaceutical Calculations in Prescription Compounding
- ❑ USP-1163 Quality Assurance in Pharmaceutical Compounding
- ❑ USP 1176-Prescription Balances and Volumetric Apparatus

QUESTIONS?





COLLEGE OF PHARMACISTS
OF BRITISH COLUMBIA

Report to the Board: Outcomes of the June 20th 2013 Audit and Finance Committee Meeting

*June 21st, 2013
Henderson Room*



Participants

Committee:

- Doug Kipp (Chair)
- Bev Harris (Vice-Chair)
- Ryan Hoag
- Jeff Slater
- Blair Tymchuk

College Staff:

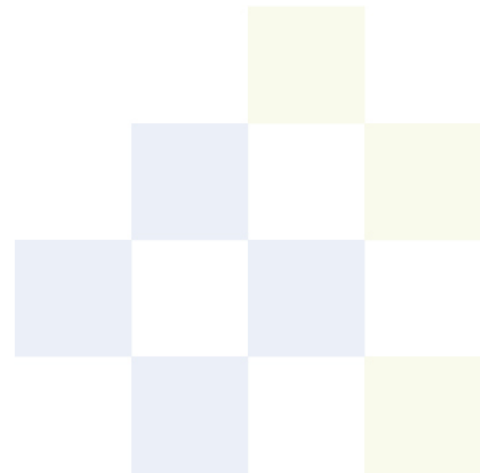
- Bob Nakagawa (Registrar)
- Mike Stonefield (COO)
- Jesse Hogan (Staff Accountant)
- Evangeline Iumin (Staff Accountant)

Invited:

- Donna Diskos, Dennis Batin (Grant Thornton - Auditors)



Key Messages from the Auditors Report



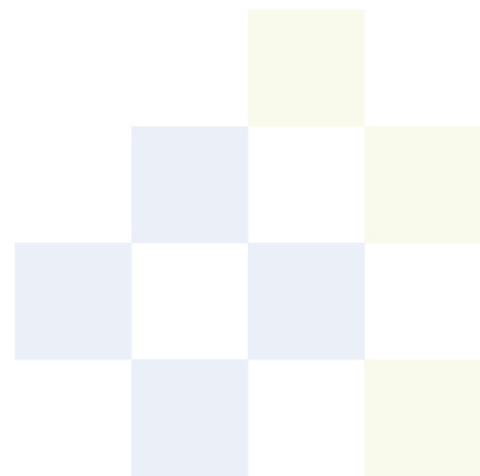
Conclusion of Independent Auditor's Report

“In our opinion, the financial statements present fairly, in all material respects, the financial position of the College of Pharmacists of British Columbia as of February 28, 2013, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.”

Grant Thornton June 2013

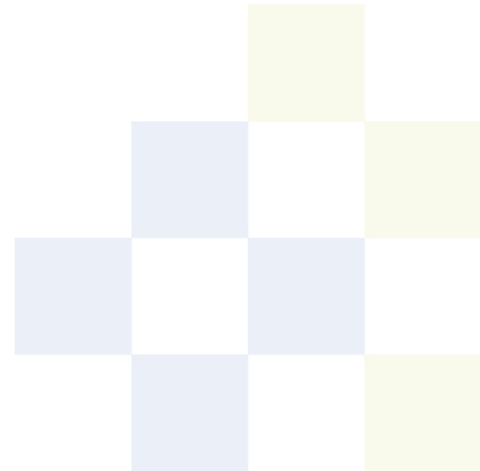


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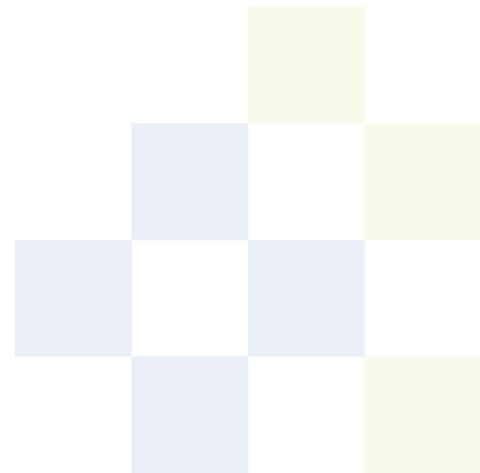
Key Points: Letter to Committee

- **No fraud or conflict of interest**
- **No legal or regulatory matters requiring disclosure**
- **Disclosures of internally restricted assets appropriately adjusted in financials**
- **Appropriate estimates of useful lives of College property and equipment being used**
- **Appropriate accounting standards used – news ones to be reviewed in upcoming fiscal year**
- **Good cooperation during audit**
- **Reliance on Auditor of JV**

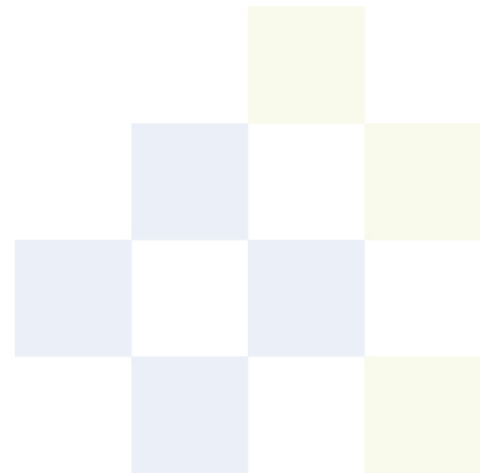


Significant transactions reviewed

- **Restricted Building Fund – audit adjusted so unspent funds that had been recorded as deferred revenue now fully recognized in year revenue received**
- **Deferred contributions – appropriately recorded**
- **Internally restricted funds – appropriately disclosed**
- **JV change in tax status reviewed – no issues**



Approval of the 2012/13 Audited Statements

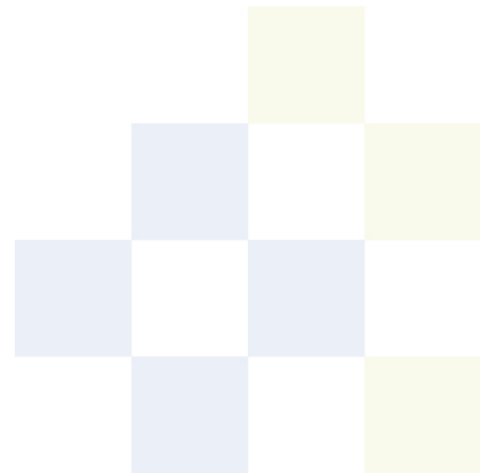


Recommendation

The Audit and Finance Committee recommends the Board approves the Audited financials statements as presented



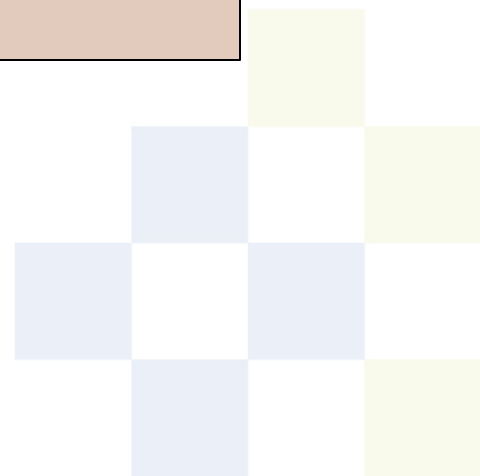
COLLEGE OF PHARMACISTS
OF BRITISH COLUMBIA



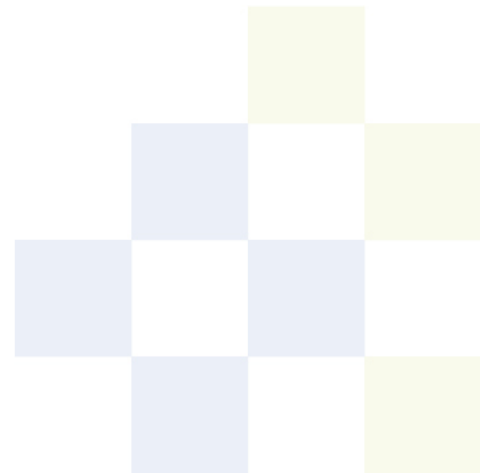
Motion - 2012/13 Audited Statements

Board Motion:

The Board approves the Audited financial statements for the fiscal year 2012/13 as presented.



Q1 and LE1 Financials



Q1 Actuals vs Budget (Exec Summary)

	2013-14 BUDGET	Q1 Budget	Q1 Actual	Q1 Variance (BUD vs. ACT) \$
TOTAL REVENUE	7,867,512	1,966,878	1,946,775	(20,103)
TOTAL EXPENSES BEFORE AMORTIZATION	7,221,457	1,750,898	1,368,924	381,974
NET SURPLUS (DEFICIT) BEFORE THE FOLLOWING:	646,055	215,980	577,851	361,871
Amortization Expenses	282,376	70,594	56,949	13,646
Joint Venture Expenses	245,021	61,255	41,824	19,431
TOTAL EXPENSES AFTER AMORTIZATION	7,748,854	1,882,748	1,467,697	415,051
NET SURPLUS (DEFICIT)	118,658	84,130	479,078	394,948



Q1 Actuals vs Budget - Revenue

	2013-14 BUDGET	Q1 Budget	Q1 Actual	Q1 Variance (BUD vs. ACT) \$
Licensure revenue				
Pharmacy Fees	1,582,159	395,540	404,250	8,710
Pharmacist Fees	3,853,821	963,455	995,165	31,710
Pharmacy Technician Fees	473,269	118,317	66,806	(51,511)
	5,909,248	1,477,312	1,466,222	(11,091)
Non Licensure revenue				
Other	1,040,992	260,248	292,285	32,037
Grants	400,000	100,000	38,034	(61,966)
Investments	517,272	129,318	150,234	20,916
	1,958,264	489,566	480,554	(9,012)
TOTAL REVENUE	7,867,512	1,966,878	1,946,775	(20,103)



Q1 Actuals vs Budget – Expenses

	2013-14 BUDGET	Q1 Budget	Q1 Actual	Q1 Variance (BUD vs. ACT) \$
Board & Registrar's Office	365,332	97,757	94,003	3,754
Grant Distribution	562,000	73,700	24,534	49,166
Registration and Licensing	333,788	76,353	51,016	25,337
Quality Assurance	202,647	53,992	10,697	43,295
Inspections	54,022	13,506	2,947	10,559
Legislation, Discipline and Investigations	821,084	213,114	83,285	129,829
Hospital Pharmacy and Practice	105,347	34,062	19,562	14,501
Public Accountability and Engagement	144,092	23,262	20,307	2,955
Finance & Administration	1,103,867	282,834	215,286	67,548
Salaries & Benefits	3,529,277	882,319	847,289	35,031
TOTAL EXPENSES BEFORE AMORTIZATION	7,221,457	1,750,898	1,368,924	381,974



LE1 vs Budget (Exec Summary)

	2013-14 BUDGET	2013-14 LE	Variance (BUD vs. LE) \$
TOTAL REVENUE	7,867,512	8,313,291	445,779
TOTAL EXPENSES BEFORE AMORTIZATION	7,221,457	7,171,080	50,377
NET SURPLUS (DEFICIT) BEFORE THE FOLLOWING:	646,055	1,142,212	496,156
Amortization Expenses	282,376	265,349	17,027
Joint Venture Expenses	245,021	167,296	77,725
TOTAL EXPENSES AFTER AMORTIZATION	7,748,854	7,603,725	145,129
NET SURPLUS (DEFICIT)	118,658	709,566	590,909



LE1 Key Changes

Revenue same trends expected through year

- **Up**
 - Pharmacist registration, PharmaNet, Grants, Investments
- **Down**
 - Technician registrants (down)

Expenses

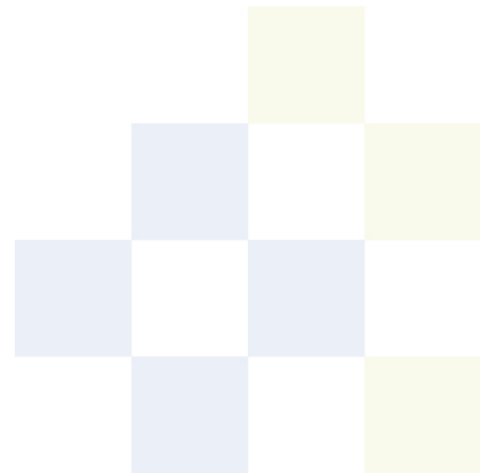
- **Up**
 - Board/Registrar's office, grants
- **Down**
 - QA/Inspectors, Finance/Admin

Will look to redeploy budget room to complete other tasks



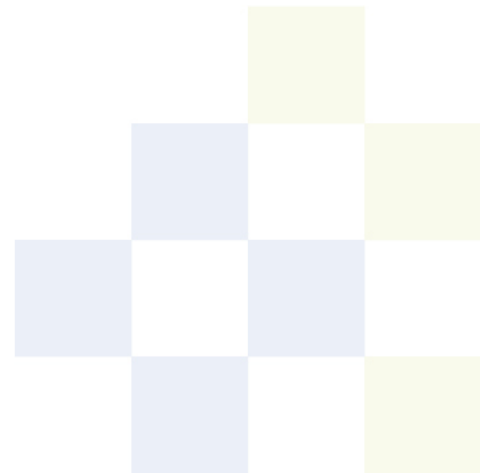
Change of JV Tax Status

- **Essentially complete**
- **CRA have**
 - Recognized change in tax status
 - Issued rebate cheque for \$104k that balances tax payments between JV and CRA
- **Waiting for final ‘notice of reassessment’**
 - JV will then make HST rebate payments to tenants
 - JV to ‘true’ the payments between CDS and CPBC
 - About \$25k expected from JV to CPBC



Summary and Conclusions

- **Q1 surplus up by \$0.4MM from budget**
 - Revenue essentially flat (\$20k var)
 - Expenses (exc. amort.) below budget (\$380k var)
- **LE1 projects increase in surplus of \$0.6MM from budget**
 - Revenue up by \$0.45MM
 - Expenses (inc amort + JV) down by \$0.15MM
- **JV tax status almost resolved and fully leased**





11.0 Engagement & Communication Strategy & Roadshow Update

INFORMATION ONLY:

or

DECISION REQUIRED:

Engagement & Communication Strategy & Roadshow Update

The College is moving ahead on a series of communications initiatives that support the work of the College. The department has been focused in the last few months on delivering the College’s engagement activities including the online and regional meetings component of stakeholder engagement on the upcoming strategic plan, handling communications with regards to several initiatives passed at the February and April Board meetings, and supporting the rollout of a number of new projects including the College’s transition to a new software provider for the PDAP portal.

Join the Conversation Regional Meetings

The Registrar and the Director of Public Accountability and Engagement held five regional meetings across the province that gave pharmacists and pharmacy technicians the opportunity to have answered any questions they may have about the College or its work. In addition, the regional meetings provided an opportunity to provide input into the strategic plan. A full report of responses gathered during the strategic planning portion of the events is included in the Engagement Report included in this briefing package.

Sessions were held on these dates in the following locations:

- Tuesday April 23, Vancouver – Hilton Vancouver Metrotown
2013 Victoria – Hotel Grand Pacific
- Thursday May 2, 2013 Prince George – Coast Inn of the North
- Monday May 6, 2013 Kelowna – Coast Inn Capri
- Thursday May 9, 2013 Langley – Pharmacy Drug Distribution Centre
- Monday May 27, 2013

Strategic Plan Public Engagement

The College continues to move forward on consultation on its new strategic plan. Currently, public consultations are underway utilizing a similar online system to the one used with pharmacists and pharmacy technicians to solicit feedback from the public on the College’s new strategic plan.



BOARD MEETING June 21, 2013

Supporting the Work of the College

The department works closely with all departments to deliver communications for a variety of important projects, initiatives, and ongoing work. During this Spring, the department worked closely with the Operations/IT and PDAP teams to develop a plan and the associated materials required to ensure that registrants were well supported during the transition. This was achieved through ensuring those who were most inconvenienced by this transition received timely and appropriate communication on the transition to the new software, and upon launch, the resources necessary to ensure that portal users had easy to understand materials that explained how to access, use, and fulfill their PDAP requirements using the new portal.

Public Awareness Campaign

24 health regulators in British Columbia have come together to launch a public awareness campaign on the role that regulated health professionals play in ensuring the safety of patients. The creative development and planning for the campaign is well underway but not yet finalized. British Columbians can expect to see the campaign launch in September.