College of Pharmacists of British Columbia

Board Meeting
Friday, November 18th, 2016
Held at the College of Pharmacists of British Columbia
200-1765 West 8th Avenue, Vancouver, BC

MINUTES

Members Present:
Blake Reynolds, Outgoing Chair
Anar Dossa, Chair, District 6
Mona Kwong, Vice-Chair, District 1
Ming Chang, District 2
Tara Oxford, District 3
Christopher Szeman, District 4
Frank Lucarelli, District 5
Arden Barry, District 7
Sorell Wellon, District 8
Norman Embree, Public
Kris Gustavson, Public (*items 9 to 15)*
Jeremy Walden, Public
George Walton, Public

Staff:
Bob Nakagawa, Registrar
David Pavan, Deputy Registrar
Ashifa Keshavji, Director of Practice Reviews and Quality Assurance
Mary O'Callaghan, Chief Operating Officer
Doreen Leong, Director of Registration, Licensure and PharmaNet
Christine Paramonczyk, Director of Policy and Legislation
Gillian Vrooman, Director of Communications and Engagement
Kitty Chiu, Executive Operations Manager
Lori Tanaka, Board & Legislation Coordinator
Jon Chen, Communications Project Officer

Invited Guests:
Michael Coughtrie, Dean, Faculty of Pharmaceutical Sciences, UBC
Kevin Sin, President, Pharmacy Undergraduate Society (PhUS), UBC

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1. **WELCOME & CALL TO ORDER**
   Outgoing Chair Blake Reynolds called the meeting to order at 9:02am on November 18th, 2016.

2. ELECTION OF CHAIR

In accordance with HPA bylaw 12(2) Board members at the November Board meeting must elect a Chair.

Outgoing Chair Blake Reynolds called for nominations, the following two names were put forward for consideration:

- Anar Dossa
- Mona Kwong

After 11 votes were electronically cast and tallied, Anar Dossa was declared as the new Board Chair for a one-year term to conclude at the start of the November 2017 Board meeting.

3. ELECTION OF VICE CHAIR

In accordance with HPA bylaw 12(2) Board members at the November Board meeting must elect a Vice Chair.

Chair Dossa called for nominations, the following two names were put forward for consideration:

- Mona Kwong
- Sorell Wellon

After 11 votes were electronically cast and tallied, Mona Kwong was declared as the new Board Vice Chair for a one-year term to conclude at the start of the November 2017 Board meeting.

4. CONSENT AGENDA

a) Items for further discussion

Item *4.b.x. PODSA Fee Increase Update* was removed from the Consent Agenda and placed onto the regular Agenda under item *15. Items Brought Froward from Consent Agenda* for further discussion.

b) Approval of Consent Items (Appendix 1)

It was moved and seconded that the Board:

Approve the Consent Agenda as amended.

CARRIED

5. CONFIRMATION OF AGENDA (Appendix 2)

It was moved and seconded that the Board:

Approve the November 18, 2016 Draft Board Meeting Agenda as circulated.

CARRIED

6. DEPUTY REGISTRAR APPOINTMENT

It was moved and seconded that the Board:

Appoint David Pavan as the Deputy Registrar of the College of Pharmacists of British Columbia in accordance with the Health Professions Act Bylaws section 22, subsection 2.

CARRIED

7. GOVERNANCE COMMITTEE UPDATE

a) Update

Board member and Chair of the Governance Committee provided a verbal update of the activities of the Governance Committee since the September Board.

b) Elected Board member terms of office

It was moved and seconded that the Board:

Directs the Registrar to pursue a bylaw amendment that would change the term of office for elected Board members from two years to three years, and from a maximum of 3 consecutive terms to a maximum of 2 consecutive terms.

CARRIED

c) Approval of the next phase of the review

It was moved and seconded that the Board:

Authorize the Governance Committee to enter into a contract with Ernst and Young to conduct Phase 2 of the proposed organizational review with a cost of up to $83,000 plus applicable taxes and out of pocket travel expenses (not to exceed $5000).

CARRIED

8. IN-CAMERA

As per HPA Bylaws section 13(7)(a):

'financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public'

9. EVIDENCE FOR THE BENEFIT OF AN ADVANCED SCOPE OF PHARMACY PRACTICE – THE ALBERTA EXPERIENCE

Dr. Ross Tsuyuki, Professor of Medicine (Cardiology) and Director, EPICORE Centre at the Faculty of Medicine and Dentistry at the University of Alberta presented new research on the impact of advanced scope of pharmacist practice, particularly prescribing and the impacts its had on patients in Alberta **(Appendix 3)**.

10. LEGISLATION REVIEW COMMITTEE:

Board member and Chair of the Legislation Review Committee Jeremy Walden presented.

a) Drug Schedules Regulation (Appendix 4)

It was moved and seconded that the Board:

Approve the following resolution in order to align with the 2016 recommendations from the National Drug Scheduling Advisory Committee which include re-classifying ibuprofen (for relief of rheumatoid arthritis, and osteoarthritis), esomeprazole (for relief of frequent heartburn), and fluticasone (for relief of seasonal allergies):

RESOLVED THAT, in accordance with the authority established in section 22(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the

Minister as required by section 22(2) of the Pharmacy Operations and Drug Scheduling Act, the board amend the Drug Schedules Regulation, B.C. Reg. 9/98, which are outlined in the schedule attached to this resolution.

CARRIED

b) HPA Bylaws – Application Committee (Appendix 5)

It was moved and seconded that the Board:

Approve the proposed amendments to the Health Professions Act bylaws that establish an Application Committee, for public posting for a period of 90 days.

CARRIED

c) HPA Standards of Practice: Parts 1, 2 and 3, and new PPP-75 (Appendix 6)

It was moved and seconded that the Board:

Approve the following resolution to amend the Health Professions Act Bylaws, Schedule F – Parts 1, 2 and 3 that create minimum standards for registrants regarding the preparation of prescription product, final product check, and patient identification, by approving the following resolution:

RESOLVED THAT, in accordance with the authority established in section 19(1) of the Health Professions Act, and subject to filing with the Minister as required by section 19(3) of the Health Professions Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

CARRIED

It was moved and seconded that the Board:

Approve Professional Practice Policy #75: Patient Identification to come into force at the same time as the bylaws.

CARRIED

11. IN-CAMERA

As per HPA Bylaws section 13(7)(a):

'financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public'

12. CERTIFIED PHARMACIST PRESCRIBER

Board member Jeremy Walden and Director of Communications Gillian Vrooman presented information as distributed in the briefing package **(Appendix 7)**.

It was moved and seconded that the Board:

Direct the Registrar to amend the Certified Pharmacist Prescriber Draft Framework by narrowing the scope of pharmacist prescribing to be within collaborative practice settings.

CARRIED

It was moved and seconded that the Board:

Direct the Registrar to develop a proposal for pharmacist prescribing within collaborative practice settings – based on the amended Draft Framework and results of the stakeholder engagement – to be brought to the Board for approval to submit to the Minister of Health for consideration.

CARRIED

13. PRACTICE REVIEW PROGRAM: PHASE 2 IMPLEMENTATION

Chair of the Practice Review Committee Michael Ortynsky presented **(Appendix 8)**.

It was moved and seconded that the Board:

Approve the policies, processes and implementation of PRP Phase 2 (hospital practice), as recommended by the Practice Review Committee as circulated.

CARRIED

14. STRATEGIC PLAN

Chief Operating Officer Mary O'Callaghan presented information as distributed in the briefing package **(Appendix 9)**.

It was moved and seconded that the Board:

Approve the exclusion of Phase 3 from the high level Draft Strategic Plan 2017/2018 – 2019/2020.

CARRIED

It was moved and seconded that the Board:

Approve the high level Draft Strategic Plan 2017/2018 – 2019/2020, with the exclusion of phase 3

CARRIED

It was moved and seconded that the Board:

Direct the Registrar to build the detailed Strategic Plan 2017/2018 – 2019/2020 based on the approved high level version, including budget and bring back to the February 2017 Board meeting for approval.

CARRIED

15. ITEMS BROUGHT FORWARD FROM CONSENT AGENDA

Item *4.b.x. PODSA Fee Increase* **(Appendix 10)** was brought forward from the consent agenda for further discussion, specifically regarding when the public posting period will close and the amendments pertaining to the PODSA fee increase may be filed with the Minister of Health. College staff had no further information to provide in this regard.

ADJOURNMENT

Chair Dossa adjourned the meeting at 4:10pm.

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4. Consent Agenda
b) Approval of Consent Items

DECISION REQUIRED

Recommended Board Motion:

Approve the Consent Agenda as amended.

i. Chair's Report
ii. Registrar's Update
    a. Activity Report
    b. Action Items & Business Arising
iii. September 16, 2016 Draft Board Meeting Minutes **[DECISION]**
iv. October 7, 2016 Draft Board Teleconference Minutes **[DECISION]**
v. 2017 Board Meeting Dates **[DECISION]**
vi. Committee Updates (Links to Minutes)
vii. Practice Review Committee – Phase 1 Update
viii. Audit and Finance Committee – August Financial Report
ix. San'yas Indigenous Cultural Safety Training – Report
x. (Moved to item 15 of the regular agenda for further discussion.)
xi. College representative on the Board of the Pharmacy Examining Board of Canada (PEBC) **[DECISION]**

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4.b.i. Chair's Report

INFORMATION ONLY

Since the September Board meeting, I have been involved in the following activities:

- Sept. 19 – Call regarding the progress of the Organizational Review
- Sept. 25 – Deputy Registrar interviews
- Oct. 4 – Practice Review Committee meeting
- Oct. 5 – Governance Committee meeting
- Oct. 7 – Board Teleconference Meeting
- Oct. 18 – Met with newly elected district 4 Board member Christopher Szeman
- Oct. 20 – Discussion with Norm Embree regarding Organizational Review
- Oct. 25 – Met with new Deputy Registrar David Pavan, and report from Ernst and Young on Organizational Review
- Oct. 26 – Attended CRNBC Certified Practice Approval committee meeting, and biweekly call with Vice-Chair Anar Dossa and Registrar Bob Nakagawa
- Nov. 3 – Tri-provincial Regulator meeting
- Nov. 9-10 – NAPRA meetings
- Nov. 14 – Biweekly call with Vice-Chair Anar Dossa and Registrar Bob Nakagawa
- Nov. 17 – Board Orientation meeting
- Nov. 18 – Last Board meeting
- Nov. 18-19 – Board retreat

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4.b.ii. Registrar's Update
a) Activity Report

INFORMATION ONLY

Since the September Board meeting, I have been involved in the following activities:

- Chaired the CPRC meeting in Ottawa and attended meetings with the Office of Controlled Substances, the Therapeutic Products Directorate and the Veterinary Drugs Directorate of Health Canada
- Deputy Registrar interviews, consideration and selection. Announced new Deputy Registrar, David Pavan.
- Networking meetings with Dean Coughtrie, Registrars Marburg and Johanssen,
- Participated in the Data Stewardship meeting of the Ministry of Health
- Telepharmacy discussions with the managers, College staff and Ministry officials
- Met with Ernst and Young re: governance review
- Joint Venture meetings
- Oversaw the Complaints portfolio, including inquiry and discipline while the Deputy Registrar position is vacant
- Participated in the NAPRA governance committee
- Attended the NABP Interactive Executive Officers Forum and participated in a panel discussion on the Canadian Experience with OSCEs
- Attended the NAPRA executive meting as Chair of CPRC
- Oversaw the election process. Announced the results and connected with all candidates.
- Discussions with the Ministry about modifications to the adaptation policy to support the Reference Drug Program.
- Board teleconference October 7th, 2016
- Teleconferences with the Chair and Vice Chair
- Attended the fall BCHR conference re: governance and the role of the Colleges.
- Participated in the .pharmacy executive as a NAPRA representative
- Numerous activities with regards to Mifegymiso
    - Globe and Mail interview
    - Presented to the 4th Contraception and Abortion Research Team meeting
    - Discussions with CPSBC Registrar Oetter and the Ministry
- Vacation October 17-21st

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4.b.ii. Registrar's Update
b) Action Items & Business Arising

INFORMATION ONLY

MOTIONS/ACTION ITEMS	RELEVANT BOARD MEETING	STATUS UDPATE
Motion: Direct the Registrar to take the following actions as outlined in the MMT Action Plan: • Develop, plan and implement new undercover investigations, • Conduct priority inspection of identified MMT dispensing pharmacies, • Continue to build and maintain collaborative relationships with key stakeholders, and • Provide recommendations to the Board to strengthen legislation and licensure requirements.	Jun 2015	IN PROGRESS
Motion: Direct staff to investigate options around site inspection fees and report back to the Board by the June 2017 Board meeting.	Sep 2016	IN PROGRESS
Motion: Pursue officially changing the name of the College of Pharmacists of British Columbia to the College of Pharmacy of British Columbia.	Sep 2016	IN PROGRESS

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4.b.iii. September 16, 2016 Draft Board Meeting Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the Draft September 16, 2016 Board Meeting Minutes as circulated.

Appendix	
1	Draft September 16, 2016 Board Meeting Minutes (appendices available on Board site)

College of Pharmacists of British Columbia

Board Meeting
September 16th, 2016
Held at the Delta Hotels Grand Okanagan Resort
1310 Water Street, Kelowna, BC

MINUTES

Members Present:
Anar Dossa, A/Chair (Vice-Chair), District 6 Board Member
Mona Kwong, District 1 Board Member
Ming Chang, District 2 Board Member
Tara Oxford, District 3 Board Member
Frank Lucarelli, District 5 Board Member
Arden Barry, District 7 Board Member
Sorell Wellon, District 8 Board Member *(absent for items 1-3)*
Norman Embree, Public Board Member *(absent for items 1-3)*
Kris Gustavson, Public Board Member
Jeremy Walden, Public Board Member *(absent for items 1-3)*
George Walton, Public Board Member

Staff:
Bob Nakagawa, Registrar
Ashifa Keshavji, A/Deputy Registrar, Director of Practice Reviews and Quality Assurance
Mary O'Callaghan, Chief Operating Officer
Kellie Kilpatrick, A/Director of Policy and Legislation
Doreen Leong, Director of Registration, Licensure and PharmaNet
Christine Paramonczyk, Director of Policy and Legislation
Gillian Vrooman, Director of Communications and Engagement
Kitty Chiu, Executive Operations Manager
Lori Tanaka, Board & Legislation Coordinator
Jon Chen, Communications Project Officer

Invited Guests:
Sandra Jarvis-Selinger, Associate Dean, Academic, Faculty of Pharmaceutical Sciences, UBC

Regrets:
Blake Reynolds, Chair, District 4 Board Member

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1. **WELCOME & CALL TO ORDER**
   A/Chair Dossa called the meeting to order at 9:04am on September 16th, 2016.

2. CONSENT AGENDA

a) Items for further discussion

Item *2.b.viii. Quality Assurance Committee – Mobile App* was removed from the Consent Agenda and placed onto the regular Agenda under item *14. Items Brought Froward from Consent Agenda* for further discussion.

b) Approval of Consent Items (Appendix 1)

It was moved and seconded that the Board:

Approve the Consent Agenda as amended.

CARRIED

3. CONFIRMATION OF AGENDA (Appendix 2)

It was moved and seconded that the Board:

Approve the September 16, 2016 Draft Board Meeting Agenda as amended.

CARRIED

4. 125TH ANNIVERSARY

Board member and Chair of the 125th Anniversary Working Group Ming Chang presented **(Appendix 3)**.

5. DELEGATION OF DEPOT INJECTIONS

A/Director of Legislation and Policy Kellie Kilpatrick presented **(Appendix 4)**.

It was moved and seconded that the Board:

Amend the following motion previously adopted at the November 2014 Board meeting:
'approve the administration of depot injections by pharmacists, as delegated by Dr. Bill MacEwan and as authorized by the College of Physicians and Surgeons for a period of 12 months',

By striking out:
'for a period of 12 months'.

CARRIED

6. EmPhAsIS – UPDATE

Nicole Tsao, co-investigator of the EmPhAsIS Study (Empowering Pharmacists in Asthma Management through Interactive SMS), presented an update to the Board **(Appendix 5)**.

7. FRAMEWORK FOR PATIENT-PRACTITIONER RELATIONSHIP PROGRAM

Registrar Nakagawa presented information as circulated in the briefing package **(Appendix 6)**.

It was moved and seconded that the Board:

Endorse the Framework for a 'Model Patient-Practitioner Relationship Program for BC Health Regulators'.

CARRIED

8. IN-CAMERA

As per HPA Bylaws section 13(7)(a):

'financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public'

9. AUDIT AND FINANCE COMMITTEE

Board member and Chair of the Audit and Finance Committee George Walton presented.

a) Expenditure Review (Appendix 7)

It was moved and seconded that the Board:

Direct the Registrar to continue the annual conference support budget totaling $24,500.

CARRIED

It was moved and seconded that the Board:

Direct the Registrar to discontinue the annual UBC Continuing Pharmacy Professional Development budget beginning with the 2017/18 fiscal year.

CARRIED

It was moved and seconded that the Board:

Direct the Registrar to discontinue the annual Clinical Skills grants budget beginning with the 2017/18 fiscal year.

CARRIED

b) Fee Changes (Appendix 8)

It was moved and seconded that the Board

Approve the addition of the following fee for implementation by January 1, 2017:

- *Add an application fee for new pharmacy licensure of $525.00*

And the following fee changes for implementation by January 1, 2017:

- *Community and hospital licensing fee from $1331.00 to $2001.00*
- *Full pharmacist – registration fee from $530.00 to $580.00*
- *Full pharmacist – registration renewal fee form $530.00 to $580.00*
- *Non-practicing pharmacist – registration fee from $504.00 to $580.00*
- *Pharmacy technician – registration fee from $353.00 to $386.00*
- *Pharmacy technician- registration renewal fee from $ 353.00to $386.00*
- *Non-practicing pharmacy technician – registration fee from $336.00 to $386.00*

CARRIED

It was moved and seconded that the Board

Directs staff to investigate options around site inspection fees and report back to the Board by the June 2017 Board meeting.

CARRIED

10. LEGISLATION REVIEW COMMITTEE

Board member and Chair of the Legislation Review Committee, Jeremy Walden presented.

a) Fee Changes (Appendix 9)

Fee changes presented for filing with the Minister were consistent with the changes presented by the Audit and Finance Committee and approved by the Board in item 9b.

HPA Bylaw Changes:

It was moved and seconded that the Board:

Approve the following resolution:

RESOLVED THAT, in accordance with the authority established in section 19(1) of the Health Professions Act, and subject to filing with the Minister as required by section 19(3) of the Health Professions Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

CARRIED

PODSA Bylaw Changes:

It was moved and seconded that the Board:

Approve the proposed draft Pharmacy Operations and Drug Scheduling Act Bylaws Schedule A – Fee Schedule and related forms for public posting, as circulated.

CARRIED

It was moved and seconded that the Board:

Request a shortened public posting period (30 days).

CARRIED

b) Community Pharmacy Standards of Practice (Appendix 10)

It was moved and seconded that the Board:

Approve the following resolution:

RESOLVED THAT, in accordance with the authority established in section 19(1) of the Health Professions Act, and subject to filing with the Minister as required by section 19(3) of the Health Professions Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

CARRIED

It was moved and seconded that the Board:

Request a shortened filing period (5 days) so that the amendments come into force by September 23, 2016.

CARRIED

c) Pharmacy Security (Appendix 11)

It was moved and seconded that the Board:

Approve the proposed draft Pharmacy Operations and Drug Scheduling Act bylaws for a second public posting period, as circulated, with the amendment that the Registrar be notified of any loss of narcotic and controlled drugs within 24 hours.

CARRIED

It was moved and seconded that the Board:

Request a shortened public posting period (30 days), provided that no significant feedback is received within the first 30 days of the posting period.

DEFEATED

d) Drug Schedules Regulation Amendment – Naloxone (Appendix 12)

The recommended amendments to the Drug Schedules Regulation classify naloxone as unscheduled in order to provide greater accessibility in an effort to be responsive to BC's public health emergency regarding the significant increase in opioid overdoses and deaths.

It was moved and seconded that the Board:

Approve the following resolution:

RESOLVED THAT, in accordance with the authority established in section 22(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minister as required by section 22(2) of the Pharmacy Operations and Drug Scheduling Act, the board amend the Drug Schedules Regulation, B.C. Reg. 9/98, as set out in the schedule attached to this resolution.

SCHEDULE

1 The Drug Schedules Regulation, B.C. Reg. 9/98, is amended in the Schedules by striking out the following:

2 Naloxone and its salts when used for opioid overdose emergencies outside hospital settings.

CARRIED

11. COLLEGE NAME CHANGE

Board member Sorell Wellon presented information as distributed in the briefing package **(Appendix 13)**.

It was moved and seconded that the Board:

Approve pursuing an official name change for the College of Pharmacists of British Columbia.

CARRIED

It was moved and seconded that the Board:

Pursue officially changing the name of the College of Pharmacists of British Columbia to the College of Pharmacy of British Columbia.

CARRIED

12. INJECTING INNOVATION INTO BC'S HEALTH FRAMEWORK: THE BC SELECT STANDING COMMITTEE ON HEALTH EXPERIENCE

Aaron Sihota provided a presentation to the Board **(Appendix 14)**.

13. GOVERNANCE COMMITTEE UPDATE

Board member and Chair of the Governance Committee provided a verbal update of the progress of the external organizational review. The review is scheduled to begin the week of September 19, 2016 and will be conducted by Ernst & Young.

14. ITEMS BROUGHT FORWARD FROM CONSENT AGENDA

a) Quality Assurance Committee – Mobile App (Appendix 15)

A/Deputy Registrar and Director of Practice Reviews and Quality Assurance Ashifa Keshavji provided an update on the development of a mobile application of the Professional Development and Assessment Program (PDAP) Portal.

ADJOURNMENT

A/Chair Dossa adjourned the meeting at 3:50pm.

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4.b.iv. October 7, 2016 Draft Board Teleconference Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the Draft October 7, 2016 Board Teleconference Minutes as circulated.

Appendix	
1	Draft October 7, 2016 Board Teleconference Minutes (Appendices available on Board site)

College of Pharmacists of British Columbia

Board Teleconference
October 7, 2016
8:00pm

MINUTES

Members Present:
Blake Reynolds, Chair & District 4 Board Member
Anar Dossa, Vice-Chair & District 6 Board Member
Tara Oxford, District 3 Board Member
Frank Lucarelli, District 5 Board Member
Arden Barry, District 7 Board Member
Sorell Wellon, District 8 Board Member
Kris Gustavson, Public Board Member
Jeremy Walden, Public Board Member

Regrets:
Norman Embree, Public Board Member
Mona Kwong, District 1 Board Member
Ming Chang, District 2 Board Member
George Walton, Public Board Member

Staff:
Bob Nakagawa, Registrar
Christine Paramonczyk, Director of Policy and Legislation
Lori Tanaka, Board & Legislation Coordinator

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1. **WELCOME & CALL TO ORDER**

   Chair Reynolds called the meeting to order at 8:00pm.

   Registrar Nakagawa conducted a roll call and confirmed that a quorum was present.

2. CONFIRMATION OF AGENDA

It was moved and seconded that the Board:

Approve the October 7, 2016 Draft Board Teleconference Meeting Agenda as circulated.

CARRIED

3. LEGISLATION REVIEW COMMITTEE

PPP-58: Medication Management (Adapting a Prescription) – Orientation Guide Amendments

Board member and Chair of the Legislation Review Committee, Jeremy Walden presented information as distributed in the briefing package **(Appendix 1)**.

It was moved and seconded that the Board:

Approve:

Professional Practice Policy 58 – Amendment to Orientation Guide – Medication management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016/October 2016), and

Professional Practice Policy 58 – Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016/October 2016)

to allow adaptations on the first and subsequent fills of an original prescription.

CARRIED

ADJOURNMENT

Chair Reynolds adjourned the meeting at 8:12pm.

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4.b.v. 2017 Board Meeting Schedule

DECISION REQUIRED

Recommended Board Motion:

Approve the 2017 Board Meeting Schedule as circulated.

The Board Meeting Schedule for 2017 is:

Thursday, February 16, 2017
Friday, February 17, 2017

Thursday, April 20, 2017
Friday, April 21, 2017

Thursday, June 15, 2017
Friday, June 16, 2017

Thursday, September 14, 2017
Friday, September 15, 2017
Location/venue for this date to be considered at a future Board meeting

Thursday, November 16, 2017
Friday, November 17, 2017

CPBC Annual General Meeting
Saturday, November 18, 2017
Please reserve this date, subject to consideration at a future Board meeting

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4.b.vi. Committee Updates (Minutes)

INFORMATION ONLY

Committees who have met and approved previous meeting minutes have submitted them to the Board for information purposes.

The following committees do not have a submission:

- Audit and Finance Committee,
- Drug Administration Committee, and
- Jurisprudence Examination Committee.

For confidentiality purposes, the Inquiry Committee has provided a summary of their meetings, but will not be submitting minutes.

Appendix – available on the Board Portal under 'Committee Minutes'	
1	Governance Committee Meeting Minutes
2	Discipline Committee
3	Inquiry Committee
4	Legislation Review Committee Meeting Minutes
5	Practice Review Committee Meeting Minutes
6	Quality Assurance Committee Meeting Minutes
7	Registration Committee Meeting Minutes

College of Pharmacists of British Columbia

Discipline Committee
Report to the Board

Commented [LT1]: Bob, did the Board still want to see the IC and DC reports?

Commented [BN2R1]: OK as part of the consent agenda

Reporting Period: August 1, 2016 – September 30, 2016

Membership:

Jerrold Casanova	Chris Kooner
Wayne Chen	Howard Kushner
Suzanne Coughtry	Derek Lee
Jody Croft	Leeza Muir
Bal Dhillon	Annette Robinson
Anneke Driessen	Jeremy Walden
James Ellsworth	Carol Williams
Patricia Gerber	Amparo Yen
Nerys Hughes	

Chair: Jerrold Casanova
Vice Chair: Patricia Gerber

Staff Resource: Valerie Tsui

Mandate: Hear and make a determination of a matter referred to the committee regarding a pharmacist's or pharmacy technician's conduct, competency and/or ability to practice, pursuant to legislation.

Responsibilities:

- Conduct hearings of a matter
- Determine disposition of the matter
- Inform respondents, complainants and the public about action taken
- Inform respondents and complainants about the discipline process as applicable

Relevant Statistical Information:

- Number of meetings: 0
- Number of hearing days: 0
- Number of discipline files heard in court: 0
- Number of files in progress: 1

College of Pharmacists
of British Columbia

Governance Committee Meeting

July 22, 2016 @ 8:00am

Held by Teleconference

Members Present:

Norman Embree, Chair
Anar Dossa, Vice-Chair
Blake Reynolds
George Walton

College Staff:

Bob Nakagawa, Registrar (ex-officio)
Ashifa Keshavji, A/Deputy Registrar (staff resource)
Lori Tanaka, Board & Legislation Coordinator (Board support)

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1. **Welcome and Call to Order**

   The meeting was called to order by Chair Norm Embree at 8:03am.

2. **Review of action from Board motion:**

   "Directs and gives authorization to the Governance Committee to search for an external consultant to conduct a complete organizational review and report back to the Board no later than at the September meeting of the results of the search."

3. **Review and discussion of submitted proposals:**

   The Governance Committee discussed the two proposals (Appendix 1 and 2) that were received as a result of the search that was conducted by the committee Chair, including:

   - Scope of work/project requirements
   - Approach
   - Deliverables
   - Timelines
   - Budget/cost
   - References

Part of the discussion also included consideration of the process by which the proposals were obtained. Board Policy 3.6 was referred to by the Registrar (Appendix 3), specifically in regards to subsection 3.6.6 with respect to employing a tendering process.

Based on the outcome of the discussions, the Governance Committee agreed to make the following recommendation to the Board:

That the Board authorizes the Governance Committee to enter into a contract with Ernst and Young to conduct Phase 1 of the proposed organizational review with a cost of up to $75,000.00 plus applicable taxes and out of pocket travel expenses (not to exceed $6,500).

4. Next steps:

Based on Board direction, the Governance Committee is motivated to have the review conducted in a timely manner, and as such they have directed staff to schedule a Board teleconference meeting within the next two weeks and provide the Board with the proposals, the recommendation and relevant policies required to make a decision.

5. Adjournment

The meeting was adjourned at 9:25am.

College of Pharmacists of British Columbia

Inquiry Committee
Report to the Board

Reporting Period: August 1, 2016 – September 30, 2016

Membership:

Carla Ambrosini	George Kamensek
Dorothy Barkley	Patricia Kean
Cindy Bondaroff	Fatima Ladha
Karen Callaway	Jim Mercer
Sally Chai	Jing-Yi Ng
Ming Chang	Alison Rhodes
Michael Dunbar	Alana Ridgeley
Norman Embree	Susan Troesch
Sukhvir Gidda	Ann Wicks
John Hope	Cynthia Widder

Chair: John Hope
Vice-Chair: Dorothy Barkley

Staff Resource: Valerie Tsui

Mandate: Investigate complaints and concerns regarding a pharmacist's conduct, competency and/or ability to practice and decide on an appropriate course of action pursuant to legislation.

Responsibilities:

- Investigate complaints on its own motion or raised by a complainant as soon as possible,
- Investigate registrants that fail to authorize a criminal records review check as well as registrants presenting a risk of physical or sexual abuse to children as determined by the Registrar of the Criminal Records Review Act,
- Determine disposition of items (1) and (2),
- Inform registrants, complainants and the Health Professions Review Board about the inquiry process and complaint outcomes, as necessary, and
- Report to the Board as applicable.

Relevant Statistical Information (year to date):

- Number of in-person meetings: 9

College of Pharmacists of British Columbia

- Number of teleconferences: 33
- Total number of files disposed: 123
    - Number of new files disposed: 78
    - Number of reconsiderations: 45
- Number of calls/tips received: 611
- Number of official complaints received: 76

Below is a comparison from 2014 and 2015 for the months of August to September.

August to September	**2016**	**2015**	**2014**
Number of in-person meetings	2	4	3
Number of teleconferences	6	6	5
Total number of files disposed	37	29	57
Number of new files disposed	25	24	45
Number of reconsiderations	12	5	12
Number of calls/tips received	120	83	108
Number of official complaints received	18	11	13

College of Pharmacists of British Columbia

Legislation Review Committee Teleconference
August 16, 2016

MINUTES

Members Present:
Mona Kwong, District 1 Board Member
Jeremy Walden, Public Board Member
Sorell Wellon, District 8 Board Member
Blake Reynolds, Chair & District 4 Board Member

Regrets:
Anar Dossa, Vice-Chair & District 6 Board Member

Staff:
Kellie Kilpatrick, A/Director of Policy and Legislation
Anu Sharma, Senior Policy & Legislation Analyst
Ranique Sekhon, Policy & Legislation Analyst

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1. **WELCOME & CALL TO ORDER**
2. **CONFIRMATION OF AGENDA (APPENDIX 1)**

   By consensus, the LRC approved the August 16, 2016 Teleconference Meeting Agenda, as circulated.

3. **AMENDMENTS TO PODSA BYLAWS (PHARMACY SECURITY)**

   The LRC recommended including definitions of the varying Schedules (i.e. Schedule I, IA) in the board briefing materials.

   By consensus, LRC approved further proposed amendments as presented, for a second public posting period.

4. **AMENDMENTS TO HPA BYLAWS SCHEDULE F – COMMUNITY PHARMACY STANDARDS OF PRACTICE**

   LRC asked about the obligations for pharmacists on counselling Schedule II drugs. Staff alluded to the section(s) in Part 1 that require pharmacists to provide/offer counselling for Schedule II drugs.

College of Pharmacists of British Columbia

LRC raised concerns on counselling logs and documentation requirements related to counselling. Suggestions to improve documentation will be considered during the modernization project.

By consensus, LRC approved to file the amendments with the Ministry of Health, with a shortened filing period request to have the amendments in force for September 23, 2016.

5. AMENDMENTS TO THE DRUG SCHEDULES REGULATION (UNSCHEDULING OF NALOXONE)

By consensus, LRC approved the proposed amendment to un-schedule naloxone from the Drug Schedules Regulation.

6. AMENDMENTS TO HPA BYLAWS SCHEDULE D – FEES

By consensus, LRC approved to file the bylaws (fee change) with the Ministry of Health.

7. AMENDMENTS TO PODSA BYLAWS SCHEDULE A – FEES SCHEDULE

By consensus, LRC approved to post the PODSA amendments for a public posting and request for a shortened public posting period.

College of Pharmacists of British Columbia

Legislation Review Committee Teleconference
October 5, 2016

MINUTES

Members Present:
Jeremy Walden, Public Board Member
Anar Dossa, Vice-Chair & District 6 Board Member
Sorell Wellon, District 8 Board Member

Regrets:
Blake Reynolds, Chair & District 4 Board Member
Mona Kwong, District 1 Board Member

Staff:
Christine Paramonczyk, Director of Policy and Legislation
Ranique Sekhon, Policy & Legislation Analyst

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1. WELCOME & CALL TO ORDER

2. PROFESSIONAL PRACTICE POLICY-58: MEDICATION MANAGEMENT (ADAPTING A PRESCRIPTION) – ORIENTATION GUIDE AMENDMENTS

Christine provided an overview of the amendments.

By majority consensus, LRC approved the proposed amendments as presented, for approval to the Board on Friday October 7, 2016.

Below are the motions that were approved by the LRC to be presented to the Board at the October 7, 2016 Board Teleconference Meeting for approval:

Recommended Motions:

1. *Approve* Professional Practice Policy 58 - Amendment to Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016/October 2016) to allow adaptations on first and subsequent fills of an original prescription.
2. *Approve* Professional Practice Policy 58 - Orientation Guide – Medication Management (Adapting a Prescription) (December 2008 – revised February 2011/April 2016/October 2016) to allow adaptations on first and subsequent fills of an original prescription.

Minutes of the Registration Committee Teleconference Meeting
College of Pharmacists of B.C.

Monday, September 26, 2016

Present: Raymond Jang (Chair), Phuong Hoang (Vice-Chair), Laura Bickerton, Carolyn Cheung, Yonette Harrod (until 4:00 pm), Derek Lee, Charles Park, Nathan Roeters, Joy Sisson, Jeremy Walden

Resource: Doreen Leong, Director, Registration, Licensure & PharmaNet
Virginia Kwong, Manager, Registration and Licensure
Bob Nakagawa, Registrar (until 3:45 pm)
Cathy Herb-Kelly, Legal Counsel

Regrets: Ashley Foreman, Vanessa Lee

Agenda Items:

1. Meeting called to order at 1500 hours.

2. Agenda (Appendix 1)

   MSC That the agenda is approved as distributed, with Item 6.1 being reviewed first.

3. Registration Committee Meeting Minutes – August 17, 2016 (Appendix 2)

   MSC That the Registration Committee Meeting Minutes from the August 17, 2016 meeting is approved as distributed.

4. Pharmacy Technician Registration - Request for an extension of the three year validity period for pre-registration, SPT results and JE results (Applicant G)

   Applicant G is requesting an extension of the three year validity period of her pre-registration application, SPT results and JE results. The applicant stated she will be attempting the PEBC Qualifying Exam (Part I and II) in April 2017, which is her final registration requirement. Pre-registration applications have a 3-year validity period as do results of the Structured Practical Training (SPT) results and Jurisprudence Exam (JE) results.

   Applicant G's pre-registration application expired on July 2, 2016, her SPT results will have expired once the results of the April 2017 Qualifying Exam (Part I and II) results are released. In addition, if she does not successfully complete the Spring Qualifying Exam in April 2017 and attempts the next Qualifying Exam in the fall, then her JE results will also be expired by the time the results are released in November 2017.

   Applicant G has completed the following requirements:

Assessment	Date of completion
Pre-registration Application	July 3, 2013
SPT	November 29, 2013
JE	October 30, 2014

Applicant G is requesting an extension based on medical and bereavement reasons. Applicant G is currently under medical and psychiatric care. A gradual return-to-work plan was developed by one of her psychiatrists and she returned to work in late July 2016.

The Registration Committee discussed at length the time period for extension of the validity of the applicant's pre-registration application, SPT results and JE results, considering the decay of knowledge and skills and considering the Committee's authority to do so. The Committee discussed additional time, sufficient for the applicant to complete the next sitting of the PEBC Qualifying Exam in April 2017 and receive the results.

MSC That the Registration Committee grant Applicant G (File 16-010) an extension of the validity period of the applicant's pre-registration application and SPT results until June 30, 2017.

5. Pharmacist Registration Application – Request to complete Reinstatement

Applicant H applied for reinstatement through the Agreement on Internal Trade (AIT). The College received her pre-registration application on August 16, 2016. The applicant checked off all the boxes on the Statutory Declaration (page 5 of the application), however a letter of standing received from the Alberta College of Pharmacists (ACP) indicated that a complaint is currently being investigated. The Complaints Director at ACP specified that they are investigating an alleged drug error made by the applicant. Follow-up with ACP indicated the investigation report would be available within the next 2-3 weeks (from email correspondence dated September 2, 2016), at which point he will determine how the matter will be resolved. The report was not completed by the date of the Registration Committee meeting.

The applicant indicated that she did not leave Box #3 on the Statutory Declaration unchecked as she thought the investigation was completed as ACP did not contact her further regarding this complaint.

The Registration Committee reviewed their authority under the *Health Professions Act, s.20(2.1)* and the requirements under the AIT.

MSC That the Registration Committee table the decision for Applicant H (16-011) to the next Registration Committee until more information is available from the applicant and/or ACP.

6. Pharmacy Technician Registration Application – Request to complete Full Registration after the December 31, 2015 deadline

Applicant I did not complete the requirements for registration through the "Currently-in-Practice" path prior to the December 31, 2015 deadline.

The College received Applicant I's pre-registration application on January 4, 2011 and the applicant has since completed the following registration assessments.

Assessment	Date of completion
Pre-registration application accepted	January 14, 2011
PTBP Pharmacology	August 2, 2011
PTBP Management of Drug Distribution	January 11, 2012
PTBP Product Preparation course	October 12, 2012
PTBP Professional Practice course* *Note: she did not pass the JE written with the Professional Practice module	April 4, 2013
Jurisprudence Exam	June 6, 2013
Structured Practical Evaluation	May 29, 2014
PEBC certification	May 12, 2016

Applicant I resides in a remote community in BC and since January 2009 has worked at a telepharmacy remote site. Applicant I stated she had completed all of the registration assessments before the December 31, 2015 deadline date except the PEBC Qualifying Exam – Part II (OSPE) as she had to retake the OSPE in April 2016.

The Registration Committee reviewed their authority to extend the December 31, 2015 deadline date due to the particular circumstances of Applicant I and potentially to the community and the potential risk to not extending the deadline. The Committee discussed the College's role in protecting public health and maintaining pharmacy services in remote areas. The Committee also reviewed two similar files that were presented to them at the July 5, 2016 meeting and their decisions.

MSC That the Registration Committee approve Applicant I's (16-012) request to allow her to apply for registration as a Pharmacy Technician through the "Currently-in-Practice" path.
(3 in favor; 6 opposed)

7. Next meeting – at the call of the chair.

8. Meeting adjourned at 1630 hours.

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4b.vii. Practice Review Committee - Phase 1 Update

INFORMATION ONLY

Purpose

To provide the Board with an update on the Practice Review Program (PRP), Phase 1 Community Practice.

Business Stream:

Update	Next Steps
• Conducted September and October 2016 reviews (Appendix 1) • Scheduled pharmacies for November and December 2016 reviews • Finalized content for registrant resources o For preparation and remediation purposes • Drafted the first PRP data report	• Schedule pharmacies for January 2017 reviews • Complete PRP data report • Enhance Pharmacy Professional Reviews for Pharmacy Technicians • Continue to develop Release 2 of Phase 1: Residential Care, packaging, compounding and other ancillary forms

Communications / Stakeholder Stream:

Update	Next Steps
• Drafted PRP Insights article for Readlinks based on findings from reviews	• Continue to develop monthly PRP Insights articles for Readlinks

Legislation Stream:

Update	Next Steps
• Updated review forms to reflect new legislation • Provided feedback on legislation based on findings from reviews	• Continue to provide feedback on legislation based on findings from reviews • Review updated Legislation Change Schedule for Phase 1 Release 2

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

Enforcement Stream:

Update	Next Steps
• Sharing PRP Information as needed • Working with Complaints Resolution team to review selected pharmacies (to prevent overlap)	• Continue to share PRP information as needed • Continue to refer to Inquiry Committee as needed • Continue to work with Complaints Resolution team to review selected pharmacies (to prevent overlap)

Human Resources / Operations Stream:

Update	Next Steps
• Two Compliance Officers (started in August and October 2016) have completed training and are now conducting reviews	• Evaluate staffing resources based on current registration and licensure statistics

IT Stream:

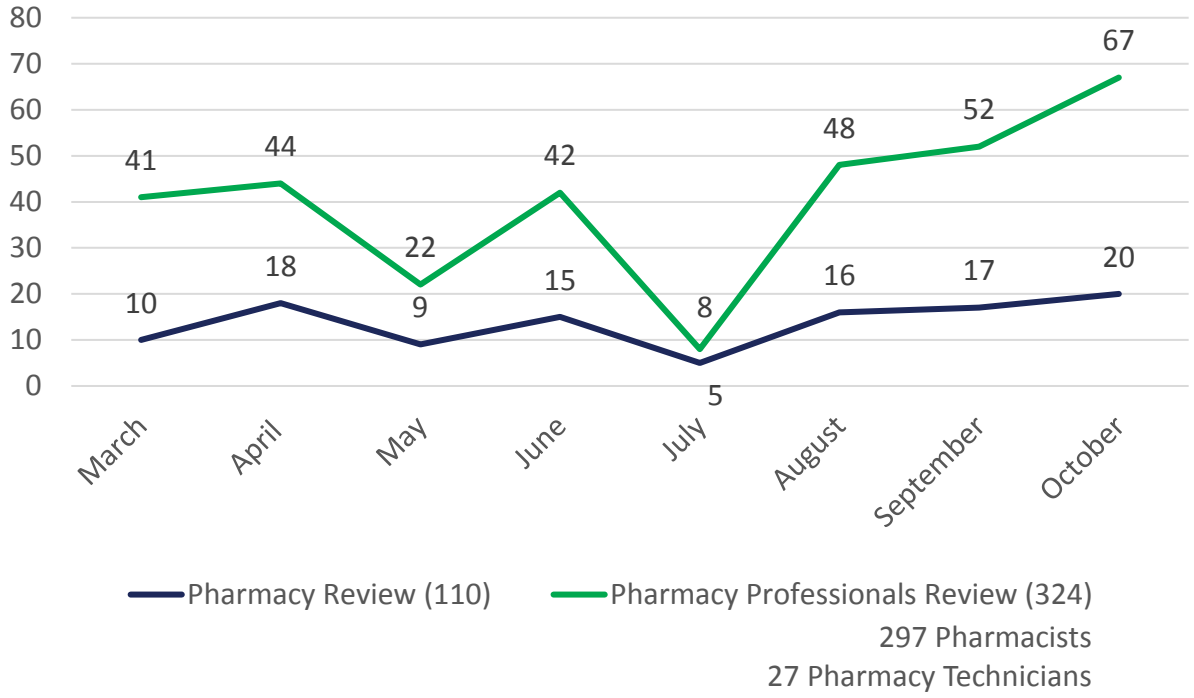
Update	Next Steps
• Completed data migration of reviews conducted on excel forms (Prior to April 18th, 2016) • Ongoing application enhancements	• Continue with application enhancements • Build reports for administrative use

Appendix	
1	Phase 1 – Community Practice Operational Statistics

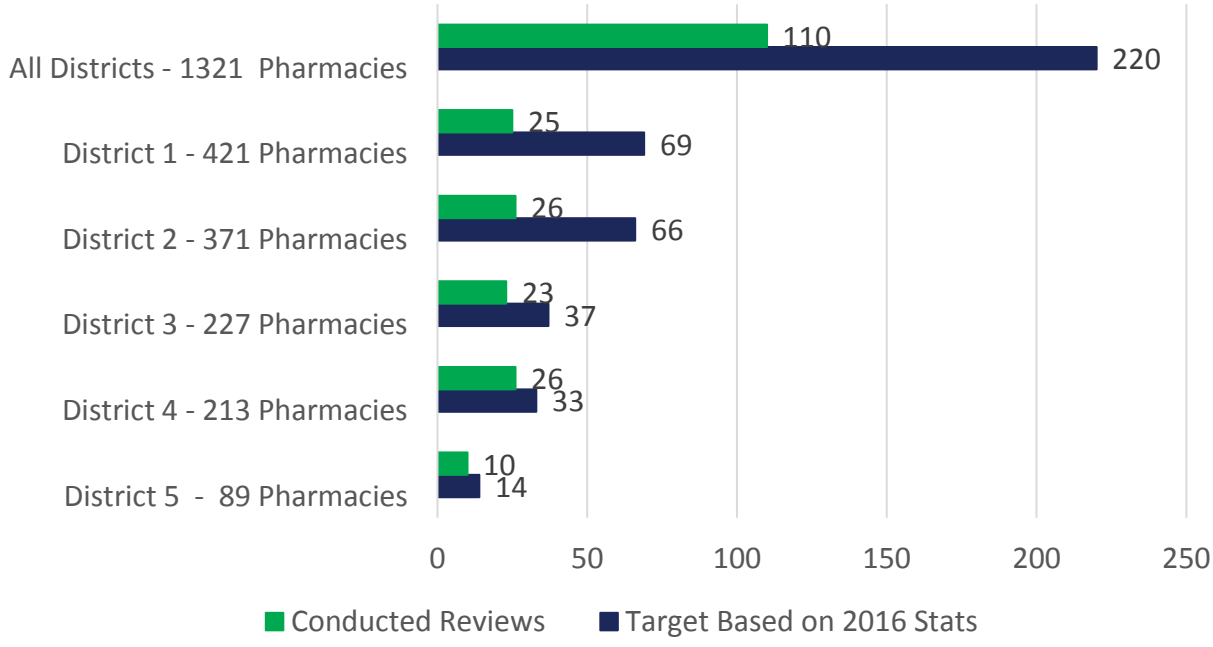
Appendix 1

PRP: Community Pharmacy Operational Statistics

2016-17 Fiscal Year Progress: March 1st, 2016 – October 31st, 2016
Conducted Pharmacy Reviews and Pharmacy Professionals Reviews



2016-17 Fiscal Year Progress: March 1st, 2016 – October 31st, 2016
Conducted Pharmacy Reviews by District



College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4b.viii. August Financial Report

INFORMATION ONLY

Purpose

To report on the highlights of the August financial reports.

Background

The August financial reports reflect **six months** activity. Attached are the Statement of Financial Position, a summary Statement of Revenue and Expenditures and more detailed reports on Revenue and on Expenditures for the six months.

Statement of Financial Position

The College continues to experience an excellent financial position. We are monitoring cash flow closely as we slowly draw down from the short term investments as per the Board approved strategic plan.

The cash balance of $896,032 is quite satisfactory. We will be cashing in more GICs over the winter as per the budget plan.

Short Term Investments are still substantial at $6,946,074.

Payables and Accruals are $761,119.

Revenue

Licensure revenues are near budget, as is the *Other Revenue* category (Pharmanet, administrative fees, etc.)

Expenses

Total Year to Date Actual expenses are lower than budget, many due to timing.

Variance updates by department:

Department	Budget	Actual	Comment
Board & Registrar's Office	$269,308	$228,833	Some expense categories are under budget but are off-set by the loyalty points legal costs.
Grant distribution	$221,619	$138,537	Both ADAPT and the physical assessment course will start up again in the fall. This will remain under budget for the year.
Registration & Licensure	$129,503	$150,112	The PODSA project manager's fees are driving the overage. This will remain over budget for the year.
Quality Assurance	$293,480	$253,637	The e-library portion will be under-budget as we have discontinued the subscriptions as of Dec. 31st.
Practice Reviews	$147,625	$79,704	The Practice Review Program is at the stage where Consulting Services requirements are very limited. This will remain under budget for the year.
Complaints Resolution	$193,716	$211,974	Legal and outside contractors' fees depend upon the timing of Discipline Hearings and undercover investigations.
Policy and Legislation	$86,100	$97,250	Due to timing of legal expenditures. This will remain over budget for the year, due to the PODSA changes.
Communications and Engagement	$252,330	$49,331	This budget line will remain under budget. Some forums or town halls will not be held. The 125th Celebration invoices will be in September's financials.
Finance and Administration	$781,063	$876,964	This category has been busy with the IT upgrades, the recruitment of the new Deputy Registrar and the Organizational Review consulting fees.

Salaries and benefits	$2,568,217	$2,397,674	Due to timing of recruitment, staff turnover.
Amortization	$206,063	$145,152	Timing – as some calculations are done at year end.

Appendix	
1	Statement of Financial Position
2	Statement of Revenue and Expenditures
3	Statement of Revenue
4	Statement of Expenses

College of Pharmacists of British Columbia
Statement of Financial Position
As at August 31, 2016

Assets	**$**
Current	
Cash	896,032.36
Short term investments	6,946,074.47
Receivables	31,411.67
Prepaids and deposits	277,892.69
Investment in Joint Venture	1,610,991.73
	9,762,402.92
Development costs	291,679.31
Property and equipment	950,956.10
	11,005,038.33

Liabilities and Net Assets	**$**
Liabilities	
Current	
Payables and accruals	761,118.99
Deferred revenue	3,190,643.91
Unearned revenue	191,185.42
	4,155,796.15
Capital lease obligations	56,334.46
	4,212,130.61
Net Assets	
Closing Balance	6,792,907.72
	11,005,038.33

College of Pharmacists of BC

Statement of Revenue and Expenditures

For the 6 months months ended August 31, 2016

	2016/17 YTD Budget	2016/17 YTD Actual	Variance (Budget vs. Actual) $	Variance (Budget vs. Actual) %
REVENUE	6 months	6 months	6 months	6 months
	2,900,173	**2,781,766**	**(118,407)**	**(4%)**
Non Licensure				
	1,163,242	**1,079,552**	**(83,690)**	**(7%)**
Total Revenue	**4,063,415**	**3,861,318**	**(202,097)**	**(5%)**
Transfer from Balance Sheet	**1,085,609**	**758,786**	**(326,823)**	**(30%)**
TOTAL REVENUE	**5,149,024**	**4,620,104**	**(528,920)**	**(10%)**
TOTAL EXPENSES BEFORE AMORTIZATION	**4,942,960**	**4,484,016**	**458,945**	**9%**
NET SURPLUS (DEFICIT) BEFORE THE FOLLOWING:	**206,064**	**136,088**	**(69,975)**	
Amortization expenses	206,063	145,152	60,912	30%
TOTAL EXPENSES AFTER AMORTIZATION	**5,149,024**	**4,629,167**	**519,856**	**10%**
NET SURPLUS(DEFICIT)	**0**	**(9,063)**	**(9,063)**	

College of Pharmacists of BC

Statement of Revenue

For the six months ended August 31, 2016

	2016/17 YTD Budget	2016/17 YTD Actual	Variance (Budget vs. Actual) $	Variance (Budget vs. Actual) %
	6 months	6 months	6 months	6 months
REVENUE				
Licensure				
Pharmacy Fees	927,197	924,056	(3,141)	(0%)
Pharmacist Fees	1,686,778	1,588,165	(98,613)	(6%)
Pharmacy Technician Fees	286,199	269,545	(16,653)	(6%)
	2,900,173	**2,781,766**	**(118,407)**	**(4%)**
Non Licensure				
Other revenue	841,438	790,767	(50,671)	(6%)
Grant revenue	117,619	87,500	(30,119)	(26%)
Investment Income - GIC	79,186	81,285	2,099	3%
Investment Income - JV	125,000	120,000	(5,000)	(4%)
	1,163,242	**1,079,552**	**(83,690)**	**(7%)**
Total Revenue	**4,063,415**	**3,861,318**	**(202,097)**	**(5%)**
Transfer from Balance Sheet	**1,085,609**	**758,786**	**(326,823)**	**(30%)**
TOTAL REVENUE	**5,149,024**	**4,620,104**	**(528,920)**	**(10%)**

College of Pharmacists of BC

Statement of Expenditures

For the six months ended August 31, 2016

	2016/17 YTD Budget	2016/17 YTD Actual	Variance (Budget vs. Actual) $	Variance (Budget vs. Actual) %
	6 months	6 months	6 months	6 months
EXPENSES				
Board and Registrar	269,308	228,833	40,475	15%
Grant Distribution	221,619	138,537	83,082	37%
Registration, Licensure and Pharmanet	129,503	150,112	(20,610)	(16%)
Quality Assurance	293,480	253,637	39,843	14%
Practice Reviews	147,625	79,704	67,921	46%
Complaints Resolution	193,716	211,974	(18,258)	(9%)
Policy and Legislation	86,100	97,250	(11,150)	(13%)
Communications and Engagement	252,330	49,331	202,999	80%
Finance and Administration	781,063	876,964	(95,901)	(12%)
Salaries and Benefits	2,568,217	2,397,674	170,543	7%
TOTAL EXPENSES BEFORE AMORTIZATION	**4,942,960**	**4,484,016**	**458,945**	**9%**
NET SURPLUS (DEFICIT) BEFORE THE FOLLOWING:	**206,064**	**136,088**	**(69,975)**	
Amortization expenses	206,063	145,152	60,912	30%
TOTAL EXPENSES AFTER AMORTIZATION	**5,149,024**	**4,629,167**	**519,856**	10%

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4b.ix San'yas Indigenous Cultural Safety Training Program

INFORMATION ONLY

Purpose

To update the Board on the San'yas Indigenous Cultural Safety (ICS) Training Program of the Provincial Health Services Authority (PHSA) of BC.

Background

ICS Training Program

The ICS training is a facilitated on-line training program (http://www.sanyas.ca/) designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people.

Facilitators guide and support each participant through interactive learning modules. Participants will learn about: terminology; diversity; aspects of colonial history such as Indian residential schools and Indian Hospitals; and, contexts for understanding social disparities and inequities. Through interactive activities participants examine culture, stereotyping, and the consequences and legacies of colonization. Participants will also be introduced to tools for developing more effective communication and relationship building skills.

There are four core ICS training programs[1]:

1) Core ICS: Intended for non-health professionals working in organizations such as justice, policing, child and family services, education, business, and government.
2) Core ICS Health: Focuses on health care issues for professionals working with Indigenous people.
3) Core ICS Mental Health: Builds on the foundation provided in Core ICS Health with a specific focus on mental health issues for professionals working with Indigenous people.
4) Core ICS Child Welfare: Has a specific focus on child welfare issues for professionals working with Indigenous children and families.

Upon completion of the program, participants receive a certificate and will have access to post-training support.

Accreditation and Cost

The cost of the program is $250.00. However, employees of the Ministry of Health and the health authorities can take the Core ICS Health and ICS Mental Health programs at no cost.

[1] The training programs are either focused on British Columbia or Ontario.

The Core ICS Health program meets the accreditation criteria of the College of Family Physicians of Canada. It has been certified by the College of Family Physicians of Canada for up to 16 Mainpro+ credits.

The Core ICS Health program focused on British Columbia is an Accredited Self-Assessment Program eligible for up to 8.0 Section 3 credits as defined by the Maintenance of Certification Program of the Royal College of Physicians & Surgeons of Canada**.** This program has been reviewed and approved by UBC Division of Continuing Professional Development.

College Support of the ICS Training Program

A staff representative of the College attended the PHSA's *Moving Forward: Building Culturally Safe Organizations* conference in March 2014. The purpose of this conference was to demonstrate the importance of Indigenous cultural competency initiatives and to identify priorities for a provincial Aboriginal cultural safety framework.

At their June 2014 meeting, Joe Gallagher who is of Sliammon First Nation ancestry and serves as the Chief Executive Officer for the First Nations Health Authority gave a presentation to the Board on the health and wellness of BC First Nations. As part of their meeting materials, the Board received a briefing note that provided an overview of PHSA's Indigenous Cultural Competency (ICC) Training Program (now called Indigenous Cultural Safety Training).

To highlight the ICC Training Program, the College included an article on it for registrants in its February 2015 ReadLinks. The article noted that this training is eligible towards CE credits.

At their February 2016 meeting, the Board directed that information on College registrant uptake of the ICS training program be presented at a future Board meeting.

Pharmacist and Pharmacy Technician Uptake of ICS Training

According to the PHSA, over 32,000 health and social services professionals in BC and Ontario have taken ICS training since it began in 2010. Of this, 163 pharmacy staff[2] have taken ICS training, and 158 of those individuals were in BC.

[2] At the time of registration, participants selected "pharmacy" as their profession; however, individual job titles are not collected.

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4b.xi College Representative on the Board of the Pharmacy Examining Board of Canada

DECISION REQUIRED

Recommended Board Motion:

Reappoint Omar Alasaly as the College of Pharmacists of British Columbia representative on the Board of the Pharmacy Examining Board of Canada for a second three-year term.

Purpose

To provide information for consideration by the Board in regards to the appointment of a College representative on the Board of the Pharmacy Examining Board of Canada (PEBC).

Background

The PEBC is the national certification body for the pharmacy profession in Canada. It is a non-profit organization that assesses the qualifications of pharmacists and pharmacy technicians on behalf of participating provincial regulatory authorities. The Board evaluates qualifications, develops and administers examinations including a national qualifying examination, and issues Certificates of Qualification.

Based in Toronto, the PEBC is governed by a national Board of Directors comprised of representatives of the pharmacy profession from across Canada. Terms on the PEBC Board are three years, and are renewable for one term. The College's current representative on the PEBC Board is Omar Alasaly, a practicing pharmacist with urban and rural community pharmacy practice experience. He also serves on the PEBC's Finance Committee and By-Laws Committee.

Discussion

Omar Alasaly will be completing his first three-year term on the PEBC Board at the end of February 2017. In September 2016, the PEBC wrote to the College indicating that it values Mr. Alasaly's experience and contributions as a PEBC Board member, and would appreciate his reappointment for a second three-year term, ending in February 2020.

Recommendation

The College recommends that the Board reappoint Omar Alasaly as the College's representative on the PEBC Board for the following reasons:

- Omar Alasaly is the current College representative on the PEBC Board, and has served on two PEBC Board committees.
- The terms of PEBC Board members are renewable for one term. As such, the College is permitted to reappoint Omar Alasaly for one more term.
- The PEBC has requested that the College reappoint Mr. Alasaly for a second term, given his experience and valuable contributions to the organization.

College of Pharmacists of British Columbia

Board Meeting

Friday, November 18th, 2016

CPBC Office, 200-1765 West 8th Avenue, Vancouver

DRAFT AGENDA

9:00am - 9:10am	**1.**	Welcome & Call to Order	Chair Reynolds
	2.	Election of Chair **[DECISION]**	Chair Reynolds
	3.	Election of Vice-Chair **[DECISION]**	Chair
	4.	Consent Agenda a) Items for further discussion b) Approval of Consent Items	Chair
	5.	Confirmation of Agenda **[DECISION]**	Chair
9:10am - 9:15am	**6.**	Deputy Registrar Appointment **[DECISION]**	Chair
9:15am - 9:30am	**7.**	Governance Committee a) Update b) Elected Board member terms of office **[DECISION]**	Norm Embree
9:30am - 10:15am	**8.**	In-camera	
10:15am - 10:30am		***BREAK***	
10:30am - 11:30am	**9.**	Evidence for the Benefit of an Advanced Scope of Pharmacy Practice - the Alberta Experience	Ross Tsuyuki
11:30am - 12:00pm	**10.**	Legislation Review Committee: a) Drug Schedules Regulation **[DECISION]** b) HPA Bylaws - Application Committee **[DECISION]** c) HPA Standards of Practice: Parts 1, 2 and 3, and new PPP-75 **[DECISION]**	Jeremy Walden
12:00pm - 1:00pm		***LUNCH***	
1:00pm - 1:15pm	**11.**	Prescription Labelling for the Visually Impaired	Rob Sleath
1:15pm - 2:15pm	**12.**	Certified Pharmacist Prescriber a) Report on Stakeholder Engagement b) Recommendations from Board Working Group **[DECISIONS]**	Jeremy Walden
2:15pm - 2:30pm		***BREAK***	
2:30pm - 3:00pm	**13.**	Practice Review Program: Phase 2 Implementation **[DECISION]**	Michael Ortynsky
3:00pm - 3:45pm	**14.**	Strategic Plan **[DECISION]**	Mary O'Callaghan
3:45pm - 4:00pm	**15.**	Items brought forward from Consent Agenda	
		CLOSING COMMENTS, ROUND TABLE EVALUATION OF MEETING, AND ADJOURNMENT	

Societal Benefit From An Advanced Scope of Pharmacy Practice

Ross T. Tsuyuki, BSc(Pharm), PharmD, MSc, FCSHP, FACC
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BCCoP Board. Vancouver, November 18, 2016.

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Disclosures

- Research Funding: Merck, Sanofi, AstraZeneca (investigator-initiated trials)
- Consulting: Merck
- President, SMHEART CONSULTING, INC.

Outline

- Expanded Scope of Practice for Pharmacists in Alberta
- Evidence for this advanced pharmacy practice

Scope of Practice in Alberta

- Prescribing in an Emergency
- Prescription Adaptation
- **Initial Access Prescribing**
- **Ordering Lab Tests**
- Administering Injections
- Pharmacy Technician Regulation

Alberta: Initial Access Prescribing

- Alberta pharmacists with at least 1 year of practice experience can apply for Additional Prescribing Authorization (APA)
- Pharmacists with APA can prescribe drugs for patients after conducting a complete patient assessment
  - can prescribe any drug in their area of competence except for narcotics and controlled drugs (e.g., benzodiazepines)
  - Independent of physician

Alberta: Initial Access Prescribing

- If a pharmacist prescribes a drug for a patient, they become legally responsible for the outcomes of that prescribing decision
- Whenever a pharmacist prescribes, they are legally required to inform the patient's usual prescriber of their action to ensure continuity of care
- Pharmacists who prescribe must have a follow-up plan in place to monitor the outcome of the prescription

Alberta: Ordering Lab Tests

- All Alberta pharmacists can order laboratory tests for patients to screen for disease or monitor response to therapy
  - Must register with the provincial provider registry
- Pharmacists must only order those lab tests that they are personally competent to order, interpret and use to achieve appropriate drug therapy outcomes
- Results are available on a province-wide network called Netcare®

World Health Organization

Health topics | Data | Media centre | Publications | Countries | Programmes | Governance | About WHO | Search

Cardiovascular disease

- Cardiovascular disease
- Strategic priorities
- Global Hearts Initiative
- Research and global partnerships
- Regional activities
- Multisector partnerships
- WRIGHT project
- Publications

New initiative launched to tackle cardiovascular disease, the world's number one killer

22 September, 2016: "Global Hearts", a new initiative from the World Health Organization (WHO) and partners launched on the margins of the UN General Assembly, aims to beat back the global threat of cardiovascular disease, including heart attacks and strokes - the world's leading cause of death.

More information

Highlights

New initiative launched to tackle cardiovascular disease, the world's number one killer

Cardiovascular diseases

World Heart Day 2015 is marked around the globe

17.5 million

people die each year from CVDs, an estimated 31% of all deaths worldwide.

Fact sheet on CVDs

>75%

of CVD deaths occur in low-income and middle-income countries.

Health topic on CVDs

80%

of all CVD deaths are due to heart attacks and strokes.

10 facts on noncommunicable diseases

Key messages to protect heart health

- Tobacco use, an unhealthy diet, and physical inactivity increase the risk of heart attacks and strokes.
- Engaging in physical activity for at least 30 minutes every day of the week will help to prevent heart attacks and strokes.
- Eating at least five servings of fruit and vegetables a day, and limiting your salt intake to less than one teaspoon a day, also helps to prevent heart attacks and strokes.

Read more on how to protect your heart

Read more about the topic

Key publications

HEARTS — Technical package for cardiovascular disease

SHAKE THE SALT HABIT — Technical package for salt reduction

http://www.who.int/cardiovascular_diseases/en/

Cardiovascular Diseases

Risk Factor	Prevalance	Deaths/y
Smoking	10-31%	6M
Dyslipidemia	40%	2.6M
Hypertension	40%	7.5M
Diabetes	10%	1.3M
Obesity	7-24%	2.8M

http://www.who.int/cardiovascular_diseases/en/

WHO Global Atlas of Cardiovascular Disease, 2011

Why Community Pharmacy?

- Pharmacists see all patients in the community (from all physicians, as well as those who don't see a physician)
  - A broad-based public health approach for screening and case-finding (e.g., diabetes control)
  - Cardiovascular diseases arise and are treated in the community
  - Not referral-based
- Systematic, proactive
- Patient education/empowerment
- Expanded scope of practice (e.g., prescribing)
- Evidence-based, application of national guidelines

Pharmacy Practice Research

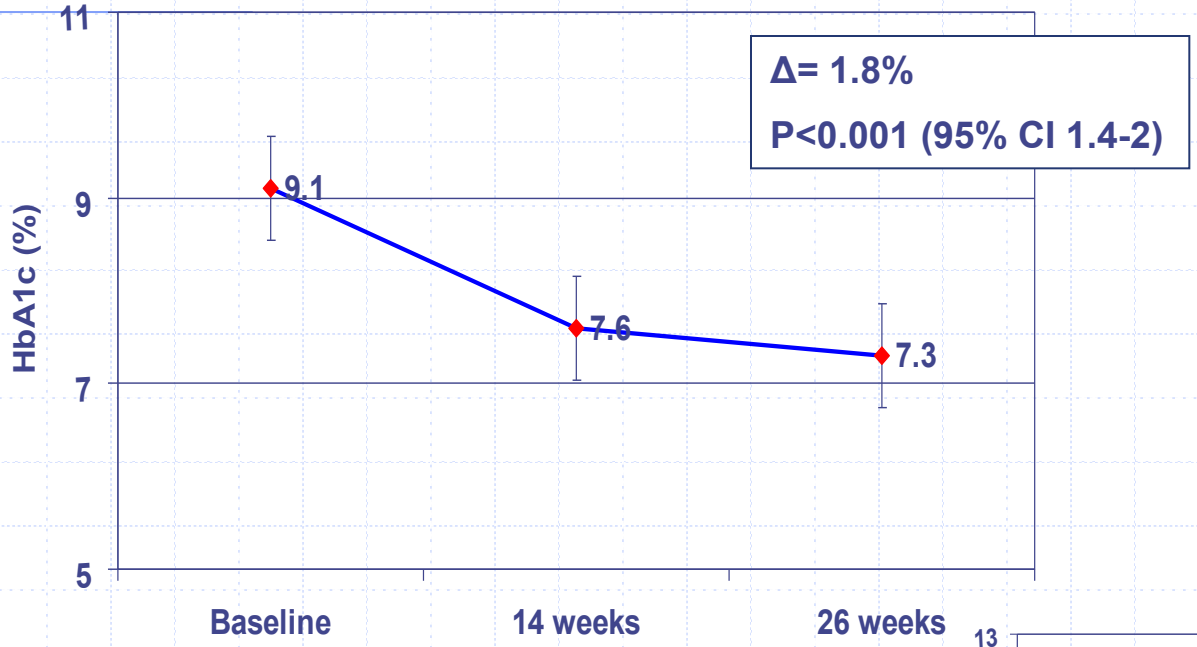
- "Interventional" practice research:
  - Pharmacists systematically find patients who are treated suboptimally (e.g., poor blood sugar control)
  - Pharmacists apply interventions:
    - Assessment of the patient
    - Prescribing
    - Regular follow-up
  - *Take responsibility* for their patient's care
- We measure impact of these interventions on patient outcomes
- Generates evidence for pharmacist care

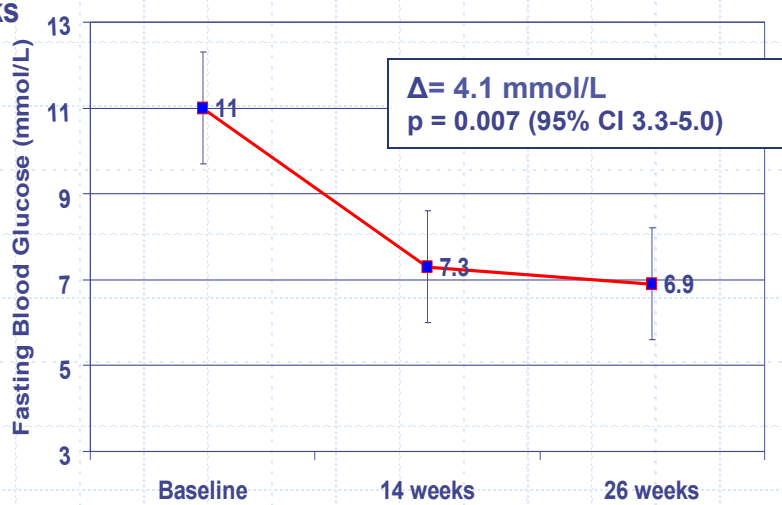
Pharmacist Prescribing in Diabetes: R_xING Study

- **Background:** glycemic control in patients with type 2 diabetes is very poor (about 50% controlled)
- **Objective:** To determine the effect of a community pharmacist prescribing intervention on glycemic control in patients with poorly controlled type 2 diabetes
- **Methods:**
  - Design: before-after design conducted in 12 community pharmacists in Alberta
  - Patients: 99 patients with poorly controlled type 2 diabetes, HbA1c of 7.5-11.0%
  - Intervention: prescribing by pharmacist (including oral medications and insulin glargine), including titration and follow-up at for 26 weeks

Al Hamarneh YNJ et al. BMJ Open 2013: 3:e003154

R_xING Results





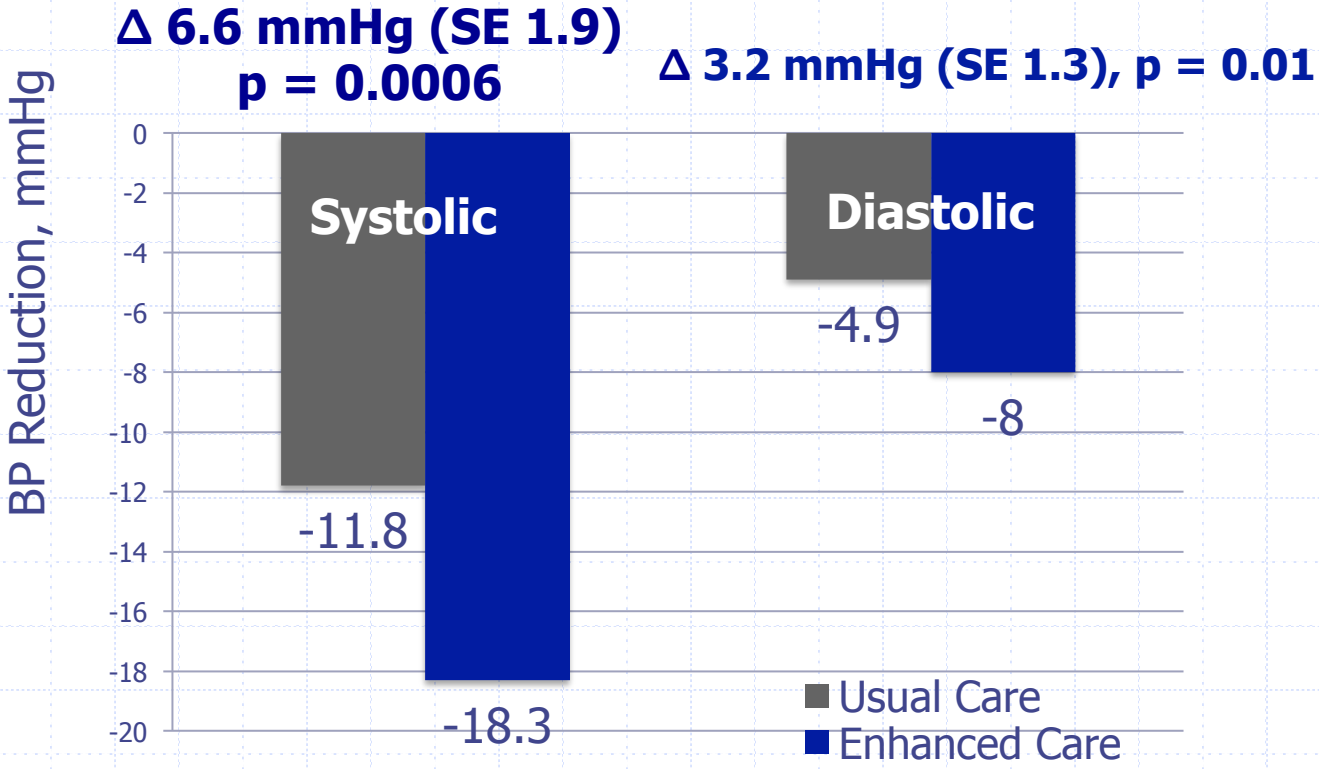
Al Hamarneh YNJ et al. BMJ Open 2013: 3:e003154

Pharmacist Prescribing in Hypertension: R_xACTION

- **Background:** Blood pressure control in the community is poor (30-90% uncontrolled)
- **Objective:** To evaluate the effect of pharmacist prescribing on systolic BP reduction in patients with poorly controlled hypertension
- **Methods:**
  - Randomized trial conducted in 23 pharmacies in Alberta
  - Patients: 248 patients with BP >140/90 or 130/80 mmHg recruited by the pharmacist
  - Intervention: pharmacist assessment of BP, CV risk, patient education, prescribing, lab monitoring, monthly follow-up according to the Canadian hypertension guidelines (CHEP)
  - Control: usual pharm and physician care (written educational materials and BP wallet card)

Tsuyuki RT, *et al.* Circulation 2015;132:93-100

R_xACTION Results



- Adjusted odds of achieving target BP 2.32 (95% CI 1.17, 4.15) in favour of intervention

Tsuyuki RT, *et al.* Circulation 2015;132:93-100

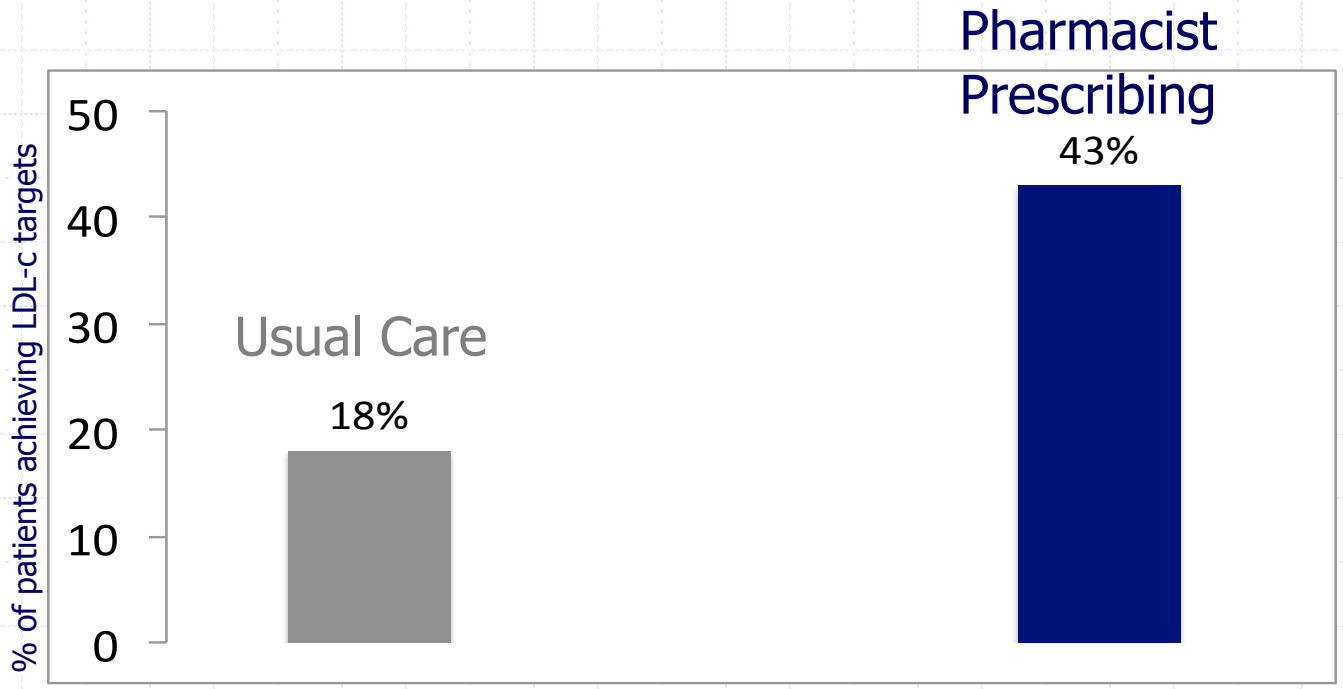
Pharmacist Prescribing in Dyslipidemia: R_xACT

- **Background:** Dyslipidemia is poorly controlled (about 50% are not treated to evidence-based targets)
- **Objective:** To evaluate the effect of pharmacist prescribing on LDL-c reduction patients with poorly controlled dyslipidemia
- **Methods:**
  - Design: randomized, controlled trial in 12 pharmacies
  - Patients: 99 patients with poorly controlled dyslipidemia, identified and recruited by their pharmacist
  - Intervention: pharmacist assessment, prescribing and follow-up for 6 months according to 2009 Canadian guidelines
  - Control: usual pharmacist and physician care

Tsuyuki RT, *et al.* Can Pharm J 2016; 149: 283-292

R_xACT Results

- Proportion of patients achieving target LDL-c levels after 6 months (p=0.007)
  - Adjusted odds ratio of achieving target: 3.17 (p<0.001)
  - Adjusted change in LDL-c: 0.546mmol/L (SE 0.157, p=0.001)



Summary, Pharmacist Prescribing Research to 2014

- Pharmacist prescribing and care has demonstrated improved patient outcomes in:
  - Type 2 diabetes
  - Hypertension
  - Dyslipidemia
- A very high level of patient satisfaction
- Empowering pharmacists to take more responsibility
  - greater job satisfaction
- But, impact on overall cardiovascular risk has not been studied…

The Effect of Community Pharmacist Prescribing and Care on Cardiovascular Risk Reduction: The R_xEACH Multicentre Randomized Controlled Trial

Ross T. Tsuyuki, BSc(Pharm), PharmD, MSc, FCSHP, FACC
Professor of Medicine (Cardiology)
Faculty of Medicine and Dentistry, University of Alberta

Yazid NJ Al Hamarneh, BPharm, PhD
Charlotte Jones, MD, PhD, FRCP(C)
Brenda Hemmelgarn, MD, PhD, FRCP(C)
And the R_xEACH Investigators

Tsuyuki RT, Al Hamarneh YN, Jones CA, Hemmelgarn BR. J Am Coll Cardiol 2016; 67(24): 2846-54.

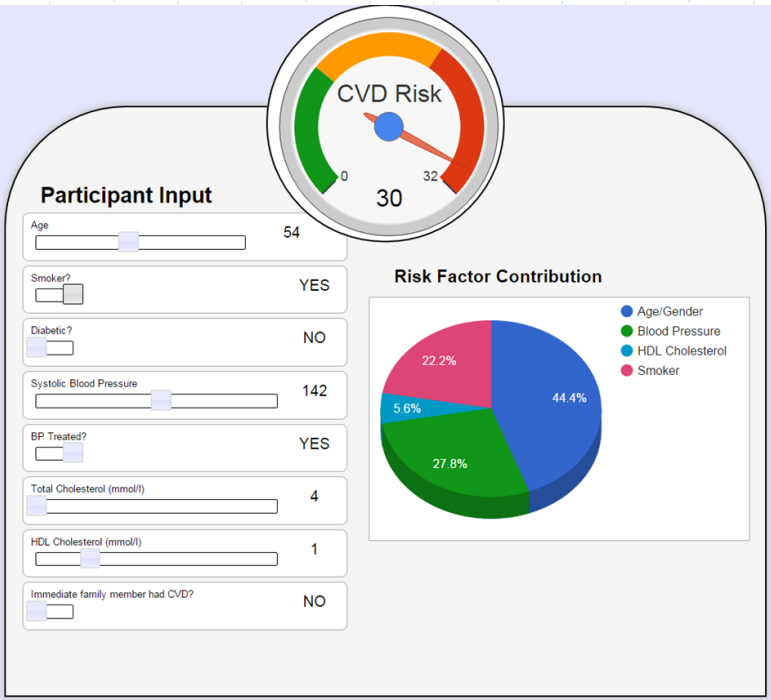
Pharmacist Prescribing and Care in Cardiovascular Risk Reduction: R_xEACH

- **Objective**: To evaluate the effect of a community pharmacy-based case finding and intervention in patients at high risk for cardiovascular events on reduction in estimated risk for major cardiovascular events
- **Methods:**
  - randomized controlled trial in 56 community pharmacies in Alberta, Canada
  - Patients: 723 at high risk for CV events (diabetes, chronic kidney disease, established vascular disease, high Framingham Risk)
  - Intervention: CV risk assessment, patient education, prescribing, lab monitoring, monthly follow-up (according to Cdn guidelines)
  - Control: usual pharmacist and physician care

Tsuyuki RT, et al. JACC 2016: doi: 10.1016/j.jacc.2016.03.528.

Web-Based Cardiovascular Risk Calculator

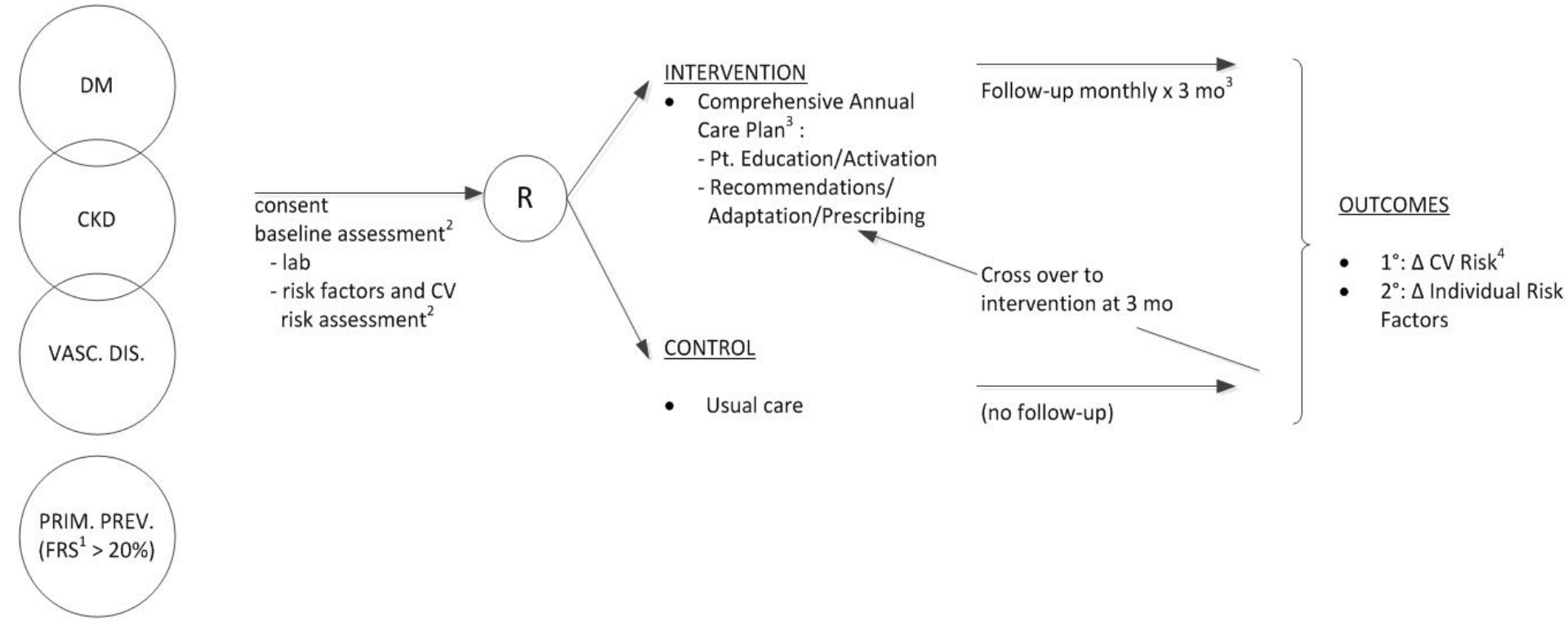
- Input demographics:
  - DM (UKPDS Risk), vascular disease (Int'l Risk), CKD (FRS), primary prevention (FRS) risk engine selected
- Graphic risk shown:
  - Sliders for modifiable risk factors
  - Contribution to risk shown
  - Print for patient



Available from
www.epicore.ualberta.ca/rxeach

Figure 1: RxEACH Study Overview

Setting: Community Pharmacies
Design: Per patient randomized controlled trial



1. PRIM. PREV. = Primary Prevention; FRS = Framingham Risk Score
2. Risk of CV events calculated using most appropriate risk engine (i.e., UKPDS, International, or Framingham)
3. Billing to Alberta Health, includes New CKD Fee Code.
4. Difference in change in CV risk (from risk engine used at baseline) between intervention and control groups.

Outcomes

Primary outcome:

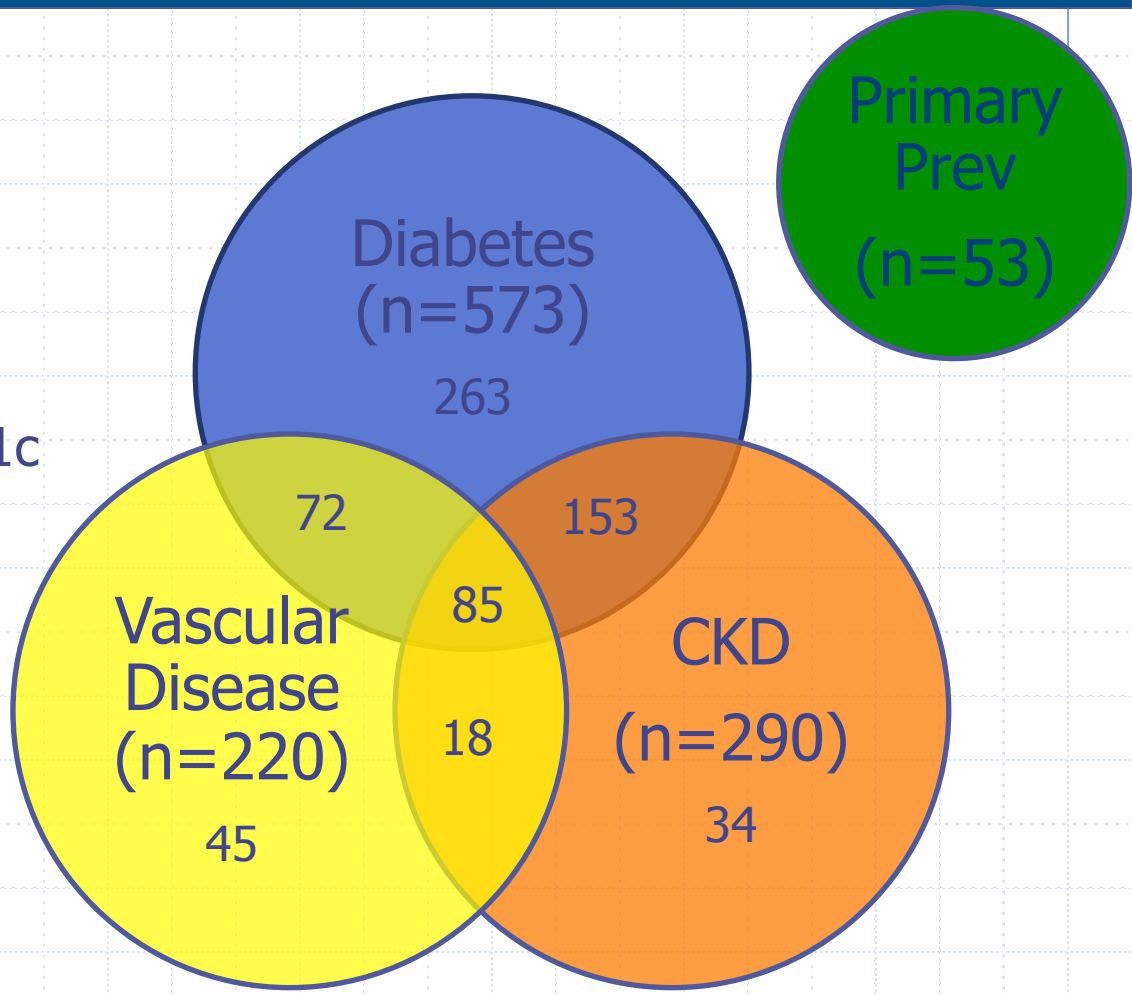
- Relative difference (baseline to 3 months) in estimated risk for cardiovascular events between intervention and usual care groups
  - Risk for future cardiovascular events was calculated using validated risk engines (UKPDS, International, Framingham)

- Secondary outcomes: change in individual risk factors

Results: Demographics

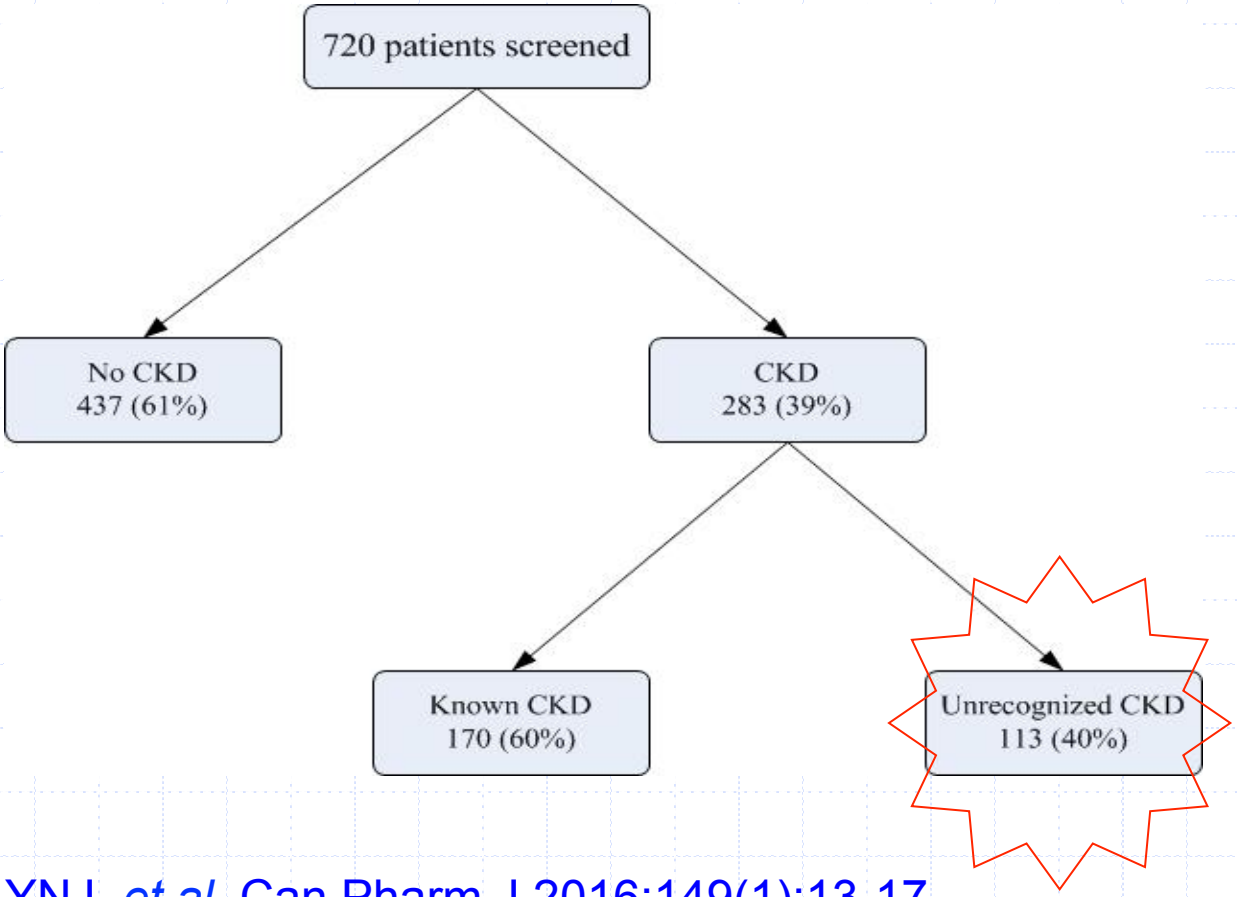
Patients: n=723
Age: 62y (SD12)
Male: 58%

Study Qualification:
- 79% uncontrolled HbA1c
- 72% uncontrolled BP
- 58% uncontrolled LDL
- 27% current smokers



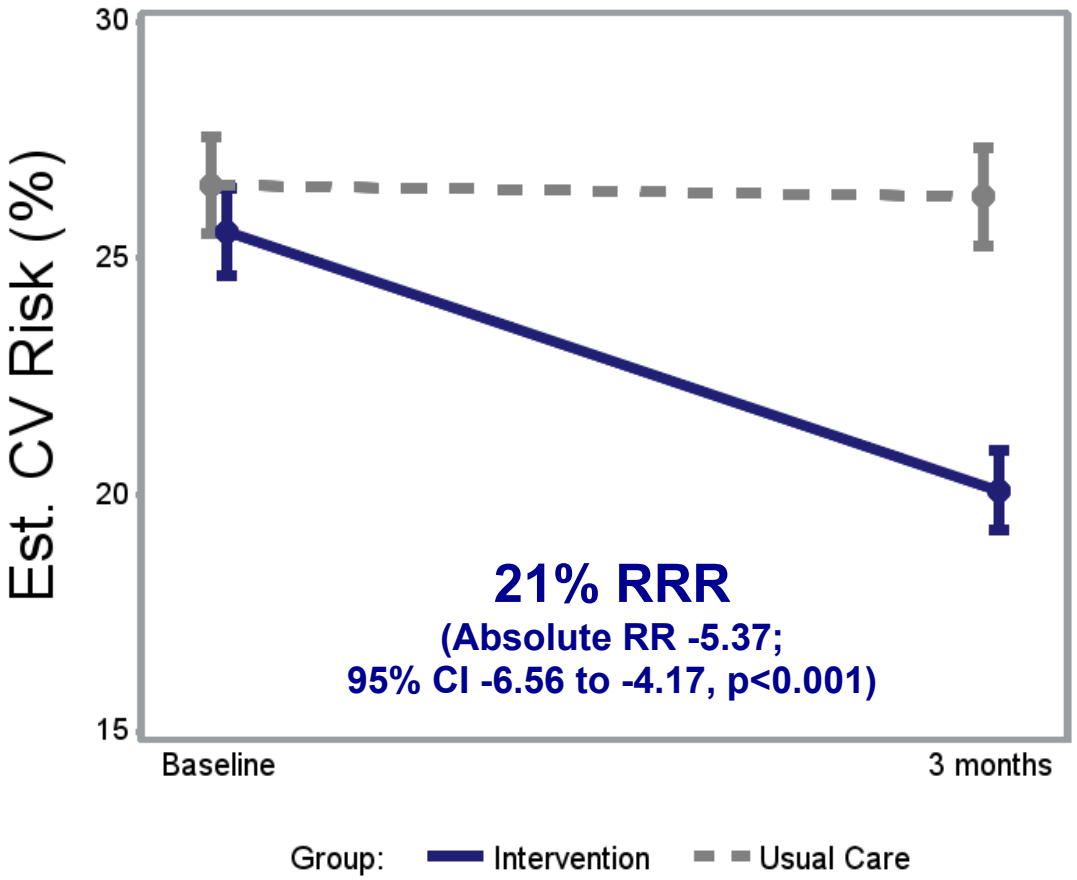
Chronic Kidney Disease Screening

- Of the 720 patients enrolled, 283 patients had CKD:



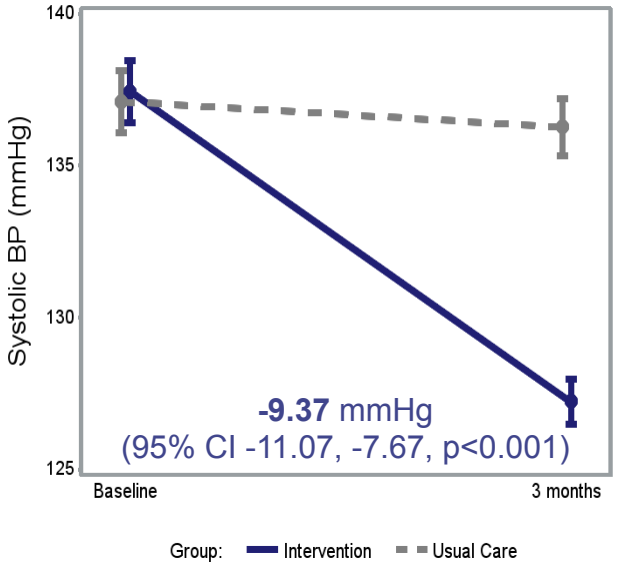
Al Hamarneh YNJ, *et al*. Can Pharm J 2016;149(1):13-17

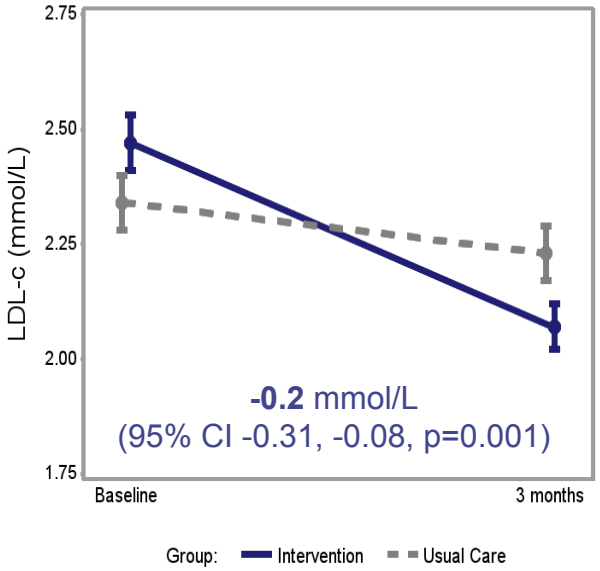
R_xEACH: Change in Risk of Cardiovascular Events

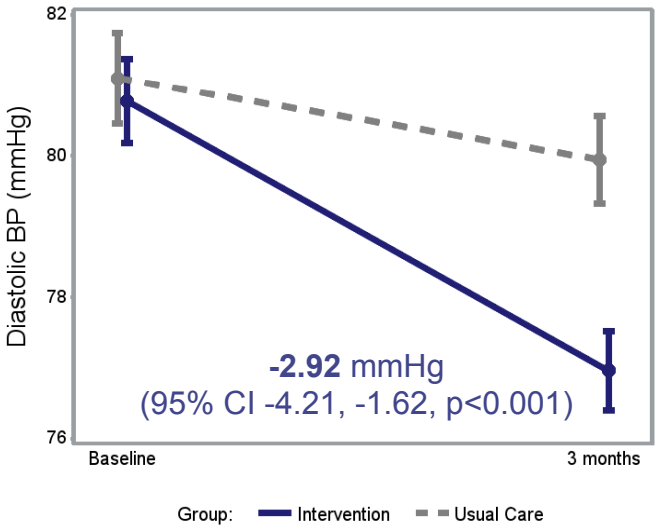


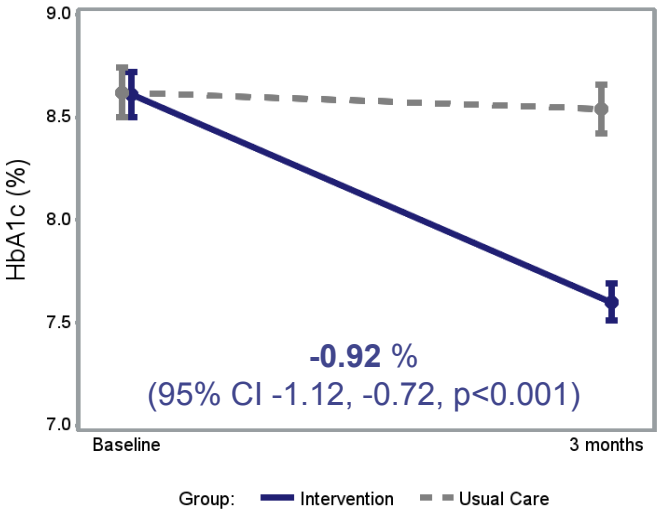
All differences adjusted for baseline values using ANCOVA

R_xEACH: Individual Risk Factors

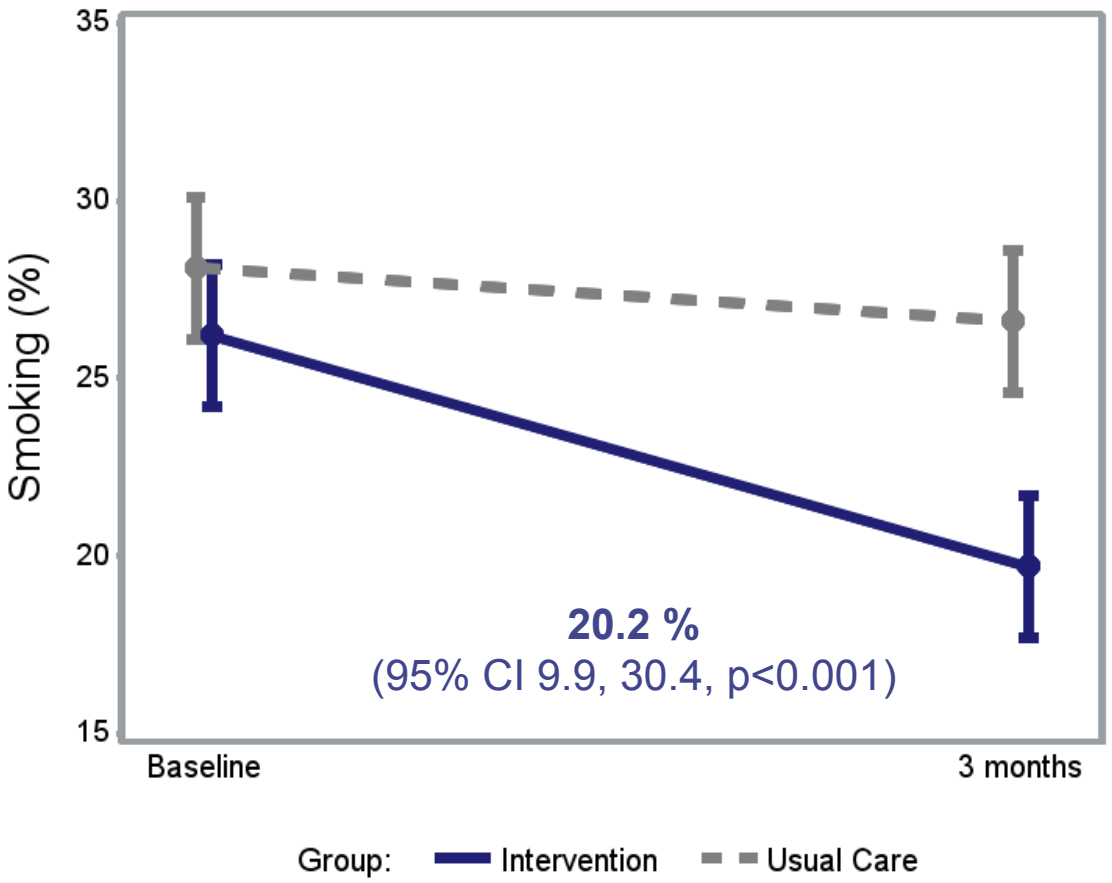








R_xEACH: Smoking Cessation



R_xEACH Conclusions -1

- Pharmacists using the CKD targeted screening guidelines identified a large number of patients with previously unknown CKD
  - validation of pharmacist ordering of lab tests
- Community pharmacist prescribing and care reduced the estimated risk for cardiovascular events by 21% in 3 months
  - Improvements in all major risk factors

Tsuyuki RT, Al Hamarneh YN, Jones CA, Hemmelgarn BR. J Am Coll Cardiol 2016; 67(24): 2846-54.

Quality of Care

- "...gave me a reason to actually care about my health". "I want her (Pharmacist) opinion…her knowledge" (patient 01)
- “he (pharmacist) didn't just prescribe drugs for us, he explained them and explained things that we could do the help ourselves… he keeps us very involved and knowledgeable." (patient 04)
- “He changes (my medicines) and made it much better" (patient 13)

Satisfaction

- “because she (pharmacist) has that relationship with her patients, she cares so she makes that time…" "…by the time you get in (to doctor), the symptom's gone…" (Patient 01)
- “can do things like this through your pharmacist, it would be much easier for you to maintain your health." (Patient 06)
- "I really feel that I matter" (Patient 14)

More Patient Perspectives

- "Well, I think our healthcare system is strained as it is... But when you can have interaction with a program like this...I think that a pharmacist, hell, they know everyting about medicines... It's another way of treating people." (PAT02)
- "doctors can't be experts in everything and if they can refer you to somebody that is more knowledgeable in the care of it then you're better off to go that route" (PAT04)
- "extremely happy with it. He's managed to get our diabetes down to a very managemable state and well with the guidelineas that's recommended" (PA-04)
- "I would highly recommend it (program). I think it's the way to go. I think you have a lot of personal contact with your pharmacists and your pharmacists knows your prescriptions and interactions about your prescriptions and what you need and what you don't kneed." (PAT05)

R_xEACH Conclusions -2

- An important advance in public health
  - High patient satisfaction
  - Complementary to, and in collaboration with, physician care
  - Could have an additional 40,000 accessible primary care providers in Canada to improve patient care and reduce our #1 cause of death

Tsuyuki RT, Al Hamarneh YN, Jones CA, Hemmelgarn BR. J Am Coll Cardiol 2016; 67(24): 2846-54.

Summary/Conclusions -1

- Pharmacists have a societal duty to provide patient care and improve health
- With an advanced scope of practice, pharmacists can do more for patients:
  - There is strong evidence for advanced scope of pharmacy practice (stronger than for other health professions)

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www.epicore.ualberta.ca/rxeach

Summary/Conclusions -2

- Evidence for advanced scope of practice:
  - Better outcomes
  - Patient satisfaction is high
  - Cheaper
- **Pharmacists are primary care providers** – expanding scope of practice is important for public health

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College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

10. Legislation Review Committee
a) Drug Schedules Regulation

DECISION REQUIRED

Recommended Board Motion:

Approve the following resolution in order to align with the 2016 recommendations from the National Drug Scheduling Advisory Committee which include re-classifying ibuprofen (for relief of rheumatoid arthritis, and osteoarthritis), esomeprazole (for relief of frequent heartburn), and fluticasone (for relief of seasonal allergies):

RESOLVED THAT, in accordance with the authority established in section 22(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minister as required by section 22(2) of the Pharmacy Operations and Drug Scheduling Act, the board amend the Drug Schedules Regulation, B.C. Reg. 9/98, which are outlined in the schedule attached to this resolution.

Purpose

To seek Board approval to amend the Drug Schedules Regulation under the *Pharmacy Operations and Drug Scheduling Act* (PODSA) in order to align with the National Drug Scheduling Advisory Committee (NDSAC) final recommendations from 2016.

Background

Subject to the federal *Food and Drugs Act* (FDA), Health Canada determines whether a drug must be sold by prescription only or can be sold over the counter (non-prescription status). Provincial regulatory authorities can further restrict the conditions of sale of non-prescription products, however they cannot be less stringent. For example, a federally non-prescription product could be assigned prescription status by a province or territory. However, a product that is regulated under the FDA with a prescription-only status cannot be given non-prescription status by a province or territory.

Typically, for those drugs determined by Health Canada to be non-prescription, most provincial regulatory authorities schedule by reference to recommendations made by National Association of Pharmacy Regulatory Authorities (NAPRA). However, BC is unique in that the

College has regulatory authority to autonomously conduct its own drug scheduling which results in a longer process for amendments to be brought into force. Nevertheless, most amendments to BC's Drug Schedules Regulation are based on recommendations from NAPRA.

NAPRA created the NDSAC to recommend appropriate placement of non-prescription drugs within a three schedule national model. "NDSAC members are chosen for their knowledge and expertise in such areas as pharmacotherapy, drug utilization, drug interactions and toxicology, pharmacy practice, academic research, the drug industry and pharmaceutical regulatory affairs at federal and provincial levels".[1] Their recommendations include an examination of the scientific evidence to support their rationale, along with allowing for public input through a public posting period.

Legislative Authority

The legislative authority for the Board to amend the Drug Schedules Regulation is outlined in section 22 of the PODSA. The *Act* states:

> ***Regulations of the board***
> ***22*** *(1) Subject to the Food and Drugs Act (Canada), the board, by regulation, may make drug schedules specifying the terms and conditions of sale for drugs and devices.*
> *(2) A regulation under subsection (1) must be filed with the minister.*

BC's process requires the College to complete an internal review of NDSAC's recommendations in order to assess any modifications for the context of BC's health sector. Next, the College submits the proposed amendments to the Ministry of Health, Professional Regulation & Oversight branch. The Ministry completes their review and if satisfied, forwards the request to Legislative Counsel for a legal review. If no issues are identified, Legislative Counsel provides the College with a tagged schedule of amendments.

Discussion

In March 2016, after receiving notification of NDSAC's final recommendations, the College staff completed a review of the recommendations. Their review ensured agreement of the recommendations for a BC context and no changes were identified. Further, in October 2016, the Ministry of Health and its legislative counsel also supported NDSAC's recommendations. Please see Appendix 1 for the tagged schedule of the Drug Schedules Regulation amendments.[2]

[1] http://napra.ca/Content_Files/Files/NDSAC_recruitment_notice_Oct2013_FINAL.pdf

[2] The new additions on the tagged schedule were modeled from the National Drug Schedules; the National Drug Schedules have been revised in accordance with NAPRA's approved recommendations and recent changes to the Federal Prescription Drug List.

NDSAC's recommendations consisted of changing the scheduling classification for Ibuprofen, Esomeprazole, and Fluticasone.[3] As of late August 2016, most Provinces and Territories across Canada have implemented NDSAC's recommendations. This means that BC residents are in a disadvantaged position compared to other Canadian residents since BC residents do not have the same access to the drugs referred to in the attached schedule. For example, Albertans can purchase Ibuprofen in a modified-release oral dosage form (that provides 600mg per dosage unit) from the self-selection area of a pharmacy, however, this same drug remains a prescription only drug in BC due to its current scheduling classification in the Drug Schedules Regulation.

Next Steps

Once approved by the Board, the Board resolution will require a final approval by the Ministry of Health. After receiving final approval from the Ministry, the College will deposit the tagged schedule with the Registrar of Regulations, at which time the amendments will come into force 60 days from the deposit date.

Recommendation

The Board approve the proposed amendments to the Drug Schedules Regulation as presented.

Appendix	
1	Tagged Schedule of Drug Schedules Regulation Amendments
2	NAPRA 2016 Recommendations - Table

[3] See Appendix 2 for a table summarizing the amendment changes and clinical indications for each drug.

Schedule

1 The Drug Schedules Regulation, B.C. Reg. 9/98, is amended in the Schedules

(a) By striking out the following:

1 Esomeprazole and its salts

1 Ibuprofen and its salts except when sold for oral administration in a concentration of 400 mg or less per dosage unit, and

1 Adrenocortical hormones and their salts and derivatives[v], including, but not limited to, hydrocortisone, hydrocortisone acetate, hydrocortisone valerate, hydrocortisone sodium succinate, clobetasone butyrate, difluprednate and triamcinolone acetonide (except

(a) hydrocortisone or hydrocortisone acetate, when sold as a single medicinal ingredient in a concentration that provides 1% or less hydrocortisone in [1]preparations for topical use on the skin,
(b) hydrocortisone or hydrocortisone acetate, when sold in combination with any other non-prescription medicinal ingredient that provides 1% or less hydrocortisone in preparations for topical use on the skin,
(c) clobetasone butyrate, when sold in a concentration of 0.05% clobetasone butyrate in cream preparations for topical use on the skin, and
(d) triamcinolone acetonide in an aqueous nasal spray that delivers 55 mcg per metered spray for adults and children 12 years of age and older)

(b) By adding the following:

1 Ibuprofen or its salts except when sold in an oral dosage form that provides 400 mg or less per dosage unit or in a modified-release oral dosage form that provides 600 mg or less per dosage unit.

3 Ibuprofen or its salts when sold in a modified-release oral dosage form that provides 600 mg or less per dosage unit.

2 Esomeprazole or its salts, when sold for the 14-day treatment for frequent heartburn at a daily dose of 20 mg, in package sizes of no more than 280 mg of esomeprazole

1 Esomeprazole or its salts except when sold for the 14-day treatment for frequent heartburn at a daily dose of 20 mg in package sizes of no more than 280 mg of esomeprazole

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[v] Prescription not required if sold for veterinary use, provided that the product is labelled by the manufacturer "for agricultural use only" or "for veterinary use only"

3 Fluticasone propionate, when sold for the treatment of allergic rhinitis in a nasal spray that delivers 50 mcg/spray for those 18 years of age and older, in package sizes containing no more than 120 metered sprays

2 Fluticasone propionate, when sold for the treatment of allergic rhinitis in a nasal spray that delivers 50 mcg/spray for those 18 years of age and older, in package sizes containing more than 120 metered sprays

1 Adrenocortical hormones and their salts and derivatives[v], including, but not limited to, hydrocortisone, hydrocortisone acetate, hydrocortisone valerate, hydrocortisone sodium succinate, clobetasone butyrate, difluprednate, triamcinolone acetonide, and fluticasone (except

(a) hydrocortisone or hydrocortisone acetate, when sold as a single medicinal ingredient in a concentration that provides 1% or less hydrocortisone in preparations for topical use on the skin,
(b) hydrocortisone or hydrocortisone acetate, when sold in combination with any other non-prescription medicinal ingredient that provides 1% or less hydrocortisone in preparations for topical use on the skin,
(c) clobetasone butyrate, when sold in a concentration of 0.05% clobetasone butyrate in cream preparations for topical use on the skin, and
(d) triamcinolone acetonide in an aqueous nasal spray that delivers 55 mcg per metered spray for adults and children 12 years of age and older
(e) fluticasone propionate, when sold for the treatment of allergic rhinitis in a nasal spray that delivers 50 mcg/spray for those 18 years of age and older)

Drug	Current state: BC DSR[1]	NDSAC recommendation	Indications and Clinical Use (based on **Health Canada's drug product database**)	Amendments (CPBC recommendations)
ibuprofen or its salts, when sold in a modified-release oral dosage form that provides 600 mg or less per dosage unit	1 Ibuprofen and its salts except when sold for oral administration in a concentration of 400 mg or less per dosage unit 3 Ibuprofen and its salts containing 400 mg or less per oral dosage unit (when sold in package sizes exceeding 18 000 mg)	be granted Schedule III status	• The relief of the signs and symptoms of rheumatoid arthritis • The relief of the signs and symptoms of osteoarthritis	1 Ibuprofen or its salts except when sold in an oral dosage form that provides 400 mg or less per dosage unit or in a modified-release oral dosage form that provides 600 mg or less per dosage unit. 3 Ibuprofen or its salts when sold in a modified-release oral dosage form that provides 600 mg or less per dosage unit.
esomeprazole or its salts, when sold for the 14-day treatment for frequent heartburn at a daily dose of 20 mg, in package sizes of no more than 280 mg of esomeprazole	1 Esomeprazole and its salts	be granted Schedule II status	• For frequent heartburn	2 Esomeprazole or its salts, when sold for the 14-day treatment for frequent heartburn at a daily dose of 20 mg, in package sizes of no more than 280 mg of esomeprazole
esomeprazole or its salts, EXCEPT when sold for the 14-day treatment for frequent heartburn at a daily dose of 20 mg in package sizes	1 Esomeprazole and its salts	be retained in Schedule I	• reflux esophagitis • maintenance treatment of patients with reflux esophagitis • nonerosive reflux disease (NERD) (i.e. heartburn and regurgitation)	1 Esomeprazole or its salts except when sold for the 14-day treatment for frequent heartburn at a daily dose of 20 mg in package sizes of no more than 280 mg of esomeprazole

[1] 1 = Schedule I (Prescription)
1A = Schedule IA (Triplicate/Duplicate Prescription Program)
2 = Schedule II (Professional Service Area)
3 = Schedule III (Professional Products Area)
4 = Schedule IV (Prescription by Pharmacist)

of no more than 280 mg of esomeprazole			• healing of NSAID*-associated gastric ulcers • reduction of risk of NSAID-associated gastric ulcers	
fluticasone propionate, when sold for the treatment of allergic rhinitis in a nasal spray that delivers 50 mcg/spray for those 18 years of age and older, in package sizes containing no more than 120 metered sprays	Adrenocortical hormones and their salts and derivativesv, including, but not limited to, hydrocortisone, hydrocortisone acetate, hydrocortisone valerate, hydrocortisone sodium succinate, clobetasone butyrate, difluprednate and triamcinolone acetonide (except […]).	be granted Schedule III status	• seasonal allergic rhinitis including hay fever, and perennial rhinitis poorly responsive to conventional treatment. In patients with allergic rhinitis, fluticasone propionate aqueous nasal spray is also indicated for the management of associated sinus pain and pressure.	3 Fluticasone propionate, when sold for the treatment of allergic rhinitis in a nasal spray that delivers 50 mcg/spray for those 18 years of age and older, in package sizes containing no more than 120 metered sprays
fluticasone propionate, when sold for the treatment of allergic rhinitis in a nasal spray that delivers 50 mcg/spray for those 18 years of age and older, in package sizes containing more than 120 metered sprays	See above.	be granted Schedule II status	• See above.	2 Fluticasone propionate, when sold for the treatment of allergic rhinitis in a nasal spray that delivers 50 mcg/spray for those 18 years of age and older, in package sizes containing more than 120 metered sprays 1 Adrenocortical hormones and their salts and derivativesv, including, but not limited to, hydrocortisone, hydrocortisone acetate, hydrocortisone valerate, hydrocortisone sodium succinate, clobetasone butyrate, difluprednate, triamcinolone acetonide, and fluticasone (except (a) hydrocortisone or hydrocortisone acetate, when sold as a single medicinal ingredient in a concentration that provides 1% or less hydrocortisone in

				preparations for topical use on the skin, (b) hydrocortisone or hydrocortisone acetate, when sold in combination with any other non-prescription medicinal ingredient that provides 1% or less hydrocortisone in preparations for topical use on the skin, (c) clobetasone butyrate, when sold in a concentration of 0.05% clobetasone butyrate in cream preparations for topical use on the skin, and (d) triamcinolone acetonide in an aqueous nasal spray that delivers 55 mcg per metered spray for adults and children 12 years of age and older) (e) fluticasone propionate, when sold for the treatment of allergic rhinitis in a nasal spray that delivers 50 mcg/spray for those 18 years of age and older

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

10. Legislation Review Committee
b) HPA bylaws – Application Committee

DECISION REQUIRED

Recommended Board Motion:

Approve the proposed amendments to the Health Professions Act bylaws that establish an Application Committee, for public posting for a period of 90 days.

Purpose

To seek approval from the Board to publicly post the proposed amendments to the *Health Professions Act* (HPA) bylaws, that establish the Application Committee as per section 19(1)(t) of the HPA.

Background

On May 19, 2016 amendments to the *Pharmacy Operations and Drug Scheduling Act* (PODSA) were given Royal Assent[1]. The amendments to PODSA will require community pharmacy owners, officers, directors and some shareholders to meet certain standards in order for their pharmacies to be licensed by the College. As a result of these amendments, the College will have the authority to refuse to license a pharmacy or impose conditions on a license if its owners, managers, officers, directors or shareholders meet certain criteria (e.g. have been convicted of a relevant crime, sued in relation to community pharmacy practices, or have broken PharmaCare billing rules, etc.).

The College has always had responsibility for licensing pharmacies in addition to registering pharmacists and pharmacy technicians. However, prior to the amendments to PODSA the College was unable to require information about pharmacy owners. The amendments to PODSA allow the College to obtain this information to ensure that people operating a pharmacy are of good conduct and have a good record as it relates to the operation of a pharmacy.

[1] Pharmacy Operations and Drug Scheduling Amendment Act, 2016, https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/40th-parliament/5th-session/bills/progress-of-bills

The amendments to PODSA are not yet in force. The Ministry of Health and the College are working to align the PODSA amendment effective date with corresponding bylaws that the College is currently developing.

Discussion

As a part of the amendments to PODSA, a new committee, "application committee," has been defined as follows:

> "application committee" means an application committee established for the purposes of this Act under section 19(1)(t) of the *Health Professions Act*;

The powers and duties of the Application Committee have been defined in the amendments to PODSA. For instance, if a pharmacy owner does not meet the criteria for licensing as per the amendments to PODSA, the Registrar must refer the application to the Application Committee. Upon receiving an application from the Registrar, the Application Committee may require additional information or evidence to further determine if a license should be issued, renewed or reinstated. They may also choose to issue a license with conditions.

Establishing the Application Committee in the HPA Bylaws

As stated above, the duty and powers of the Application Committee are defined in the amendments to PODSA. However, the composition of the committee must be defined in the HPA bylaws, in accordance with section 19(1)(t) of the HPA. These bylaws have been drafted for review and approval (see Appendix 1).

In determining the composition of the Application Committee, College staff and legal counsel reviewed the composition of similar existing committees. It was decided that the Application Committee should closely mirror the Registration Committee, since the duties and powers of both of these committees are quite similar. Also, the Application Committee's composition should be similar to the other committees named in the HPA (i.e., Registration Committee, Quality Assurance Committee, Inquiry Committee and Discipline Committee). All of these committees have the following composition:

- Consisting of at least 6 persons appointed by the board.
- At least 1/3 of the committee must consist of public representatives, at least one of whom must be an appointed board member.

The proposed HPA bylaws outlines that the Application Committee's composition will be the same as that noted above for the other similar existing committees. Also, the draft bylaws allows the Application Committee to meet in panels. Meeting in panels allows for flexibility in having a smaller group of committee members (3-5) meet rather than always requiring all members of the committee to meet for every meeting. It is cost effective, efficient and is not as

onerous especially during such times when the volume of applications to review is high. Lastly, all general provisions regarding committees in the existing bylaws will also apply to the Application Committee.

Next Steps

If approved by the Board, the proposed HPA bylaws will be publicly posted for a 90 day public posting period on the College's website. After the 90 day public posting period, College staff will review comments received and finalize the bylaws for filing. It is expected that the final bylaws and draft terms of reference for the Application Committee will be brought forward for the Board's consideration at their April 2017 meeting.

Recommendation

The Board approve the proposed amendments to the HPA bylaws that establish the Application Committee, for a 90 day public posting period.

Appendix	
1	Proposed HPA bylaws Application Committee

Health Professions Act – BYLAWS

Table of Contents

11. Application for Reinstatement
12. Order to Attend a Discipline Committee Hearing
13. Application for Certification – Drug Administration

Definitions

1. In these bylaws:

"*Act*" means the *Health Professions Act*;

"appointed board member" means

(a) a person appointed to the board under section 17(3)(b) of the *Act,* or

(b) prior to the first election referred to in section 17(2)(a) of the *Act*, a person appointed under section 17(2)(a) of the *Act* to represent the public on the first board;

"ballot" means an electronic ballot;

"board" means the board of the college;

"board member" means an appointed board member or an elected board member;

"chair" means the chair of the board elected under section 12;

"child-resistant package" means a package that complies with the requirements of the Canadian Standards Association Standard CAN/CSA-Z76.1-06, published in 2006 as amended from time to time;

"controlled drug substance" means a drug which includes a controlled substance listed in Schedule I, II, III, IV or V of the *Controlled Drugs and Substances Act* (Canada);

"college" means the College of Pharmacists of British Columbia continued under section 15.1(4) of the *Act*;

"deliver" with reference to a notice or other document, includes mail by post or electronically to, or leave with a person, or deposit in a person's mailbox or receptacle at the person's residence or place of business;

"director" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"dispense" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act;*

"drug" has the same meaning as in section 1 of the *Pharmacy*

Operations and Drug Scheduling Act;

"elected board member" means a full pharmacist board member or a pharmacy technician board member;

"examination" means an examination, given orally or in writing, or a practical examination, or any combination of these, and includes a supplemental examination;

"full pharmacist" means a member of the college who is registered in the class of registrants established in section 41(a);

"full pharmacist board member" means

(a) a full pharmacist elected to the board under section 17(3)(a) of the *Act* or appointed to the board under section 10, or

(b) prior to the first election referred to in section 17(2)(a) of the *Act*, a person appointed under section 17(2)(a) of the *Act* to represent the health profession on the first board;

"hospital" has the same meaning as in section 1 of the *Hospital Act*;

"in good standing" in respect of a registrant means

(a) the registration of the registrant is not suspended under the *Act*, and

(b) no limits or conditions are imposed on the registrant's practice of pharmacy under section 20(2.1), 20(3), 32.2, 32.3, 33, 35, 36, 37.1, 38, 39, or 39.1 of the *Act*;

"limited pharmacist" means a member of the college who is registered in the class of registrants established in section 41(b);

"manager" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"medication" has the same meaning as "drug";

"non-practising pharmacist" means a member of the college who is registered in the class of registrants established in section 41(f);

"owner" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"personal information" means "personal information" as defined in Schedule 1 of the *Freedom of Information and Protection of Privacy Act*;

"pharmacy assistant" has the same meaning as "support person" in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"pharmacy services" means the services a registrant is authorized under the *Act* to provide;

"pharmacy technician" means a member of the college who is

registered in the class of registrants established in section 41(e);

"pharmacy technician board member" means a pharmacy technician elected to the board under section 17(3)(a) of the *Act* or appointed to the board under section 10;

"practising pharmacist" means a full pharmacist, limited pharmacist, temporary pharmacist or student pharmacist;

"practitioner" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"prescription" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"public representative" means a person who

(a) is not a registrant or former registrant, and

(b) has no close family or business relationship with a registrant or former registrant,

and includes an appointed board member;

"quality assurance assessor" means an assessor appointed under section 26.1(4) of the *Act*;

"record" means a "record" as defined in Schedule 1 of the *Freedom of Information and Protection of Privacy Act*;

"Regulation" means the Pharmacists Regulation, B.C. Reg. 417/2008;

"student pharmacist" means a member of the college who is registered in the class of registrants established in section 41(d);

"temporary pharmacist" means a member of the college who is registered in the class of registrants established in section 41(c);

"vice-chair" means the vice-chair of the board elected under section 12 of the *Act*.

PART I – College Board, Committees and Panels

Composition of Board

2. The board consists of

(a) 7 full pharmacist board members,

(b) 1 pharmacy technician board member, and

(c) the appointed board members.

Composition of the Board – Transitional

2.1 Despite section 2, until the start of the November 2010 board meeting, the board consists of

(a) 7 full pharmacist board members, and

(b) the appointed board members

Electoral Districts

3. (1) For the purpose of elections of full pharmacist board members under section 17(3)(a) of the *Act*, electoral districts are established as follows:

(a) the province of British Columbia is divided into 7 electoral districts, the boundaries of which are set out in Schedule "B";

(b) the number of full pharmacist board members elected from each electoral district is 1;

(c) electoral district boundaries described in paragraph (a) may be changed only by special resolution amending Schedule "B";

(d) a full pharmacist who has only 1 place of practice which is not a hospital must be assigned to an electoral district from among Districts 1 to 5, according to the location of the full pharmacist's place of practice;

(e) a full pharmacist who has only 1 place of practice which is a hospital must be assigned to District 6 or 7, according to the location of the hospital;

(f) a full pharmacist who practices in more than 1 electoral district must be assigned to the electoral district in which the full pharmacist's primary place of practice is located;

(g) a full pharmacist who does not practice must be assigned to the electoral district within which he or she resides.

(2) For the purpose of election of pharmacy technician board members under section 17(3)(a) of the *Act*, the electoral district is the province of British Columbia.

Notice of Election

4. (1) An election under section 17(3)(a) of the *Act* must be held in each calendar year, by electronic means approved by the registrar, at a date determined by the registrar that is at least 21 days prior to the date of the November board meeting in that year.

(2) The registrar must deliver a notice of election in Form 1 to every full pharmacist and pharmacy technician assigned to the electoral districts which are to elect board members in the election, at least 60 days prior to the election date.

(3) The accidental omission to deliver notice of an election to, or the non-receipt of such a notice, by any person entitled to receive notice does not invalidate the election, any proceedings in relation thereto, or the results thereof.

Eligibility and Nominations

5. (1) To be eligible for election to the board under section 17(3)(a) of the *Act*, a registrant must be

(a) a full pharmacist or pharmacy technician,

(b) in good standing, and

(c) assigned to the electoral district in which he or she is nominated.

(2) A full pharmacist or pharmacy technician is not eligible to be elected to the board if he or she is employed by the college or is engaged in a contract or assignment providing goods or services to the college.

(3) A nomination for a full pharmacist board member must be endorsed by 3 full pharmacists who are in good standing and are assigned to the electoral district in which the nominee is standing for election.

(4) A nomination for a pharmacy technician board member must be endorsed by 3 pharmacy technicians who are in good standing.

(5) A nomination must be delivered to the registrar at least 45 days prior to the election date.

(6) A nomination must be in Form 2.

Election Procedure

6. (1) If there is only 1 nominee for a vacant position at the close of nominations, the nominee for that position is elected by acclamation.

(2) Only full pharmacists and pharmacy technicians, who are in good standing, are eligible to vote in an election under section 17(3)(a) of the *Act.*

(3) A full pharmacist or pharmacy technician eligible to vote under subsection (2) is eligible to vote only in the electoral district to which he or she is assigned for an election.

(4) The registrar must deliver to each full pharmacist and pharmacy technician who is eligible to vote the instructions for voting electronically in the election at least 30 days prior to the election date.

(5) Each full pharmacist and pharmacy technician who is eligible to vote is entitled to 1 ballot and may vote in favour of 1 candidate for the

vacant position.

(6) A ballot does not count unless it is cast no later than 5:00 p.m. Pacific Time on the election date.

(7) The candidate for a vacant position receiving the most votes on the return of the ballots is elected.

(8) In the case of a tie vote, the registrar must select the successful candidate by random draw.

(9) In the event that there are no nominees for a vacant position, the board may fill the vacant position in accordance with section 10.

(10) The registrar must supervise and administer all elections under section 17(3)(a) of the *Act* and may establish additional procedures consistent with these bylaws for that purpose.

(11) The registrar may determine any dispute or irregularity with respect to any nomination, ballot or election.

(12) The registrar must use Form 3 to certify newly elected members of the board under section 17.1(1) of the *Act*.

(13) If there is an interruption of electronic service during the nomination period or election, the registrar may extend the deadline for delivery of nominations or casting of ballots for such period of time as the registrar considers necessary in the circumstances.

Terms of Office

7. (1) The term of office for an elected board member is 2 years, commencing at the start of the November board meeting following that board member's election.

(2) An elected board member may serve a maximum of 3 consecutive terms.

(3) The terms of office of the elected board members from odd-numbered electoral districts must commence and end in odd-numbered years, and the terms of office of elected board members from even-numbered electoral districts must commence and end in even-numbered years.

(4) Subsections (1) to (3) do not apply prior to the first election referred to in section 17(2)(a) of the *Act*.

Ceasing to Hold Office as a Board Member

8. (1) An elected board member ceases to hold office if he or she

(a) ceases to be a full pharmacist or pharmacy technician, in good

standing,

(b) submits a written resignation to the chair,

(c) becomes an employee of the college or engaged in a contract or assignment providing goods or services to the college,

(d) is removed by a special resolution of the board, if notice of the proposal to remove the elected board member has been included with the notice of the board meeting, or

(e) is absent from 3 or more consecutive board meetings for reasons which the board finds unacceptable.

(2) Subsection (1) does not apply prior to the first election referred to in section 17(2)(a) of the *Act*.

First Election and Terms of Office

9. Despite section 7(1) and (3), the term of office for the first elected full pharmacist board members from Districts 2, 4 and 6 is 1 year, commencing at the start of the November 2009 board meeting.

Vacancy

10. (1) In the event of a vacancy in an elected board member position, the board may, by special resolution, appoint a full pharmacist or pharmacy technician, as applicable, eligible under section 5 for election to fill the position until the next election.

(2) Subsection (1) does not apply prior to the first election referred to in section 17(2)(a) of the *Act*.

Remuneration of Board and Committee Members

11. All board members and committee members are equally entitled to be

(a) remunerated for time spent on business of the college in the amount approved by the board from time to time, and

(b) reimbursed by the college for reasonable expenses necessarily incurred in connection with the business of the college.

Chair and Vice-Chair

12. (1) The chair must

(a) preside at all board meetings,

(b) sign certificates, diplomas and other instruments executed on behalf of the college as required, and

(c) act in accordance with the requirements of his or her office for the proper carrying out of the duties of the board.

(2) At the November board meeting in each calendar year, the board members must elect a chair by a majority vote in accordance with the following procedure:

(a) the acting chair for the meeting must call for nominations;

(b) if there is only 1 nominee, he or she is elected by acclamation;

(c) if there is more than 1 nominee, an election must be held by secret ballot, and the person with the most votes is elected;

(d) if there is a tie vote, there must be a second vote immediately following the first vote;

(e) if there is a second tie vote, the new chair must be selected by random draw.

(3) The chair's term of office as chair is 1 year, commencing at the election of the vice-chair under subsection (4), and ending at the start of the November board meeting in the next calendar year.

(4) Immediately following the election of the chair under subsection (2), the board members must elect a vice-chair by a majority vote in accordance with the procedure set out in subsection (2).

(5) The vice-chair's term of office as vice-chair is 1 year, commencing at his or her election under subsection (4), and ending at the start of the November board meeting in the next calendar year.

(6) The vice-chair must perform the duties of the chair in the chair's absence.

(7) In the absence of both the chair and the vice-chair, an acting chair for a board meeting must be elected by a majority vote of the board members present.

(8) Despite subsections (2) to (5), the board members must elect a chair and vice-chair in accordance with the procedure set out in subsection (2), each to serve a term ending at the start of the November 2009 board meeting.

Board Meetings

13. (1) The board must meet at least 4 times in each calendar year, including one meeting in November, and must provide reasonable notice of board meetings to board members, registrants and the public.

(2) The accidental omission to deliver notice of a board meeting to, or the non-receipt of a notice by, any person entitled to receive notice does not invalidate proceedings at that meeting.

(3) Despite subsection (1), the chair or registrar may call a meeting of the board without providing notice to registrants or the public if necessary

to conduct urgent business.

(4) The registrar must call a board meeting at the request of the chair or any 3 board members.

(5) The registrar must provide the following to members of the public on request:

(a) details of the time and place of a board meeting;

(b) a copy of the agenda;

(c) a copy of the minutes of any preceding board meeting.

(6) Subject to subsection (7), board meetings must be open to registrants and the public.

(7) The board may exclude any person from any part of a board meeting if it is satisfied that

(a) financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public,

(b) a person involved in a criminal proceeding or civil suit or proceeding may be prejudiced,

(c) personnel matters or property acquisitions will be discussed,

(d) the contents of examinations will be discussed,

(e) communications with the Office of the Ombudsman will be discussed, or

(f) instructions will be given to or opinions received from legal counsel for the college, the board, or a committee.

(8) If the board excludes any person from a part of a board meeting, it must have its reasons for doing so noted in the minutes of the meeting.

(9) The registrar must ensure that minutes are taken at each board meeting and retained on file, and must publish them on the college website.

(10) A majority of the total number of board members constitutes a quorum.

(11) The chair is entitled to vote on all motions, and is also entitled to speak in debate, but not in preference to other board members.

(12) A written resolution signed by all board members is valid and binding

and of the same effect as if such resolution had been duly passed at a board meeting.

(13) In case of an equality of votes the chair does not have a casting or second vote in addition to the vote to which he or she is entitled as a board member and the proposed resolution does not pass.

(14) The board may meet and conduct business using video-conferencing or tele-conference connections or by other electronic means when some or all of the board members are unable to meet in person.

(15) Except as otherwise provided in the *Act*, the regulations, or these bylaws, the most recent edition of Robert's Rules of Order governs the procedures at meetings of the board.

Registration Committee

14. (1) The registration committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the registration committee must consist of public representatives, at least one of whom must be an appointed board member.

Inquiry Committee

15. (1) The inquiry committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the inquiry committee must consist of public representatives, at least one of whom must be an appointed board member.

Practice Review Committee

15.1 (1) The practice review committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the practice review committee must consist of public representatives, at least one of whom must be an appointed board member.

(3) The practice review committee is responsible for monitoring standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants.

(4) The practice review committee may receive reports made to the registrar, inquiry committee or discipline committee in respect of

(a) matters specified in section 17(1) of the *Pharmacy Operations and Drug Scheduling Act,* including without limitation reports under section 18 of that Act, and

(b) matters specified in section 28(1) of the *Health Professions Act*, including without limitation reports under section 28(3) of that Act.

(5) Upon receipt of a report described in subsection (4), the practice review committee may

(a) review the report, and

(b) as it considers appropriate in the circumstances, refer a matter arising from that review to the inquiry committee, quality assurance committee or registrar.

Application Committee

15.2 (1) The application committee within the meaning of section 1 of the *Pharmacy Operations and Drug Scheduling Act [SBC 2003] c.77 is established consisting of at least 6 persons appointed by the board.*

(2) At least 1/3 of the application committee must consist of public representatives, at least one of whom must be an appointed board member.

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Discipline Committee

16. (1) The discipline committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the discipline committee must consist of public representatives, at least one of whom must be an appointed board member.

Quality Assurance Committee

17. (1) The quality assurance committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the quality assurance committee must consist of public representatives, at least one of whom must be an appointed board member.

Drug Administration Committee

18. (1) The drug administration committee is established consisting of at least 4 and no more than 7 persons appointed by the board.

(2) The committee must include

(a) one full pharmacist,

(b) one medical practitioner confirmed by the College of Physicians and Surgeons of British Columbia as suitable for membership

on the committee,

(c) one registered nurse confirmed by the College of Registered Nurses of British Columbia as suitable for membership on the committee, and

(d) one person nominated by the Ministry of Health Services.

(3) The drug administration committee

(a) must review, develop and recommend to the board standards, limits and conditions respecting the performance by practising pharmacists of restricted activities under section 4(1) (c.1) of the Regulation for the purposes of preventing diseases, disorders and conditions, and

(b) may

(i) review the role of practising pharmacists in regard to the performance of restricted activities under section 4(1) (c.1) of the Regulation, and

(ii) make recommendations to the board, for submission to the Ministry of Health Services, respecting the standards, limits and conditions for practice and any other requirements it considers necessary or appropriate to support the performance by practising pharmacists of restricted activities under section 4(1) (c.1) of the Regulation for the purposes of treating diseases, disorders and conditions.

(4) The committee may consult, as it considers necessary or appropriate, with registrants or other individuals who have expertise relevant to drug administration or on any other matter considered by the committee.

Committees

19. (1) A person appointed to a committee established under these bylaws

(a) serves for a term determined by the board not exceeding 2 years, and

(b) is eligible for reappointment but may not serve more than 3 consecutive terms.

(2) A committee member may be removed by a majority vote of the board.

(3) The board must appoint a committee chair and a committee vice-chair from among the members of the committee.

(4) Each committee must submit a report of its activities to the board

annually or as required by the board.

(5) The registrar is an ex officio non-voting member of the committees established under these bylaws.

(6) The chair is a non-voting ex-officio member of all committees, except in respect of a committee to which he or she has been appointed under these bylaws, in which case he or she has the right to vote.

Committee Panels

20. (1) The registration committee, inquiry committee, practice review committee, application committee, discipline committee and quality assurance committee may meet in panels of at least 3 but not more than 5 persons, and each panel must include at least 1/3 public representatives.

(2) The chair of a committee referred to in subsection (1) must appoint the members of a panel and must designate a chair of the panel.

(3) A panel of a committee referred to in subsection (1) may exercise any power or perform any duty of that committee.

Meetings of a Committee or Panel

21. (1) A majority of a committee constitutes a quorum.

(2) All members of a panel constitute a quorum.

PART II – College Administration
Registrar/Deputy Registrar

22. (1) The registrar is authorized to establish, by bylaw, forms for the purposes of the bylaws, and to require the use of such forms by registrants.

(2) If a deputy registrar is appointed by the board,

(a) the deputy registrar is authorized to perform all duties and exercise all powers of the registrar, subject to the direction of the registrar, and

(b) if the registrar is absent or unable to act for any reason, the deputy registrar is authorized to perform all duties and exercise all powers of the registrar.

Seal

23. (1) The board must approve a seal for the college.

(2) The seal of the college must be affixed, by those persons designated by the board, to the documents determined by the board.

Fiscal Year

24. The fiscal year of the college commences on March 1st and ends on the last day of February of the following year.

Banking

25. The board must establish and maintain such accounts with a chartered bank, trust company or credit union as the board determines to be necessary from time to time.

Payments and Commitments

26. The board must approve an operating and capital budget for each fiscal year, and may amend the approved budget from time to time.

Investments

27. The board may invest funds of the college in accordance with the board's investment policy which must be consistent with sections 15.1 and 15.2 of the *Trustee Act.*

Auditor

28. (1) The board must appoint a chartered accountant or a certified general accountant to be the auditor.

(2) The registrar must submit the financial statement to the auditor within 60 days of the end of the fiscal year.

(3) A copy of the auditor's report must be included in the annual report.

Legal Counsel

29. The board or, with the approval of the registrar, a committee or panel, may retain legal counsel for the purpose of assisting the board, a committee or a panel in exercising any power or performing any duty under the *Act*.

General Meetings

30. (1) General meetings of the college must be held in British Columbia at a time and place determined by the board.

(2) The first annual general meeting must be held before October 1, 2010, and after that an annual general meeting must be held at least once in every calendar year and not more than 20 months after the holding of the last preceding annual general meeting.

(3) The following matters must be considered at an annual general meeting:

(a) the financial statements of the college;

(b) the annual report of the board;

(c) the report of the auditor.

(4) Every general meeting, other than an annual general meeting, is an extraordinary general meeting.

(5) The board

(a) may convene an extraordinary general meeting by resolution of the board, and

(b) must convene an extraordinary general meeting within 60 days after receipt by the registrar of a request for such a meeting signed by at least ten percent of all full pharmacists and pharmacy technicians, who are in good standing.

Notice of General Meetings

31. (1) The registrar must deliver notice of an annual or extraordinary general meeting to every board member and registrant at least 21 days prior to the meeting.

(2) Notice of a general meeting must include

(a) the place, day and time of the meeting,

(b) the general nature of the business to be considered at the meeting,

(c) any resolutions proposed by the board, and

(d) any resolutions proposed under section 32 and delivered to the registrar prior to the mailing of the notice.

(3) The accidental omission to deliver notice of a general meeting to, or the non-receipt of a notice by, any person entitled to receive notice does not invalidate proceedings at that meeting.

(4) General meetings must be open to the public.

(5) The registrar must

(a) provide reasonable notice of each general meeting to the public, and

(b) provide to members of the public on request a copy of the notice given under subsection (1) in respect of the meeting.

Resolutions

32. Any 3 full pharmacists or pharmacy technicians, who are in good

standing, may deliver a written notice to the registrar at least 60 days prior to the date of an annual or an extraordinary general meeting requesting the introduction of a resolution.

Voting at a General Meeting

33. (1) A full pharmacist or pharmacy technician present at a general meeting is entitled to 1 vote at the meeting.

(2) In case of an equality of votes the chair of the general meeting does not have a casting or second vote in addition to the vote to which he or she is entitled as a full pharmacist or pharmacy technician, if any, and the proposed resolution does not pass.

(3) Except as these bylaws otherwise provide, the most recent edition of Robert's Rules of Order governs the procedures at an annual or extraordinary general meeting.

(4) A resolution passed at an annual or extraordinary general meeting is not binding on the board.

Proceedings at General Meetings

34. (1) Quorum is 25 registrants consisting of full pharmacists or pharmacy technicians, or both.

(2) No business, other than the adjournment or termination of the meeting, may be conducted at a general meeting at a time when a quorum is not present.

(3) If at any time during a general meeting there ceases to be a quorum present, business then in progress must be suspended until there is a quorum present.

(4) In the case of a general meeting other than an extraordinary general meeting under section 30(5)(b),

(a) if there is no quorum within 30 minutes from the time appointed for the start of the meeting, or

(b) if there is no quorum within 30 minutes from any time when there is no quorum during the meeting,

the meeting must be adjourned to one month later, at the same time and place, and those full pharmacists and pharmacy technicians who attend that later meeting will be deemed to be a quorum for that meeting.

(5) In the case of an extraordinary general meeting under section 30(5)(b),

(a) if there is no quorum within 30 minutes from the time appointed

for the start of the meeting, or

(b) if there is no quorum within 30 minutes from any time when there is no quorum during the meeting,

the meeting must be adjourned and cancelled and no further action may be taken in respect of the request under section 30(5)(b) for that meeting.

(6) In the absence of both the chair and the vice-chair of the board, an acting chair for a general meeting must be elected by a majority vote of the full pharmacists and pharmacy technicians present.

(7) A general meeting may be adjourned from time to time and from place to place, but no business may be transacted at an adjourned meeting other than the business left unfinished at the meeting from which the adjournment took place.

(8) When a meeting is adjourned in accordance with subsection (4) or by resolution, notice of the rescheduled meeting must be delivered in accordance with section 31.

Notice to Public Representatives

35. Every notice or mailing to registrants must also be provided to public representatives serving on the board or a committee.

PART III – College Records
Body Responsible for Administering the *Freedom of Information and Protection of Privacy Act*

36. (1) The registrar is the "head" of the college for the purposes of the *Freedom of Information and Protection of Privacy Act.*

(2) The registrar may authorize the deputy registrar, a person employed by the college or a person who has contracted to perform services for the college to perform any duty or exercise any function of the registrar that arises under the *Freedom of Information and Protection of Privacy Act.*

Fees for Information Requests

37. Subject to section 75 of the *Freedom of Information and Protection of Privacy Act*, an applicant who requests access to a college record under section 5 of the *Freedom of Information and Protection of Privacy Act* must pay the fees set out in the Schedule of Maximum Fees in B.C. Reg. 323/93 for services required to comply with the information request.

Disclosure of Annual Report

38. The registrar must make each annual report under section 18(2) of

the *Act* available electronically and free of charge on the college website, must notify registrants that the report is available, and must provide a paper copy of the report to any person on request upon payment of the fee set out in Schedule "D".

Disclosure of Registration Status

39. (1) If an inquiry about the registration status of a person is received by the board or the registrar, the registrar must disclose, in addition to the matters required by section 22 of the *Act*,

(a) whether the discipline committee has ever made an order relating to the person under section 39 of the *Act* and the details of that order,

(b) whether the person has ever consented to an order under section 37.1 of the *Act* and the details of that order, and

(c) whether the person has ever given an undertaking or consented to a reprimand under section 36 of the *Act* and the details of that undertaking or reprimand.

(2) When acting under subsection (1), the registrar must not release the name of, or information which might enable a person to identify

(a) a patient, or

(b) another person, other than the registrant, affected by the matter,

except with the consent of the patient or the other person.

Manner of Disposal of College Records Containing Personal Information

40. The board must ensure that a college record containing personal information is disposed of only by

(a) effectively destroying a physical record by utilizing a shredder or by complete burning,

(b) erasing information recorded or stored by electronic methods on tapes, disks or cassettes in a manner that ensures that the information cannot be reconstructed,

(c) returning the record to the person the information pertains to, or

(d) returning the record to the registrant who compiled the information.

PART IV – Registration
Classes of Registrants

41. The following classes of registrants are established:

(a) full pharmacist;

(b) limited pharmacist;

(c) temporary registrant;

(d) student pharmacist;

(e) pharmacy technician;

(f) non-practising registrant.

Full Pharmacist Registration

42. (1) For the purposes of section 20(2) of the *Act*, the requirements for full pharmacist registration are

(a) graduation with a degree or equivalent qualification from a pharmacy education program recognized by the board for the purpose of full pharmacist registration and specified in Schedule "C",

(b) successful completion of the jurisprudence examination required by the registration committee,

(c) successful completion of an English language proficiency examination acceptable to the registration committee, if the person has not graduated from a pharmacy education program in Canada or the United States accredited by the Canadian Council for Accreditation of Pharmacy Programs or the Accreditation Council for Pharmacy Education,

(d) successful completion of the structured practical training required by the registration committee, if any,

(e) successful completion of the Pharmacy Examining Board of Canada Evaluating Examination, if the person has not graduated from a pharmacy education program in Canada or the United States accredited by the Canadian Council for Accreditation of Pharmacy Programs or the Accreditation Council for Pharmacy Education,

(f) successful completion of the Pharmacy Examining Board of Canada Qualifying Examination - Part I and Part II,

(g) evidence satisfactory to the registration committee that the person is of good character and fit to engage in the practice of pharmacy, and

(h) receipt by the registrar of

(i) a signed application for full pharmacist registration in

Form 4,

(ii) the application fee specified in Schedule “D”,

(iii) a notarized copy, or other evidence satisfactory to the registration committee, of the person’s degree or equivalent qualification, and that he or she is the person named therein,

(iv) a statutory declaration in Form 5,

(v) if applicable, the fee for the jurisprudence examination specified in Schedule “D”,

(vi) a criminal record check authorization in the form required by the *Criminal Records Review Act*,

(vii) if the person has engaged in the practice of pharmacy or another health profession in another jurisdiction, an authorization for a criminal record check in that jurisdiction,

(viii) a letter or certificate, in a form satisfactory to the registration committee and dated within three months prior to the date of the application, of the person’s good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to engage in the practice of pharmacy or another health profession,

(ix) a certified passport size photograph of the person taken within one year prior to the date of application,

(x) a notarized copy, or other evidence satisfactory to the registration committee, of the person’s Canadian citizenship or authorization to work in Canada, and

(xi) proof of professional liability insurance as required under section 81.

(1.1) If an applicant for registration does not complete the requirements for full registration in subsection (1) within 12 months from the date of application, the applicant must provide

(a) a letter or certificate, in a form satisfactory to the registration committee and dated within three months prior to the date of full registration, of the person’s good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to engage in the practice of pharmacy or another health profession, and

(b) a notarized copy, or other evidence satisfactory to the

registration committee, of the person's Canadian citizenship or authorization to work in Canada.

(2) Despite subsection (1), the person may be granted full pharmacist registration if he or she

(a) is registered in another Canadian jurisdiction as the equivalent of a full pharmacist and has provided notarized evidence, or other evidence satisfactory to the registration committee, of such registration and that he or she is the person named therein, and

(b) meets the requirements established in subsection (1)(g) and (h)(i) to (iv) and (vi) to (xi).

(3) Despite subsection (1), the registration committee has discretion, in satisfying itself under section 20 of the *Act* that the person meets the conditions or requirements for registration as a full pharmacist member of the college, to consider whether the person's knowledge, skills and abilities are substantially equivalent to the standards of academic or technical achievement and the competencies or other qualifications established in subsection (1)(a), and to grant full pharmacist registration on that basis, if the person also meets the requirements established in subsection (1)(b) to (h).

(4) A full pharmacist may use only the abbreviation "R.Ph.".

(5) A full pharmacist must not

(a) delegate any aspect of practice to a pharmacy technician, or

(b) authorize a pharmacy technician to perform or provide any aspect of practice under supervision.

Certification of Practising Pharmacists for Drug Administration

43. (1) A practising pharmacist may apply to the registrar under this section for certification that the practising pharmacist is qualified and competent to perform a restricted activity under section 4(1) (c.1) of the Regulation.

(2) The registrar must grant certification under this section if the practising pharmacist has

(a) provided evidence satisfactory to the registrar that the practising pharmacist has

(i) successfully completed within the year prior to application an education program in drug administration, approved by the board for the purposes of section 4.1(c) of the Regulation and specified in Schedule "C",

(ii) a current certificate in cardiopulmonary resuscitation from a program approved by the board and specified in Schedule “C”, and

(iii) a current certificate in first aid from a program approved by the board and specified in Schedule “C”,

(b) submitted a signed application for certification in Form 13, and

(c) paid the fee specified in Schedule “D”.

(3) If certification is granted under this section, the registrar must enter a notation of certification for drug administration in the register in respect of the practising pharmacist.

(4) To maintain certification under this section, a practising pharmacist must declare upon registration renewal

(a) that he or she has successfully completed a continuing education program in drug administration approved by the board and specified in Schedule “C” if an injection has not been administered in the preceding three years, and

(b) that he or she has successfully completed a continuing education program in administering a drug by intranasal route approved by the board and specified in Schedule “C” if a drug has not been administered by intranasal route in the preceding three years, and

(c) maintain current certification in cardiopulmonary resuscitation from a program approved by the board and specified in Schedule “C”, and

(d) maintain current certification in first aid from a program approved by the board and specified in Schedule “C”.

(5) The registrar must remove a practising pharmacist’s notation of certification from the register if the practising pharmacist fails to meet any of the requirements in subsection (4), and the practising pharmacist must not again perform a restricted activity under section 4(1) (c.1) of the Regulation until

(a) the requirements in subsection (4) are met to the satisfaction of the registrar, and

(b) the registrar has re-entered a notation of certification for drug administration in the register in respect of the practising pharmacist.

Intranasal Drug Administration

43.1 A practising pharmacist who has been certified under section 43(1) must complete the program specified in Schedule C on intranasal

drug administration prior to administering an intranasal drug.

Limited Pharmacist Registration

44. (1) An applicant under section 42 or 52 may be granted limited pharmacist registration for a period of up to one year if

(a) the applicant

(i) does not meet the requirements established in section 42(1)(b)(c)(e) and (f) or (3), or section 52(2)(a) and (c), as applicable,

(ii) meets the requirements established in section 42(1)(d), or section 52(2)(b), as applicable, and

(iii) is capable, in the opinion of the registration committee, of practising as a limited pharmacist without any risk to public health and safety, or

(b) the applicant

(i) meets the requirements established in section 42(1)(b)(c)(e) and (f) or (3), or section 52(2)(a) and (c), as applicable,

(ii) does not meet the requirements established in section 42(1)(d), or section 52(2)(b), as applicable, and

(iii) is capable, in the opinion of the registration committee, of practising as a limited pharmacist without any risk to public health and safety.

(2) Limited pharmacist registration may be renewed twice, but in any case, the total period of registration in this class must not exceed 3 years.

(3) Full pharmacist registration may be granted to a limited pharmacist who has met all the requirements in section 42(1) or (3), or section 52, as applicable.

(4) A limited pharmacist may provide pharmacy services as if he or she is a full pharmacist, but only under the supervision of a full pharmacist approved by the registration committee for that purpose.

(5) A limited pharmacist must not delegate any aspect of practice.

(6) A limited pharmacist may use only the title “pharmacist (limited)” and must not use any abbreviations.

Temporary Registration

45. (1) Despite sections 42 and 47, a person may be granted temporary pharmacist registration or temporary pharmacy technician

registration, for a period of up to 90 days, if

(a) an emergency has been declared by the registrar in accordance with criteria established by the board,

(b) the person

(i) is registered in another jurisdiction in Canada or the United States as the equivalent of a full pharmacist or a pharmacy technician, and

(ii) has provided notarized evidence, or other evidence satisfactory to the registration committee, of such registration and that the person is the person named therein.

(2) The registration of a temporary pharmacist or temporary pharmacy technician may be renewed once for an additional period of up to 90 days.

(3) A temporary pharmacist may provide services as if he or she is a full pharmacist, and may apply for certification, and be certified, under section 43.

(4) A temporary pharmacy technician may provide services as if he or she is a pharmacy technician,

(5) A temporary pharmacist may use only the title “pharmacist (temporary)” and must not use any abbreviations.

(6) A temporary pharmacy technician may use only the title “pharmacy technician (temporary)” and must not use any abbreviations.

Student Pharmacist Registration

46. (1) A person may be granted student pharmacist registration if the person

(a) is enrolled as a student in a pharmacy education program recognized by the board for the purpose of full pharmacist registration and specified in Schedule ”C”,

(b) provides evidence satisfactory to the registration committee that the person is of good character and fit to engage in the practice of pharmacy, and

(c) has delivered to the registrar

(i) a signed application for registration in Form 6,

(ii) the application fee specified in Schedule “D”,

(iii) a notarized copy, or other evidence satisfactory to the registration committee of the person’s enrolment and

educational standing, and that he or she is the person named therein,

(iv) a statutory declaration in Form 5,

(v) a criminal record check authorization in the form required under the *Criminal Records Review Act*,

(vi) if the person has engaged in the practice of pharmacy or another health profession in another jurisdiction, an authorization for a criminal record check in that jurisdiction,

(vii) a letter or certificate, in a form satisfactory to the registration committee and dated within three months prior to the date of the application, of the person's good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to engage in the practice of pharmacy or another health profession,

(viii) a certified passport size photograph of the person taken within one year prior to the date of application, and

(ix) a notarized copy, or other evidence satisfactory to the registration committee, of the person's Canadian citizenship or authorization to work in Canada.

(2) A person described in subsection (1)(a) must be registered under this section

(a) within 6 months of their enrolment as a student in the pharmacy education program, and

(b) before undertaking a period of structured practical training or providing pharmacy services.

(3) A person who is enrolled as a student in a pharmacy education program that is not recognized by the board for the purpose of registration may be granted student registration if the applicant meets all requirements established in subsection (1)(b) and (c).

(4) A person described in subsection (3) must be registered under this section before undertaking a period of structured practical training, or providing pharmacy services.

(5) A student pharmacist may only provide pharmacy services while under the supervision of a full pharmacist

(5.1) Despite subsection (5), a student pharmacist may only perform a restricted activity under section 4(1)(c.1) of the Regulation while under the supervision of

(a) a full pharmacist who is certified under section 43, or

(b) a person who is

(i) not a member of the college,

(ii) registered as a member of another college established or continued under the Act, and

(iii) authorized under the Act to perform the restricted activity in the course of practising the designated health profession for which the other college is established or continued.

(6) The registration of a student pharmacist may be renewed if he or she

(a) remains enrolled in a pharmacy education program described in subsection 1(a),

(b) applies in writing in a form acceptable to the registration committee,

(c) pays any outstanding fine, fee, debt or levy owed to the college, and

(d) pays the fee specified in Schedule "D".

(7) A student pharmacist must not delegate any aspect of practice.

(8) A student registrant may use only the title "pharmacist (student)" and must not use any abbreviations.

Pharmacy Technician Registration

47. (1) For the purposes of section 20(2) of the *Act,* the requirements for pharmacy technician registration are

(a) graduation with a diploma or certificate from a pharmacy technician education program recognized by the board for the purpose of pharmacy technician registration and specified in Schedule "C",

(b) successful completion of the jurisprudence examination required by the registration committee,

(c) successful completion of an English language proficiency examination acceptable to the registration committee, if the person has not graduated from a pharmacy technician education program in Canada accredited by the Canadian Council for Accreditation of Pharmacy Programs.

(d) successful completion of the structured practical training required by the registration committee, if any,

(e) successful completion of the Pharmacy Examining Board of

Canada Evaluating Examination, if the person has not graduated from a pharmacy technician education program in Canada accredited by the Canadian Council for Accreditation of Pharmacy Programs.

(f) successful completion of the Pharmacy Examining Board of Canada Pharmacy Technician Qualifying Examination – Part I and Part II,

(g) evidence satisfactory to the registration committee that the person is of good character and fit to engage in practice as a pharmacy technician, and

(h) receipt by the registrar of

(i) a signed application for registration in Form 7,

(ii) the application fee specified in Schedule "D",

(iii) a notarized copy, or other evidence satisfactory to the registration committee, of the person's diploma, certificate or equivalent qualification, and that he or she is the person named therein,

(iv) a statutory declaration in Form 5,

(v) if applicable, the fee for the jurisprudence examination specified in Schedule "D",

(vi) a criminal record check authorization in the form required by the *Criminal Records Review Act*,

(vii) if the person has practised as a pharmacy technician or in another health profession in another jurisdiction, an authorization for a criminal record check in that jurisdiction,

(viii) a letter or certificate, in a form satisfactory to the registration committee and dated within three months prior to the date of the application, of the person's good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to practise as a pharmacy technician or in another health profession,

(ix) a certified passport size photograph of the person taken within one year prior to the date of application,

(x) a notarized copy, or other evidence satisfactory to the registration committee, of the person's Canadian citizenship or authorization to work in Canada, and

(xi) proof of professional liability insurance as required under

section 81.

(1.1) If an applicant for registration does not complete the requirements for full registration in subsection (1) within 12 months from the date of application, the applicant must provide

(a) a letter or certificate, in a form satisfactory to the registration committee and dated within three months prior to the date of full registration, of the person's good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to engage in the practice of pharmacy or another health profession, and

(b) a notarized copy, or other evidence satisfactory to the registration committee, of the person's Canadian citizenship or authorization to work in Canada.

(2) Despite subsection (1), the person may be granted pharmacy technician registration if he or she

(a) is registered in another Canadian jurisdiction as the equivalent of a pharmacy technician and has provided evidence, satisfactory to the registration committee, of such authorization and that he or she is the person named therein, and

(b) meets the requirements established in subsection (1)(g) and (h)(i) to (iv) and (vi) to (xi).

(3) Despite subsection (1), the registration committee has discretion, in satisfying itself under section 20 of the *Act* that the person meets the conditions or requirements for registration as a pharmacy technician member of the college, to consider whether the person's knowledge, skills and abilities are substantially equivalent to the standards of academic or technical achievement and the competencies or other qualifications established in subsection (1)(a), and to grant full pharmacy technician registration on that basis, if the person also meets the requirements established in subsection (1)(b) to (h).

(4) Despite subsection (1), the person may be granted pharmacy technician registration if he or she

(a) applies on or before December 31, 2015,

(b) has worked for at least 2000 hours as the equivalent of a pharmacy assistant in the 3 year period immediately preceding the date of application,

(c) has

(i) successfully completed the Pharmacy Examining Board of Canada Evaluating Examination, or

(ii) been certified as the equivalent of a pharmacy technician in

the Province of Ontario or Province of Alberta prior to January 1, 2009, or in another jurisdiction recognized by the registration committee, or

(iii) successfully completed an accredited pharmacist degree program in Canada or in the continental United States,

(d) has successfully completed the pharmacy technician bridging programs, and

(e) meets the requirements in subsection (1)(b) to (d) and (f) to (h).

(5) A pharmacy technician must not

(a) perform a restricted activity under section 4(1)(a) or (c.1) of the Regulation,

(b) act under section 25.92 of the *Act,* or

(c) be appointed as a pharmacy manager.

(6) A pharmacy technician may use only the title "pharmacy technician" and may use only the abbreviation "R.Ph.T.".

Non-Practising Registration

48. (1) A full pharmacist or pharmacy technician may be granted non-practising registration if the registrar has received

(a) a signed application for non-practising registration in Form 8,

(b) the registration fee specified in Schedule "D",

(c) a statutory declaration in Form 5, and

(d) a criminal record check authorization in the form required under the *Criminal Records Review Act*.

(2) A non-practising registrant must not provide pharmacy services in British Columbia.

(3) A non-practising registrant who was formerly a full pharmacist may use only the title "pharmacist (non-practising)" and must not use any abbreviations.

(4) A non-practising registrant who was formerly a pharmacy technician may use only the title "pharmacy technician (non-practising)" or "technician (non-practising)" and must not use any abbreviations.

Certificate of Registration and Registration Card

49. (1) The registrar must issue a certificate in Form 9 to a person who is granted full pharmacist or pharmacy technician registration.

(2) A registration card must be issued to a person who is granted

registration, and is valid from the date issued until the date shown on the card.

Examinations

50. (1) An applicant who fails a required examination under this Part, may write the examination again to a maximum of 4 times except where the Pharmacy Examining Board of Canada for its examinations, determines otherwise.

(2) If an invigilator has reason to believe that an applicant has engaged in improper conduct during the course of an examination, the invigilator must make a report to the registration committee, and may recommend that the registration committee take one or more of the following courses of action:

(a) fail the applicant;

(b) pass the applicant;

(c) require the applicant to rewrite the examination;

(d) disqualify the applicant from participating in any examination for a period of time.

(3) After considering a report made under subsection (2), the registration committee may take one or more of the courses of action specified in subsection (2).

(4) An applicant disqualified under subsection 2(d) must be provided with written reasons for disqualification.

Registration Renewal

51. (1) To be eligible for a renewal of registration, a registrant must

(a) provide the registrar with a completed Form 10,

(b) pay the registration renewal fee specified in Schedule “D”,

(c) pay any other outstanding fine, fee, debt or levy owed to the college,

(d) attest that he or she is in compliance with the *Act*, the regulations, and these bylaws, and is in compliance with any limits or conditions imposed on his or her practice under the *Act*,

(e) meet all applicable requirements of the quality assurance program under Part V,

(f) if certified under section 43, meet all applicable requirements of section 43(4),

(g) provide proof of professional liability insurance as required

under section 81, and

(h) provide an authorization for a criminal record check in the form required under the *Criminal Records Review Act*, if the college does not have a valid authorization on file.

(2) Form 10 must be delivered to each registrant no later than 30 days before the registration renewal date and must describe the consequences of late payment and non-payment of fees.

(3) Each registrant must submit the monies required under subsection (1) and a completed Form 10 to the college on or before the registration expiry date.

(4) On receipt of the monies required under subsection (1) and a completed Form 10, the registrar must issue a receipt stating that the registrant is, subject to his or her compliance with the *Act*, the regulations, and the bylaws, entitled to practice the profession of pharmacy or practise as a pharmacy technician, as applicable, in the Province of British Columbia as a member of the college.

(5) If a registrant fails to submit the monies required under subsection (1) and a completed Form 10 on or before the registration expiry date, he or she ceases to be registered.

(6) In this section, ”registrant” does not include a student pharmacist.

Reinstatement

52. (1) The registration of a former registrant or a non-practising registrant, whose registration is not suspended or cancelled under the *Act* and who has been out of practice for more than 90 days but less than 6 years must, subject to sections 20 and 39 of the *Act*, be reinstated by the registration committee if the former registrant or non-practising registrant

(a) has met all the applicable requirements of the quality assurance program approved by the board, and

(b) has delivered to the registrar

(i) a signed application for reinstatement in Form 11,

(ii) a statutory declaration in Form 5,

(iii) an authorization for a criminal record check in the form required by the *Criminal Records Review Act*, and

(iv) the registration reinstatement fee and transfer fee, if applicable, specified in Schedule “D”.

(2) The registration of a former registrant or a non-practising registrant, whose registration is not suspended or cancelled under the *Act* and

who has been out of practice for 6 years or more must, subject to sections 20 and 39 of the *Act*, be reinstated by the registration committee if the former registrant or non-practising registrant

(a) successfully completes the jurisprudence examination required by the registration committee,

(b) successfully completes the structured practical training required by the registration committee,

(c) successfully completes the Pharmacy Examining Board of Canada Qualifying Examination - Part II, and

(d) has delivered to the registrar

(i) a signed application for reinstatement in Form 11,

(ii) a statutory declaration in Form 5,

(iii) an authorization for a criminal record check in the form required by the *Criminal Records Review Act*, and

(iv) the registration reinstatement and transfer fee, if applicable specified in Schedule "D".

Reinstatement Following Late Registration Renewal

53. The registration of a former registrant who ceased to be registered under section 51(5) must, subject to sections 20 and 39 of the *Act*, be reinstated by the registration committee if the former registrant

(a) applies for reinstatement in Form 11 not later than 90 days following the expiry of his or her registration,

(b) meets the requirements of section 52(1),

(c) is not in contravention of the *Act*, the regulations, or these bylaws, and

(d) pays the registration reinstatement and late registration renewal fees specified in Schedule "D".

Registration Information

54. (1) For the purposes of section 21(2)(f) of the *Act*, the registrar must enter and maintain on the register the most recent electronic mail address for each registrant.

(2) A registrant must notify the registrar immediately of any change of name, address, telephone number, electronic mail address, names and addresses of the pharmacies where the registrant provides pharmacy services, or any other registration information previously provided to the registrar.

PART V – Quality Assurance

Quality Assurance Program

55. (1) In this Part, **"program"** means the quality assurance program established by the board in accordance with this section.

(2) The program consists of the following:

(a) continuing professional development;

(b) assessment of professional performance.

Continuing Professional Development

56. (1) Each full pharmacist and pharmacy technician must complete learning activities for the purpose of continuing professional development, in accordance with the policy approved by the board.

(2) Each full pharmacist and pharmacy technician must

(a) keep records in a form satisfactory to the quality assurance committee of the learning activities that the full pharmacist or pharmacy technician undertakes for the purpose of meeting the requirement established in subsection (1), and

(b) provide, on the request of and in accordance with the direction of the quality assurance committee, copies of the records referred to in paragraph (a).

(3) The quality assurance committee may conduct a review of the records provided under subsection 2(b).

Assessment of Professional Performance

56.1 (1) The quality assurance committee may require a full pharmacist or pharmacy technician to undergo an assessment of professional performance

(a) upon referral from the practice review committee under section 15.1(5), or

(b) if the quality assurance committee determines an assessment is appropriate in the circumstances upon a review of records conducted under section 56(3).

(2) For the purpose of an assessment under subsection (1) the quality assurance committee or an assessor appointed by the quality assurance committee may do one or more of the following:

(a) conduct an interview of the full pharmacist or pharmacy technician;

(b) assess the practice competency of the full pharmacist or pharmacy technician;

(c) require the full pharmacist or pharmacy technician to undergo any other type of assessment determined by the quality assurance committee to be appropriate in the circumstances.

PART VI – Inquiries and Discipline
Consent Orders

57. The record of an undertaking or consent given under section 36 of the *Act*, a consent order under section 37.1 of the *Act*, or an agreement under section 32.2(4)(b) or 32.3(3)(b) of the *Act*, must

(a) include any consent to a reprimand or to any other action made by the registrant under section 32.2(4)(b), 32.3(3)(b), 36 or 37.1 of the *Act*,

(b) include any undertaking made by the registrant under section 36 of the *Act*,

(c) specify the length of time that an undertaking specified in paragraph (b) is binding on the registrant,

(d) specify the procedure that the registrant may follow to be released from an undertaking specified in paragraph (b), and

(e) subject to sections 22 and 39.3 of the *Act* and sections 39(1) and 60(1), specify which limits or conditions of the undertaking, consent order or agreement may be published, disclosed to the public, or both.

Notice of Disciplinary Committee Action Under Section 39.1 of *Act*

57.1 The discipline committee must deliver notice to a registrant not fewer than 14 days before making an order under section 39.1 of the *Act* in respect of the registrant.

Citation for Disciplinary Hearing

58. (1) On the direction of a panel of the discipline committee, the registrar may join one or more complaints or other matters which are to be the subject of a discipline hearing in one citation as appropriate in the circumstances.

(2) On the direction of a panel of the discipline committee, the registrar may sever one or more complaints or other matters which are to be the subject of a discipline hearing as appropriate in the circumstances.

(3) On the direction of a panel of the discipline committee, the registrar may amend a citation issued under section 37 of the *Act*.

(4) If a citation is amended under subsection (3) prior to a discipline hearing, the amended citation must be delivered to the respondent by personal service or sent by registered mail to the respondent at the

last address for the respondent recorded in the register not fewer than 14 days before the date of the hearing.

(5) If a citation is amended under subsection (3) prior to a discipline hearing, and the amended citation changes the date, time or place of the hearing, the registrar must notify any complainant of the amendment not fewer than 14 days before the date of the hearing.

Hearings of Discipline Committee

59. (1) No person may sit on the discipline committee while he or she is a member of the inquiry committee.

(2) No member of the discipline committee may sit on the panel hearing a matter in which he or she:

(a) was involved as a member of the inquiry committee, or

(b) has had any prior involvement.

(3) Information about the date, time and subject matter of the hearing must be provided to any person on request.

(4) The discipline committee must provide notice by registered mail or by personal service to a person who is required to attend a hearing under section 38(6) of the *Act* in Form 12.

(5) All discipline hearings must be recorded and any person may obtain, at his or her expense, a transcript of any part of the hearing which he or she was entitled to attend.

Notice of Disciplinary Decision

60. (1) In addition to any notification required under section 39.3 of the *Act* with respect to any of the actions referred to in section 39.3(1)(a) to (e) of the *Act*, the registrar

(a) must notify all registrants,

(b) must notify the regulatory bodies governing the practice of pharmacy or the services of pharmacy technicians in every other Canadian jurisdiction, and

(c) may notify any other governing body of a health profession inside or outside of Canada.

(2) Notification provided to all registrants under subsection (1)(a)

(a) must include all information included in the public notification under section 39.3 of the *Act*, and

(b) unless otherwise directed by the inquiry committee or the discipline committee, as the case may be, must exclude any information withheld from the public notification under section

39.3(3) or (4) of the *Act*.

(3) Unless otherwise directed by the inquiry committee or the discipline committee, as the case may be, notification provided to other regulatory or governing bodies under subsection (1)(b) or (c) may include information that has been withheld from the public notification under section 39.3(3) or (4) of the *Act*.

Retention of Discipline Committee and Inquiry Committee Records

61. Records of the inquiry committee and discipline committee must be retained permanently.

Registrant Under Suspension

62. (1) If the registration of a registrant is suspended, the registrant must

(a) not engage in the practice of pharmacy or provide the services of a pharmacy technician,

(b) not hold himself or herself out as a registrant,

(c) not hold office in the college,

(d) not be a manager,

(e) not make appointments for patients or prospective patients,

(f) remove the registrant's name and any sign relating to the registrant's practice from any premises where the registrant practiced pharmacy or provided the services of a pharmacy technician and any building in which any such premises are located,

(g) not contact or communicate with patients or prospective patients, except for the following purposes:

(i) to advise a patient or a prospective patient of the fact and duration of the suspension, and

(ii) to advise a patient or prospective patient that another registrant will continue to act or provide services in the suspended registrant's place, or

(iii) to refer a patient or prospective patient to another registrant, who is in good standing.

(h) pay any fee required by the college when due in order to remain a registrant and any other outstanding fine, fee, debt or levy owed to the college, and

(i) immediately surrender his or her registration card to the registrar.

(2) No registrant or former registrant is entitled to any refund of any fine, fee, debt or levy paid to the college solely on the basis that it was paid during or in relation to a period of suspension from practice.

(3) During the period of suspension,

(a) a suspended full pharmacist may permit another full pharmacist in good standing to practice pharmacy, and

(b) a suspended pharmacy technician may permit a full pharmacist or another pharmacy technician, in good standing, to provide pharmacy services,

in the premises where the full pharmacist or pharmacy technician formerly practiced pharmacy or provided pharmacy services, as applicable.

Fines

63. The maximum amount of a fine that may be ordered by the discipline committee under section 39(2)(f) of the *Act* is $100,000.

PART VII –Registrant Records
Definitions

64. In this Part, **"patient's representative"** means

(a) a "committee of the patient" under the *Patient's Property Act*,

(b) the parent or guardian of a patient who is under 19 years of age,

(c) a representative authorized by a representation agreement under the *Representation Agreement Act* to make or help in making decisions on behalf of a patient,

(d) a decision maker or guardian appointed under section 10 of the *Adult Guardianship Act*, or

(e) a temporary substitute decision maker chosen under section 16 of the *Health Care (Consent) and Care Facility (Admission) Act*.

Purpose for which Personal Information may be Collected

65. No registrant may collect personal information regarding a patient without the patient's consent unless

(a) the information relates directly to and is necessary for providing health care services to the patient or for related administrative purposes, or

(b) the collection of that information is expressly authorized by or under an enactment.

Source of Personal Information

66. (1) A registrant must collect personal information about a patient directly from the patient, unless the patient otherwise consents.

(2) Despite subsection (1), a registrant may collect personal information about a patient from another person if he or she has reasonable grounds to believe

(a) that the patient has been made aware of the matters set out in section 67(1) and has authorized collection of the personal information from another person,

(b) that the patient is unable to give his or her authority and the registrant, having made the patient's representative aware of the matters set out in section 67(1), collects the information from the representative or the representative authorizes collection from another person,

(c) that compliance with subsection (1) would:

(i) prejudice the best interests of the patient,

(ii) defeat the purpose or prejudice the use for which the information is collected, or

(iii) prejudice the safety of any person,

(d) that compliance with subsection (1) is not reasonably practicable in the circumstances of the particular case,

(e) that the collection is for the purpose of assembling a family or genetic history of a person and is collected directly from that person,

(f) that the information is publicly available,

(g) that the information:

(i) will not be used in a form in which the patient concerned is identified, or

(ii) will be used for statistical or research purposes and will not be published in a form that could reasonably be expected to identify the patient.

(h) that non-compliance with subsection (1) is necessary if the information is about law enforcement or anything referred to in sections 15(1) or (2) of the *Freedom of Information and Protection of Privacy Act*.

Collection of Personal Information

67. (1) If a registrant collects personal information directly from a patient, or from a patient's representative, the registrant must take such steps as

are, in the circumstances, reasonable to ensure that the patient or patient's representative is aware of

(a) the fact that the personal information is being collected,

(b) the purpose for which the personal information is being collected,

(c) the intended recipients of the personal information,

(d) whether or not the supply of the personal information is voluntary or mandatory and, if mandatory, the legal authority for collecting the personal information,

(e) the consequences, if any, for that patient if all or any part of the requested personal information is not provided, and

(f) the rights of access to personal information provided in section 80.

(2) The steps referred to in subsection (1) must be taken before the personal information is collected or, if that is not practicable, as soon as practicable after the personal information is collected.

(3) A registrant is not required to take the steps referred to in subsection (1) in relation to the collection of personal information from a patient, or the patient's representative, if the registrant has taken those steps in relation to the collection, from the patient or patient's representative, of the same information or information of the same kind for the same or a related purpose, on a recent previous occasion.

(4) Despite subsection (1), a registrant is not required to comply with subsection (1) if the registrant believes on reasonable grounds

(a) that non-compliance is authorized by the patient concerned,

(b) that compliance would:

(i) prejudice the interests of the patient concerned, or

(ii) defeat the purpose or prejudice the use for which the information is collected,

(c) that compliance is not reasonably practicable in the circumstances of the particular case, or

(d) that the information is about law enforcement or anything referred to in sections 15(1) or (2) of the *Freedom of Information and Protection of Privacy Act*.

Manner of Collection of Personal Information

68. Personal information must not be collected by a registrant

(a) by unlawful means, or

(b) by means that in the circumstances intrude to an unreasonable extent upon the personal affairs of the patient concerned.

Accuracy of Personal Information

69. The registrant must make every reasonable effort to ensure that personal information collected about patients is current and is legibly, accurately and completely recorded.

Right to Request Correction of Personal Information

70. (1) A person who believes there is an error or omission in a record containing his or her personal information may request that the registrant having the record in his or her custody or control correct the information.

(2) If, after receiving a request for correction under subsection (1), the registrant disagrees that there is an error or omission in the record, the registrant must note the request in the record with particulars of the correction that was sought.

Use of Personal Information

71. A registrant may use personal information about a patient only

(a) for the purpose of providing health care services to, or performing health, care services for, the patient, or for a related administrative purpose, or

(b) for a use or disclosure consistent with a purpose specified in paragraph (a)

(i) if the patient has consented to the use, or

(ii) for a purpose for which that information may be disclosed by the registrant under section 72 or otherwise under the *Act*.

Disclosure of Personal Information

72. A registrant must maintain confidentiality of personal information about a patient, and may disclose personal information about a patient only

(a) if the patient concerned has consented to the disclosure,

(b) for the purpose of providing health care services to, or performing health care services for, the patient, or for a related administrative purpose, or for a disclosure consistent with either purpose,

(c) for the purpose of complying with an enactment of, or an

arrangement or agreement made under an enactment of, British Columbia or Canada,

(d) for the purpose of complying with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of information,

(e) to an employee of, or contractor providing services to, the registrant, if the information is necessary for the performance of the duties of, or for the protection of the health or safety of, the employee or contractor,

(f) to a lawyer acting for the registrant, for use in civil or criminal proceedings involving the registrant,

(g) if necessary to comply with the *Coroners Act*,

(h) if necessary to comply with the *Ombudsman Act*,

(i) for the purposes of

(i) collecting a debt or fine owing by a patient to the registrant, or

(ii) making a payment owing by the patient to a registrant,

(j) to an auditor, the college or any other person or body authorized by law, for audit purposes,

(k) if the registrant believes on reasonable grounds that there is a risk of significant harm to the health or safety of any person and that the use or disclosure of the information would reduce that risk,

(l) so that the next of kin or a friend of an injured, ill or deceased individual may be contacted,

(m) in accordance with the *Act*, the regulation, or these bylaws, or

(n) as otherwise required by law.

Definition of Consistent Purpose

73. A use or disclosure of personal information is consistent with the purposes of providing health care services to a patient or related administrative purposes under sections 71 and 72 if the use or disclosure has a reasonable and direct connection to either purpose.

Storage of Personal Information

74. A registrant must ensure that all records pertaining to his or her practice, and containing personal information about patients are safely and securely stored

(a) at the pharmacy, or

(b) off site.

Manner of Disposal of Records

75. A registrant must ensure that records referred to in section 74 are disposed of only by

(a) transferring the record to another registrant, or

(b) effectively destroying a physical record by utilizing a shredder or by complete burning, or

(c) erasing information recorded or stored by electronic methods on tapes, disks or cassettes in a manner that ensures that the information cannot be reconstructed.

Registrant Ceasing to Practice

76. (1) Except where records must be retained for the purpose of Part 3 of the *Act* and Part 3 of the *Pharmacy Operations and Drug Scheduling* Act, in any case where a pharmacy is closed or a registrant ceases to practise, for any reason, the records referred to in section 74 must be transferred in accordance with this Part, and the college must be notified and provided with a written summary of the steps taken to transfer those records.

(2) A registrant must make appropriate arrangements to ensure that, in the event that the registrant dies or becomes unable to practise for any reason and is unable to dispose of records referred to in section 74 those records will be safely and securely transferred to another registrant.

(3) A registrant who transfers records containing personal information about a patient transferred in accordance with subsection (1) or (2) must notify the patient.

Protection of Personal Information

77. (1) A registrant must protect personal information about patients by making reasonable security arrangements against such risks as unauthorized access, collection, use, disclosure or disposal.

(2) A registrant must take reasonable measures to ensure that a third party, including a volunteer, employee or contractor of the registrant, or a limited pharmacist does not access, collect, use, disclose, store or dispose of personal information about patients except in accordance with this Part.

Contracts for Handling Personal Information

78. A registrant must ensure that, if personal information about patients is transferred to any person or service organization for processing, storage or disposal, a contract is made with that person which

includes an undertaking by the recipient that confidentiality and physical security will be maintained.

Remedying a Breach of Security

79. A registrant must take appropriate measures to remedy any unauthorized access, use, disclosure or disposal of personal information about patients under this Part as soon as possible after the breach is discovered, including

(a) taking steps to recover the personal information or to ensure its disposal if it cannot be recovered,

(b) taking steps to ensure that any remaining personal information is secured,

(c) notifying

(i) anyone affected by the unauthorized access including patients and other health care providers,

(ii) the college, and

(iii) law enforcement officials, if criminal action may have contributed to the unauthorized action, and

(d) modifying existing security arrangements to prevent a re-occurrence of the unauthorized access.

Patient Access to Personal Information

80. (1) For the purposes of this section, **"**access to" means the opportunity to examine or make copies of the original record containing personal information about a patient.

(2) If a patient or a patient's representative makes a request for access to personal information about the patient, the registrant must comply as soon as practical but not more than 45 days following the request by

(a) providing access to the patient or patient's representative,

(b) providing access to the remainder of the personal information if that information excepted from disclosure under subsection (3) can reasonably be severed, or

(c) providing written reasons for the refusal of access to the personal information or to any portion thereof.

(3) The registrant may refuse to disclose personal information to a patient or a patient's representative

(a) if there is a significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient,

(b) if there is a significant likelihood of harm to a third party, or

(c) if the disclosure could reasonably be expected to disclose personal information regarding another individual.

(4) If a patient or a patient's representative requests a copy of an original record containing personal information about the patient to which a registrant has given the patient or patient's representative access, a copy must be provided if it can reasonably be reproduced.

(5) A registrant may charge a reasonable fee for the reproduction of personal information which does not exceed the fee specified in Schedule "G".

(6) Subject to subsection (3), a patient under 19 years of age may have access to a record if, in the opinion of the registrant, the patient is capable of understanding the subject matter of the record.

(7) Except if authorized by the patient, a registrant must not provide access to the records of a patient who is under 19 years of age to the guardian or parent of the patient if the subject matter of the record is health care which was provided without the consent of a parent or guardian in accordance with the requirements of section 17 of the *Infants Act.*

Part VIII – General
Liability Insurance

81. (1) Each registrant, other than a student registrant or a non-practising registrant, must obtain and at all times maintain professional liability insurance coverage with a limit of liability not less than $2,000,000 insuring against liability arising from an error, omission or negligent act of the registrant.

(2) Each registrant, other than a student registrant or a non-practising registrant, must obtain and at all times maintain professional liability insurance coverage with a limit of liability not less than $2,000,000 insuring against liability arising from an error, omission or negligent act of an employee of the registrant.

Part IX – Marketing and Advertising

Definitions

82. In this Part:

"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;

"marketing" includes

(a) an advertisement,

(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

(c) contact with a prospective client initiated by or under the direction of a registrant.

Marketing and Advertising

83. (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) Schedule I drug price advertising must include

(a) the proprietary (brand) name, if any, for the drug and/or the device,

(b) the drug product’s generic name and the manufacturer’s name,

(c) the dosage form and strength,

(d) total price for a specific number of dosage units or quantity of the drug product, and

(e) the phrase “only available by prescription”.

(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) Any marketing undertaken or authorized by a registrant in respect of his or her professional services must not be

(a) false,

(b) inaccurate,

(c) reasonably expected to mislead the public, or

(d) unverifiable.

(6) Marketing violates subsection (5) if it

(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

(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

(d) 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) The home page of any pharmacy that advertises on a website must clearly show

(a) that the pharmacy is licensed in British Columbia,

(b) the contact information for the college,

(c) a notice to patients that pharmacy practice issues may be reported to the college,

(d) the physical location of the pharmacy operation,

(e) the 10 digit pharmacy telephone number, and

(f) the name of the pharmacy's manager.

Part X – Patient Relations
Patient Relations Program

84. (1) The board must establish a patient relations program to seek to prevent professional misconduct, including professional misconduct of a sexual nature.

(2) For the purposes of the patient relations program, the board must

(a) establish and maintain procedures by which the college deals with complaints of professional misconduct of a sexual nature,

(b) monitor and periodically evaluate the operation of procedures established under subsection (a), and

(c) develop guidelines for the conduct of registrants with their patients.

(3) The registrar must provide information to the public regarding the college's complaint, investigation, and discipline processes.

(4) In this section, "**professional misconduct of a sexual nature**" means

(a) sexual intercourse or other forms of physical sexual relations between the registrant and the patient,

(b) touching of a sexual nature, of the patient by the registrant, or

(c) behavior or remarks of a sexual nature by the registrant towards the patient,

but does not include touching, behavior and remarks by the registrant towards the patient that are of a clinical nature appropriate to the service being provided.

Part XI – Standards of Practice

Community Pharmacy, Hospital Pharmacy, Residential Care Facilities and Homes

85. Standards, limits, and conditions for the practice of the health profession of pharmacy and the provision of pharmacy technician services by registrants, referred to in section 19(1)(k) of the *Act* are established in Parts 1 to 3 of Schedule "F".

Drug Administration

86. Standards, limits, and conditions respecting practising pharmacists and drug administration, referred to in section 19(1)(k) of the *Act*, are established in Part 4 of Schedule "F".

Part XII – Standards of Professional Ethics
Code of Ethics

87. Standards of professional ethics for registrants, including standards for the avoidance of conflicts of interest, referred to in section 19(1)(l) of the *Act,* are established in Schedule "A".

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

10. Legislation Review Committee
c) HPA Standards of Practice: Parts 1, 2 and 3, and new PPP-75

DECISION REQUIRED

Recommended Board Motions:

1) *Approve the following resolution to amend the Health Professions Act Bylaws, Schedule F – Parts 1, 2 and 3 that create minimum standards for registrants regarding the preparation of prescription product, final product check, and patient identification, by approving the following resolution:*

RESOLVED THAT, in accordance with the authority established in section 19(1) of the Health Professions Act, and subject to filing with the Minister as required by section 19(3) of the Health Professions Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

2) Approve Professional Practice Policy #75: Patient Identification to come into force at the same time as the bylaws.

Purpose

To seek approval from the Board for amendments to the *Health Professions Act (HPA)* – Bylaws, Schedule F, Parts 1, 2 and 3, along with a new Professional Practice Policy (PPP). The bylaws were amended in an effort to create minimum standards for activities associated with current day practice, namely preparing prescription products and completing final product checks; in addition to establishing requirements to identify patients and residents in hospital and residential-care settings.

Background

For the purpose of this note, the topics of preparing a prescription product and final product check will be discussed together and patient identification will be discussed separately.

Legislative Authority
Section 16 of the HPA outlines the duty and objects of the College; the foremost duty is to serve and protect the public. Section 16(1)(d) directs the College to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants. Further, section 19(1)(k) of the HPA authorizes the board to make bylaws to establish standards, limits or conditions for the practice of pharmacy by registrants.

Discussion

Preparation of a Prescription Product and Final Product Check
Two primary high-risk activities that are performed by registrants in all practice settings include the preparation of a prescription product and the completion of a final product check. These activities are technical in nature and in most settings they are completed by pharmacy technicians. The scope of practice for technicians is outlined in the College's existing bylaws and they include these two activities along with a list of other activities. However, a gap in the bylaws exist in which there is a lack of requirements regarding what the preparation of a prescription product and the final product check involves.

Furthermore, performing these activities elicits a risk to patient safety as a small error may result in an adverse drug event for a patient. Establishing minimum requirements that must be obliged by registrants during the completion of these two aforementioned activities reduces the risk of errors and thereby reduces the likelihood of drug-related harm for patients. The proposed bylaws outlined below aim to address the legislation gap and more importantly, reduce the risk of patient harm.

The HPA Bylaws, Schedule F, Parts 1, 2 and 3 have been amended to include minimum requirements for all registrants who prepare prescription products and complete final product checks. The minimum requirements create obligations for registrants to ensure the dosage, form, strength, and quantity are correct and align with the prescription/order; in addition to checking the drug is not expired and will not expire within the duration of use. All of these requirements are based on the National Association of Pharmacy Regulatory Authorities' Model Standards of Practice for Canadian Pharmacy Technicians.

Additionally, the amendments include documentation requirements. It is important to note that the documentation requirements reflect alignment and consistency with existing bylaws. For example, the new requirement related to the documented identity of a registrant completing the final check and how it must be readily available and retained for at least three years aligns with section 8(1) of the *Pharmacy Operations and Drug Scheduling Act* (PODSA) – Bylaws. This section requires all prescriptions, patient records, invoices and other documentation related to Schedule I, II, and II drugs be retained for at least three years.

The College will also be developing a resource guide to publish on its website that will support registrants to comply with the new requirements.

Patient Identification

Proper patient identification is integral to patients receiving safe pharmacy services. It is important to ensure the correct patient receives the right drug with the right dosage in addition to a number of other specific 'right' requirements. There is a high risk to patient safety if the wrong drugs are sent to the wrong patient. This risk is alleviated by establishing patient identification requirements for all registrants.

Patient identification requirements exist for scenarios in which there is a face to face interaction between a patient and a registrant. Most of these scenarios involve entering dispensing information into PharmaNet.[1] However, there are no patient identification requirements for scenarios in which a registrant may not have a face to face interaction with their patients. Generally, these latter scenarios are in hospital and residential care settings.

The HPA Bylaws, Schedule F, Parts 2 and 3 have been amended[2] to include a new minimum standard in which registrants are required to use two person-specific identifiers to identify a patient prior to the provision of any pharmacy service. These person-specific identifiers do not require the registrant to have face to face interaction with the patient. The new PPP is titled *Professional Practice Policy #75: Patient Identification* and outlines how registrants may ensure compliance with this new standard. For instance, the PPP lists examples of person-specific identifiers such as, name and personal health number etc., which do not require the patient to provide a piece of identification directly to the registrant.[3]

Consultation

In Spring 2016, these new requirements were presented in the form of two PPP's to the Practice Review Program Hospital Pharmacy Workshop, hospital registrants from all the College committees, the Community Pharmacy Advisory Committee, the Residential Care Advisory committee, and the Practice Review Committee (PRC) for consultation. The initial draft PPP's have been revised based on the consultation feedback. Further analysis completed by the College have transformed the initial PPP's into HPA Bylaws, Schedule F, standards of practice and a new PPP.

[1] Patient identification requirements exist for practice settings that dispense through PharmaNet as per section 22 of the *Pharmacy Operations and Drug Scheduling Act* Bylaws along with supplemental insight from the existing PPP-54 Identifying Patients for PharmaNet Purposes.
[2] See Appendix 1 for the draft amended bylaws.
[3] See Appendix 2 for the draft PPP.

In September 2016, the second consultation phase was completed and it consisted of an email survey. The survey was sent to the BC Pharmacy Association, the Neighborhood Pharmacy Association, the Canadian Society of Hospital Pharmacists BC Branch, the Pharmacy Technician Society of BC, and all College committees. Additionally, in October 2016, the PRC formally endorsed the HPA amendments and new PPP. See Appendix 3 for details on both Phase 1 and Phase 2 consultations.

The majority of the feedback received during the second phase was supportive of the amendments. Further, there was a consensus on understanding the new requirements and agreeing they are appropriate for pharmacy practice and to protect public health.

Practice Review Program

The HPA bylaw amendments will be incorporated into the College's Practice Review Program (PRP). More specifically, these amendments will support Phase 2 (hospital practice) of PRP by creating bylaw requirements that are applicable to both pharmacy technicians and hospital settings.

Next Steps

As per section 19(3) of the HPA, bylaws must be filed with the Minister of Health. The amended bylaws will come into effect 60 days from the filing request date to the Ministry of Health. If approved by the Board, the bylaw amendments will be in effect by mid-January 2017.

Recommendation

The Board approve the amendments to the HPA Bylaws Schedule F, Parts 1, 2, 3 that create minimum standards for registrants regarding the preparation of a prescription product, final product check, and patient identification for filing with the Ministry of Health. Additionally, that the Board approves Professional Practice Policy #75: Patient Identification to come into force at the same time as the bylaws. See Appendix 4 for the Schedule to the Resolution.

Appendix	
1	Appendix 1 – HPA Bylaws, Schedule F, Parts 1, 2 & 3
2	Appendix 2 – PPP #75: *Patient Identification*
3	Appendix 3 – Consultation details
4	Appendix 4 – Schedule to the Resolution

Health Professions Act – BYLAWS

SCHEDULE F

PART 1 - Community Pharmacy Standards of Practice

Table of Contents

Application

1. This Part applies to all registrants providing pharmacy services in a community pharmacy.

Definitions

2. In this Part:

"community pharmacy" has the same meaning as in section 1 of the bylaws of the college under the *Pharmacy Operations and Drug Scheduling Act*;

"drug therapy problem" means a potential or actual adverse consequence of drug therapy that interferes with achieving the goals of the drug therapy;

"final check" means ensuring that:

(a) the prescription product and the prescription product label match the prescription information and the information on the manufacturer's label with respect to:

(i) drug,

(ii) dosage form,

(iii) strength,

(iv) quantity, and

(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(2)(a) to (g);

(c) the drug has not expired and will not expire within the duration of use; and

(d) a pharmacist has completed a clinical assessment of the prescription after reviewing the patient profile.

"**incentive**" means money, gifts, discounts, rebates, refunds, customer loyalty schemes, coupons, goods or rewards;

"patient representative" means a person who is authorized to act on a patient's behalf;

"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;

"prescription copy" means a copy of a prescription given to a

patient by a registrant for information purposes only;

"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;

"refill" means verbal or written approval from a practitioner authorizing a registrant to dispense additional quantities of drug(s) pursuant to a prescription;

"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 *Act*;

"*Residential Care Facilities and Homes Standards of Practice*" means the standards, limits and conditions for practice established in Part 3 of this Schedule.

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.

Community Pharmacy Technicians

4. (1) Pharmacy technicians in a community pharmacy may prepare, process and compound prescriptions, including

(a) receiving and transcribing verbal prescriptions from practitioners,

(b) ensuring that a prescription is complete and authentic,

(c) transferring prescriptions to and receiving prescriptions from other pharmacies,

(d) ensuring the accuracy of a prepared prescription,

(e) performing the final check of a prepared prescription, and

(f) ensuring the accuracy of drug and personal health information in the PharmaNet patient record.

(2) Despite subsection (1), a pharmacy technician in a community pharmacy may dispense a drug but must not

(a) perform the task of ensuring the pharmaceutical and therapeutic suitability of a drug for its intended use, or

(b) do anything described in

(i) sections 6(5), 6(10), 10(2), 11(3), 11(4), 12, 13(2), 13(3)

or 13(4) of this Part, or

(ii) Part 4 of this Schedule

(c) dispense a drug pursuant to HPA Bylaws Schedule F, Part 5

(3) A pharmacy technician must identify his or her registrant class in any interaction with a patient or a practitioner.

Pharmacy Assistants

5. 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

6. (1) A registrant must ensure that a prescription is authentic.

(2) Upon receipt from the practitioner, a prescription must include the following information:

(a) the date the prescription was written;

(b) the name of the patient;

(c) the name of the drug or ingredients and strength if applicable;

(d) the quantity of the drug;

(e) the dosage instructions including the frequency, interval or maximum daily dose;

(f) refill authorization if applicable, including number of refills and interval between refills;

(g) the name and signature of the practitioner for written prescriptions;

(3) For the purpose of subsection (4), “prescription” includes a new prescription, a refill, a renewal or a balance owing.

(4) At the time of dispensing, a prescription must include the following additional information:

(a) the address of the patient;

(b) the identification number from the practitioner’s regulatory college;

(c) the prescription number;

(d) the date on which the prescription was dispensed;

(e) the manufacturer's drug identification number or the brand name of the product dispensed;

(f) the quantity dispensed;

(g) written confirmation of the registrant who

(i) verified the patient identification

(ii) verified the patient allergy information,

(iii) reviewed the personal health information stored in the PharmaNet database in accordance with section 11.4;

(iv) performed the consultation,

(v) performed the final check including when dispensing a balance owing, and

(vi) identified and addressed a drug therapy problem, if any.

(5) A full pharmacist must

(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 drug therapy problems, 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 unless s.25.92(2) of the *Act* applies, and

(e) take appropriate action respecting a drug therapy problem.

(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 record of a verbal authorization, and include his or her signature or initial.

(8) A registrant must not dispense a prescription issued for more than one patient.

(9) For refill authorizations, a registrant

(a) may

(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

(iii) document the refill authorization on the original prescription if

(A) a computerized transaction log is maintained, or

(B) a new prescription number is assigned, and

(b) must

(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) If a full pharmacist authorizes a prescription renewal, he or she must

(a) create a written 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

7. (1) Prescription authorizations may be received by facsimile from a practitioner to a pharmacy, if

(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 6(2), the prescription includes

(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) 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

(a) the information set out in section 6(2),

(b) the name, address and 10 digit 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 Drug List.

(4) Prescription transfers may be completed by facsimile transmission if

(a) the transferring registrant includes his or her name and the address of the pharmacy with the information required in section 8(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

8. (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) A prescription copy must contain

(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 signature of the registrant supplying it, and

(h) an indication that it is a copy.

(3) Upon request, a registrant must transfer to a pharmacy licenced in

Canada a prescription for a drug if

(a) the drug does not contain a controlled drug substance, and

(b) the transfer occurs between a registrant and another registrant or an equivalent of a registrant in another Canadian jurisdiction.

(4) A registrant who transfers a prescription to another registrant under subsection (3) must

(a) enter on the patient record

(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

(b) transfer all prescription information listed in subsection (2) (a) to (f).

(5) A registrant must make prescriptions available for review and copying by authorized inspectors of Health Canada.

Prescription Label

9. (1) All drugs dispensed pursuant to a prescription or a full pharmacist-initiated adaptation must be labeled.

(2) The label for all prescription drugs must include

(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

(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.

Preparation of Prescription Product

9.1 (1) A registrant who prepares a prescription product must ensure that:

(a) the prescription product label matches the prescription information and the information on the manufacturer's label with respect to:

(i) drug,
(ii) dosage form,
(iii) strength,
(iv) quantity,
(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(2)(a) to (g);

(c) the drug is not expired and will not expire within the duration of use; and

(d) his or her identity is documented in writing.

(2) A pharmacy manager must ensure that the record in paragraph (1)(d) is readily available and is retained for at least three years from the date on which the prescription product was last dispensed.

Dispensing

10. (1) A registrant may adjust the quantity of drug to be dispensed if

(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) A full pharmacist may adjust the quantity of drug to be dispensed, if

(a) he or she consults with a practitioner and documents the result of the consultation, and

(b) if

(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) All drugs must be dispensed in a container that is certified as child-resistant unless

(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, or

(e) the drugs are prescribed for medical assistance in dying.

(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.

(6) Before dispensing a prescription product, a registrant must perform a final check and record his or her identity in writing.

(7) A pharmacy manager must ensure the record in paragraph (6) is readily available and retained for at least three years after the last date on which that prescription product was last dispensed.

Patient Record

11. (1) A patient record must be established and maintained for each patient for whom a Schedule I drug is dispensed.

(2) The patient record must include

(a) the patient's full name,

(b) the patient's personal health number,

(c) the patient's address,

(d) the patient's telephone number if available,

(e) the patient's date of birth,

(f) the patient's gender,

(g) the patient's clinical condition, allergies, adverse drug reactions and intolerances if available including the source and date the information was collected,

(h) the date the drug is dispensed,

(i) the prescription number,

(j) the generic name, strength and dosage form of the drug,

(k) the drug identification number,

(l) the quantity of drug dispensed,

(m) the intended duration of therapy, specified in days,

(n) the date and reason for discontinuation of therapy,

(o) the directions to the patient,

(p) the identification of the prescribing practitioner,

(q) special instructions from the practitioner to the registrant, if appropriate,

(r) past and present prescribed drug therapy including the drug name, strength, dosage, frequency, duration and effectiveness of therapy,

(s) the identification of any drug therapy problem and the description of any action taken,

(t) the description of compliance with the prescribed drug regimen, and

(u) Schedule II and III drug use if appropriate.

(3) If a full pharmacist obtains a drug history from a patient, he or she must request and if appropriate record the following information on the patient record:

(a) medical conditions and physical limitations,

(b) past and current prescribed drug therapy including the drug name, strength, dosage, frequency, duration and effectiveness of therapy,

(c) compliance with the prescribed drug regimen,

(d) Schedule II and III drug use.

(4) A full pharmacist must review the patient's personal health information stored on the PharmaNet database before dispensing a drug and take appropriate action if necessary with respect to any concern regarding the appropriateness of the drug or any drug therapy problem.

Pharmacist/Patient Consultation

12. (1) A full pharmacist must offer to consult with the patient or patient's representative at the time of dispensing a prescription in person or, where not practical to do so, by telephone.

(2) Where a patient declines the consultation, the full pharmacist must document that the consultation was offered and declined.

(3) The full pharmacist must conduct the consultation in a manner that respects the patient's right to privacy.

(5) The pharmacist/patient consultation for a new prescription must

include:

(a) confirmation of the identity of the patient,

(b) name and strength of drug,

(c) purpose of the drug,

(d) directions for use of the drug including the frequency, duration and route of therapy,

(e) potential drug therapy problems, including any avoidance measures, and action recommended if they occur,

(f) storage requirements,

(g) prescription refill information,

(h) information regarding

(i) how to monitor the response to therapy,

(ii) expected therapeutic outcomes,

(iii) action to be taken in the event of a missed dose, and

(iv) when to seek medical attention, and issues the pharmacist considers relevant to the specific drug or patient.

(6) The pharmacist/patient consultation for a refill prescription must include:

(a) confirmation of the identity of the patient,

(b) name and strength of drug,

(c) purpose of the drug,

(d) directions for use of the drug including frequency and duration,

(e) whether the patient has experienced a drug therapy problem.

(7) If a drug therapy problem is identified during patient consultation for a new or refill prescription, the full pharmacist must take appropriate action to resolve the problem.

(8) If an adverse drug reaction as defined by Health Canada is identified, the full 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.

Schedule II and III Drugs

13. (11) 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.

(1) A pharmacist must offer to consult with the patient or the patient's representative regarding the selection and use of a Schedule II drug at the time of purchase.

(2) The pharmacist/patient consultation for a Schedule II drug must include potential drug therapy problems, including any avoidance measures, and action recommended if they occur.

(3) A pharmacist must be available for consultation with a patient or patient's representative respecting the selection and use of a Schedule III drug.

Sole Pharmacy Services Provider

14 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

(a) pharmacy services are provided in a manner that is consistent with the *Residential Care Facilities and Homes Standards of Practice,*

(b) patient therapeutic outcomes are monitored to enhance patient safety, and

(c) appropriate provision has been made for safe and effective distribution, administration and control of drugs.

Prohibition on the Provision of Incentives

15 (1) A registrant must not provide or distribute, or be a party to the provision or distribution of, an incentive to a patient or patient's representative for the purpose of inducing the patient or patient's representative to

(a) deliver a prescription to a particular registrant or pharmacy for dispensing of a drug or device specified in the prescription, or

(b) obtain any other pharmacy service from a particular registrant or pharmacy.

(2) Subsection (1) does not prevent a registrant from

(a) providing free or discounted parking to patients or patient's representatives,

(b) providing free or discounted delivery services to patients or patient's representatives, or

(c) accepting payment for a drug or device by a credit or debit card that is linked to an incentive.

(3) Subsection (1) does not apply in respect of a Schedule III drug or an unscheduled drug, unless the drug has been prescribed by a practitioner.

Health Professions Act – BYLAWS

SCHEDULE F

PART 2 – Hospital Pharmacy Standards of Practice

Table of Contents

Application

1. This Part applies to all registrants providing pharmacy services in a hospital pharmacy or a hospital pharmacy satellite.

Definitions

2. In this Part:

"bulk/batch drug repacking" means the repackaging in a single process of multiple units, not for immediate use;

"bulk compounding" means the preparation of products which are not commercially available in anticipation of a practitioner's order;

"*Community Pharmacy Standards of Practice*" means the standards, limits and conditions for practice established in Part 1 of this Schedule;

"final check" means ensuring that:

(a) the prescription product and the prescription product label match the product information with respect to:

(i) drug,

(ii) dosage form,

(iii) strength, and

(iv) quantity;

(b) the drug is not expired and will not expire within the duration of use; and

(c) a pharmacist has completed a clinical assessment of the prescription after reviewing the patient profile.

"hazardous drugs" means pharmaceutical preparations in which the concentration, toxicity, environmental persistence, degradation characteristics, flammability, corrosiveness, or reactivity represents a risk to the health of humans or other living organisms;

"hospital pharmacy" has the same meaning as in section 1 of the bylaws of the college under the *Pharmacy Operations and Drug Scheduling Act*;

"hospital pharmacy satellite" has the same meaning as in section 1 of the bylaws of the college under the *Pharmacy Operations and Drug Scheduling Act*;

"individual patient prescription system" means a form of drug distribution in which drugs are dispensed in patient-specific labelled drug containers;

"master formula" means a set of instructions outlining in detail the materials, equipment, and procedures required to produce a specific quantity of a product;

"multiple pouch packaging" means a pouch containing drugs to be administered at

a particular time;

"unit dose distribution" means a form of drug distribution in which orders for each patient are dispensed individually and packaged in unit-of-use packages containing one dose;

"ward stock" means drugs that are stocked in a patient care area and are not labelled for a particular patient.

Drug Distribution

3. (1) The pharmacy's manager must establish a drug distribution system that

(a) provides drugs in identified dosage units ready for administration whenever possible and practical,

(b) protects drugs from contamination,

(c) provides a method of recording drugs at the time of administration, and

(d) eliminates or reduces the need to maintain ward stock.

(2) A unit dose, monitored dose, multiple pouch packaging or individual patient prescription drug distribution system must be used for dispensing drugs.

(3) Sterile products must be prepared and distributed in an environment that is in accordance with

(a) the Canadian Society of Hospital Pharmacists' Guidelines for Preparation of Sterile Products in Pharmacies,

(b) the USP Pharmaceutical Compounding – Sterile Products Guidelines, and

(c) such other published standards approved by the board from time to time.

(4) Hazardous drugs must be handled and prepared in accordance with the Requirements for the Safe Handling of Antineoplastic Agents in Health Care Facilities published by the Workers Compensation Board of British Columbia and such other published standards approved by the board from time to time.

Preparation of Prescription Product

3.1 (1) A registrant who prepares a prescription product must ensure that:

(a) the prescription product label matches the product information with respect to:

(i) drug,
(ii) dosage form,
(iii) strength,
(iv) quantity; and

(b) the drug is not expired and will not expire within the duration of use.

Patient Identification

3.2 Unless dispensing to staff, outpatients or the general public under section 4(5), all registrants must use at least two person-specific identifiers to confirm the identity of a patient before providing any pharmacy service to the patient.

Drug Label

4. (1) Drug container labels must include

(a) the generic name of the drug, strength and dosage form, and

(b) hospital approved abbreviations and symbols.

(2) Only hospital pharmacy staff may alter a drug container label.

(3) Inpatient prescription labels must include

(a) a unique patient name and identifier,

(b) the generic name of the drug, strength and dosage form,

(c) parenteral vehicle if applicable, and

(d) hospital approved abbreviations and symbols.

(4) The following information must be included on the inpatient prescription label if not available on the medication administration record:

(a) the frequency of administration;

(b) the route of administration or dosage form;

(c) auxiliary or cautionary statements if applicable;

(d) the date dispensed.

(5) All drugs dispensed to staff, outpatients or the general public from a hospital pharmacy or hospital pharmacy satellite must be labeled and dispensed according to the *Community Pharmacy Standards of Practice.*

(6) Prior to releasing a prescription product, a registrant must perform a final check of the prescription product and record his or her identity in writing as required by section 17.

Returned Drugs

5. (1) Unused dispensed drugs must be returned to the hospital pharmacy.

(2) Previously dispensed drugs must not be re-dispensed unless

(a) they are returned to the hospital pharmacy in a sealed dosage unit or container as originally dispensed,

(b) the labeling is intact and includes a legible drug lot number and expiry date, and

(c) the integrity of the drug can be verified.

Drug Transfer

6. A registrant who supplies a Schedule I drug to another registrant or practitioner must comply with section 8(3) and (4) of the *Community Pharmacy Standards of Practice.*

Inpatient Leave of Absence and Emergency Take-Home Drugs

7. (1) A system must be established to provide drugs to an emergency department short stay patient requiring take-home drugs, who is unable to obtain them from a community pharmacy within a reasonable time frame.

(2) All take-home drugs issued from the emergency department must be documented in the patient's health record.

(3) All inpatient leave of absence drugs must be documented in the patient's health record.

(4) Labels for inpatient pass and emergency department take-home drugs must include

(a) the hospital's name,

(b) the patient's name,

(c) the practitioner's name,

(d) the drug name, strength and directions for use,

(e) identification of the person preparing the drug, and

(f) the date the drug is issued.

(5) Drugs must be dispensed in a container that is certified as child-resistant unless

(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.

Investigational and Special Access Program Drugs

8. Registrants must comply with the policies and directives of Health Canada with respect to storage and dispensing of Special Access Program or investigational drugs.

Drug Repackaging and Compounding

9. (1) A registrant must supervise all bulk/batch drug repackaging and bulk drug compounding.

(2) Bulk/batch drug repackaging records must be kept for three years after the repackaging date.

(3) A master formula record must be kept for each bulk compounded drug product.

(4) A separate production record must be kept for each compounded bulk product and must include

(a) the date of compounding,

(b) the lot or batch number assigned to the compounded product,

(c) the manufacturer's name and lot number for each raw material used,

(d) handwritten identification of each registrant and pharmacy assistant involved in each step of the compounding process,

(e) the process including weights and measures performed,

(f) the results of all quality control testing,

(g) a statement of the final yield,

(h) signatures for final verification and authorization for release,

(i) a sample label, and

(j) the expiry date of the product.

(5) A production record must be kept for a period of three years after the expiry date of the compounded batch.

(6) A label must be affixed to the finished bulk/batch repackaged or bulk compounded drug and must contain

(a) generic name(s) of the drug,

(b) strength and quantity of active ingredients,

(c) dosage form,

(d) total amount of final product,

(e) expiry date of the compound,

(f) manufacturer identification and lot number or hospital pharmacy control number,

(g) storage conditions, if applicable,

(h) auxiliary labels, if applicable, and

(i) the name of the hospital.

Hospital Pharmacy Technicians

10. (1) Pharmacy technicians in a hospital pharmacy or hospital pharmacy satellite may

prepare, process and compound prescriptions, including

(a) receiving and transcribing verbal prescriptions from practitioners,

(b) ensuring that a prescription is complete and authentic,

(c) transferring prescriptions to and receiving prescriptions from other pharmacies,

(d) ensuring the accuracy of a dispensed prescription,

(e) performing the final check of a dispensed prescription, and

(f) ensuring the accuracy of drug and personal health information in the PharmaNet patient record.

(2) Despite subsection (1), a pharmacy technician in a hospital pharmacy or hospital pharmacy satellite may dispense a drug but must not

(a) perform the task of ensuring the pharmaceutical and therapeutic suitability of a drug for its intended use,

(b) do anything described in

(i) sections 13, 15 or 16 of this Part

(ii) Part 4 of this Schedule, or

(c) dispense a drug pursuant to HPA Bylaws Schedule F, Part 5.

(3) A pharmacy technician must identify his or her registrant class in any interaction with a patient or a practitioner.

Hospital Pharmacy Assistants

11. Specific technical functions may be performed by a pharmacy assistant in a hospital pharmacy or hospital pharmacy satellite after the pharmacy's manager has established written procedures for performing the functions.

Patient Record

12. (1) The registrant must ensure the preparation and maintenance of patient records for each patient for whom drugs are prepared are complete, accurate and current, except patients admitted for less than 24 hours to

(a) surgical day care,

(b) ambulatory care,

(c) emergency short-stay, or

(d) other short-stay diagnostic or treatment units.

(2) The patient record must include

(a) the patient's full name and admission date,

(b) the hospital number and location,

(c) the patient's date of birth and gender,

(d) the attending practitioner's name,

(e) the patient's weight and height if applicable to therapy,

(f) the patient's allergies, adverse drug reactions, intolerances, and diagnoses,

(g) a chronological list of drugs which have been prescribed for the patient since admission to hospital, or, if admission is prolonged, for a minimum period of two years, and

(h) a list of all current drug orders including

(i) the drug name,

(ii) the drug strength,

(iii) the dosage,

(iv) the route,

(v) the dosage form,

(vi) intravenous diluent if applicable,

(vii) the directions for use,

(viii) administration time or frequency,

(ix) the attending practitioner,

(x) the quantity,

(xi) the start and stop date, or length of therapy, and

(xii) the date drug was dispensed, refilled or discontinued.

Patient Oriented Pharmacy Practice

13. (1) During pharmacy hours the full pharmacist must review the drug order before the drug is dispensed.

(2) The full pharmacist must check the drug order for

(a) the patient's name, hospital number and location,

(b) the signature of the practitioner,

(c) the name of the drug,

(d) the dosage form and strength,

(e) the route and frequency of administration,

(f) the duration of treatment if limited,

(g) directions for use,

(h) the date and time the order was written, and,

(i) in the case of verbal and/or telephone orders, the name and signature of the person who received the order.

(3) The full pharmacist must review the pharmacy patient record before dispensing the patient's drug and at appropriate intervals thereafter to assess

(a) appropriateness of therapy,

(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) intravenous administration problems including potential incompatibilities, drug stability, dilution volume and rate of administration, and

(h) any other drug related problems.

(4) The full pharmacist must notify the patient's nursing staff immediately if a problem with a prescription for a ward stock item is discovered.

(5) The full pharmacist must monitor drug therapy to detect, resolve and prevent drug-related problems at a frequency appropriate for the medical condition being treated.

(6) Monitoring includes but is not limited to

(a) a review of the patient record and/or health record,

(b) discussion with the patient's practitioner and/or other appropriate individual, and

(c) use of physical assessment skills when trained to do so.

(7) The full pharmacist must provide drug information, including patient-specific

information to patients and health care personnel.

(8) A full pharmacist, or a limited or student pharmacist under the direct supervision of a full pharmacist, must provide drug consultation to an outpatient or the outpatient's representative, or to an inpatient on request, and must

(a) confirm the identity of the patient,

(b) identify the name and strength of drug,

(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

(i) how to monitor the response to therapy,

(ii) expected therapeutic outcomes,

(iii) action to be taken in the event of a missed dose, and

(iv) when to seek medical attention, and

(i) provide other information unique to the specific drug or patient.

(9) If a full pharmacist requests a history from a patient or a patient's representative, the following information must be obtained:

(a) medical conditions and physical limitations;

(b) allergies, adverse drug reactions, and idiosyncratic responses;

(c) past and current prescribed drug therapy including the drug name, strength, dosage, frequency and duration and effectiveness of therapy;

(d) compliance with the prescribed drug regimen;

(e) Schedule II and III and unscheduled drug use.

(10) A full pharmacist must provide information about the assessment, management and prevention of drug poisoning within the hospital.

Medication Administration

14. (1) The registrant must collaborate with nursing and medical staff to develop written policies and procedures for the safe administration of drugs.

(2) A medication administration record of all prescribed drugs for each patient must be produced from the pharmacy-maintained patient record.

(3) The medication administration record must include

(a) the patient's full name and identification number,

(b) the patient's location in the hospital,

(c) the presence or absence of known allergies, adverse drug reactions, and intolerances,

(d) the date or period for which the drug administration record is to be used,

(e) the name, dosage and form of all drugs currently ordered,

(f) complete directions for use for all drugs,

(g) stop or expiry dates for drug orders for which there is an automatic stop policy (if not reported by another means),

(h) predetermined, standard medication administration times for regularly scheduled drugs, and

(i) changes to drug orders.

Residential Care

15. A full pharmacist providing pharmacy care to residential care patients residing in a facility that is not licensed under the *Community Care and Assisted Living Act* must

(a) use a monitored dosage, multiple pouch packaging or unit dosage system except where the form of the drug does not permit such packaging,

(b) restrict ward stock to drugs that do not have a high potential for toxicity or require a complex dosage titration, and are commonly prescribed on a "when needed" basis,

(c) maintain a current patient record for each patient,

(d) provide administration records of all current drugs for each patient from the pharmacy maintained patient record within seventy-two hours of admission and at least monthly thereafter,

(e) review each patient's drug regimen at least every six months preferably in the setting of multidisciplinary rounds, and

(f) maintain a written record of drug reviews in the patient's permanent health record, including the date of each review, identified concerns and recommendations.

Documentation

16. (1) The full pharmacist must document directly in the patient record all activities and information pertaining to the drug therapy of the patient.

(2) The documentation must include but is not limited to

(a) actual or potential drug-related problems that warrant monitoring,

(b) recommendations for changes in drug selection, dosage, duration of therapy, and route of administration,

(c) recommendations for monitoring the response to drug therapy,

(d) notations of consultations provided to other health care professionals about the patient's drug therapy selection and management,

(e) notations of drug-related patient education and/or consultation provided,

(f) clarification of drug orders and practitioner's telephone orders received directly by the registrant, and

(g) allergies, adverse drug reactions and intolerances.

17. Documentation of the identity of any registrant who prepared a prescription product or performed a final check must be in writing, readily available and retained for at least three years after the date on which the prescription product was last dispensed.

Health Professions Act – BYLAWS

SCHEDULE F

PART 3 – Residential Care Facilities and Homes Standards of Practice

Table of Contents

Application

1. This Part applies to registrants providing pharmacy services in or to facilities and homes.

Definitions

2. In this Part:

"administration" means the provision of a drug to a resident as prescribed, or for drugs listed in Schedule II or III of the Drug Schedules Regulation, B.C. Reg. 9/98, or unscheduled drugs initiated by a registered nurse;

"audit" means a periodic review of the pharmacy services provided in accordance with this Part;

"*Community Pharmacy Standards of Practice*" means the standards, limits and conditions for practice established in Part 1 of this Schedule;

"facility" means a community care facility licensed under the *Community Care and Assisted Living Act* to provide care to 7 or more persons;

"final check" means ensuring that:

(a) the prescription product and the prescription product label match the prescription information and the information on the manufacturer's label with respect to:

(i) drug,

(ii) dosage form,

(iii) strength,

(iv) quantity and

(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(8)(a) to (g);

(c) the drug is not expired and will not expire within the duration of use; and

(d) a pharmacist has completed a clinical assessment of the prescription after reviewing the patient profile.

"home" means a community care facility licensed under the *Community Care and Assisted Living Act* to provide care to 3 to 6 persons;

"licensed practical nurse" means a registrant of the College of Licensed Practical Nurses of British Columbia;

"medication safety and advisory committee" means a committee appointed under section 8.2 of the Adult Care Regulations, B.C. Reg.

536/80;

"monitored dose system" means a system of drug distribution in which drugs are dispensed for an individual resident at scheduled times from packaging which protects a dose or doses from contamination until a designated medication time;

"natural product" has the same meaning as in the *Natural Health Products Regulations* under the *Food and Drug Act* (Canada) as amended from time to time;

"registered nurse" means a registrant of the College of Registered Nurses of British Columbia;

"registered psychiatric nurse" means a registrant of the College of Registered Psychiatric Nurses of British Columbia;

"resident" means a person who lives in and receives care in a facility or home;

"Schedule II and III drugs" mean drugs listed in Schedule II or III of the *Drug Schedules Regulation*.

Supervision of Pharmacy Services in a Facility or Home

3. (1) A registrant must not provide pharmacy services in or to a facility or home unless appointed to do so by the licensee of that facility or home.

(2) A registrant must not allow any person to interfere with the provision of pharmacy services in accordance with the *Act* or the *Pharmacy Operations and Drug Scheduling Act*.

(3) The full pharmacist appointed to provide services to the facility or home must do the following:

(a) visit and audit the medication room at the facility at least every 3 months,

(b) visit and audit the medication room or storage area at the home at least once annually,

(c) make a record of all audits and meetings of the medication safety and advisory committee held in accordance with this bylaw, which must be retained in the pharmacy for at least 3 years, and

(d) arrange a meeting of the medication safety and advisory committee at least once in every 6 month period for a facility and once a year for a home.

(4) The full pharmacist appointed to provide services to a facility or home must be a member of and advise the medication safety and advisory committee

about the policies and procedures in place for the

(a) safe and effective distribution, administration and control of drugs,

(b) monitoring of therapeutic outcomes and reporting of adverse drug reactions in respect of residents,

(c) reporting of drug incidents and discrepancies, and

(d) training and orientation programs for staff members who store, handle, or administer drugs to residents.

(5) The policies and procedures referred to in subsection (4) must be included in a manual kept in the facility, home and pharmacy.

(6) Except where a person in care self-administers drugs in accordance with regulations under the *Community Care and Assisted Living Act,* the registrant must ensure that all drugs are stored in a separate and locked area that is not used for any other purpose.

(7) The registrant must ensure that a copy of this Part is available in the facility or home.

Quality Management

4. A pharmacy providing services to a facility or home must have a documented ongoing quality management program that

(a) monitors the pharmacy services provided, and

(b) includes a process for reporting and documenting drug incidents and discrepancies and their follow-up.

Pharmacy Technicians

5. (1) Pharmacy technicians providing pharmacy services to a facility or home may prepare, process and compound prescriptions, including

(a) receiving and transcribing verbal prescriptions from practitioners,

(b) ensuring that a prescription is complete and authentic,

(c) transferring prescriptions to and receiving prescriptions from other pharmacies,

(d) ensuring the accuracy of a dispensed prescription,

(e) performing the final check of a dispensed prescription, and

(f) ensuring the accuracy of drug and personal health information in the PharmaNet patient record.

(2) Despite subsection (1), a pharmacy technician providing pharmacy services

to a facility or home may dispense a drug but must not

(a) perform the task of ensuring the pharmaceutical and therapeutic suitability of a drug for its intended use,

(b) do anything described in

(i) sections 3(3), 3(4), 13(4), 15 or 16 of this Part,

(ii) Part 4 of this Schedule, or

(c) dispense a drug pursuant to HPA Bylaws Schedule F, Part 5.

(3) A pharmacy technician must identify his or her registrant class in any interaction with a patient or a practitioner.

Prescription Authorizations

6. (1) A registrant may only dispense a drug to a resident upon receipt of a prescription.

(2) When a resident is readmitted following hospitalization, new prescriptions must be received for that resident before drugs may be dispensed.

(3) A prescription may be transmitted to the pharmacy servicing the facility or home verbally, electronically or in writing.

(4) If a prescription is transmitted to the pharmacy by facsimile, the registrant must comply with section 7 of the *Community Pharmacy Standards of Practice.*

(5) If a prescription is transmitted verbally, the registrant must make a written record of the verbal authorization, and include his or her signature or initial.

(6) If a prescription is transmitted electronically, the registrant must use the facsimile or make a written copy as the permanent record for dispensing, numbering, initialling and filing.

(7) A prescription, written and signed by a practitioner on a resident's record, may be electronically transmitted to the pharmacy and the registrant may dispense the drug.

(8) Upon receipt from the practitioner, a prescription must include the following information:

(a) the date the prescription was written;

(b) the name of the resident;

(c) the name of the drug or ingredients and strength where applicable;

(d) the quantity of the drug;

(e) the dosage instructions including the frequency, interval or maximum

daily dose;

(f) refill authorization if applicable, including number of refills and interval between refills;

(g) the name and signature of the practitioner for written prescriptions.

(9) A registrant may accept a new drug order that is transmitted verbally from a practitioner to a facility's registered nurse, registered psychiatric nurse or licensed practical nurse, if

(a) the drug does not contain a controlled drug substance,

(b) the registered nurse, registered psychiatric nurse or licensed practical nurse writes the verbal order on a practitioner's order form or electronic equivalent, and

(c) transfers the written order to the pharmacy.

Preparation of Prescription Product

6.1 (1) A registrant who prepares a prescription product must ensure that:

(a) the prescription product label matches the prescription information and the information on the manufacturer's label with respect to:

(i) drug,
(ii) dosage form,
(iii) strength,
(iv) quantity; and
(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(8)(a) to (g);

(c) the drug is not expired and will not expire within the duration of use; and

(d) his or her identity is documented in writing.

(2) A pharmacy manager must ensure the record in paragraph (1)(d) is readily available and is retained for at least three years from the date on which the prescription product was last dispensed.

Patient Identification

6.2 All registrants must use at least two person-specific identifiers to confirm the identity of a resident before providing any pharmacy service to the resident.

Dispensing

7. (1) All prescriptions dispensed to residents must be dispensed in a monitored dose system except where the form of the drug does not permit such packaging, and each package must contain not more than a 35 day supply of medication.

(2) Where directions for the use of a drug are changed by the practitioner, the registrant must, following receipt of the required confirmation, initiate and dispense a new prescription.

(3) Before dispensing a prescription product, a registrant must perform a final check and must record his or her identity in writing.

(4) A pharmacy manager must ensure a record in paragraph (3) is readily available and is retained for at least three years from the date on which the prescription product was last dispensed.

Contingency Drugs

8. (1) A registrant may establish a supply of contingency drugs to permit the commencement of therapy upon receipt of a prescription, until the drug supply arrives from the pharmacy.

(2) Contingency drugs must be prepared by the pharmacy and dispensed in a monitored dose system in accordance with section 7(1).

(3) A list of the contingency drugs must be available in the facility, home and pharmacy.

(4) Records of use of contingency drugs must be kept in the facility or home and must include

(a) the date and time the drug was administered,

(b) the name, strength and quantity of the drug administered,

(c) the name of the resident for whom the drug was prescribed,

(d) the name or initials of the person who administered the drug, and

(e) the name of the practitioner who prescribed the drug.

Nurse Initiated Drugs

9. (1) A registrant may provide Schedule II or III drugs and unscheduled drugs for a resident upon the request of a registered nurse if the medication safety and

advisory committee has approved protocols for doing so.

(2) A record of use of all medications must be on the resident's medication administration record.

Standing Orders

10. (1) Standing orders for Schedule II and III drugs and unscheduled drugs that are administered for common self-limiting conditions may be established by the medication safety and advisory committee.

(2) Standing order drugs must be authorized and signed for by a practitioner annually and a record of the signed authorization must be kept in the facility or home.

(3) A record of use of all medications must be on the resident's medication administration record.

Returned Drugs

11. (1) A registrant must provide for the return of all discontinued drugs at the time of the next scheduled delivery.

(2) Policies and procedures must be in place to ensure that upon the hospitalization of a resident, the resident's drugs are returned to the pharmacy.

(3) Previously dispensed drugs must not be re-dispensed unless

(a) they have been returned to the pharmacy in a single-drug, sealed dosage unit or container as originally dispensed,

(b) the labelling is intact and includes a legible drug lot number and expiry date, and

(c) the integrity of the product can be verified.

Drug Containers and Prescription Labels

12. (1) All drugs dispensed pursuant to a prescription must be labeled.

(2) The label for all prescriptions must include

(a) the name, address and 10-digit telephone number of the pharmacy,

(b) the prescription number and dispensing date,

(c) the full name of the resident,

(d) the name of the practitioner or registered nurse,

(e) the strength of the drug,

(f) the dosage instructions including the frequency, interval or maximum

daily dose,

(g) the route of administration,

(h) medical indication for use for all “as required” prescription authorizations, and

(i) any other information required by good pharmacy practice.

(3) For single-entity products the label must include

(a) the generic name and at least one of

(i) the brand name,

(ii) the manufacturer’s name, or

(iii) the drug identification number.

(4) For multiple-entity products 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 compounded preparations the label must include all active ingredients.

(6) If the pharmacy is unable to supply prescribed Schedule II or III drugs or unscheduled drugs to a resident and the resident has obtained a supply from another source, the drug must be in the original sealed packaging and be sent to the pharmacy for

(a) identification,

(b) repackaging in a monitored dose system if appropriate,

(c) labeling, and

(d) notation on the resident’s record and the medication administration record.

(7) If labels are produced to be attached to a resident’s medication administration record, the label must state “for MAR”.

(8) All drugs must be labelled with the drug expiry date and manufacturer’s lot number, except multi-drug sealed dosage units.

(9) A registrant must not delegate the labelling of drugs in a monitored dose system to an employee of a facility or home.

Resident Records

13. (1) A registrant must maintain a record for each resident.

(2) The record must include

(a) the resident's full name, personal health number, birth date, gender, practitioner name, name of the facility or home, and if possible, the resident's location within the facility or home,

(b) diagnoses,

(c) the presence or absence of known allergies, adverse drug reactions or intolerances relevant to drugs,

(d) the prescription number, names and drug identification numbers or natural product numbers for all drugs dispensed,

(e) the medical indication for use for all "as required" prescription authorizations and drugs dispensed,

(f) directions for use, dosage form, strength, quantity, route of administration, dosage times, dates dispensed, and

(g) the dates and reasons for early discontinuation of drug therapy if applicable.

(3) When a drug is to be administered on a "when necessary" basis, the record and prescription label must clearly indicate

(a) the specific indication for which the drug is to be given,

(b) the minimum interval of time between doses, and

(c) the maximum number of daily doses to be administered.

(4) A full pharmacist must review the resident record before dispensing a drug and take appropriate action when necessary with respect to

(a) the appropriateness of drug therapy,

(b) drug interactions,

(c) allergies, adverse drug reactions, and intolerances,

(d) therapeutic duplication,

(e) contraindicated drugs,

(f) the degree of compliance,

(g) the correct dosage, route, frequency and duration of administration and dosage form, and

(h) any other potential drug-related problems.

Resident Medication Administration Records

14. (1) The registrant must provide a medication administration record for each resident.

(2) The medication administration record must be current for each resident based on the information on the resident's record and must be sent to the facility or home each month.

(3) A resident's medication administration record must include

(a) the resident's full name,

(b) the resident's location within the facility or home, where possible,

(c) the name of the practitioner,

(d) allergies,

(e) diagnoses,

(f) the month for which the record is to be used,

(g) the name and strength of all drugs currently being administered, including those to be administered on a "when necessary" basis, and

(h) full directions for use.

Resident Medication Review

15. (1) The full pharmacist responsible for a facility must

(a) review each resident's drug regimen on site or by videoconference at least once every 6 months with a practitioner if available, or a registered nurse and a facility staff member approved by the medication safety and advisory committee, and

(b) review the resident's personal health information stored on the PharmaNet database before releasing any drug to the facility.

(2) A full pharmacist must maintain a record of the reviews referred to in subsection (1) in the resident's record and in the record at the pharmacy, and the record of review must include information about

(a) the people in attendance,

(b) the date of the review, and

(c) recommendations, if any.

(3) At a facility or home, if a resident's practitioner does not attend the review, the full pharmacist must advise the practitioner of any recommendations arising from the review.

(4) The full pharmacist responsible for a home must

(a) review each resident's drug regimen and document the result of the

review at least once every 6 months, and

(b) conduct the review on site at least once in every 12 month period.

(5) To continue dispensing drugs for a resident in a facility or home, prescriptions must be received from the resident's practitioner every six 6 months, either by written, verbal or electronic communication.

Resident Oriented Pharmacy Practice

16. (1) When a resident is first admitted to a facility or home, the full pharmacist must obtain a history for the resident, and the following information must be obtained if available:

(a) allergies, adverse drug reactions, and intolerances,

(b) past and present prescribed drug therapy including the drug name, strength, dosage, frequency and duration of therapy,

(c) compliance with prescribed drug regimen,

(d) Schedule II, III and unscheduled drug use, and

(e) laboratory results.

(2) The full pharmacist must routinely provide written or verbal drug information relevant to a resident's drugs to the medical, nursing or other appropriate facility or home staff.

(3) If an adverse drug reaction as defined by Health Canada is identified, a full pharmacist must

(a) notify the resident's practitioner,

(b) make an appropriate entry on the resident's record, and

(c) report the reaction to the Canada Vigilance Program Regional Office.

(4) Where a self-medication program is deemed suitable for a resident, the full pharmacist must comply with all applicable regulations under the *Community Care and Assisted Living Act* and must

(a) participate in the development of policies and procedures for the program, including appropriate storage and security requirements,

(b) ensure a drug consultation with the resident occurs,

(c) ensure authorization from the resident's practitioner and the medication safety and advisory committee is obtained,

(d) include any drugs in the self-medication program in the drug regimen review referred to in section 13(4), and

(e) document the consultation referred to in paragraph (b) in the resident's

record.

(5) The drug consultation referred to in subsection (4)(b), should occur in person with the resident or resident's representative and must

(a) confirm the identity of the resident,

(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 information regarding

(i) how to monitor response to therapy,

(ii) expected therapeutic outcomes,

(iii) action to be taken in the event of a missed dose, and

(iv) when to seek medical attention, and

(h) provide other information unique to the specific drug or resident.

Respite Care

17. (1) When a resident is admitted for short-stay respite care, the registrant must confirm all prescription authorizations with the resident's practitioner.

(2) The registrant must dispense drugs using a monitored dose system and provide medication administration records.

(3) Emergency stay respite care residents who arrive without notice may be administered drugs from their own supply if it is reasonable and safe to do so only until a supply is obtained from the pharmacy.

Leave of Absence Drugs

18. (1) The registrant must establish a system to ensure that leave-of-absence drugs are prepared correctly.

(2) The label on a leave of absence medication must include

(a) the facility or home name,

(b) the resident's name,

(c) the practitioner's name,

(d) the drug name, strength, quantity and complete directions for use,

(e) the initials of the person preparing the drug, and

(f) the date of issue.

(3) All leave of absence drugs must be documented on the resident's medication administration record.

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY- 75**
POLICY FOCUS: **Patient Identification**

Section 3.2 of Part 2 and section 6.2 of Part 3 of Schedule F to the HPA Bylaws require registrants to identify patients using at least two person-specific identifiers because registrants and patients may not be in the same location at the point of care. This Policy specifies acceptable ways of identifying particular individuals based on Accreditation Canada's Required Organizational Practices Handbook 2016.

POLICY:

1. Acceptable person-specific identifiers are:
   - patient/resident's full name,
   - home address, if confirmed by the patient/resident or family,
   - date of birth,
   - personal identification number (e.g. hospital account number, medical record number), or
   - an accurate photograph.

2. In long-term or continuing care settings where the registrant is already familiar with the patient or resident, facial recognition is also an acceptable person-specific identifier.

3. The following are examples of person-specific identifiers that are not acceptable:

   a. a patient/resident's room or bed number,
   b. a home address that has not been confirmed with the patient or resident or his/her family, or
   c. facial recognition in acute-care settings.

Phase 1 and Phase 2 Consultation Details
Issue: Product Preparation, Final Product Check, and Patient Identification

Phase 1a of Consultation: In Person Consultation - Practice Review Program Hospital Pharmacy Workshop	
Date:	March 8, 2016 at the Executive Inn and Hotel, Burnaby

Participants:	• Attendees:
	  o 35 attendees:
	  ▪ 31 pharmacists from hospital practice
	  ▪ 2 pharmacists from community practice
	  ▪ 2 public members
	  o The attendees were: Adil Virani, Aleisha Enemark, Alison Rhodes, Anar Dossa, Arden Barry, Bal Dhillon, Blake Reynolds, Fady Moussa, Grace Burns, Jack da Silva, Joan Fronda, Joanne Konnert, Karen Dahri, Leeann McKenzie, Lynda Moleschi, Mark Wu, Michelle Koberinski, Mike Ortynsky, Nilofar Partovi, Patrick Chai, Ravinder Minhas, Raymond Jang, Robyn Miyata, Sean Spina, Steve Chong, Shirin Abadi, Yonette Harrod
	• Support: Ken McGregor (Consultant), Paul Tier (Consultant)
	• Facilitator: Sam Louie (Consultant)

Purpose:	• Staff presented new requirements in the form of Professional Practice Policies (PPPs) for review and feedback.
Feedback Highlights:	• The topics of patient identification, preparation of a product, and final check were key focus areas, and the requirements were discussed at length. • The feedback informed the content of the initial PPPs.

Phase 1b of Consultation: Email Survey	
Dates:	May 5 – 9, 2016
Audience:	An email survey was sent to the members of the following College committees: • Hospital registrants from all the College committees • The Hospital Practice Advisory Committee • The Community Practice Advisory Committee • The Residential Care Advisory committee • The Practice Review Committee
Response:	• 21 survey responses (additional responses received after the deadline were also reviewed)

Purpose:	Gaining feedback from key stakeholders to ensure that the content in the draft initial PPPs accurately reflect current day practice.
Feedback Highlights:	• Majority consensus indicated content in the PPPs accurately reflected the requirements of product preparation, final check, and patient identification in current day practice. • Feedback regarding nuances between community and hospital settings were incorporated into the current draft versions of the PPP and bylaw amendments.

Phase 2 of Consultation: Email Survey	
Dates:	September 1 – 18, 2016
Target Audience:	An email survey was sent to the following: • The BC Pharmacy Association • The Neighborhood Pharmacy Association • The Canadian Society of Hospital Pharmacists of BC • The Pharmacy Technician Society of BC • All College committees
Response:	51 responses: • 25 from registrants in hospital practice • 15 from registrants in community practice • 11 from "Other" (e.g., public member or response from an organization)
Purpose:	To ensure the revised PPP and draft bylaws reflect current day practice and are written in understandable language.
Feedback Highlights:	• Majority consensus that the new requirements reflect current day practice and that they were understood clearly. • Some responses inquired about the intention behind the documentation in writing requirement. • Some responses did not support the notion that relevant product preparation and final check documentation must be readily available and retained for a minimum of three years.

Schedule of Amendments

Parts 1, 2 and 3 of Schedule F of the *Health Professions Act* - Bylaw are amended to include requirements for patient identification (for hospital and residential care settings), preparation of a prescription product, and performing the final check as follows:

1. Section 2 of Part 1 is amended by adding the following definition:

"final check" means ensuring that:

(a) the prescription product and the prescription product label match the prescription information and the information on the manufacturer's label with respect to:

(i) drug,

(ii) dosage form,

(iii) strength,

(iv) quantity, and

(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(2)(a) to (g);

(c) the drug has not expired and will not expire within the duration of use; and

(d) a pharmacist has completed a clinical assessment of the prescription after reviewing the patient profile.

2. Section 9.1 is added to Part 1 as follows:

Preparation of Prescription Product

9.1 (1) A registrant who prepares a prescription product must ensure that:

(a) the prescription product label matches the prescription information and the information on the manufacturer's label with respect to:

(i) drug,
(ii) dosage form,
(iii) strength,
(iv) quantity,
(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(2)(a) to (g);

(c) the drug is not expired and will not expire within the duration of use; and

(d) his or her identity is documented in writing.

(2) A pharmacy manager must ensure that the record in paragraph (1)(d) is readily available and is retained for at least three years from the date on which the prescription product was last dispensed.

3. Section 10 of Part 1 is amended by adding the following:

(6) Before dispensing a prescription product, a registrant must perform a final check and record his or her identity in writing.

(7) A pharmacy manager must ensure the record in paragraph (6) is readily available and retained for at least three years after the last date on which that prescription product was last dispensed.

4. Section 2 of Part 2 is amended by adding the following definition:

"final check" means ensuring that:

(a) the prescription product and the prescription product label match the product information with respect to:

(i) drug,

(ii) dosage form,

(iii) strength, and

(iv) quantity;

(b) the drug is not expired and will not expire within the duration of use; and

(c) a pharmacist has completed a clinical assessment of the prescription after reviewing the patient profile.

5. Sections 3.1 and 3.2 are added to Part 2 as follows:

Preparation of Prescription Product

3.1 (1) A registrant who prepares a prescription product must ensure that:

(a) the prescription product label matches the product information with respect to:

(i) drug,
(ii) dosage form,
(iii) strength,
(iv) quantity; and

(b) the drug is not expired and will not expire within the duration of use.

Patient Identification

3.2 Unless dispensing to staff, outpatients or the general public under section 4(5), all registrants must use at least two person-specific identifiers to confirm the identity of a patient before providing any pharmacy service to the patient.

6. Section 4 of Part 2 is amended by adding the following:

(6) Prior to releasing a prescription product, a registrant must perform a final check of the prescription product and record his or her identity in writing as required by section 17.

7. Part 2 is amended by adding the following:

17. Documentation of the identity of any registrant who prepared a prescription product or performed a final check must be in writing, readily available and retained for at least three years after the date on which the prescription product was last dispensed.

8. Section 2 of Part 3 is amended by adding the following definition:

"final check" means ensuring that:

(a) the prescription product and the prescription product label match the prescription information and the information on the manufacturer's label with respect to:

(i) drug,

(ii) dosage form,

(iii) strength,

(iv) quantity and

(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(8)(a) to (g);

(c) the drug is not expired and will not expire within the duration of use; and

(d) a pharmacist has completed a clinical assessment of the prescription after reviewing the patient profile.

9. Sections 6.1 and 6.2 are added to Part 3 as follows:

Preparation of Prescription Product

6.1 (1) A registrant who prepares a prescription product must ensure that:

(a) the prescription product label matches the prescription information and the information on the manufacturer's label with respect to:

(i) drug,

(ii) dosage form,

(iii) strength,

(iv) quantity; and

(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(8)(a) to (g);

(c) the drug is not expired and will not expire within the duration of use; and

(d) his or her identity is documented in writing.

(2) A pharmacy manager must ensure the record in paragraph (1)(d) is readily available and is retained for at least three years from the date on which the prescription product was last dispensed.

Patient Identification

6.2 All registrants must use at least two person-specific identifiers to confirm the identity of a resident before providing any pharmacy service to the resident.

10. Section 7 of Part 3 is amended by adding the following:

(3) Before dispensing a prescription product, a registrant must perform a final check and must record his or her identity in writing.

(4) A pharmacy manager must ensure a record in paragraph (3) is readily available and is retained for at least three years from the date on which the prescription product was last dispensed.

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

12. Certified Pharmacist Prescriber

DECISION REQUIRED

Recommended Board Motions:

1. *Direct the Registrar to amend the Certified Pharmacist Prescriber Draft Framework by narrowing the scope of pharmacist prescribing to within collaborative practice settings.*
2. *Direct the Registrar to develop a proposal for pharmacist prescribing within collaborative practice settings – based on the amended Draft Framework and results of the stakeholder engagement – to be brought to the Board for approval to submit to the Minister of Health for consideration.*

Purpose

To review the Certified Pharmacist Prescriber Engagement Report and determine next steps for the Draft Framework and a possible proposal for pharmacist prescribing in BC.

Background

Development of a framework and proposal for pharmacist prescribing stretches back to 2010 when the Board first decided to move forward with a feasibility study. It was later included in the College's 2014/15 – 2016/17 Strategic Plan and a dedicated task group was formed to lead the initiative.

In May 2015, the Advanced Practice Pharmacist Task Group (later re-named to Certified Pharmacist Prescriber Task Group) developed "Establishing Advanced Practice Pharmacists in British Columbia" which proposed pharmacist prescribing in response to the Ministry of Health's call for feedback on several cross sector policy discussion papers. In response to the College's submission, the Ministry of Health requested additional information on societal need, eligibility criteria, and managing perverse incentive to prescribe in addition to further stakeholder engagement.

As a result, the Task Group developed the Certified Pharmacist Prescriber Draft Framework (Draft Framework), which includes information on societal need, proposed eligibility criteria

and standards limits and conditions, as well as practical use cases, and used the Draft Framework to help facilitate stakeholder engagement.

The Draft Framework was approved for stakeholder engagement by the College Board at the November 2015 Board meeting, and a series of consultations were held in Spring/Summer 2016.

The College completed its engagement on pharmacist prescribing, including analyzing the extensive feedback received, and has prepared a report on the results of the engagement which will be published on the College's website following the November Board meeting.

The College would like to thank everyone who contributed feedback during this engagement. From College staff, to members of the Certified Pharmacist Prescriber Task Group and subject matter experts from the UBC Faculty of Pharmaceutical Sciences, many also contributed considerable effort and time to support this engagement.

Certified Pharmacist Prescriber Task Group

The College would also like to extend a sincere thank you to the members of the Certified Pharmacist Prescriber Task Group for their considerable contributions to this initiative. Originally named the Advanced Practice Pharmacist Task Group, their work stretched back to 2010 and included providing recommendations to the Board on policy development related to pharmacist prescribing, stakeholder engagement, and significant contributions to the Draft Framework.

With the Task Group's work now completed, the College Board will use the Draft Framework and the results of the extensive stakeholder engagement to help guide the next steps for this initiative.

Discussion

The Certified Pharmacist Prescriber Engagement Report consolidates all the feedback received through the pharmacist prescribing engagement under four key themes: confidence in pharmacists prescribing, collaboration and communication, improving patient care and support for the initiative.

What We Heard

Overall, stakeholder groups were quite divided in their level of confidence in pharmacists prescribing and support for the initiative. Feedback indicated overwhelming support for the initiative from pharmacists and pharmacy technicians, while responses from other prescribers illustrated strong resistance. Public respondents were divided. This pattern was apparent across the four key themes of confidence in pharmacists prescribing, collaboration and communication, improving patient care, and support for the initiative.

Concerns about business interests in pharmacist prescribing were mentioned across stakeholder groups. Many respondents felt that the conflict of interest and profit incentive in community practice could negatively impact patient safety. Concerns about workload expectations were also raised. Numerous pharmacist respondents also commented on the conflict of interest for pharmacist owners and identified that pharmacist prescribing might provide greater access to health care in small, rural and remote communities – excluding pharmacist owners could limit the benefits of pharmacist prescribing from reaching these communities.

The greatest convergence across stakeholder groups surrounded the opportunity pharmacist prescribing could have in providing greater access to care, especially for minor ailments, emergency situations, continuity of care and for patients without a primary care provider.

Feedback from pharmacists and other prescribers also highlighted that pharmacist prescribing might work best in interdisciplinary team-based settings (such as hospital practice). The use of team-based care with access to more patient information and lab test results provided respondents with greater confidence in pharmacist prescribing. Pharmacist prescribing in hospital practice also does not cause the same concern for business conflicts of interest identified in community pharmacy – a frequent point of concern for respondents.

College Board Pharmacist Prescriber Ad-hoc Working Group

Five Board Members met on November 4, 2016 to review the results of the pharmacist prescribing engagement and develop a recommendation on the next steps for the College Board's consideration.

Collaborative Practice Pharmacist Prescribing

After reviewing the results of Engagement Report, and reflecting further on the initiative, the group came to the consensus that the recommendation to the College Board for next steps should include narrowing the scope of the Draft Framework and the proposal for the Minister of Health, to pharmacist prescribing within collaborative practice.

Pharmacist prescribing within collaborative practice settings would take place in interdisciplinary team-based settings where physicians and nurse practitioners would continue to be responsible for the diagnosis. Access to health records and diagnostics, including lab tests, would also be required. Certified Pharmacist Prescribers would also be restricted from dispensing medications they prescribed for a patient.

Reasons for restricting pharmacist prescribing to collaborative practice include:

- **Conflict of Interest**
  Separating pharmacist prescribing from dispensing and business interests removes the concern for a potential business conflict of interest – a frequent point of concern for respondents.
- **Interdisciplinary team-based settings**
  Collaborative practice settings involve working closely in an interdisciplinary team to care for patients. In this setting, physicians or nurse practitioners provide the diagnosis – an area many other prescribers felt pharmacist prescribers would not have the expertise to practice in.
- **Access to patient health information and lab tests**
  Pharmacists working in collaborative practice settings already have access to patient health information and lab tests. Lack of access to patient information, and diagnostic tests (including lab tests) outside of interdisciplinary settings was a key point of concern identified by many pharmacists and other prescribers.

Minor Ailments and Emergency Refills

Pharmacy professionals, the public and other prescribers all highlighted some examples where pharmacist prescribing could have the opportunity to improve access to care for minor ailments, refills and renewals. However, significant concerns still remained around prescribing for minor ailments including access to electronic health records, access to and ordering of lab tests, and conflict of interest with prescribing and dispensing.

The working group of the Board suggested that the College may want to look more closely at how the authority in Professional Practice Policy 58 to adapt prescriptions (including renewals) could help improve access to safe and effective drug therapy for patients.

Recommendation

With an interdisciplinary team-based setting that includes access to health records and diagnostic information, and restriction from prescribing and dispensing, the College Board Pharmacist Prescriber Working Group recommends:

1. *Direct the Registrar to amend the Certified Pharmacist Prescriber Draft Framework by narrowing the scope of pharmacist prescribing to within collaborative practice settings.*
2. *Direct the Registrar to develop a proposal for pharmacist prescribing within collaborative practice settings – based on the amended Draft Framework and results of the stakeholder engagement – to be brought to the Board for approval to submit to the Minister of Health for consideration.*

Next Steps

Depending on the College Board decision at the November 2016 Board meeting, the Draft Framework may need to be updated to reflect the revised scope and collaborative practice setting requirements. Feedback on other areas of the Draft Framework, such as education program requirements, will also be used to further develop the Draft Framework. It will also be revised to focus more closely on the benefit to patient care.

Based on a revised Draft Framework, the College will also develop a proposal for collaborative practice pharmacist prescribing in BC to submit to the Minister of Health for consideration.

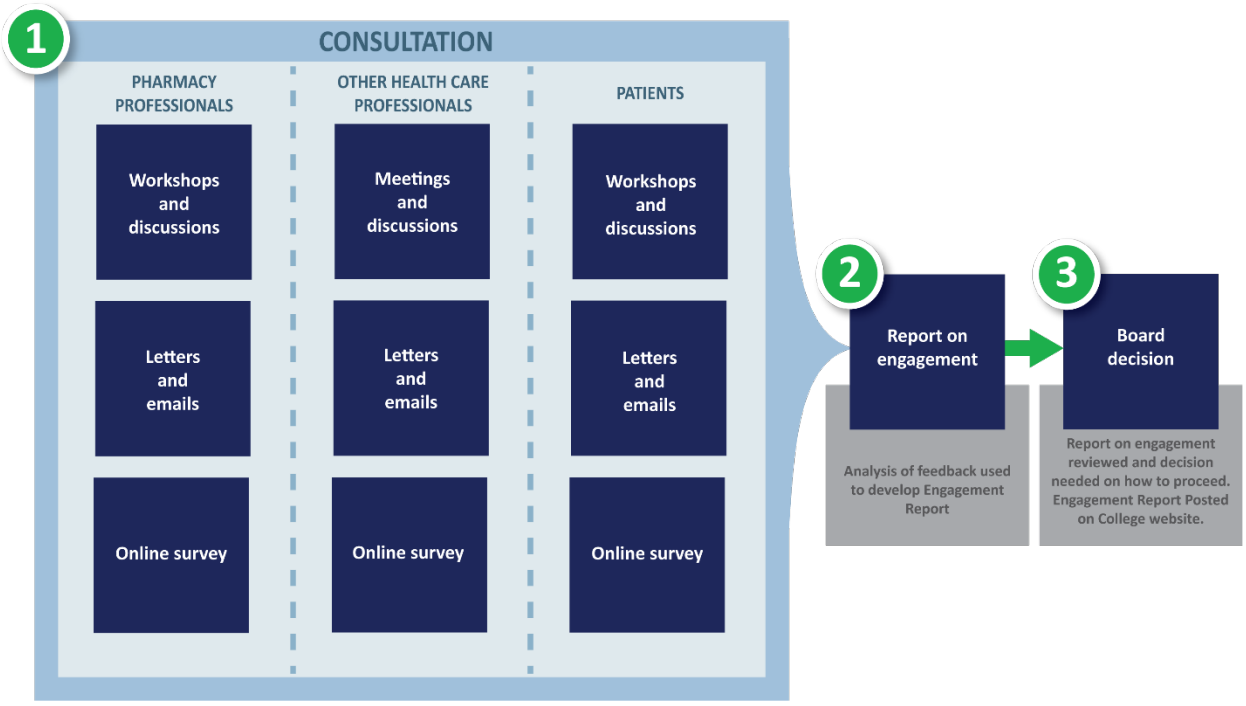
The College will need to assess the work and time required to revise the Draft Framework and develop a proposal for pharmacist prescribing within collaborative practice settings to the Minister of Health, and determine the timeframe for completing the next steps for this initiative.

Once complete, both the revised Draft Framework and the proposal for pharmacist prescribing will be brought to the Board for approval.

Pharmacist Prescribing Engagement Overview

Consultation Process

The College followed International Association for Public Participation (IAP2) best practices in planning and executing the pharmacist prescribing engagement. The College clearly communicated the engagement process to stakeholders, including identifying how the feedback received would be used and how the results of the engagement would be shared – this is an essential part of an effective and transparent engagement strategy and following IAP2 Core Values.



The pharmacist prescribing consultation period ran from February 2016 through to August 2016. The College received feedback on the framework through a variety of methods ranging from in-person workshops, and meetings with stakeholder group representatives, to online survey responses and further feedback through letters and emails.

Analysis and reporting on the results of the engagement occurred through September to October 2016. The resulting Engagement Report was prepared by College staff and presented to the College Board at the November 2016 Board Meeting.

The Engagement Report will also be made available on the College's website – an important step in providing the results of the engagement back to participants, demonstrating transparency and following IAP2 best practices.

Engagement Overview

The level of participation during the Certified Pharmacists Prescriber Engagement was one of the largest the College has ever experienced. We would like to thank everyone who provided feedback during the consultation period as well as those who helped build awareness of the opportunity to provide input.

To solicit feedback on pharmacist prescribing in BC and the Draft Framework, the College conducted extensive stakeholder engagement on pharmacists prescribing. Feedback was collected in the follow ways:

- 1,501 completed responses through an online survey (over 11,400 comments provided)
- 13 in-person workshops/discussions (a web-conference was used for those who could not attend in person)
- 3 meetings with other prescribing regulatory bodies
- 10 official letters of response
- 7 emails from individuals

During the course of our online consultation period there were more than 6,900 visits to the Certified Pharmacist Prescribing Engagement page on the College's website. We also reached over 200,000 through our social channels (Twitter, Facebook and Instagram) which shared information about the draft framework and encouraged participation in the online survey.

Organizations the College heard from through the Pharmacist Prescribing Engagement

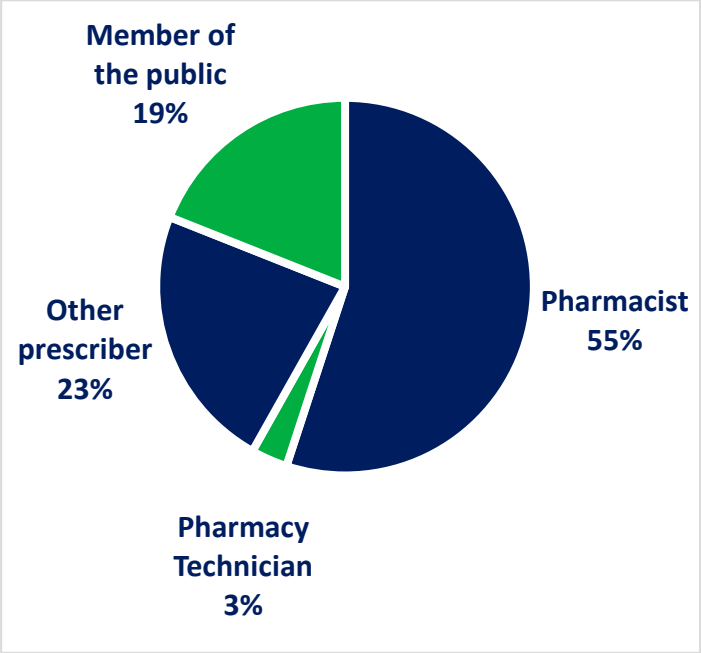
- Association of Registered Nurses of BC
- BC Pharmacy Association
- BC College of Family Physicians
- BC Health Authorities (Pharmacy Directors)
- BC Nurse Practitioner Association
- Best Medicines Coalition
- Better Pharmacare Coalition (BC)
- British Columbia Association for People on Methadone (BCAPOM)
- Canadian Arthritis Patient Alliance
- Canadian Society of Hospital Pharmacists of BC
- Canadian Council of the Blind
- College of Pharmacists of BC Hospital, Community and Residential Care Advisory Committees
- College of Registered Nurses of BC
- College of Naturopathic Physicians of British Columbia
- College of Physicians and Surgeons of BC
- Doctors of BC
- Gastrointestinal Society
- The Kidney Foundation of Canada BC & Yukon
- University of British Columbia – Faculty of Pharmaceutical Sciences
- Patient Voices Network (BC Patient Safety and Quality Council)
- Pharmacy Leaders of Tomorrow
- Society of General Practitioners of BC
- Specialists of BC
- Vancouver Area Network of Drug Users (VANDU)

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

Online Survey Engagement Demographics

The College asked survey respondents to identify if they were a pharmacist, pharmacy technician, other prescriber or member of the public. While the majority of responses came from pharmacists (over 820), the College received many responses from both other prescribers (over 340 responses) and the public (over 280 responses). The College also heard from a small selection of pharmacy technicians (over 45) on their thoughts on pharmacist prescribing and how it could impact their practice.



Purpose of the Engagement

At the November 2015 Board Meeting, the College committed to working with stakeholders (pharmacists and pharmacy technicians, other prescribers, and the public) to solicit feedback on the Draft Framework and the future of pharmacist prescribing in BC.

Specifically, the College desired to:

- Learn how stakeholders feel about introducing pharmacist prescribing in British Columbia.
- Hear from stakeholders on any risks that have not been identified and planned for in the Draft Framework, and identify any gaps that have not been addressed.
- Receive input on eligibility requirements, especially educational prerequisites, to become a Certified Pharmacist Prescriber.
- Receive feedback on how pharmacist prescribing could work in BC which could be used to make recommendations to change the Draft Framework as needed.
- Provide the College Board with feedback on how stakeholders feel about pharmacist prescribing, to help in decision making on next steps.
- Possibly supplement a proposal to the Minister of Health for pharmacist prescribing in BC, depending on the Board's decision to proceed.

Appendix

1	Certified Pharmacist Prescriber Engagement Report
2	Official Letters of Response

College of Pharmacists
of British Columbia

CERTIFIED PHARMACIST PRESCRIBER

Engagement Report

November 4, 2016

CONTENTS

INTRODUCTION

In November 2015, the College of Pharmacists of BC Board approved the Certified Pharmacist Prescriber Draft Framework (Draft Framework) to be used for stakeholder consultations on pharmacist prescribing in BC.

Using the Draft Framework as a discussion document, the College engaged with pharmacy professionals, other prescribers and patients to solicit feedback.

The engagement on pharmacist prescribing ran from February through to August 2016 and included both in-person and online consultations as well as written submissions. The College held 15 different workshops and stakeholder meetings, and heard from over 25 different groups and organizations. The College's also received over 11,400 comments from over 1,500 respondents through its online survey.

This report consolidates all the feedback received through the pharmacist prescribing engagement under four key themes:

- confidence in pharmacists prescribing,
- collaboration and communication,
- improving patient care, and
- support for the initiative.

The engagement report is intended to help inform the Draft Framework and assist the College Board in making a decision on how the College should move forward with the framework for pharmacist prescribing in BC.

The College would like to thank everyone who contributed feedback during this engagement. The College would also like to thank College staff, members of the Certified Pharmacist Prescriber Task Group and subject matter experts from the UBC Faculty of Pharmaceutical Sciences who contributed considerable effort and many evenings to help develop the Draft Framework and support the engagement process.

Background

Work towards forming a framework and proposal for pharmacist prescribing stretches back to 2010 when the College Board first directed the College to move forward with a feasibility study. It was later included in the College's 2014/15 – 2016/17 Strategic Plan and a dedicated task group was formed to lead the initiative.

In May 2015, the Task Group developed "Establishing Advanced Practice Pharmacists in British Columbia" which proposed pharmacist prescribing in response to the Ministry of Health's call for feedback on several cross sector policy discussion papers. In response to the College's submission, the Ministry of Health requested additional information on societal need, eligibility criteria, and managing perverse incentive to prescribe in addition to further stakeholder engagement.

The task group developed the Draft Framework in response to the Ministry of Health's feedback and to help facilitate stakeholder engagement – it includes information on societal need, proposed eligibility criteria and standards, limits and conditions, as well as practical use cases.

The College Board approved the Draft Framework for stakeholder engagement at the College's November 2015 Board meeting and the College launched the pharmacist prescribing engagement in early 2016.

Purpose

The College Board approved the Draft Framework for pharmacist prescribing at the November 2015 Board Meeting. As part of that approval, the College committed to working with stakeholders (pharmacists and pharmacy technicians, other prescribers, and the public) to solicit feedback on the Draft Framework and the future of pharmacist prescribing in BC.

Specifically, the College wanted to:

- Learn how stakeholders feel about introducing pharmacist prescribing in British Columbia.
- Hear from stakeholders on any risks that have not been identified and planned for in the Draft Framework, and identify any gaps that have not been addressed.
- Receive input on eligibility requirements and educational prerequisites, to become a Certified Pharmacist Prescriber.
- Receive feedback on how pharmacist prescribing could work in BC which could be used to make recommendations to change the Draft Framework as needed.
- Provide the College Board with feedback on how stakeholders feel about pharmacist prescribing, to help in decision making on next steps.
- Possibly supplement a proposal to the BC Minister of Health for pharmacist prescribing in BC, depending on the College Board's decision to proceed.

SUMMARY

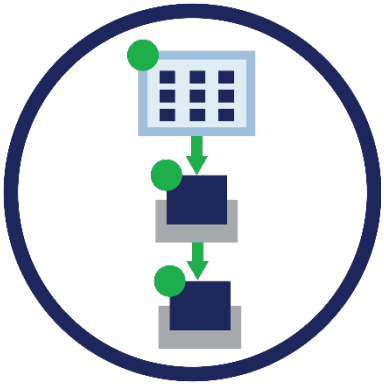
Overall, stakeholder groups were quite divided in their level of confidence in pharmacists prescribing and support for the initiative. Feedback indicated overwhelming support for the initiative from pharmacists and pharmacy technicians, while responses from other prescribers illustrated strong resistance. Public respondents were divided. This pattern was apparent across the four key themes of confidence in pharmacists prescribing, collaboration and communication, improving patient care, and support for the initiative.

A greater focus on team-based care was suggested frequently by patients, either as an area to focus on in pharmacist prescribing, or as an alternative strategy to pharmacist prescribing for improving patient care. Both pharmacists and other prescribers highlighted concerns related to collaboration and communication and expressed a desire for more direct communication between pharmacists and physicians. Pharmacists also emphasized the need to have access to lab test results.

Concerns about business interests in pharmacist prescribing were mentioned across stakeholder groups. Many respondents felt that the conflict of interest and profit incentive in community practice could negatively impact patient safety. Concerns about workload expectations were also raised. Numerous pharmacist respondents also commented on the conflict of interest for pharmacist owners and indicated preventing pharmacist owners from prescribing may not be the best approach. Many pharmacists identified that pharmacist prescribing might provide greater access to health care in smaller, rural and remote communities – excluding pharmacist owners could limit the benefits of pharmacist prescribing from reaching these communities.

Feedback from some pharmacists and other prescribers highlighted that pharmacist prescribing might work best in interdisciplinary team-based settings (such as hospital practice). The use of team-based care with access to more patient information and lab test results provided respondents with greater confidence in pharmacist prescribing. Pharmacist prescribing in hospital practice also does not cause the same concern for business conflicts of interest identified in community pharmacy – a frequent point of concern for respondents.

The greatest convergence across stakeholder groups surrounded the opportunity pharmacist prescribing could have in providing greater access to care, especially for minor ailments, emergency situations, continuity of care and for patients without a primary care provider.



ENGAGEMENT PROCESS

The College followed International Association for Public Participation (IAP2) best practices in planning and executing the pharmacist prescribing engagement. The engagement process was communicated to stakeholders, including identifying how the feedback received would be used and how the results of the engagement would be shared – this is an essential part of an effective and transparent engagement strategy and following IAP2 Core Values.

A dedicated pharmacist prescribing web page was published on the College's website which provided an overview of the Draft Framework, the purpose of the engagement and the engagement process, and invited participation in the consultation. The page was also intended to include the results of the engagement with the publication of this report.

The pharmacist prescribing consultation period was conducted from February 2016 through to August 2016. The College received feedback on the Draft Framework through a variety of methods ranging from in-person workshops, and meetings with stakeholder group representatives, to online survey responses and further feedback through letters and emails.

The College initially sought feedback from pharmacy professionals in community, residential and hospital practice before opening the online survey and engaging with patients and other prescribers.

Analysis and reporting on the results of the engagement occurred through September to October 2016. The resulting Engagement Report was prepared by College staff and presented to the College Board at the November 2016 Board Meeting.

This Engagement Report was also made available on the College's website following the November 2016 College Board Meeting – an important step in providing the results of the engagement back to participants, demonstrating transparency and following IAP2 best practices.

PHARMACIST PRESCRIBING ENGAGEMENT PROCESS

1

The College held a series of workshops and discussions with stakeholders, and also invited feedback through an online survey. Some organizations and individuals also provided the College with letters and emails that expressed their feedback on the Certified Pharmacist Prescriber Draft Framework and their thoughts on the future of pharmacist prescribing in BC.

2

All stakeholder feedback gathered through the in-person and online consultations and letters and emails received was consolidated and reviewed by independent data analysis company hired by the College. The analysis of the feedback was used by College staff to develop this Engagement Report.

3

The Engagement Report will be presented to the College Board. Through the Engagement Report, the feedback the College received will help support the College Board in forming its decision on pharmacist prescribing, including next steps for the Draft Framework and determining whether developing a proposal for pharmacist prescribing in BC is appropriate.

The Engagement Report will be posted online on the College's website to ensure participants and stakeholders can be informed of the results of the pharmacists prescribing engagement.

WHO WE HEARD FROM

The level of participation during the Certified Pharmacist Prescriber Engagement was one of the largest the College has ever experienced. We would like to thank everyone who provided feedback during the consultation period as well as those who helped build awareness of the opportunity to provide input.

Engagement Overview

To solicit feedback on pharmacist prescribing in BC and the Draft Framework, the College conducted extensive stakeholder engagement on pharmacists prescribing. Feedback was collected in the follow ways:

- 1,501 completed responses through an online survey
- 13 in-person workshops/discussions (a web-conference was used for those who could not attend in person)
- 3 meetings with other prescribing regulatory bodies
- 10 official letters of response
- 7 emails from individuals

Throughout February to June 2016, the College held 16 different workshops and stakeholder meetings with pharmacy professionals, other prescribers and patients – we heard from over 200 individuals through workshops and meetings.

The College's online consultation ran from June 3 to July 15 and invited pharmacy professionals, the public and other stakeholders to review the framework and share their thoughts on pharmacists prescribing in BC through an online survey. The College extended the initial online consultation period by two weeks at the request of stakeholders from June 30 to July 15.

Organizations the College Heard From

The College heard from and over 25 different groups and organizations during the course of the engagement.

ORGANIZATIONS WE HEARD FROM

- Association of Registered Nurses of BC
- BC Pharmacy Association
- BC College of Family Physicians
- BC Health Authorities Pharmacy Directors
- BC Nurse Practitioner Association
- BC Psychiatric Association
- Best Medicines Coalition
- Better Pharmacare Coalition (BC)
- British Columbia Association for People on Methadone
- Canadian Arthritis Patient Alliance
- Canadian Society of Hospital Pharmacists of BC, BC Branch
- Canadian Council of the Blind
- College of Pharmacists of BC Hospital, Community and Residential Care Advisory Committees
- College of Registered Nurses of BC
- College of Naturopathic Physicians of British Columbia
- College of Physicians and Surgeons of BC
- Doctors of BC
- Gastrointestinal Society
- The Kidney Foundation of Canada BC & Yukon
- University of British Columbia – Faculty of Pharmaceutical Sciences
- Patient Voices Network (BC Patient Safety and Quality Council)
- Pharmacy Leaders of Tomorrow
- Society of General Practitioners of BC
- Specialists of BC
- Vancouver Area Network of Drug Users

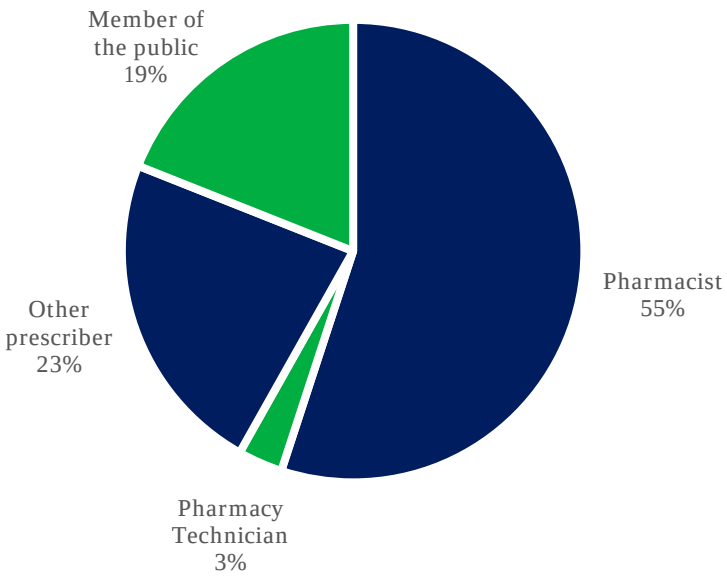
Online Engagement

During the course of the online consultation period there were more than 6,900 visits to the Certified Pharmacist Prescriber Engagement page on the College's website. The College also estimates it reached over 200,000 impressions through its social channels (Twitter, Facebook and Instagram) which was used to share information about the Draft Framework and encourage participation in the online survey.

Over 1,500 completed the online survey providing over 11,400 answers to a range of questions on pharmacist prescribing.

Online survey demographics

The College asked survey respondents to identify if they were a pharmacist, pharmacy technician, other prescriber or member of the public. While the majority of responses came from pharmacists (over 820 responses), the College received many responses from both other prescribers (over 340 responses) and the public (over 280 responses). The College also heard from a number of pharmacy technicians (over 45 responses) on their thoughts on pharmacist prescribing and how it could impact their practice.

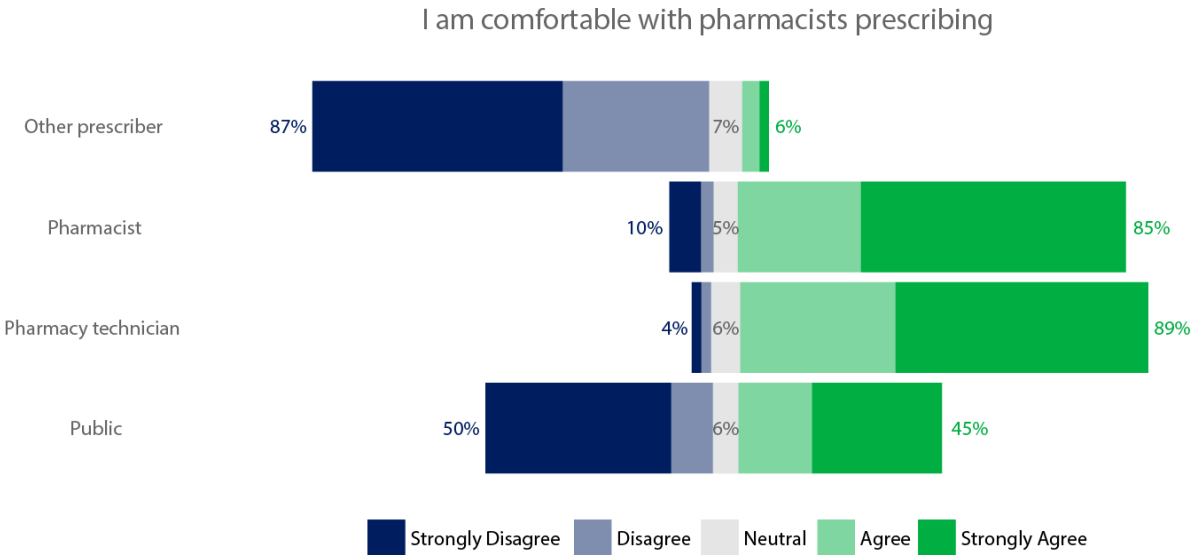


CONFIDENCE IN PHARMACIST PRESCRIBING

The College sought feedback on confidence in pharmacist prescribing based on the draft framework. This covered seeking input on educational requirements, the approach to managing conflict of interest, and other standards, limits and conditions in the Draft Framework. It also included gauging the level of confidence pharmacy professionals and other prescribers would have in a certified pharmacist prescriber, and the level of confidence a patient would have in receiving care through a pharmacist prescribing.

Confidence in Ability to Prescribe

Overall, stakeholder groups were quite divided in their level of confidence in pharmacists prescribing. While pharmacists and pharmacy technicians showed rather high levels of confidence on this matter, other prescribers showed low levels of confidence. Members of the public were often divided.



Comments in the survey highlight that among stakeholder groups[1], there were generally three types of respondents:

- Those who are extremely positive in their responses
- Those who are extremely negative in their responses
- Those who offer mixed, nuanced, or balanced responses

The first two groups rarely provided detailed feedback, other than expressing their enthusiasm for or opposition to pharmacists prescribing. The third group, however, often had many questions about the Draft Framework, showed balanced points of view, and provided useful ideas and suggestions.

Responses from other prescribers and pharmacists tended to form into three or more like-minded groups – the majority of respondents expressed views that were not uniformly in strong disagreement or agreement with elements of the Draft Framework.

The major concerns amongst other prescriber respondents were the risk of pharmacists being inadequately trained to prescribe, fragmentation of patients' care, and inadequate diagnosis. They were also concerned that patients wouldn't get a full physical assessment that would be done at a physician's office, potentially allowing for conditions to be missed by a pharmacist prescriber.

Unlike the other prescriber respondents, pharmacists had greater confidence in pharmacists receiving adequate training. They were generally more concerned with liability, issues with financial interest and pressure to hit quotas, remuneration, and conflict of interest.

In the case of public respondents, there was more of a division between those who responded positively to the framework and those who disagreed with it. Pharmacy Technicians were generally quite positive which could be a result of both the small number of technician respondents and their overall high support for the Draft Framework.

[1] Except for pharmacy technicians, whose sample size was too small to make any certain conclusion.

Public Confidence in Pharmacist Prescribing

Public confidence in pharmacist prescribing is divided. The public also struggled with the Draft Framework and understanding how pharmacist prescribing could work in BC.

While 45% of public respondents agreed that they were comfortable with pharmacist prescribing, only 43% agreed that they felt confident in a pharmacist's ability to make the best prescribing decision for a patient. That percentage rose slightly by 5 percent to 48% when asked if they felt confident given that additional training and education was necessary to become a Certified Pharmacist Prescriber.

Public confidence did not substantially change when respondents were asked if they felt confident in a pharmacist's ability to make the best decision for a patient they saw regularly. Only 43% agreed to a certain degree while 51% disagreed. The level of confidence in a pharmacist's ability to make the best prescribing decision when they had access to the patient's chart was even more divided, with 46% of public respondents agreeing, 45% disagreeing and 8% being neutral.

Should pharmacist prescribing move forward in BC, these results highlight the need to further communicate and educate the public on the role of pharmacists and how safe and quality care could be provided to the public through pharmacist prescribing. Many comments, from all stakeholder groups, also stressed the need to get a better understanding of the public's needs and desire for a pharmacist expanded scope of practice.

"My doctor has a limited amount of time with me and often I feel rushed and forget things I want to discuss with him. Being able to discuss without an appointment (or with one) my health care related concerns and the medications that go along with them, with my local community pharmacist, it would give me more of a sense of being in control of the outcomes." – Public Respondent

Confusion is possible. There is a huge problem with discontinuity in health care - Walk in Clinic, MD office, Public health, Emergency, hospital, Naturopath, and now Pharmacist - it makes this worse. How about a team working together for the patients' benefit/health all in one location and all paid on salary so there is great continuity and no conflict of interest. – Public Respondent

"I won't need to make appointments way in advance to my doctor just to get a refill, and it will save me a lot of time since I don't need to wait in line for walk-in offices. I also would like that my pharmacist can be more involved in my meds. Right now I have to relate things my doctor tells me to my pharmacist, or he has to call my doctor and there's a delay." – Public Respondent

"Refills will be easier, but who will order the blood work?" – Public Respondent

"Since I do not have a regular doctor in the city where I live, and it is considerably difficult finding a GP here… having a pharmacist prescriber would greatly reduce the burden of visiting walk in clinics." – Public Respondent

"My trust is in the physician's ability to diagnose a problem. There is a different level of expertise between a physician and pharmacist in this regard." – Public Respondent

"I anticipate relying on the pharmacist prescribing in emergencies or unexpected situations where I can't get to my doctor." – Public Respondent

"Could potentially add confusion if physician is not properly notified or does not agree with care decisions made by pharmacist." – Public Respondent

"This would only work effectively with close collaboration with physicians. I'm not confident that this close relationship would truly come to fruition. As with any expansion of scope of practice the reality is the profession having its scope encroached on will most likely become a barrier. An initiative such as this would have more success, and I mean a realized benefit for patients and not implementation of an initiative, if it is gradual and the model of integrated and collaboration taught to the new physicians and pharmacists." – Public Respondent

"I want a physician who has the knowledge base to diagnose and evaluate my condition. If my physician is unsure about which pharmaceutical to use, he can consult with my pharmacist. If my pharmacist sees a physician-prescribed drug which, in his view, is contraindicated, his job is to contact my physician and give advice about the reason to change and, possibly, an alternative prescription to make. This patient-safety check is the role that the public sees and understands as the role of a pharmacist." – Public Respondent

"My doctor sees me for all of 5 minutes and doesn't really know me at all. They just write a prescription and half the time they are wrong on their diagnosis. My pharmacist sees me way more often and takes the time to talk about the drugs and gives me way more information about how my body will benefit or suffer" – Public Respondent

Confidence with Pharmacist Prescribing for Minor Ailments

All respondent groups provided comments suggesting that pharmacist prescribing may be appropriate for minor ailments – these conditions are self-limiting, last for a short period of time, are less serious in nature and typically do not require lab tests or a doctors' visit. Pharmacists, the public and pharmacy technicians expressed the most interest in having pharmacist prescribers treat minor ailments, while other prescribers expressed the least interest.

The majority of public respondents said they would use Certified Pharmacist Prescribers for prescription renewals, prescription refills and minor ailments. Many public respondents shared that they were frustrated with having to revisit physicians for recurring, long term issues. They saw pharmacist prescribers as a health professional they could access for a timely prescription renewal, or to treat an issue they felt was not serious (such as a cold, eczema, or birth control pills). Some indicated they would not use pharmacist prescribing services.

"I would still go back to my doctor for medical issues not related to taking regular medication." – Public Respondent

"Simple medical conditions would not require a visit to my doctor who is already overloaded with patients." – Public Respondent

"I would not accept care from a pharmacist prescriber so my relationship would remain with my primary care provider." – Public Respondent

"I see myself not using my family doctor's time for simple issues like eczema, bladder infections and birth control pills." – Public Respondent

"Fewer doctor and clinic visits for standard ailments like colds. A no brainer. Could transform our system. Do it yesterday. It will save the system so much money, and patients so much time and hassle." – Public Respondent

"I would prefer to go to pharmacists for minor ailment where I won't have to wait and can get quick service." – Public Respondent

"I believe pharmacists should be able to write simple prescriptions, renew prescriptions and maybe even diagnose simple ailments." – Public Respondent

I have no family doctor. A prescribing pharmacist would make access to health care easier. – Public Respondent

Yes, I would go to pharmacist for minor issues and be happy that the pharmacist can refer and collaborate if the issue requires it. This will allow the GP more time to give more in depth care to patients who require it. – Public Respondent

"Never want to stop seeing my physician. I love my physician. I can't imagine having any relationship with a pharmacist. I don't see how they could ever have the what physicians offer with private offices, examinations, delivering babies, seeing me in hospital or in the emergency department or calling a pharmacist to do a house call when I'm sick or my kids are." – Public Respondent

"[For birth control, it] is a huge unnecessary barrier to have to go to the doctor and then pharmacy....it should be over the counter by now almost. Would really open up the conversation and could potentially decrease teenage pregnancy with more education and accessibility...seriously! OPT clinics don't have the best times and or locations to meet the needs of teenagers. – Public Respondent

Many other prescriber respondents emphasized that physician visits for minor ailments or renewals are still an important opportunity to check-in with patients. However, some other prescribers still suggested that pharmacist prescribers could benefit patients through providing prescription renewals and treating minor ailments.

"It allows patient to avoid unnecessary doctor visits by accessing health care services and necessary information from a certified pharmacist prescriber. Moreover, it allows the certified pharmacist prescribers to deal with any patient prescription issues, which saves the unnecessary time waste from patient revisiting physicians for prescription issues, refills, or similar issues." – Other Prescribing Respondent

"Even in the case of minor ailments, patients often raise more serious health concerns when seeking treatment for minor conditions and in these cases, it is more efficient to address all health concerns in a single visit." – Letter from Doctors of BC

"Providing refills prior to a physician reassessment when drugs have run out." – Other Prescribing Respondent

Filling in gaps of care is very important and taking care of minor issues which do not typically require involvement of the primary care physician will free up their time." – Other Prescribing Respondent

"Risk that patients could make less frequent visits for physical examinations as appropriate for their condition." – Other Prescribing Respondent

"Long term standard prescriptions require regular visits to a doctor to renew them. Allow pharmacists more freedom in renewing prescriptions. Also, allow pharmacists more time to share their knowledge with their client eg. age related side effects and drug interactions, with percentage possibilities. Only the computer generated red flags are sometimes noted to the client, it seems." – Other Prescribing Respondent

"Care can be provided in a more timely manner. Also patients who require more complex care of a physician or emergency center will have better access if minor complaints are taken care of by a pharmacist or emergency center will have better access if minor complaints are taken care of by a pharmacist." – Other Prescribing Respondent

"I believe you are over estimating the number of physician visits that would be reduced, as seeing a pharmacist who isn't skilled would likely lead to the patient seeing their doc anyway." – Other Prescribing Respondent

"They [patients] would be more likely to not miss medication due to poor access to primary care providers for refills." – Other Prescribing Respondent

"Quicker treatment for minor ailments. Safer prescribing looking at their renal function/drug monitoring pathways." – Other Prescribing Respondent

Benefit if they prescribe for minor issues only. Benefit from counseling around medications/side effects. Benefit from prescribing emergency prescriptions to avoid interruption of medications. – Other Prescribing Respondent

Pharmacists and pharmacy technicians emphasized the opportunity pharmacist prescribing has in treating minor ailments and providing prescription renewals in a more timely way for patients.

"Patients suffering from minor aliments would not have to be turned away while suffering if they can't find a doctor on short notice or late hours." – Pharmacy Technician

"Currently, some MDs will send the patient to the pharmacist to make a recommendation ie. allergic rhinitis case – so they are asking the pharmacist to prescribe for this minor ailment already." – Pharmacist Respondent

"In October 2015, the McMaster Health Forum convened a citizen panel to explore models for pharmacist prescribing in Ontario. The purpose of the panel was to guide the efforts of policymakers, managers and professional leaders who make decisions about the health-care system. What they found was that patients overwhelmingly preferred allowing pharmacists to prescribe medications for minor aliments without the patient having to see their family doctor, but patients were not in favour of allowing pharmacists with special training to prescribe them a broad range of prescription drugs without patients seeing their physician."
- Letter from the BC Pharmacy Association

I believe the biggest impact that pharmacist prescribing authority will have on my daily practice is the amount of patients that we have to refer to the emergency department for minor ailments such as need for antibiotics, cold sore medication, and general reauthorization of prescriptions. Living in a rural community where the doctors are completely overwhelmed by patients and workload, I believe this is essential to provide better health care services to the people of our community. Our local hospital is only open until 8 pm and we have no walk in clinic, the nearest is 45 minutes away. Patients with mobility issues lack the care they need as most doctors here book 2 months away as they all have an overload of patients. Due to their increased workload, most doctors here refuse fax requests, so the patients are left with not many options other than the emergency department. This initiative would benefit the people of our community, and many other communities likewise. – Pharmacy Technician

As a military pharmacist (BC license) who works under a federal jurisdiction, I already have an expanded scope of practice and independently prescribe (schedule 1 drugs included) for 14 minor ailments. – Pharmacist Respondent

"[Pharmacist prescribing] would most definitely benefit the patient. Access to prescription medication for minor ailments and for short term use would be incredibly convenient for people. I have complete confidence in the ability to prescribe schedule one drugs in certain situations. It would shorten wait times at walk-in clinics, and patients may be more likely to seek treatment earlier when they know it won't be an unreasonable hassle." – Pharmacy Technician

"Pharmacists are the most accessible health care providers. On a daily basis I get questions from patients that are in need of some therapeutic intervention. In many cases, these patients present late at night or at times where they cannot get in to see a medical professional on the same day. I think that in certain cases, a prescribing pharmacist can play a major role and help these patients. Also, pharmacist prescribers can elevate some of the burden currently placed on physicians. There are many times patients can be effectively and safely treated by prescribing for minor ailments. Pharmacists are truly "medication experts" and currently I do not believe that our knowledge is being properly utilized in the traditional community pharmacy. A lot of patient, pharmacist and physician time is wasted on a daily basis when it comes to medication issues. Whether it is interactions, dosing errors, or inaccurate prescriptions, a pharmacist could easily step in make a change to therapy. Once a diagnosis has been made by a physician, I truly believe that pharmacists should be able to make changes to therapy if problems arise. All together, pharmacists can really help improve patient outcomes, but also make the healthcare system much more efficient." – Pharmacist Respondent

"Patients are currently seeking care from pharmacists for minor conditions (e.g. cold), and pharmacists can recommend over-the-counter medications for the patients. With additional education and training. I firmly believe pharmacists can take care of patients safely and effectively. Allowing pharmacists to treat chronic illnesses could alleviate workload of physicians." – Pharmacist Respondent

"Most Pharmacists I know are very aware of their training and knowledge. I believe most community pharmacists would be comfortable in minor ailments prescribing and would universally refer clients who have unusual symptoms or complex issues not well handled by a pharmacist. In fact, my intuition would lead me to believe that in the early transition years of prescribing, most pharmacists will be very conservative." – Pharmacist Respondent

"I would have confidence in pharmacist prescribing provided it is a minor ailment or a minor adjustment to chronic drug therapy." – Pharmacist Respondent

Many patients visit the pharmacy before visiting the physician if they feel that it is not serious and can be taken care of with sole over the counter medications. These patients are often referred back to the physician and return with a prescription. It could become more efficient and cost effective if pharmacists can assess and prescient for minor ailments.
– Pharmacist Respondent

"It will speed up the time for patients seeking help from minor illness."
– Pharmacist Respondent

"Qualified pharmacists, many of us with many years of practice experience, are a great first line option to prescribe for minor ailments for the general public." – Pharmacist Respondent

Confidence with Pharmacist Prescribing in Collaborative Care Environments

Feedback from some pharmacists and other prescribers highlighted that pharmacist prescribing might work best in a clinical setting.

The use of team-based care and access to more patient information and lab tests provided respondents with greater confidence in pharmacist prescribing within a clinical setting. Many hospital pharmacists working in interdisciplinary teams indicated they were already covering much of the scope included in the Draft Framework. Their practice setting involves working closely in an interdisciplinary care team to care for patients. In this setting, physicians or nurse practitioners provide the diagnosis – an area many other prescribers felt pharmacist prescribers would not have the expertise to practice in.

Pharmacists working in collaborative practice settings already have access to patient health information and lab tests. This was a key point of opposition and concern for the community practice setting.

Pharmacists and some other prescribers also highlighted admission and discharge in hospital practice as a scenario where pharmacists prescribing could be beneficial.

Pharmacist prescribing in collaborative settings like hospital practice, where there is no incentive to prescribe and dispense, does not cause the same concern for a potential business conflict of interest – a frequent point of concern for respondents.

Pharmacist prescribing within an institutional setting (collaborative and independent prescribing) by hospital pharmacists already exist and this has clearly been shown to benefit hospital patients, physicians and the health care system. Pharmacist prescribing can further enhance medication reconciliation on admission and discharge, reduce the number of prescribing errors, reduce logistical burden to physicians and contribute towards timely and seamless hospital discharge. Formal recognition of prescribing by hospital pharmacists with the Certified Pharmacist Prescriber Initiative would greatly enhance provision of care to hospitalized patients as well as contribute to a more efficient and successful transition back into the community. As well, hospital pharmacists do not carry a conflict of interest with prescribing as their wages are salaried by the various health authorities and there is no profit generation with dispensing of medication within a hospital.
– Letter from Canadian Society of Hospital Pharmacists, BC Branch

Pharmacist prescribers need to be readily accessible, evenings, weekends and at night for the emergency room when wanting to discharge patients from the emergency room.
– Other Prescribing Respondent

"I agree that pharmacists who have the additional certification and updated education can provide good quality prescribing care especially when there is ready access to diagnostic test results or being able to order them. In the hospitals, pharmacists already make prescribing decisions under the name of physicians with whom they have established relationships with. My concern is that many community pharmacies still have a work flow structure that does not accommodate prescribing. When the revenue is primarily through dispensing, pharmacist may feel a lot of pressure to focus on that instead of the steps needed to prescribe."
– Pharmacist Respondent

We have carefully considered the unique circumstances of hospital based pharmacists being granted prescribing authority. In this situation, the hospital pharmacist is part of an onsite collaborative team, and has ready access to a unified patient record that includes admitting history, physical examination assessments, investigations, consultations from other allied health providers, and progress notes. The patient in this circumstance has had the benefit of a medical or nurse practitioner assessment, leading to a diagnosis and treatment plan. In the most complex situations, the pharmacist has been directly involved with medication review and management in a collaborative relationship with either the medical or nurse practitioner. The role of the hospital pharmacist is not one of providing an assessment, diagnosis, and prognosis: this role is provided by the attending physician and/or nurse practitioner, whose training and expertise is focused on assessment and diagnosis. It seems entirely appropriate for hospital pharmacists to provide prescriptions at time of discharge, having been engaged in the medication optimization and management during the patient's stay.
– Letter from the College of Physicians and Surgeons of British Columbia

The devil is in the details, what the documentation includes, format, ability to integrate with EMRs. This is separate also from having confidence that the decision, rationale, monitoring and follow up were appropriate. Physicians are liable for their patient care, and if they don't look carefully at information provided and take steps to double check that all is as advertised, they could end up with problems. It is one thing to willingly work in a team setting e.g. a multidisciplinary clinic or hospital with regular reviews, and to be out in the community getting missives from various pharmacists you don't know and have no good way to assess their competence. – Other Prescribing Respondent

Education and Training Requirements

Generally, there was a strong sense from respondents that the Draft Framework did not require sufficient training or education for pharmacists to prescribe. This is understandable as the College specifically included only high level educational requirements in the Draft Framework with the intention of developing more detailed requirements based on the feedback provided through the pharmacist prescribing engagement.

Both pharmacists and other prescriber respondents were asked what kind of additional education/training should be required to become a Certified Pharmacist Prescriber. Although public respondents were not specifically asked for feedback on educational requirements, their comments echoed the other stakeholder groups and contributed to a lack of confidence in pharmacist prescribing without further education.

Other prescriber respondents were mostly divided between having pharmacists attend medical school, complete a residency, or train for specific skills. Clinical training requirements were specified by almost all respondents.

In line with responses from other prescribers, the majority of pharmacist respondents specified that pharmacists should have some practical, clinical training and experience. Many also asked for training or clear guidelines in communication, documentation, and patient follow-up for inter-professional collaboration.

Pharmacist respondents also indicated the knowledge, skills and abilities pharmacists should have before prescribing. Suggestions included:

- diagnostics,
- differential diagnosis,
- prescribing responsibilities,
- physical assessment, and
- therapeutics.

"I think the pharmacist should be able pass a course and must practice certain amount of years before allowing to be certified. On hands experience is very important and cannot be substituted with just passing a course (think about getting a driver's license)."

"Pharmacists should have the same regulations and training support that is available to NPs as prescribers; this would allow more acceptance from other health care providers on pharmacists' ability to prescribe with competence." – Pharmacist Respondent

"Additional training in physical assessment, as with the CSHP-BC PA course. Community or hospital-based residency for those not under the new entry-to-practice PharmD program." – Pharmacist Respondent

"[Confidence in pharmacist prescribing] would depend on type of training pharmacist receives and whether there will be specific conditions for prescribing only." – Public Respondent

The pharmacist would have to be educated in psychology, clinical pathology, dermatology and counselling. Education in establishing the risk verses benefit for individuals taking into consideration their circumstances and history. There would need to be an extended period of experience gained in primary care shadowing family physicians and then treating under supervision in a longitudinal setting. – Other Prescribing Respondent

"Education about medical/legal responsibilities that go with prescribing. Pharmacists area of specialization should be supported by CEs and experience. Update on legislative changes accompanying CPP licensing." – Pharmacist Respondent

"Hospital Pharmacy Residency + accredited Physical Assessment training" – Pharmacist Respondent

Enhanced clinical training/residency in surgical, medical, and community settings. Further, there should be a written exam including complex cases that take into account multiple comorbidities that reflect the aging population. – Other Prescribing Respondent

"Very similar education that physicians required to have - essentially, pharmacist should be a physician that is not required to have procedural skills. – Other Prescribing Respondent

"I feel for many topics the training is already in place and the clinical experience for most pharmacist is very high. (eg. allergies, cold and flu, eye infections, bladder infections, skin infections, eczema, yeast infections, lice, scabies just to name a few). I feel if very advanced prescribing is to be done by pharmacist (eg based on changing lab values of a patient), then a training program on that class of medication prescribing should be considered. (eg TSH interpretation for synthroid).The injection training course is a very good example. Extra training was given on the diseases being treated and then good training was given on injecting. This has been a very effective successful model in B.C.." – Pharmacist Respondent

"I think they need a lot deeper knowledge about medical conditions and their management as well as a greater knowledge with respect to mechanism of action and selection of drugs. Medical school would be good" – Other Prescribing Respondent

"Would need a few YEARS of [additional] training in diagnosis and assessment of patients (more focused on disease/ pathology/ physical exam than meds and treatment)."
– Other Prescribing Respondent

"Training in a consistent practice of patient assessment, documentation and follow up which can be used for any therapeutic area in which a pharmacist has competence." – Other Prescribing Respondent

I think that it is important for pharmacists to also have training on cultural safety. – Public Respondent

Education methods

Suggestions from pharmacists and other prescribers for education and training ranged from in-person training courses, residencies to online courses. Other prescribers leaned towards 2 year residencies and practicums, while pharmacists suggested a range options from comprehensive online modules, to hospital residencies, to existing clinical, diagnostic and physical assessment courses.

Some pharmacists said that limiting training to an exam or test was insufficient to become a Certified Pharmacist Prescriber, while others were concerned that additional training and education could be costly in time and money. These respondents stressed that educational requirements should not be overly burdensome — otherwise, uptake could be low.

"Emphasis should be placed on the pharmacists approach to assessment and synthesis of clinical decision making. The process should remain the same, the results dictate the course of action. I would assume over time these skills will become standard instruction to student pharmacists at university. A series of voluntary courses tailored to the specific applicants needs in order to demonstrate proficiency in assessment and prescribing (e.g. Physical assessment, laboratory interpretation, literature or guideline critic and application, etc.)" – Pharmacist Respondent

"Two years of direct clinical patient care (hospital and clinic). Really, when you look at the case studies, especially where the case states, "visit to a WIC or doctor or emergency is avoided," then this scope of practice is replacing a primary care assessment. Therefore, prescribing pharmacists should have the same rigorous clinical training that MDs receive."
– Other Prescribing Respondent

"An intensive application accompanied by case studies and demonstration of self-study to prescribe for minor ailments that the pharmacist considers is in their scope of practice and comfort level." – Pharmacist Respondent

"In Alberta Pharmacists were required to submit care plan examples in order to gain prescribing authority. This shows that they are capable of meeting all of the standards of care required for independent prescribing. I feel that this would be sufficient although it would likely be beneficial to offer educational opportunities for pharmacists to develop these skills." – Pharmacist Respondent

"Training modules either online or on-site with comprehensive information about condition assessment and treatment options." – Pharmacist Respondent

"Additional education should be equivalent to a two year Family Medicine residency and maintain the same standard of continued medical education as outlined by the CCFP." – Other Prescribing Respondent

"Practicums should be mandatory - this cannot be taught in a weekend or through an online course. There should be practice specialties such as cardiology, oncology, nephrology, etc. as well as a general practice prescriber. Each group should have their own authorized scope of practice - including types of drugs which can be prescribed. Extra courses should be mandatory - interpretation and monitoring of lab tests in particular as well as courses in diagnostics. We are ill-equipped to diagnose disease." – Pharmacist Respondent

"I think further training should encompass the process of prescribing including training on assessing patients, decision making, developing an action plan, implementing an action plan and follow up with the patient. Depending on some self-assessment, a pharmacist should be able to determine if they require more training & education in a certain area and if they do, attend additional training sessions. In any case, Pharmacists should be comfortable in their own competence before embarking on prescribing." – Pharmacist Respondent

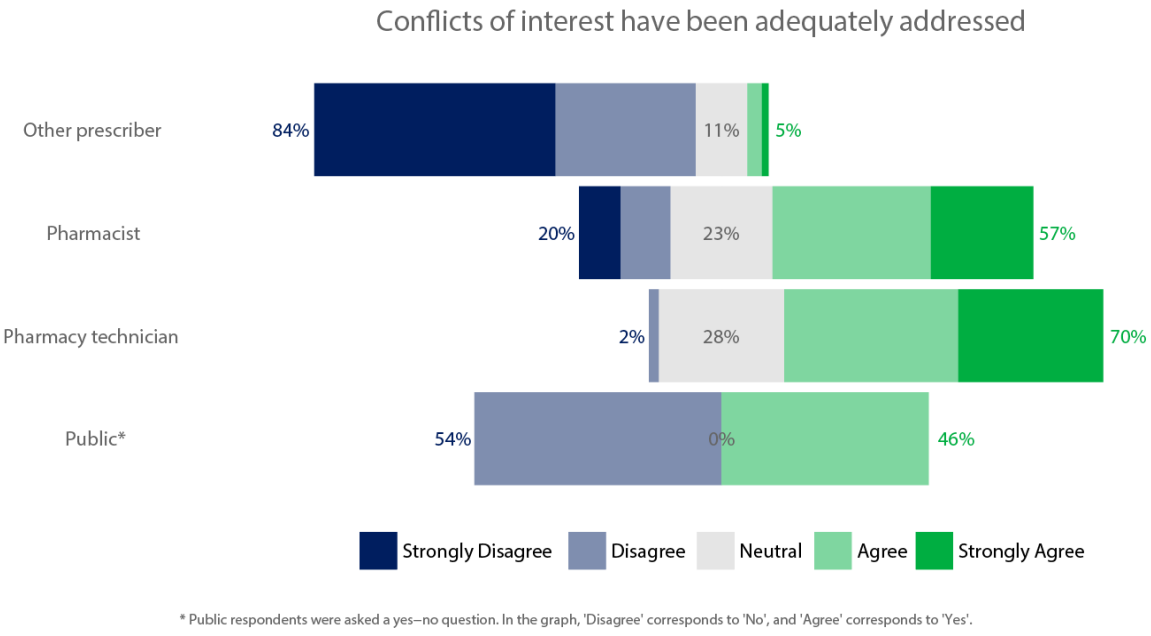
"In Scotland our prescribing pharmacists spent time in primary care with GP's seeing and discussing patient presentations/prescribing decisions" - Other prescribing respondent

The scope of prescribing should be equivalent or exceed that of NPs and NDs - considering pharmacists have more pharmacotherapeutic knowledge than these other prescribers and may be in better positions to monitor for outcomes on the prescribing (e.g. assessing safety, efficacy, and adherence). – Pharmacist Respondent

Conflict of Interest

Conflict of interest was one of the main aspects that created an obstacle to confidence in pharmacist prescribing. Perspectives ranged from concerns related to profit incentives and workload pressures that could negatively impact patient care to concerns that restricting the eligibility of pharmacist owners could negatively impact access to care (particularly in rural and remote communities).

Only 57% of pharmacist respondents agreed that that the Draft Framework had appropriately addressed the conflict of interest that could arise from a pharmacist both prescribing and dispensing to a same patient. Five percent of other prescribing respondents agreed with this. While 46% of public respondents said they would feel comfortable with the same pharmacist prescribing and dispensing.



* Public respondents were asked a yes–no question. In the graph, 'Disagree' corresponds to 'No', and 'Agree' corresponds to 'Yes'.

Concerns about business interests in pharmacist prescribing

Concerns about business interests in pharmacist prescribing were mentioned across stakeholder groups. Many other prescribing respondents believed that the conflict of interest and profit incentive could negatively impact patient care and patient safety.

Concerns about workload expectations were also raised. However, it should be noted that the College recently made amendments to the *Pharmacy Operations and Drug Scheduling Act (PODSA) Bylaws* on requirements with respect to pharmacy workload to ensure that registrant and pharmacy staff levels are sufficient and workload volumes – including meeting quotas, targets or similar measures – do not compromise patient safety or compliance with College bylaws, Code of Ethics or Standards of Practice.

"Please make sure patients are protected from these big corporations who are only looking at the money and the prescribing numbers....all they want to see is which pharmacist is prescribing more." – Public respondent

"If we allow profit-focused entities to operate in the prescribe and dispense model, we would be only as good as the street dealer. Conflict of Interest both actual and perceived needs to be better addressed and more safeguards be put in place. Certified Pharmacist Prescribers must be independent of control by businesses." - Pharmacist respondent

"Unless pharmacists are removed from the profit motive of the store that they're working [at] there will be a complete conflict of interest… with any of this they have to not benefit from selling any drugs that they decide to dispense." – Other Prescribing Respondent

"I support this move. I just think if it passes, stores with pharmacies need to have some legislation around the pharmacist's work load and staffing. They ask them to do way too much alone and that can be dangerous. Please address this before making any changes. Be proactive-lives depend on it." – Public respondent

"…if you want this project to be successful, fair, and beneficial to the patients is to focus on the point of billing the financial benefits directly to the pharmacists and not to the corporates (same with med reviews and other professional services, corporates force pharmacists to do it). Once you approve this project, all the corporates will encourage their pharmacists to be a prescriber pharmacist, then they will set targets for them and putting them under pressure." – Pharmacist respondent

"A strong auditing process (with significant penalties) is required to ensure that there is not abuse of the system. I believe that the majority of pharmacists are very ethical and can handle the conflict. But there are a few who are not and the system needs to ensure that abuse is caught easily and heavily fined." – Pharmacist Respondent

Conflict of interest a focus of opposition for some other prescribers

Some comments indicated that not all other prescribers have a blanket opposition to pharmacists prescribing for specific treatments in specific contexts and environments. Instead, their resistance focused specifically on the suggestion within the Draft Framework that pharmacists be able to both prescribe and dispense.

"[Pharmacists should prescribe] only in a more limited scope than what is outlined in this document unless prescribers are forced to do a year of extra clinical training." – Other Prescribing Respondent

"The principles supporting the separation of the professional activities of prescribing from dispensing must be maintained to ensure safe, effective pharmacotherapy. The situation would be quite different if the community pharmacist was part of a collaborative community team and their role was limited to prescribing as part of the team (a team in which medical and/or nurse practitioners would be providing patient assessment and diagnosis). Again, the dispensing would be provided by another pharmacist independent to that team." – Letter from the College of Physicians and Surgeons of British Columbia

"If there is primary care need that's not met between walk-in clinics and family practices, there may be a role for [Certified Pharmacist Prescribers] for patients who cannot get care elsewhere in a timely fashion. In that case, the pharmacist should be required to maintain a Medical Record and take the role as Most Responsible Provider, which includes managing the patient longitudinally. For patients who are attached to family practices and can get adequate care, I would advise against encouraging them to use [Certified Pharmacist Prescribers] for convenience because segmentation never leads to improved care." – Other Prescribing Respondent

Conflict of interest and pharmacist owners

Numerous pharmacist respondents commented on the restriction on pharmacist owners. conflict of interest in regards to pharmacist owners. The Draft Framework reflects Part 1, Section 5(1) of the *BC Pharmacy Operations and Drug Scheduling Act (PODSA)* which prevents a person authorized to prescribe drugs from owning a pharmacy. Many felt it was unfair, limited in scope and at times even insulting to prevent pharmacist owners from prescribing.

Feedback on this subject also highlighted the desire for the College to better assess and protect pharmacist prescribers from business pressures and introduce mechanisms to better safeguard the profession as a whole from conflicts of interest. A broader approach to addressing the conflict of interest is seen as preferable to excluding all pharmacist owners. Many pharmacists identified that pharmacist prescribing might provide greater access to health care in smaller, rural and remote communities. Feedback indicated that excluding pharmacist owners who work in these communities could limit the benefits of pharmacist prescribing from reaching these communities.

"Pharmacist prescriber should be able to practice individually according to their own competency and comfort level without being interfere by their superiors or corporate pressure/quotas. [Their] should be strict rules in place [to] avoid this situation." – Pharmacist Respondent

"It's very troubling the potential exclusion of independent pharmacy owners, it's seem like more and more pharmacy is catering to the big box stores. The conflict of interest as currently written should apply to everyone that would benefit from the prescriptions. This includes pharmacy mangers and staff which receive bonuses for prescription count. Singly out independent pharmacy owners is closed minded. Only way to make fair across the board is to remove the conflict clause. Other professions such as optometrist naturopaths and vets sell things they prescribe." – Pharmacist Respondent

"The BCPhA urges the College to pursue regulations so this prohibition does not negatively impact access to health care, particularly in rural areas. We understand the College's concerns about the "perverse incentive", but believe the solution lies not in prohibition but in enhancing the existing Conflict of Interest Standards developed by the College."
– Letter from the BC Pharmacy Association

"As private community pharmacy owner in interior BC, it will not change anything if Rx authority is not granted to owner. Also I am not able to afford additional pharmacist for that at this moment. College also need to view business point of view for pharmacist owner. How much it will benefit pharmacist in salary as comparison to responsibility. Is it really worth it? How pharmacist doing it will get benefit in salary and not just corporate?" – Pharmacist Respondent

"Being the only pharmacist in a small community, there are already so many limitations with access to physicians, time and distance to travel for medical services, that not allowing the only pharmacist whether they be any owner or employee would penalize residents already strapped for health services." – Pharmacist Respondent

Unaddressed Risks

Pharmacists and other prescribing respondents identified risks they felt weren't adequately addressed in the Draft Framework. Common risks identified included:

- Inadequate training to diagnose conditions
- Misdiagnosis which could potentially be harmful to patients
- Disruption and fragmentation of patient care
- Double-doctoring or too many prescribers
- Lack of access to lab test results
- Room for more errors in patient care

Many survey responses, emails and letters from stakeholders also indicated that the case studies in the Draft Framework didn't present sufficient possible diagnoses for cases, and courses of action to take in those circumstances. Other respondents underlined that the Draft Framework didn't sufficiently address possible pitfalls of pharmacists prescribing or the ambiguous situations pharmacist prescribers might find themselves in when treating patients.

"If a Certified Pharmacist Prescriber prescribes a medication but does not inform the primacy care physician and there is an adverse event, who is responsible?" – Other Prescribing Respondent

"The prescribing authority booklet created by the college is all positive and supportive of the initiative. It should be much more balanced and explore the possible pitfalls of pharmacist prescribing. What if there are several pharmacist prescribers for a single patient? What about hand-off for vacations, leaves, retirement, leaving the workplace? Is monitoring really going to be possible? I'm not sure the conflict of interest has been adequately addressed. I would also like to see some support in the document from the BC College of Physicians and Surgeons as well as perhaps naturopaths?" – Pharmacist respondent

Certain respondents also highlighted that the Draft Framework could create more confusion among patients and might have an adverse effect on the public's level of trust in pharmacists.

"Multiple prescribers can lead to confusion and errors between patients and doctors. [This is] already an issue between MDs and specialists." – Other Prescribing Respondent

"We already know patients suffer from having too many prescribers and a lack of coordination of care and yet the [College of Pharmacists of BC] is recommending to add another layer of prescribers?" – Pharmacist Respondent

"I don't understand how a pharmacist can obtain the knowledge to prescribe without doing thorough physicals, etc. I worry that labwork usage will increase, and patients won't necessarily trust what the pharmacist tells them so they will come to me for a second opinion. In addition to fighting with Dr. Google for trust with patients, I will have to fight Dr. pharmacist. Also, this will also decrease longitudinal care - something that is a battle with walk-in clinics." – Other Prescribing Respondent

Many pharmacist and other prescribing respondents also felt that issues around liability were not addressed in the Draft Framework. These comments often related to insurance costs and identifying shared responsibilities between pharmacist prescribers and other prescribers. There was also desire to understand situations where pharmacists could be liable and how the extended scope of work could put pharmacist prescribers at greater risk.

"At this point, I'm unsure of the consequences of a certified pharmacist prescriber refusing to prescribe in remote communities in a situation where referral to a physician or other healthcare professional is not a reasonable alternative. If the pharmacist prescriber feels that providing care is beyond their scope of practice, but the need is urgent or alternative care is not feasible for the patient, is liability for the outcome incurred by the pharmacist prescriber whether or not therapeutic intervention is provided?" – Pharmacist Respondent

"I believe that there is considerable risk to the pharmacist here. Their liability will increase exponentially. Their free time will diminish; they will, of course, carry pagers and be on call for their patients 24/7 (free-of-charge like family doctors). They will have to take on the responsibility of writing legal reports and filling out all insurance forms associated with their patients." – Other Prescribing Respondent

Respondents also had questions and concerns related to workflow, cost and remuneration. Pharmacist respondents were also particularly unsure about how they would be compensated for patient assessment involved in prescribing, and expressed concerns about potentially being put under pressure to provide quality care while still managing their daily workload.

The Draft Framework did not include any detail on possible payment models as this falls outside of the College's role as a regulator. However, the College recognizes that reimbursement methods would need to be addressed should the province move forward with pharmacist prescribing.

"Billing issues, especially with third party payers, have to be a consideration, even if the College doesn't consider them to be within its mandate. Pharmacists are too pressured within the current system- a way of adequately compensating them to take the time to make proper assessments needs to be developed." – Pharmacist respondent

"1) Are we a provider? Do we get provider status? Billing number?
2) Who is willing to pay for these services?
3) How are these services being paid for and supported?
4) Why are you allowing the same pharmacist to prescribe and dispense?
It is difficult to reconcile new job functions with the demands of dispensing. Integrating it into a functional workflow is impossible. The solution is to have the prescribing pharmacist focus on prescribing only." – Pharmacist respondent

Some respondents also thought there was a risk that collaboration and communication between pharmacists and other prescribers could erode rather than improve.

"A potential risk is overlap from other healthcare professionals. There will undoubtedly be strong opinions from other disciplines, specifically the College of Physicians and Surgeons. We need to ally with the CPS to come up with a framework that works." – Pharmacist Respondent

"There is a reason why medical physicians do not both diagnose the disease and dispense the cure - this will open the door to absolute power in the therapeutic relationship". – Other prescribing respondent

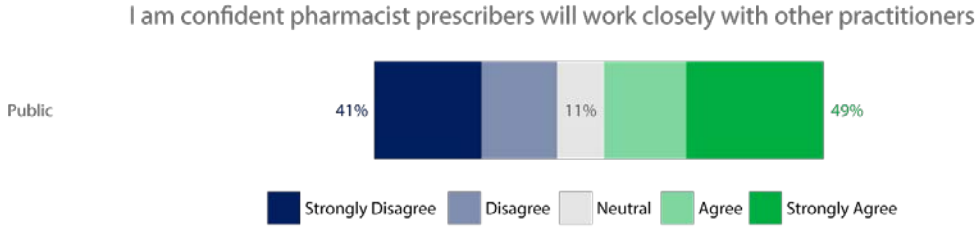
COLLABORATION AND COMMUNICATION

The College sought feedback from stakeholders on the collaboration and communication that would be necessary in pharmacist prescribing. Public respondents shared their thoughts on how they would expect pharmacist prescribers to communicate and collaborate with other prescribers. We also heard from pharmacists and other prescribers on their communication and collaboration thoughts surrounding pharmacists prescribing. Pharmacists also identified the types of tools and resources they would need to support pharmacist prescribing. We also heard from pharmacy technicians on how they could contribute to pharmacist prescribing.

Public Expectations for Collaboration

The majority of public respondents (81%) thought that a Certified Pharmacist Prescriber should always notify their primary care provider after making a prescribing decision – this is a key communication requirement proposed in the Draft Framework. Overall, 61% of public respondents also agreed that they would encourage their primary care provider, or others involved with their care, to work more collaboratively with a Certified Pharmacist Prescriber to improve their care.

However, levels of confidence that a pharmacist prescriber would appropriately consult with other members of a patients care team were not as high. Only 49% of public respondents agreed that a Certified Pharmacist Prescriber would consult appropriately, while 41% disagreed and 11% were neutral. Feedback indicated that for collaboration to work, roles would need to be clearly defined and communicated effectively with prescribers and the public.



Some public respondents felt that pharmacist prescribing could improve collaboration and communication between pharmacists and physicians and benefit them in the care they receive. However, many expressed concern that collaboration and communication between pharmacists and physicians is not strong and identified a risk that pharmacist prescribing could cause confusion and break downs in communication, and possibly result in duplication of services. Others highlighted the important role of physicians in providing a diagnosis.

"I would feel like my health care team was more on the same page about my care." – Public Respondent

"Health Care Teams work best when each member has clear roles. Overlapping roles leads to lack of clarity and even conflict." – Public Respondent

"I would still see my doctor. I can imagine though that some people would not. From your introduction statement it said that it would reduce the number of assessments a person has to have. It now sounds rather more like you intend to create more." – Public Respondent

"I think it would be important for the pharmacist and physician to share information so they know what treatment the other is prescribing." – Public Respondent

"My trust is in the physician's ability to diagnose a problem. There is a different level of expertise between a physician and pharmacist in this regard." – Public Respondent

"It would free up my doctor from visits to just renew prescriptions or deal with minor issues. It would be good if the pharmacist could fax a chart note to the GP so the GP has info on what is going on." – Public Respondent

"My pharmacist should be providing additional information to my physician, not replacing my doctor's prescribing practices. My medical history is complex and my pharmacist is not adequately informed by my history." – Public Respondent

"I'm not opposed to the investigation of the possible benefit of such an initiative. There is merit in this initiative if there is strong collaboration with physicians, appropriate training with strong oversight, and a phased in process to evaluate effectiveness." – Public Respondent

"Breaking up care between too many providers. Only 1 person should be the quarterback. Things will inevitably get messed up, no matter how good the intent of communication." – Public Respondent

"This would only work effectively with close collaboration with physicians. I'm not confident that this close relationship would truly come to fruition. As with any expansion of scope of practice the reality is the profession having its scope encroached on will most likely become a barrier. An initiative such as this would have more success, and I mean a realized benefit for patients and not implementation of an initiative, if it is gradual and the model of integrated and collaboration taught to the new physicians and pharmacists." – Public Respondent

"Could potentially add confusion if physician is not properly notified or does not agree with care decisions made by pharmacist." – Public Respondent

"I would hope my physician would be informed of what is happening & why the decision was made to prescribe a certain drug. I would plan on seeing my Dr within a few wks to consult with him & let him know what was happening from my point of view." – Public Respondent

Public sees value in greater collaboration between pharmacists and physicians

Many members of the public identified the benefit of greater collaborations and team-based care, even when they indicated they may not see their primary care provider less if a pharmacist prescriber was available to them. Others identified they would use both their primary care provider and the services of a pharmacist prescriber. A greater focus on team-based care was also a frequent suggestion as an alternative strategy to pharmacist prescribing for improving patient care.

"It would not [change my relationship with my physician]. I believe by doctor and their team need to be the central source of information and care. I would welcome the pharmacist as part of this team." – Public Respondent

"We need to become more collaborative in health care, not more siloed. Please go back to the drawing board and find ways for patients to have improved primary care, not more fragmented care." – Public Respondent

"As a mother my level of care and that of my kids would not change it would just be a more comprehensive team approach." – Public Respondent

"I think I would still go to my physician whenever I had the chance - but once I get a prescription from them, I would rather have the pharmacist make changes instead of them having to wait and fax the doctor back when problems arise. The pharmacists [know] a lot about the medications - and they are the ones that find most of the problems with them." – Public Respondent

"I believe by doctor and their team need to be the central source of information and care. I would welcome the pharmacist as part of this team." – Public Respondent

"Develop a framework that addresses the care team issues that already exist. Be the leaders in establishing an intelligent and bullet proof approach. The physicians have at times taken a lofty - we are untouchable - approach. This has at times crippled the management of the use of funds available for innovation and improvements to health care. Learn from their mistakes and demonstrate that by not making the same ones." – Public Respondent

Better Solutions for Patient Information Sharing Needed

We heard from pharmacists and other prescribers on the best methods for a pharmacist prescriber to communicate with a patient's primary care provider, the documentation that should be required, and how pharmacist prescribing could possibly improve interprofessional relationships.

Many pharmacists and other prescribers indicated that the fax machine was currently the most common method of communication between pharmacists and physicians. While familiar, the fax was often described as archaic and insufficient for pharmacist prescribing. Others prescribers suggested phone, email or access to *my eHealth* as a preferred means to communicate.

However, both pharmacists and other prescribers, highlighted problems with these methods and expressed a desire for more direct communication between pharmacists and physicians. Several other prescribing respondents suggested a team based, collaborative approach so that pharmacists and physicians could work together rather than prescribing in silos.

"Fax, or email would be nice too, although our whole system is still archaically working with fax. It would be nice to have the pharmacy software integrated with physician communication, this would lessen the paperwork burden of documentation for the pharmacists." – Pharmacist Respondent

"This may be problematic as multiple phone calls in the middle of a busy clinic would be disruptive. Ideally we could share an EHR that would provide immediate access to information as well as ways to communicate. It also would be ideal if the primary care providers and pharmacists in a defined community to get to know each other through combined CPD and other events." – Other Prescribing Respondent

"It feels like, once again, simple problems will be taken away from GPs, leaving us with an even higher concentration of complex, multiple problems, including chronic pain which is such a huge issue. Can pharmacists get involved there? That would be extremely valuable collaboration, and true team-based care." – Other Prescribing Respondent

Numerous respondents believed that a more widely adapted Electronic Medical Record (EMR) system would allow physicians and pharmacists to better access and share and information needed to prescribe and care for patients. But, they also believe that the current medical system lacks the infrastructure needed to support this.

"This maybe a couple years down the road but having one universal account associated with a patients PHN that all healthcare professionals can access and write down notes on. This can be streamlined to having a secure instant messaging system if the other healthcare professional is online at the same time another one is." – Pharmacist Respondent

"The only modern way is with interoperable EMR, which currently does not exist in BC. I don't want to receive more faxes, which then have to be scanned and put into the patient file." – Other Prescribing Respondent

"How are Certified Pharmacist Prescribers going to follow up patients that are admitted or discharged to/from hospital? Are they going to be the Primary Care Providers that review the admission and discharge summaries from the physicians that were involved in their care? How are they going to obtain this information? Will they have an EMR like Primary Care Physicians?" – Other Prescribing Respondent

Various pharmacists suggested that existing patient databases such as PharmaNet or Med Access should be more inclusive to all health care providers and have functionalities that would allow prescribers to incorporate their prescribing notes and diagnosis. They identified that these systems needed mechanisms in place to ensure the security and confidentially of patient information.

"Pharmanet. Hopefully one day we will have shared access to patients charts as well as dispensing history Many Physicians already complain about the extensive faxes that Pharmacies already send them. Coming up with some kind of electronic method of communication is CRITICAL." – Pharmacist Respondent

"Is the pharmacist going to have access to a medical record. Through medaccess (sic) would be best in Duncan as that is what most physicians use here on the island." – Other Prescribing Respondent

Some pharmacist respondents thought physicians wouldn't want to use different methods of communication. However, while there were some other prescribers who showed resistance, citing a lack of time and being inundated by pharmacist requests as reasons for not wanting to communicate, these were a minority among the other prescriber respondent group. Most other prescribers indicated that more communication and collaboration would be preferable.

"[B]est method would be to have pharmacists working in the primary care team like the UBC model and have direct access to the chart." – Other Prescribing Respondent

"In addition, the College should aggressively pursue collaboration with PharmaNet to improve functionality and allow pharmacists to modify information (eg. allergy assessments). Ideally, PharmaNet can be used to document prescribing decisions in a way that other health care providers can view (eg. if the patient is later admitted to hospital)." – Pharmacist Respondent

"In a joint pre-arranged meeting either in person or virtual to that discussion can flow in both directions on a team basis - certainly not to unilaterally notify the physician or NP of changes that the pharmacist has made which will reduce continuity, trust and fragment care." – Other Prescribing Respondent

As long as we have the correct patient information (diagnosis, lab work, etc.), I would be comfortable in doing so. We MUST have access to a properly framed electronic health record so that we can check to see a patient's lab values and any other diagnostic work. At the bare minimum, we should be able to see if they had a lab test done, that way, we know that they are being monitored for a specific thing. Having access to PharmaNet alone is not enough." – Pharmacist Respondent

While some of the feedback provided suggests large scale solutions for pharmacist prescribing that would be difficult to implement in the short term, respondents also made specific recommendations for additions to the Draft Framework to assist with communication and collaboration:

- Guidelines on how pharmacist prescribers should communicate and follow-up with primary care providers and other health professionals
- Use case examples around communication in various situations and circumstances
- Guidance on communication methods and step-by-step processes to support collaboration and communication

Documentation in Pharmacist Prescribing

Overall, responses from other prescribers and pharmacists, while there are some suggestions for improving documentation, it is currently not a key area of concern with pharmacist prescribing as laid out in the Draft Framework. Instead, responses indicated that there is a great need for pharmacists and primary care providers to better share patient information securely and safely, with better solutions in the Draft Framework to address this need.

However, while many other prescribers thought the documentation required was sufficient, it didn't necessarily mean that they thought the initiative presented a sufficient mechanism to ensure strong collaboration and communication between health professionals, or that they agreed with pharmacist prescribing. Some felt that the documentation was insufficient mainly because there was a lack of training and expertise, and requirements specified in the Draft Framework. Some pharmacists also stressed that if excessive documentation was required it would cause inefficiencies and too much burden on pharmacists and physicians and would impact patient care.

"It's sufficient for documentation, but how will follow up be implemented? What about if a GP has decided a medication needs to be stopped and the Patient can seek it out through other sources? What sort of sharing or documentation will be available between the GP and pharmacist?" – Other Prescribing Respondent

"Sounds appropriate. This will increase jobs for pharmacists as this process with take more time in addition to dispensing already prescribed drugs." – Other Prescribing Respondent

"Very thorough [but] does not go both ways, so much room for error." – Other Prescribing Respondent

"It's more than enough. [The] best is to come up with worksheets like in a flow chart manner. Documentation can be quite tedious and it'll affect the overall ability for pharmacists to prescribe." – Pharmacist Respondent

"Primary care providers do not want to be deluged by even more unsolicited information they will have to wade through to search for useful information and errors they will have to correct. This will make for a less safe system. Patients records will become more fragmented not less and they will be disadvantaged by this. This documentation does not replace a proper relationship under which the whole patient and their needs are monitored." – Other Prescribing Respondent

Additional Resources and Support Needed for Pharmacists

Pharmacist respondents shared what they would need in their current practice to support pharmacist prescribing. In general, respondents identified the following needs:

- additional and continuous education,
- office space or a consultation room,
- access to patient files, information, digital records,
- access and ordering of lab tests,
- supplementary staff, and
- necessary time to spend with patients.

The issue of time was important as many felt that the Draft Framework did not take into consideration the additional time needed for pharmacists to properly assess, consult and follow up with patients. Pharmacist respondents stressed they also needed support managing patient expectations in regards to what a pharmacist prescriber can do, as well as managing pharmacy business expectations.

"[…] it may be wise to prove pharmacists have the knowledge and skills BEFORE implementing such a widespread program - this would improve pharmacists confidence, streamline the process for all involved (ex. standardized forms, same procedure regardless of pharmacist or pharmacy, etc), and further prepare the docs and public for what is to come. In my experience, in BC these initiatives tend to be thrown out there for pharmacy to fumble with and only after that do the rules and procedures get added and changed and finalized. It would be nice not to have to find our way through this "in the dark"." – Pharmacist Respondent

"It's up to the industry (management and owners) to staff the Dispensary properly to allow for this extra service. I am not confident that this will happen in my current workplace. Management hires support staff with no Pharmacy experience, there is no registered Pharmacy tech and no Pharmacist overlap. There is no control over customer inflow. Management will create Prescriber quotas. CPBC needs to work with industry to create a suitable work environment."

Access to Labs

While access and ordering of lab tests is not included in the scope of the Draft Framework, many pharmacists highlighted access to patient lab test results, as well as the opportunity to order lab tests to monitor patients as an important tool for prescribing.

"I would hope that pharmacist can order lab work because questions about iron supplements are common in practice." – Pharmacist Respondent

"I worked in Alberta for a year and [pharmacist prescribing] worked well out there- only thing is you really need access to labs (and should be able to order them as well)." – Pharmacist Respondent

"I am a pharmacist and I think if we had access to labs, or could order and then prescribe I would be comfortable [in prescribing]." – Pharmacist Respondent

"I agree but I think the missing component of the lack of ability to order labs could significantly reduce the effectiveness of potential interventions." – Pharmacist Respondent

"I think it would be important to interpret labs, make informed decisions using patient consult and lab results. I do this already with women's health and hormones and more often than not our local physicians defer to me for recommendations on prescriptions." – Pharmacist Respondent

"With prescribing rights needs to come the ability for pharmacists to order labs so that we can properly follow up and monitor patients. Also this would come in handy for those cases like drug interactions or when physicians are not ordering labs for proper monitoring. I have seen many times where patients are missing INR orders especially when put on interacting drugs such as antibiotics." – Pharmacist Respondent

Pharmacy Technician Role in Pharmacist Prescribing

Many pharmacy technician respondents viewed the expansion of a pharmacist's scope into prescribing positively. Respondents expressed that they felt pharmacist prescribing would have a positive impact in their daily practice and felt that pharmacist prescribing services would be beneficial to patients.

Responses broadly highlighted that there was room to include the role of pharmacy technicians in supporting pharmacist prescribers. Various technician respondents (and some respondents from other stakeholder groups) saw an opportunity for pharmacy technicians to perform within their full scope of work, which was said often to be underutilized. Pharmacy technicians identified that they could help pharmacists find more time to spend with patients, if pharmacy technicians took on more responsibilities within their scope that they are trained for.

"In my opinion I do not feel that the pharmacy technicians scope of practice will change. However I do believe that pharmacy technicians will play a larger role in the pharmacy functions. As the role of pharmacist continues to move more and more toward clinical services, I feel that pharmacy technicians will step more into the roles that we are trained for. Pharmacists will need technicians to help ease the workload as they are focused on providing essential clinical services to patients." – Pharmacy Technician Respondent

"This may increase the workload of pharmacy technicians however would be necessary to improve the ability to provide health services that would then benefit the best interest of a patient's well-being." – Pharmacy Technician Respondent

Pharmacist respondents feel they will need additional time and resources to be able to perform prescribing duties. As one pharmacy technician stated, this will also call for more collaboration between pharmacists and pharmacy technicians.

"This will create an even closer collaboration between pharmacists and technicians. They will need each other even more in order to provide better care. In order for the pharmacists to be able to successfully prescribe medications, the technician must gather all the necessary information from the patient or care giver regarding all the medications, also ensure that the patient profile is up to date, direct the patient to the right health care provider for assistance and most importantly with the pharmacist now prescribing and assessing patients, the technician's role in prescriptions checking is very important." – Pharmacy Technician Respondent

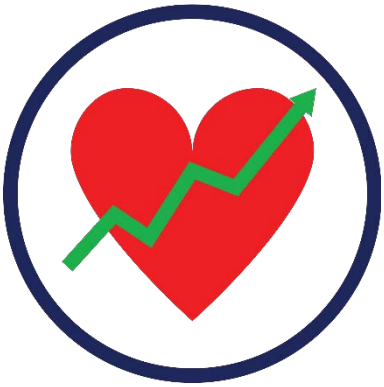
"RPhT's could be better utilized in the current pharmacy practice situation and, with Certified Pharmacist Prescribers, RPhT's could be part of the process of assessment by having them trained to do a BPMH, immunization hx, medical conditions and allergies prior to sitting down with the Certified Pharmacist Prescriber." – Pharmacy Technician Respondent

"It would allow Pharmacy Technicians to perform their full scope of practice, be the support person to the Pharmacist that we were trained to be. Exciting prospect in my opinion." – Pharmacy Technician Respondent

"Allows [pharmacy technicians] to fully work to their scope checking prescriptions and performing majority of drug distribution." – Pharmacy Technician Respondent

"I think RPhTs will be more likely to be practicing to their full scope, and possibly taking on additional responsibilities in accord with their training. This should make the workflow more even and patient focussed." – Pharmacy Technician Respondent

"My pharmacy now has two registered technicians. I find the pharmacy runs very smooth with the pharmacist having more time to help patients, do vaccines and medication reviews and not just standing in one spot checking prescriptions all day and rushing to help patients with little time." – Pharmacy Technician Respondent



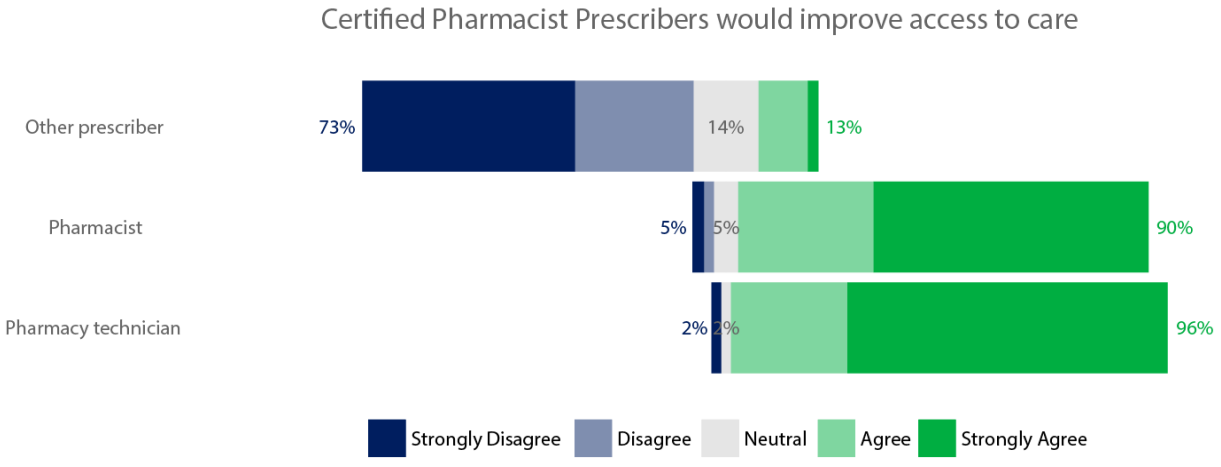
IMPROVING PATIENT CARE

Improving patient care was one area where respondent from all respondent groups suggested some potential openness to pharmacist prescribers. In this area respondents had more balanced and nuanced points of view.

Improving Access to Patient Care

Pharmacists, pharmacy technicians, other prescribers and the public all mentioned the opportunity for pharmacist prescribing to improve timely access to care for patients – especially for minor ailments. However, not all respondents were as supportive of pharmacist owners role in providing increased access to care through pharmacist prescribing.

Pharmacist and pharmacy technician respondents tended to agree (90% and more) that pharmacist prescribers would improve a patient's access to care. While 73% of other prescribing respondents disagreed to some extent, the remaining 27% either agreed or were neutral. This is a higher level of agreement than expressed for other aspects of pharmacist prescribing. The majority (53%) of public respondents also agreed that they would find receiving care from a Certified Pharmacist Prescriber to be more accessible.



"I honestly feel people would seek treatment earlier if they knew it was going to be convenient for them. No long wait at a walk-in clinic, or a weeks wait to see your doctor. I believe patients find pharmacists to be more accessible than a Doctor, and anything that makes healthcare more convenient will inevitably increase patient compliance." – Pharmacy Technician Respondent

Numbers were similar when other prescribers were asked if there was value in pharmacist owners having the authority to prescribe to improve access to health services (17% were neutral and 12% agreed). However, pharmacist respondents tended to support these statements somewhat less, relative to their high support of other aspects of pharmacist prescribing. Almost 20% of pharmacist respondents either disagreed or were neutral in regards to the value of having pharmacist owners prescribing to specifically improve access to health services.

"I am fresh out of school and fresh in my knowledge base. I know the most up to date treatment algorithms for most chronic conditions. Minor ailment prescribing would be fantastic as I am sick of feeling powerless when I disagree with a physician and when I have the evidence to support my decisions. The biggest culprit is the massive amount of incorrect or unnecessary antibiotic prescriptions I see. My only concern is the conflict of interest of both prescribing and selling the medication. Pharmacy is sometimes a tough area especially for owners because profit may influence their decisions." – Pharmacist Respondent

Other prescribing respondents were in line with the public's response to whether some patients might find receiving care from a pharmacist prescriber to be more accessible. Just over half (51%) of other prescribing respondents agreed to some extent that patients would find receiving care from a pharmacist prescriber more accessible – 54% of public respondents also indicated pharmacist prescribing could make care more accessible. However, respondents still emphasized that quicker or better access to care does not necessarily correspond to better quality of care.

"This would reduce stress on walk-in clinics and seeing drs for easy prescription refills (ex. birth control)" – Public Respondent

"Patients who don't have ready access to other PCP [primary care provider] will benefit from Pharmacists acting as their PCP (as their most responsible providers), when it's compared to lack of access." – Other Prescribing Respondent

"I would need to see my physician less frequently [with pharmacist prescribing], I know the physician will not like this, but it would create more access for patients who need to see the doctor." – Public Respondent

"It is another access point, but I would rather see more collaboration and less silos." – Other Prescribing Respondent

"I would assume that the strain on the health care providers would be lessened. Often the only reason a person goes to see their health care provider is to renew a prescription, think how much more efficient the whole system would be by streamlining the process to one."
– Public Respondent

"[Pharmacist Prescribing could improve access] …if they don't have a family physician. If there is an acute medication issue or concern and they don't have access to their PCP [primary care provider]." – Other Prescribing Respondent

"Better and timely access to medication through a reliable health care professional."
– Public Respondent

"Quicker and easier access to meds, at risk of flawed assessments and wrong diagnosis." – Other prescribing respondent

"Decreased wait times in physicians offices which will allow for more patients to access their physician for other ailments and needs. I can only see this as being beneficial to the health care system." – Public Respondent

Pharmacists and pharmacy technicians also emphasized the specific benefit for patients living in small, rural and remote communities, while, some pharmacists also suggested that without pharmacist owners having the authority to prescribe, improved access to care would be limited in small communities where pharmacies are frequently staffed by a pharmacist owner. Some other prescribers suggested that pharmacist prescribing may be appropriate when patients do not have access to a physician or a nurse practitioner.

"Only in settings where there is not access to doctors or nurse practitioners who are trained in diagnosis and examination of patients." – Other Prescribing Respondent

"I think this would improve access and help relieve physician workload in rural areas."
– Pharmacist Respondent

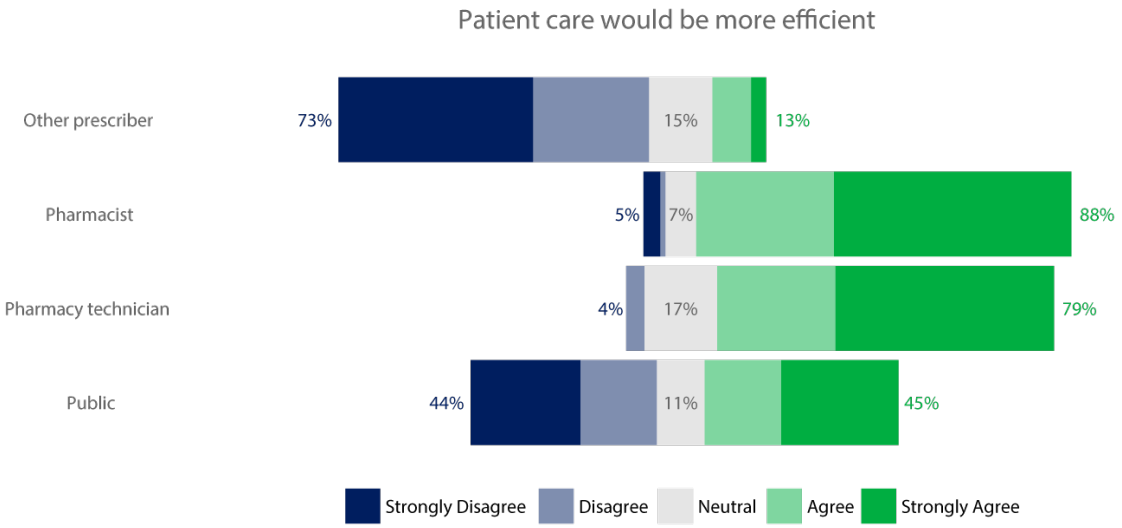
"Should only be allowed in rural areas with no access to doctor care."
– Other Prescribing Respondent

Emergency prescriptions for continuity of care by pharmacists is an excellent opportunity for collaborative work, but beyond emergency, there should be no pharmacist prescribing.
– Other Prescribing Respondent

Improving Care

Respondents also weighed in on if pharmacist prescribing could improve patient care through greater efficiency, continuity of care, and greater monitoring of drug therapy.

The majority of pharmacist and pharmacy technician respondents thought that pharmacist prescribers could improve efficiency of care. Public respondents were almost equally divided (45% agreed, 11% neutral, 44% disagreed).



Members of the public were also divided when asked if they wanted a Certified Pharmacist Prescriber to create a monitoring and follow-up plan with them. Slightly more public respondents agreed (51%) that a monitoring and follow-up plan developed with a pharmacist prescriber would help improve the care they receive.

"I think this is a great idea. anything to reduce wait time and make things easier for patients, the customers of the entire health care system. Drs and health care providers seem to forget this." – Public Respondent

"I am quite concerned about this proposal. I am opposed to it. If/when the future certified pharmacist prescriber prescribes medications, what responsibility for patient health outcomes would be ascribed to the pharmacist? How could this be accurately measured? Allowing pharmacists to prescribe within the scope of their training seems potentially dangerous. I would ask the question, "How can you know what you don't know?"" – Public Respondent

"I already have used a pharmacist as a source of information to relay to my doctor in order to optimize treatment for my hypothyroid condition. So in my case I have already indirectly received care from a pharmacist and that model worked fine for me. It would make sense to develop a form of this kind." – Public Respondent

"I feel I will be able to make more informed decisions, if I have a pharmacist prescriber on board. I feel I will have to see my physicians less frequently. Also, I think It will push my physician to really focus on primary care including accurate diagnosis and my overall health while having the pharmacist take care of my prescriptions." – Public Respondent

"My doctor has a limited amount of time with me and often I feel rushed and forget things I want to discuss with him. Being able to discuss without an appointment (or with one) my health care related concerns and the medications that go along with them, with my local community pharmacist, it would give me more of a sense of being in control of the outcomes." – Public Respondent

Pharmacists and pharmacy technicians expressed greater confidence in the benefits of increased drug therapy monitoring – 83% of pharmacists and 91% of pharmacy technicians agreed or strongly agreed that pharmacist prescribing monitoring and follow up plans would improve quality of patient care. However, some pharmacists still had doubts surrounding their ability to provide increased monitoring unless pharmacist prescribers were provided with the tools, resources and time required to monitor and follow up with patients.

"I am not sure pharmacists in Alberta are actively engaged in this work in any substantial way. So while it could improve the quality of care, in the real world of a busy pharmacy, I am not sure it will." – Pharmacist Respondent

"A CDE pharmacist should be able to prescribe diabetes medications and order lab tests." – Pharmacist Respondent

"In many ways: increased efficiency, increased transparency, increased involvement in their own health outcomes, decreased wait times in clinics and for available doctor's appointments, the list goes on. I am especially excited at the prospect of patients having more chances to engage with Pharmacy professionals, as this gives us more chances to improve their level of care with our skills and expertise about drug therapies and medication management." – Pharmacy Technician

"It's a good ideal but in reality pharmacists may not have the time or resources to monitor and follow up on patients. Also without access to lab work or ability to order lab work, how will pharmacists properly diagnose or monitor patients." – Pharmacist Respondent

"Many patients inform me today that they look their pharmacist preferentially now given their extensive knowledge of drugs and their effects compared to physicians and NPs." – Pharmacist Respondent

"I believe that one of the biggest benefits for patients is simply having timely access to the care that they require. If patients are forced to wait weeks to see their doctor or spend hours sitting in emergency, in my observations, people tend to procrastinate or ignore entirely dealing with concerns they may have regarding their health. Working with a pharmacist on their personal health goals and outcomes allows patients to be more involved with their own health." – Pharmacy Technician

"More timely access to treatment and appropriate changes in therapy without delay in time for referral, pharmacist focus on drug therapy and time for follow up will improve patient outcomes." – Pharmacist Respondent

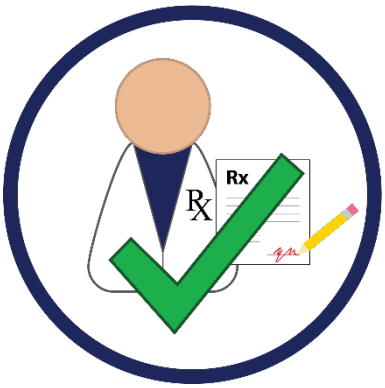
"I have been frustrated for many years by the inability to provide timely and effective treatments to patients even though I had complete confidence in my ability to triage the severity of the condition and recognize the urgency for immediate treatment and follow-up. To send patients to the ER or their primary care clinic felt incredibly inefficient and a complete waste of public resources." – Pharmacist Respondent

A greater number of other prescribers agreed with this aspect of pharmacist prescribing compared to other sections (such as confidence in a pharmacists ability to prescribe). Responses showed 21% felt neutral on this and 12% agreed, while 67% still disagreed that patient care would improve. However, many of these respondents found the framework's wording and logic to be faulty which might explain their lack of confidence in the possible benefits for patients.

"I am a supporter a (sic) expanding SOP of pharmacists as I believe that they are key to high quality care but we need to look at systems of care and how we all fit into new models of care. otherwise we continue to create more silos, more fragmentation and the potential for adverse events and consequences for our patients." – Other Prescribing Respondent

"The Draft Framework states that one of the expected benefits of Pharmacists prescribing will be increased patient access to health care services because other prescribers, such as MDs and NPs, can instead "focus on other medical issues." It also states that this would "reduce the number of practitioners patient must visit to be assessed and if necessary access drug therapy." Following the same reasoning, why not just allow MDs and NPs to dispense medication? This would be far simpler solution, if in fact, the reasoning of the College of Pharmacists is correct." – Letter from the Society of General Practitioners of BC

"MD's don't want more faxes from pharmacists that they then have to integrate into the patient's medical record, and follow-up on. This will create even more unpaid work for physicians and worsen not improve longitudinal care." – Other Prescribing Respondent

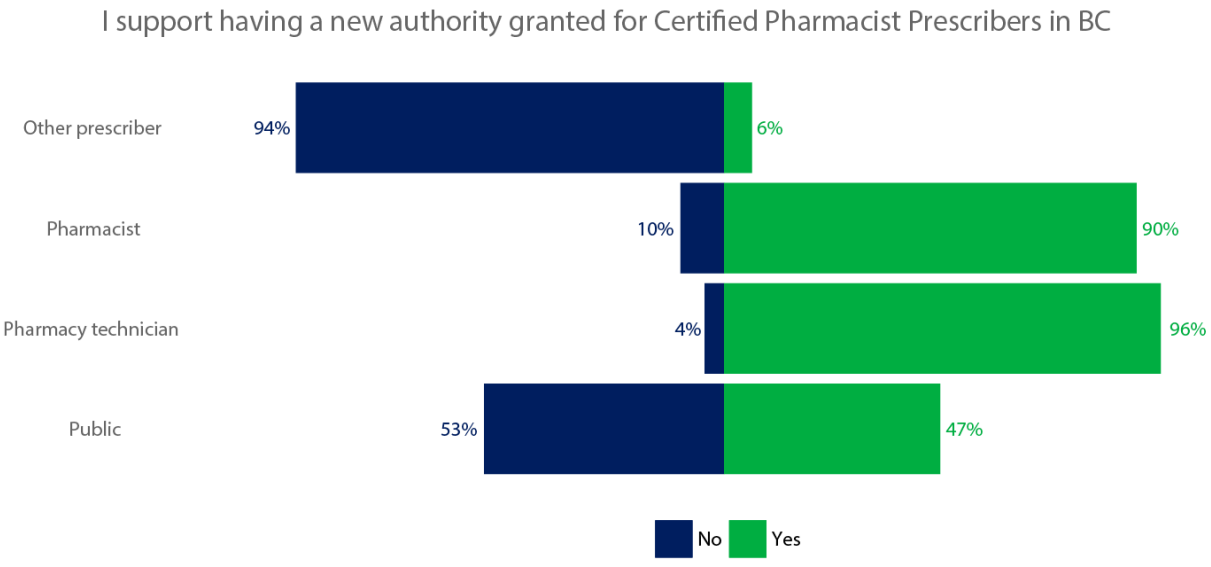


SUPPORT FOR MOVING FORWARD WITH PHARMACIST PRESCRIBING

The College heard from pharmacists, pharmacy technicians, other prescribers and the public on whether they supported moving forward with a proposal for pharmacist prescribing. The feedback showed that support for pharmacist prescribing greatly varied between stakeholders, from high to low.

Levels of Support for Moving Forward with the Initiative

Overall, feedback indicated overwhelming support for the initiative from pharmacists and pharmacy technicians, while responses from other prescribers illustrated strong resistance. Public respondents remained divided. However, numerous comments and feedback underline that respondent opinions are much more nuanced and there are still many questions about how pharmacists prescribing could work in BC.



Pharmacist and pharmacy technician respondents demonstrated very high levels of support (90% and 96% respectively) for having a new authority granted for pharmacist prescribing in BC. 89% of pharmacists and 96% of pharmacy technicians indicated that they believed patients would like to receive more services from pharmacists. However, caveats and issues to resolve were still identified for pharmacist prescribing to move forward. Many pharmacist owners also indicated they would only support the proposal for pharmacist prescribing if pharmacist owners are included in the authority to prescribe.

"Strongly believe that pharmacist prescribing will improve healthcare and patient outcome, and at the same time, fully utilize pharmacists' abilities to their full potential."
– Pharmacist Respondent

"It is long overdue and we (BC) are way behind the curve on this!" – Pharmacist Respondent

"Before working in BC, I worked in Alberta with 2 pharmacists with prescribing authority. In my experience, it was hugely beneficial for patients that didn't have time to wait in a walk in, or just needed refills in a medication they were on for a long time. The pharmacists I worked with were very knowledgeable, and it is really good to see their knowledge being used to this extent. Our patients trusted the pharmacists' opinions and were very grateful for the added service."
– Pharmacy Technician

"This is a successful model already being followed in other provinces." – Pharmacist Respondent

"Only with the proper required education, access to lab values, and some sort of control program to keep the big companies from monetizing our abilities and putting quotas on their staff. Doctors (as far as I know) work independently so they aren't encouraged to see as many patients as possible by their head office. This is a problem with chain pharmacies that needs to be addressed before this moves forward." – Pharmacist Respondent

Appropriate with current healthcare system limitations to improve patient outcomes and utilize knowledge and skill sets of pharmacists who are easily accessible. – Pharmacist Respondent

BC is the only province where pharmacists cannot prescribe in some capacity. It is time to catch up with the times. – Pharmacist Respondent

"I don't think our system is ready for this yet. We need comprehensive electronic health records including access to lab values for it to work/add value." – Pharmacist Respondent

"As physician availability decreases and the number of physicians practicing in BC does not meet the demands for services, it makes sense to increase the pharmacist scope of practice. I see much frustration and desperation amongst the patients at my pharmacy when treatment is sorely needed, and yet they must wait hours at an emergency walk in clinic, and weeks or up to a month to see their GP if they are lucky enough to have one. It would alleviate much stress, frustration, and physician backlog if pharmacists were authorized to prescribe within an established framework, and established scope." – Pharmacy Technician

"Definitely. BUT, not until all the pieces are in place with our entire medical system!!!" – Pharmacist Respondent

"We have been waiting for this for many years. We have very credible and talented clinical pharmacy practitioners who are ready for this type of work and will do a great job."
– Pharmacist Respondent

"It is absolutely paramount to address current issues in the system before moving forward and creating more complex future complications which would result in frustration and break-down of communication between pharmacist/physician. Pharmacist must be compensated in a direct method to protect them from being over worked by their employer/owner. The electronic health record needs to become a reality to support pharmacist prescribers so there is a proper method of communication with the physician." – Pharmacist Respondent

"As an owner, I am hopeful that the College will see that we should be included in this exciting initiative." – Pharmacist Respondent

Public respondents had mixed opinions on supporting this initiative, with 53% opposed and 47% in favor of a new authority for pharmacist prescribing. Responses were also divided on whether they would like to receive more health services from pharmacists. 42% of public respondents indicated they would like to receive more services through pharmacists and 15% were undecided, while 41% disagreed. When asked whether they would use pharmacist prescribing services, the public response shifted slightly further towards agreement (52% indicated they would use pharmacist prescribing services).

"I work with 2nd year pharmacy students as a health mentor and I think they would be an asset to alleviating some of the pressure on family doctors for patients who just need simple prescription renewals. I support this move. I just think if it passes, stores with pharmacies need to have some legislation around the pharmacist's work load and staffing. They ask them to do way too much alone and that can be dangerous. Please address this before making any changes. Be proactive-lives depend on it." – Public Respondent

"Leave things as they are. It works well in the relationship between my Dr.s and my Pharmacists." – Public Respondent

"It's about time this get introduced in BC. This would make our health care more efficient." – Public Respondent

"This service would help to alleviate the shortage of physicians in BC, would complement existing services, reduce patients' time waiting or on waitlists to see physicians, enable patients who do not have a physician (due to shortages) who would see different physicians at clinics to have the care of one medical professional who knows their history, free up physicians to see patients who have more serious problems, release the burden of overwhelming caseloads on physicians, etc. I strongly believe that all pharmacists who wish to be certified to initiate prescriptions, whether or not they are pharmacy owners, should have the opportunity to be trained and licensed to perform this service." – Public Respondent

"I feel like this is a slippery slope to have pharmacist prescribing medications. Too many mistakes can be made. At least with a physician prescribing medications a pharmacist is able to double check to be sure there are no mistakes.... Even then mistakes are made! I don't believe having a pharmacist take a full medical history etc is a good use of their time, also that is a lot of liability to put on them." – Public Respondent

"My primary concern is pharmacists prescribing when it's not necessary, especially when they make money on prescriptions." – Public Respondent

"This is an innovative and absolutely necessary approach to alleviating the current stress on our healthcare system. I support this wholeheartedly as a patient." – Public Respondent

Do this as soon as possible. It's long overdue. It's a workable solution to the lack of GP-attachment, ER overcrowding, walk-in clinic wait times, ballooning health care system budgets, the coming demographic flood of chronic disease patients, everything. That this has not been accomplished already is mystifying. Fix this. – Public Respondent

Other prescribers were largely opposed to a new authority for pharmacist prescribing. Only 6% indicated support for the initiative to move forward.

"So much of a doctors time is spent writing prescriptions for basic healthcare such as birth control, herpes medication, simple urinary tract infections etc, that could easily be looked after by a certified pharmacist. This would free up doctors for more complex conditions." – Other Prescribing Respondent

"I think the pharmacists scope of practice should be expanded to include an improved communication and collaboration with family physicians especially around medication reviews for complex patients, but pharmacists should not be acting as a replacement for the patient's family doctor." – Other Prescribing Respondent

"In the current Primary Care environment, there are tens of thousands of orphaned patients, many with complex medical health conditions. These are the people Certified Pharmacist Prescribers will be seeing. In essence, Certified Pharmacist Prescribers will be these patients' GPs, responsible for all aspects of their continued care. There will be no easy cases nor collaboration with a GPs, as there are fewer and fewer of us office GPs left. So by all means, come join us as we take care of BC's citizens, with all the 24/7 responsibilities, liabilities/ costs of running a medical practice." – Other Prescribing Respondent

"I do not support this at all. Pharmacists do not have the training and will never have adequate training to do what physicians do." – Other Prescribing Respondent

"Overall this would be of great benefit for the entire health care team as well as patients." – Other Prescribing Respondent

"I think this will be a duplication of service, disruption of physician systems, unsafe for patients in certain (unpredictable) cases and an invasion of physician territory by pharmacists. I think pharmacists should continue with monitoring physician prescriptions for mistakes and interactions, dispense medication safely and provide patients with valuable information and not prescribe medication other than symptomatic medications." – Other Prescribing Respondent

Other prescriber respondents, pharmacists and pharmacy technicians were asked whether they would encourage patients to seek care from pharmacist prescribers. Pharmacists and pharmacy technician respondents indicated they would (93% and 98% agreed respectively). Other prescriber respondents were very opposed to encouraging patients to seek care from pharmacist prescribers (only 8% agreed).

Would Pharmacists Pursue Becoming a Certified Pharmacist Prescriber?

We also heard from pharmacists on their interest in becoming a pharmacist prescriber if the opportunity existed. Pharmacists clearly indicated they would pursue becoming a prescriber with almost 90% indicating that they would pursue the certification. Some pharmacists shared that they support a move towards pharmacist prescribing, but would not pursue becoming a pharmacist prescriber because they are retiring soon or are not working in direct patient care. While only 11% indicated they would not be interested in pursuing the certification, many respondents identified issues they would like to see addressed before pursuing the certification.

"It depends on how the BC College frames the new authority. Past experience shows that the new legislation will be extremely difficult to follow in practice and require a heavy load of over documenting. Good ideas poorly executed." – Pharmacist Respondent

"Maybe - depending on the requirements - as I'm relatively close to retirement." – Pharmacist Respondent

"If it would benefit me in my current workplace. If I was going to be supported in my current workplace." – Pharmacist Respondent

"As a Pharm D. student, this only seems appropriate as an additional means of expanding our scope of practice, as well as using our substantial knowledge to benefit British Columbians and our communities." – Pharmacist Respondent

"I would if I still had quite a few years left in my pharmacy career, but I am cutting back my hours and looking at retiring within the next few years." – Pharmacist Respondent

"I do not believe that this is an appropriate role unless you have a doctorate and works alongside a doctor in an office or hospital and NEVER in a community setting." – Pharmacist Respondent

"If I wanted to be a prescriber I would have become an MD." – Pharmacist Respondent

"Will only be possible to practice if restrictions on ownership change but would like to do it for knowledge or even as a locum." – Pharmacist Respondent

"I cannot wait for this opportunity and am willing to do whatever it takes in terms of preparation." – Pharmacist Respondent

"As long as the work environment supports it (that is up to management). I am not confident in management's ability to do this." – Pharmacist Respondent

"I have been waiting many years for this authority." – Pharmacist Respondent

"If the training/certification process seemed sufficient." – Pharmacist Respondent

"I have this designation in Alberta, and would pursue it in BC as well." – Pharmacist Respondent

"I am a pharmacist working in a primary care practice with 7 physicians who would support my ability to prescribe." – Pharmacist Respondent

CAVEATS AND LIMITATIONS

The interpretation of the results in this Engagement Report – like many other stakeholder engagements – is subject to limitations and caveats ranging from methodological and survey design challenges, to response bias and response mirroring. These limitations are reasons why the results and analysis could differ from the exact conditions “on the ground”.

However, these limitations do not mean that the feedback is without merit or insight. The results from this stakeholder engagement were rich with insight into the initiative and Draft Framework. Where possible, the analysis completed attempted to account for and mitigate these issues.

BC COLLEGE OF FAMILY PHYSICIANS
The home of family medicine

Blake Reynolds, Chair
College of Pharmacists of BC
200 - 1765 West 8th Ave
Vancouver, BC
V6J 5C6

July 6, 2016

Dear Mr. Reynolds,

The BC College of Family Physicians (BCCFP) has reviewed with interest the *Certified Pharmacist Prescriber Draft Framework.* As a professional college we understand the importance of broad stakeholder engagement when considering changes with potential system wide impact. As a result, in addition to encouraging our members to participate in the online survey, we are writing directly to you to provide feedback regarding the proposed new authority for pharmacist prescribing.

As you are aware, the BC College of Family Physicians is the home of family medicine in British Columbia representing more than 4600 family physicians. We support family physicians to provide quality patient care, enhanced practice management and continuing professional development. We advocate for the Patient's Medical Home, a vision for patient-centred, team-based family medicine and primary care.

The vision for the Patient's Medical Home model includes ten pillars, or practice model goals; each supported by evidence that demonstrates enhancement of primary health care in BC. These key pillars include patient-centred, person focused, interprofessional team-based care offering patients timely access to continuous, comprehensive and coordinated care that meets individual patient and community health care needs.

It is in the context of this vision that we write regarding our concerns with the suggested introduction of pharmacist prescribing. It is unquestionable that the contributions and work of pharmacists within the health care team are crucial to safe patient care; however, it is not evident that the proposed framework supports and promotes team-based/ interdisciplinary care. In fact, the proposed framework seems to encourage more professional silos with greater opportunity for patients to get lost between providers.

Prescribing is a privilege with inherent responsibilities, to be considered only by taking the whole patient into account. The decision to prescribe any medication involves conducting a complete clinical assessment, which may include a physical examination and diagnostic investigations. In addition, management must respect patient values and beliefs and include non-pharmacologic options. The framework proposed by the CPBC does not clarify the competencies and the training requirements for pharmacists to conduct complete assessments or physical examinations.

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The framework also does not outline a process of consultation or confidential communication with other care providers should the pharmacist identify an issue that falls outside of their scope of expertise. There is concern that the pharmacist would not have complete information as they will not have access to the patient's full medical record including specialist consultations. The seamless transition of patient care between providers is a significant challenge in the existing care system and there is concern that this new practice may exacerbate this patient safety issue.

It is unclear if the CPBC has considered the impact of this proposal on team-based care and the Primary Care Home models rolling out across the province, but has simply not clarified it within the framework and survey. There also remains a significant worry regarding the perceived conflict of interest of having pharmacists prescribe medications as they stand to benefit financially from prescribing privileges.

The BCCFP believes that looking at policies and scopes of practice is an important part of system quality improvement to address the issues of access and comprehensiveness. However, we believe that in order to be successful in our health care improvement efforts, we need improved collaboration. We hope that our feedback will be considered and reflected within the results of the stakeholder engagement report. We welcome further dialogue to help inform the final framework and move forward collaboratively to achieve efficient team-based care within the province.

Sincerely,

Christie Newton, MD, CCFP, FCFP
President

cc: Dr. Ernie Chang, President Society of General Practitioners
Mary Kjorven, Chair - College of Registered Nurses of BC
Honourable Terry Lake, Minister of Health
Dr. Alan Ruddiman, President Doctors of BC
Dr. G.A. Vaughan, President - College of Physicians and Surgeons of British Columbia

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July 20, 2016

Mr. Bob Nakagawa
Registrar
College of Pharmacists of British Columbia
200 – 1765 W. 8th Avenue
Vancouver, BC V6J 5C6

Dear Bob:

On behalf of the BC Pharmacy Association's Board of Directors, please find the attached submission on the College of Pharmacists of BC's Certified Pharmacist Prescriber Initiative Draft Framework.

One of the key goals of the Association is to see that pharmacists are able to practice at their profession's highest and fullest levels. The Association supports allowing pharmacists to initiate prescriptions, as this expansion of scope reflects the aspirations of pharmacists in British Columbia.

In our attached submission, the BCPhA makes recommendations on areas that the College should explore and clarify while developing the final Certified Pharmacist Prescriber framework.

We would be pleased to meet with you to discuss our submission in further detail.

Sincerely,

Geraldine Vance
CEO

Cc: College of Pharmacists of BC Board of Directors
BCPhA Board of Directors

Certified Pharmacist Prescriber Initiative Draft Framework

BC Pharmacy Association submission to the
College of Pharmacist of BC

July 2016

British Columbia
Pharmacy Association

Executive Summary

The College of Pharmacists of BC has developed the Certified Pharmacist Prescriber Initiative Draft Framework, which outlines the societal need for pharmacist prescribing in British Columbia. The framework includes an environmental scan of expanded scope of practice for pharmacists in other jurisdictions as well as other non-physician prescribers in BC. In its document, the College proposes eligibility criteria, renewal requirements and the standards, limits and conditions to qualify as a Certified Pharmacist Prescriber. The document was developed by the Certified Pharmacist Prescriber Task Group at the direction of the College Board and is being used for stakeholder engagement.

The pharmacist prescriber initiative has been identified as a strategic priority by the College Board. In its proposal, the College makes the case that allowing pharmacists to initiate prescribing for Schedule I drugs will meet a number of key priorities in the health-care system, including reforming primary health care, better and more effective use of health human resources and strengthening multidisciplinary collaborative environments.

Since 1999, pharmacists have been prescribing and dispensing drugs with the ethics and professionalism benefitting the profession.

Pharmacists have the professional responsibility to both improve their patients' drug therapy outcomes and improve the health-care system. Pharmacist prescribing authority is not new in British Columbia. Since 1999, BC pharmacists have had the authority to provide emergency refill supplies of medication. In 2000, BC pharmacists were the first to be granted independent authority to prescribe emergency contraceptives. In 2009, pharmacist scope of practice was expanded to include adapting prescriptions written by authorized prescribers as well as administering injections. The College's current proposal would expand pharmacists' scope, allowing them to prescribe Schedule I medications. However the use of term "prescribing" for Schedule II and III drugs is unclear in the framework.

Since 1999, pharmacists have had limited prescribing and dispensing authority (emergency refills) with the ethics and professionalism benefitting the profession. The BCPhA was surprised by the proposal's recommendation to exclude pharmacist owners from prescribing because of ethical challenges, since there has been no evidence to show this is an issue.

The BC Pharmacy Association supports allowing pharmacists to initiate prescriptions. Pharmacist expansion of scope reflects the aspiration of BC pharmacists, and one of the Association's key goals is "Pharmacists are able to practice the profession of pharmacy at the highest levels and to its fullest extent."

We urge the College to provide greater clarity on pharmacist authority around the dispensing Schedule II and III drugs[1]. It is well understood that both the public and private payers have challenged pharmacist authority to dispense Schedule II and III drugs, most notably vaccines. They have done this based on the position that pharmacists do not have the authority to prescribe even Schedule II and III drugs.

[1] *Certified Pharmacist Prescriber Initiative Draft Framework*. (2016, February).

During the development of the final framework, the BCPhA recommends the College explore three areas: physician, payer and patient attitudes toward pharmacist prescribing; impact on accessibility to care, especially in rural areas; and reputational impact on the profession. Without taking these into consideration, even if the legislation is passed, having the authority to prescribe is a hollow victory.

Attitudes toward pharmacist prescribing: prescribers, payers and patients

While we support allowing pharmacists to initiate prescriptions, gaining prescriber input and support is key to the framework being accepted by government and obtaining widespread adoption of this practice. Pharmacists in BC have had the authority to adapt a prescription since 2009, yet prescription renewals far outweigh therapeutic substitution prescriptions by 25 to 1.[2] Studies have shown that prescriber attitudes are a critical factor influencing pharmacists' adoption of this scope of practice. In 2016, community pharmacists participating in two BC Pharmacy Association town halls on therapeutic substitutions and adaptations cited pushback from prescribers as their top reason for not undertaking therapeutic substitution prescriptions.

In a 2013 study on what factors influence pharmacists' adoption of prescribing, Alberta pharmacists, who were the first to have the full range of prescribing authority in 2007, said the relationship with the physician was the primary consideration when deciding whether to undertake prescribing a medication for a patient. If they believed the patient's primary care physician would not be supportive of pharmacist prescribing, they would be reluctant to undertake this expanded scope.[3]

Gaining prescriber input and support is key to the framework being accepted by government.

In fact, figures show that although pharmacists in Alberta have a wide range of prescribing privileges, pharmacists were more likely to prescribe to adjust ongoing medications rather than initiate a new prescription. The most common forms of prescribing were ensuring continuity of therapy, adapting, and substituting medication due to shortage.[4]

Simply citing resource shortages as a reason for pharmacist prescribing is not enough to assuage concerns by physicians. In a January 2010 position statement, the College of Family Physicians of Canada explicity said decisions to allow other health-care professionals to prescribe should not be made merely on the fact that there are resource shortages, but must be based on evidence showing efficacy. They recommended a collaborative care model, which includes the patient's physician.[5]

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[2] BC Ministry of Health Number of Prescription Adaptations and Renewal Fees Claimed in 2014/15.

[3] Makowsky, M. J., Guirguis, L. M., Hughes, C. A., Sadowski, C. A., & Yuksel, N. (2013). Factors influencing pharmacists' adoption of prescribing: Qualitative application of the diffusion of innovations theory. *Implementation Science Implementation Sci*, 8(1). doi:10.1186/1748-5908-8-109

[4] Guirguis, L. M., Makowsky, M. J., Hughes, C. A., Sadowski, C. A., Schindel, T. J., & Yuksel, N. (2014). How have pharmacists in different practice settings integrated prescribing privileges into practice in Alberta? A qualitative exploration. *J Clin Pharm Ther Journal of Clinical Pharmacy and Therapeutics*, 39(4), 390-398. doi:10.1111/jcpt.12165

[5] College of Family Physicians of Canada. (2010, January). Prescribing Rights for Health Professionals [Position Statement].

And in response to the 2007 legislation change in Alberta allowing pharmacist prescribing, the Canadian Medical Association (CMA) said forcefully "that pharmacists not be given independent prescribing authority."[6]

Closer to home, a 2011 study of BC family physicians' perceptions of pharmacists adaptations showed that physicians felt they had not been communicated with enough and felt they were not sufficiently included in the development of the adaptation initiative. The study recognized that physicians were "essential stakeholders". To receive their support, doctors' concerns should be addressed and they should be provided with detailed communication.[7]

Using this learning, the BCPhA recommends the College engage with physicians while developing the final framework to ensure successful implementation across the province.

Physician attitudes toward pharmacist prescribing is only one factor in the success of this proposed framework. A critical piece of its success is ensuring payment for pharmacist prescribing. Other Canadian jurisdictions have demonstrated that having authority to provide a service, but no one willing to pay for it, is of little value to the system. For a cross Canada comparison on similar pharmacist services and payment, the Canadian Foundation for Pharmacy has published a chart online[8].

Services that are not funded by payers have little uptake by patients, who would have to pay out of pocket. For example, in a survey about pharmacists' medication management services, 81 per cent of patients said they would use the service if it were 100 per cent paid for by the government. Only 8 per cent said they would use the service if they had to pay out of pocket for it.[9]

And while the BCPhA appreciates that pharmacists have been making available and selling Schedule II and III drugs to patients, the Association questions the framework's use of the term "prescribing" when describing this activity. Because the term "prescribing" has not been formalized for Schedule II and III, payers do not currently pay for pharmacists to provide this service. It's important for the College to be aware of this issue and address it in the development of the final framework.

Another challenge is having an expanded authority that patients don't embrace. In October 2015, the McMaster Health Forum convened a citizen panel to explore models for pharmacist prescribing in Ontario. The purpose of the panel was to guide the efforts of policymakers, managers and professional leaders who make decisions about the health-care system. What they found was that patients overwhelmingly preferred allowing pharmacists to prescribe medications for minor aliments without the patient having to see their family doctor, but patients were not in favour of allowing pharmacists with special training to prescribe them a broad range of prescription drugs without patients seeing their physician.[10]

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[6] Kondro, W. (2007). Canada's doctors assail pharmacist prescribing. *Canadian Medical Association Journal*, 177(6), 558-558. doi:10.1503/cmaj.071212

[7] Henrich, N., Joshi, P., Grindrod, K., Lynd, L., & Marra, C. (2011). Family physicians' perceptions of pharmacy adaptation services in British Columbia. *Canadian Pharmacists Journal*, 144(4), 172-178. doi:10.3821/1913-701x-144.4.172

[8] Fees and claims data for government-sponsored pharmacist services, by province [Chart]. (n.d.).

[9] Lynd, L., & Marra, C. (2013, December 31). *BC Medication Management Project: Qualitative Evaluation Final Report* (Rep.).

[10] Exploring Models for Pharmacist Prescribing in Ontario: Citizen Brief (Rep.). (2015, October 17).

This was the same conclusion from another review, which said effectively communicating the benefits of pharmacist prescribing with individuals is key.[11]

In order to ensure success of pharmacist prescribing, the BCPhA recommends the College consider undertaking a thoughtful process that engages patients and helps the College understand potential barriers to providing this service to patients and how to effectively remove these barriers.

Rural access to care

The College rightly maintains that the pharmacist prescriber initiative will improve patient safety and aligns with primary health-care reform. While patient safety is a key component of public health, access to care is just as critical.

The College's proposal states "that a pharmacy owner cannot prescribe drugs pursuant to the BC Pharmacy Operations and Drug Scheduling Act (PODSA)". The BCPhA urges the College to pursue regulations so this prohibition does not negatively impact access to health care, particularly in rural areas. We understand the College's concerns about the "perverse incentive", but believe the solution lies not in prohibition but in enhancing the existing Conflict of Interest Standards developed by the College.

One only needs to look at the worsening state of access to care in British Columbia to recognize the impact this ban would have. The number of British Columbians without a family doctor continues to climb. As of 2016, more than 200,000 British Columbians looking for a family doctor can't find one. This number is higher than it was in 2010, when the government began an investment of millions of dollars, promising that all British Columbians would have access to a family doctor. This demonstrates that the current approach will continue to leave far too many British Columbians without a medical home and dependent on a patchwork of services to meet their health-care needs.

Rural care is a case in point. As studies show, one of the main obstacles in providing access to health care in rural communities is attracting and retaining health-care providers.[12]

The BCPhA recognizes that rural areas can be defined in many ways. The BCPhA used the physicians' Rural Practice Subsidiary Agreement (RSA) which assigns isolation points to rural communities. The higher the number of points, the more isolated a community is. The most isolated communities are designated as 'A' communities.

The BCPhA mapped community pharmacy locations to RSA-designated communities. There are currently 89 community pharmacies that serve 66 rural-designated communities in BC. Of those 66 communities, 60 per cent have only one pharmacy in town. (See Table 1: Number of Community Pharmacies in Rural Communities). In these areas, it is not unusual for the primary pharmacist on duty to be the owner of the pharmacy. And a 2015 survey of pharmacists in rural BC, respondents said that more than 80 per cent of their patients would have to travel between one to two hours to access health

[11]Faruquee, C. F., & Guirguis, L. M. (2015). A scoping review of research on the prescribing practice of Canadian pharmacists. *Canadian Pharmacists Journal / Revue Des Pharmaciens Du Canada*, 148(6), 325-348. doi:10.1177/1715163515608399

[12] Romanow, R. (2003). Building on Values. The Future of Health Care in Canada: Executive Summary. *HealthcarePapers Hcpap*, 3(4), 11-22. doi:10.12927/hcpap.2003.17376

services if they were not operating.[13] While likely not the intention of the College's proposal, in its current form the prohibition would deny patients in these rural areas access to primary health care.

In order for the pharmacist prescribing framework to solve the issue of accessibility to primary care, the BCPhA urges the College to pursue regulations so that this prohibition does not negatively impact access to health care, especially in rural areas. We know that 87 per cent of BC's population lives in urban areas, yet BC is unique in the Canadian context as it has many remote communities with a few hundred residents.[14] Given this unique situation, at the very least, the College should consider a separate program for pharmacist owners in rural and remote areas.

The ban on pharmacists who own pharmacies also inadvertently creates a disadvantage for small business owners. The ban would favour corporate ownership and create an uneven playing field that harms independent pharmacy operators across the province. In fact, in rural areas 85 per cent of community pharmacies are independent operators.

Reputational impact on the profession

Not only is the College's proposed ban on pharmacy owners prescribing medication on the basis of "perverse incentive" an issue of access to care, it negatively impacts the profession as a whole.

Pharmacists are one the most trusted professions. In a 2012 poll by Ipsos, pharmacists ranked fourth out of all professions in Canada.[15]

Pharmacists like all other professionals are consistently faced with challenges and ethical dilemmas that they must solve on a daily basis. Pharmacists must take an oath adhering to the College's Code of Ethics that lists ten standards they must abide by. One of these standards explicitly states, that registrants must "act in the best interests of their patients and…not exploit the professional relationship for any…financial…gain."

There are varying challenges that face all professionals who are working for compensation. In a health-care environment the pledge to put a patient's best interests first always drives professional judgement.

The BCPhA believes that there is little evidence to support the belief that pharmacist owners cannot manage this ethical challenge, while other prescribers who also run health-care businesses (e.g. physicians, dentists, naturopaths, midwives, optometrists) can. Based on discussions with other provinces there have been no reports of such unethical practices by pharmacists.

There are varying challenges that face all professionals who are working for compensation. In a health-care environment the pledge to put a patient's best interests first always drives professional judgement. Regulators of other professionals and in other jurisdictions have not put this in place, so the BCPhA asks the College to be sensitive to the impact this will have on the reputation of a self-regulating profession.

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[13] BC Pharmacy Association. (July 2015). Time to Fix the Rural Health-Care Deficit

[14] Strengthening Rural Canada: Fewer & Older: The Population and Demographic Dilemma in Rural British Columbia (Rep.). (2015, April).

[15] Ispos. (2012, June 16). Life-Savers, Medical Professionals Top the List of Most Trusted Professionals [Press release].

If the profession itself does not believe it can adhere to ethical codes of conduct, then it would seem that putting this requirement in place would be a vote of no confidence in the professionalism of its registrants.

There are other models on how to best manage conflicts besides outright banning of pharmacist owner prescribing. The BCPhA urges the College to monitor this issue over time and bring in the appropriate regulation based on evidence, not conjecture.

Final Summary

The BC Pharmacy Association supports the College's proposal for pharmacist prescribing. We urge the College to clarify dispensing of Schedule II and III drugs in the framework and to further explore key areas that may be a barrier to making pharmacist prescribing successful.

This includes engaging with physicians early in the process, seeking understanding of patient attitudes toward pharmacist prescribing and understanding whether the government and other payers will support funding this proposal.

The BCPhA also recommends removing the restriction on pharmacist owner prescribing through appropriate regulation under PODSA, and we recommend looking at other ways of addressing this ethical challenge such as enhancing the Conflict of Interest Standards. This will allow for expanded scope of practice for the profession of pharmacy and better health outcomes at optimal costs for patients.

British Columbia has been a leader in expanded scope of practice (e.g. immunizations, therapeutic substitutions, and renewals). We believe that BC can demonstrate this same leadership by coupling expansion of pharmacist prescribing authority of Schedule I drugs with payment of this service.

Table 1: Number of Community Pharmacies in Rural Communities

A, B, C, and D Communities

RSA communities are designated A, B, C, or D based on the number of isolation points they receive as outlined below:

'A' communities – 20 or more
'B' communities – 15 to 19.9
'C' communities – 6 to 14.9
'D' communities – 0.5 to 5.9

COMMUNITIES	NUMBER OF PHARMACIES	RSA CATEGORY
Alert Bay	1	A
Armstrong	2	
Ashcroft	1	A
Barriere	1	B
Brentwood Bay	2	
Chase	1	B
Chetwynd	1	A
Christina Lake	1	A
Clearwater	1	A
Cobble Hill	1	
Elkford	1	A
Enderby	2	C
Fort Langley	1	
Fort Nelson	2	A
Fort St. James	1	A
Fraser Lake	2	A
Fruitvale	1	
Gabriola Island	1	C
Garibaldi Highlands	1	
Golden	2	A
Houston	1	A
Invermere	2	A
Kaslo	1	A
Keremeos	2	C
Kimberley	2	A
Ladysmith	2	C
Lake Cowichan	2	C
Langford	1	
Lantzville	1	
Lillooet	2	B
Logan Lake	1	C
Lumby	1	
Lytton	1	

COMMUNITIES	NUMBER OF PHARMACIES	RSA CATEGORY
Mackenzie	2	A
Madeira Park	1	C
Marysville	1	
Midway	1	
Mill Bay	2	C
Nakusp	1	A
Nanoose Bay	1	
North Saanich	1	
Okanagan Falls	1	
Osoyoos	2	C
Peachland	1	
Pemberton	1	C
Pender Island	1	B
Port Hardy	2	A
Port McNeill	1	A
Princeton	2	A
Quathiaski Cove	1	
Queen Charlotte City	1	A
Revelstoke	2	A
Rossland	1	
Saanichton	2	
Salmo	1	
Scotch Creek	1	
Shawnigan Lake	1	C
Sicamous	1	
Sooke	2	
Sorrento	1	C
Sparwood	2	A
Tofino	2	
Tumbler Ridge	1	
Ucluelet	2	A
Vanderhoof	2	A
TOTAL	**89**	

BCPA
BC PSYCHIATRIC ASSOCIATION
A Division of the British Columbia Medical Association

BRITISH COLUMBIA PSYCHIATRIC ASSOCIATION

College of Pharmacists of British Columbia
200 – 1765 West 8th Ave.
Vancouver, BC
V6J 5C6
communications@bcpharmacists.org

RE: Certified Pharmacist Prescriber draft framework input.

July 15, 2016

Dear Sir/Madam:

The BC Psychiatric Association has reviewed the Draft Framework of the Certified Prescribing Pharmacist Initiative, which has been proposed by the College of Pharmacists BC as a "priority of the College Board in response to the need for improved patient safety". We are concerned that rather than enhancing public safety, the framework as proposed would place British Columbians at greater risk of harm. We note that a number of other physician groups have expressed concerns about this initiative; we endorse the concerns raised by our colleagues and encourage their review in this process. We will limit the scope of our further comments to mental health.

In reviewing the expansion of prescribing authority for pharmacists, the diagnosis and treatment of mental health conditions should be excluded from consideration. This should include, but not be limited to, the diagnosis of conditions such as psychotic illnesses, depression, and anxiety, and the prescribing of medications classified primarily as antipsychotics, mood stabilizers, antidepressants, anxiolytics, and sedative-hypnotics.

The accurate diagnosis of mental illness requires considerable expertise, and in some cases is possible only the context of a longitudinal relationship with a patient. Diagnoses based on cross-sectional assessment, particularly by those without focused training and substantial clinical experience, are unreliable. The treatment of mental illness requires regular follow-up, and it often behooves the clinician to also provide strategic psychotherapeutic interventions. In the absence of a well-established doctor-patient relationship, treatment is not only less likely to succeed, but carries a risk of further alienating patients already feeling disenfranchised by the stigma of mental illness.

Most jurisdictions in Canada clearly confine the authority of pharmacists to initiate treatment, limiting them to smoking/tobacco cessation and minor ailments/conditions. These are ailments that may be reliably self-diagnosed by the patient, do not require investigations such lab tests, can be reliably differentiated from more serious diagnoses, and are self-limiting conditions that need minimal and short-term follow-up. Mental illness falls decidedly outside of this scope. Without this limitation, British Columbia's Certified Pharmacist Prescribers would be authorized to initiate Provincial Schedule I treatment for chronic ailments that need not only significant expertise in diagnosis, but require also a firmly established alliance between patient and physician to support ongoing care. This would be an unprecedented relaxation of existing safeguards and standards of practice, and a cause for significant concern.

Respectfully submitted,

The BC Psychiatric Association

ARNBC and BCNPA Joint Response to the College of Pharmacists of B.C. Certified Pharmacist Prescriber Initiative Draft Framework

We would like thank the College of Pharmacists of B.C. for providing an opportunity for the Association of Registered Nurses of BC (ARNBC) and the BC Nurse Practitioner Association (BCNPA) to offer a nursing perspective on the Certified Pharmacists Prescriber Initiative Draft Framework. We believe that this type of collaboration between colleges and associations is vital to strengthening interprofessional collaboration in B.C. ARNBC and BCNPA are generally in favour of expanding the scope of pharmacists to include prescribing authority.

As professional associations, we have some concerns about the lack of opinion, support and corroboration by the BC Pharmacy Association throughout this document. It is our understanding that the regulatory colleges in B.C. are mandated to protect the public. In general, this would suggest that the role of regulation is to respond to legislative changes, rather than advocate to have legislative changes made. For this reason, we are somewhat cautious that there do not appear to be specific linkages and supporting documents from the Pharmacy Association and would suggest that this would strengthen the case and the document. While we recognize and respect that this Framework could lead to increased accessibility for patients, we also note that accessibility is not a generally considered a safety issue.

We have jointly reviewed this document and are happy to provide some observations, recommendations and input for your consideration.

Section 4.0 - Position of the College of Pharmacists of B.C.

- Page 11 states that the "*College is responsible for making sure every pharmacist and pharmacy technician in B.C. is fully qualified and able to provide the public with competent care*."
    - It would be helpful to provide additional information about the suggested educational program and assessment requirements – how long will the education component be, how will it be delivered (and by whom?) , how frequently will it require updating, etc.

  - How will the College as a regulatory body ensure competency among pharmacists applying for prescribing authority?
  - This document builds a case for certified pharmacist prescribers in improving primary care access. However, nursing knows that pharmacists across B.C. practice under different roles, and some, such as clinical pharmacists, have more knowledge and experience in areas such as patient assessments or interpreting lab values compared to others. How will the College manage these differences?
- With respect to the Multidisciplinary Drug Administration Committee, it would be helpful to have more information on this committee (i.e.: which members from other health professions will be included, representation, etc.)

Section 6.0 "Benefits of the Certified Pharmacist Prescriber Initiative for B.C.'s Healthcare System"

- The benefits noted are quite compelling. However, aside from 'improving patient health outcomes', none of the listed benefits are accompanied by associated references. It would be enormously beneficial to research some literature from other successful jurisdictions, to support these key points.

Section 7.1 "Proposed Eligibility Criteria"

- Components listed under the educational program include "testing on therapeutic, patient assessment, and the *ordering and interpreting of laboratory tests*." Standard 5 also states that "pharmacists must conduct a patient assessment that may include, as appropriate …laboratory values..."

  However under section 8.3, it states that "while the College identifies the value of the Certified Pharmacist Prescriber having the authority and ability to *order and interpret laboratory tests*, this element falls outside of the scope of the Certified Pharmacist Prescriber Initiative, as it is not within the College's jurisdiction."

  As written, it is unclear whether ordering and interpreting laboratory tests will be part of the role of a Certified Pharmacists Prescriber. Currently, it is listed as a key component of the educational program and a standard, however, at the same time, falls outside of the scope of the Certified Pharmacist Prescriber Initiative as indicated in section 8.3.

If pharmacists are granted the authority to prescribe, but unable to order and interpret laboratory tests (which are needed to conduct thorough assessment), how will this be reconciled?

Section 7.2 "Proposed Renewal Requirements"

- What would an "additional 15 units of continuing education in the area of prescribing" equate to.

Section 7.3 "Proposed Standards, Limits and Conditions"

- Standard 13: "After prescribing, pharmacists must…"
    - It would be preferable to include the need for pharmacists to communicate this information with the patient's primary care provider or healthcare team after prescribing. This is listed under the last point of standard 16 (in relation to documentation) "the pharmacist must document in the patient's record the patients' primary health care provider and other relevant health professionals, as appropriate were notified and provided with relevant information" (page 15).

- Limit 4: "A Certified Pharmacist Prescriber must not self-prescribe or prescribe for a family member or friend unless there is an emergency and no other prescriber is available."
    - What does an 'emergency' refer to within this context? Who determines something is emergent, and how is the attempt to have reached another prescriber recorded? This requires clarity as 'emergent' is a judgement rather than a specific condition.

Section 8.1 "Considerations for Standards, Limits and Conditions"

- RE: prescribing and dispensing
    - While this document outlines safeguards for prescribing and dispensing, we believe there could still be a conflict of interest. It would be beneficial to include a condition related to dispensing and prescribing in the event that failing to do so compromises patient outcomes. For example, within the Alberta College of Pharmacists' 'Standards of Practice for Pharmacists and Pharmacy Technicians', standard 15 states that "a pharmacists who prescribes a drug or blood product at initial access based on the pharmacist's own assessment of the patient must

not dispense the drug him-or herself, unless the pharmacist is satisfied that adhering to this standard will compromise the health of the patient" (Page, 9. https://pharmacists.ab.ca/sites/default/files/StandardsOfPractice.pdf)

Section 8.3 "Ordering and Accessing Laboratory Tests"

- Point of clarification: should the title of section 8.3 "Ordering and Accessing Laboratory Tests" be amended to "Ordering and *Interpreting* Laboratory Tests?" The text under section 8.3 specifically refers to ordering and interpreting, not accessing.

Appendix 1: "Pharmacist Prescribing Case Illustrations"

- While the case scenarios outline detail about assessments, more detail should be considered in terms of the need for greater *physical* assessments, such as a lung assessment when prescribing inhalers. Some pharmacist colleagues of nurse practitioners have completed additional full physical assessment courses, and it would be beneficial to include this as part of the educational component for certification.

Conclusion

This document outlines the strong need for interprofessional collaboration in achieving the triple aim of improving the patient experience, the health of populations, and cost effectiveness - a position that we are strongly supportive of. As such, we believe that all healthcare providers such as pharmacists should be utilized to their full potential. We are cautious about some of the areas noted in this short review, and would like to see more clarity and specificity if at all possible.

Thank you for the opportunity to provide comments on the College of Pharmacists Certified Pharmacist Prescriber Initiative Draft Framework. We look forward to watching this advance through the system.

COLLEGE OF
REGISTERED NURSES
OF BRITISH COLUMBIA

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August 9, 2016

Bob Nakagawa, Registrar
College of Pharmacists of BC
200 – 1765 West 8 Avenue
Vancouver, BC V6J 5C6

Dear Bob:

Thank you for taking time to meet with me and Christine Penney, Deputy Registrar and Chief Officer, Policy, Practice and Quality Assurance, on July 27, 2016. We appreciated the opportunity to candidly discuss CPBC's Certified Pharmacist Prescriber Initiative with you and to understand more about the foundations of the proposed change.

Further to our conversation, I want to provide our feedback in writing so that it could be shared, as desired, with your Board and staff. CRNBC appreciates the collaborative approach to consultation taken by CPBC and we hope that our written comments will be of assistance to you and your team.

As mentioned in our meeting, CRNBC recognizes the inherent conflict presented when prescribers who own pharmacies also have a role in dispensing. We expressed our concern about how the certified pharmacist prescriber initiative appears to embrace this approach and we were explicit in sharing our concern about the impact this could have on patient safety.

We also indicated our concern with the use of a five week preparatory course to deliver the competencies required for the certified pharmacist prescriber. We understand that pharmacists completing the course would be expected to assess and essentially diagnose a patient's health concern. Having experience with nurses who undertake certified practices that include an expanded scope of assessing and diagnosing, a five week course seems unreasonably short. We appreciate that the College would rely on a pharmacist's own assessment of his or her competence in assessing and diagnosing a patient, but were unclear about how this would be monitored or assessed as part of quality assurance programming. As well, we raised the question about how the initiative would align with primary health care.

Finally, we expressed our concern about the College's overall purpose in positioning the certified pharmacist prescribing initiative as a strategic goal of the College. We respectfully shared our concern about any College spearheading an initiative that supports the expansion of a scope of practice without clear indication from the system (ie: ministry of health, health authorities, etc.) that the expansion is required for improved patient safety or population health.

Again, we appreciate the opportunity to convey our thoughts and feedback on the CPBC's initiative. We understand that a substantive amount of work has gone into researching and preparing the information in a way that can be shared with stakeholders and the public.

We welcome any questions you may have about our feedback and look forward to working collaboratively with you as s the CPBC progresses with the consultation process.

Sincerely,

Cynthia Johansen, MAL, MSc
Registrar/CEO

doctors of bc
British Columbia Medical Association

July 15, 2016

Mr. Bob Nakagawa
Registrar
College of Pharmacists of British Columbia
200 – 1765 West 8th Avenue
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Ms. Gillian Vrooman
Director, Communications and Engagement
College of Pharmacists of British Columbia
200 – 1765 West 8th Avenue
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VIA Electronic Submission

Dear Mr. Bob Nakagawa & Ms. Gillian Vrooman:

Re: Certified Pharmacists Prescriber Initiative Draft Framework

Doctors of BC appreciates the opportunity to review and comment on the College of Pharmacists of BC's Certified Pharmacists Prescriber Initiative Draft Framework. We believe that pharmacists are important members of a multidisciplinary health care team and play a critical role in supporting chronic disease management and ensuring patient safety.

Attached is the Doctors of BC's response to the College of Pharmacists' Draft Framework.

We welcome the opportunity to discuss this further with you.

Sincerely,

Alan Ruddiman, MB.BCh.(Wits), Dip. PEMP, FRRMS
President, Doctors of BC

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RESPONSE TO COLLEGE OF PHARMACISTS OF BC:

Certified Pharmacist Prescriber Initiative Draft Framework

doctors of bc

JULY 2016

CONTENTS

Certified Pharmacist Prescriber Initiative

In June 2016, the College of Pharmacists of British Columbia (the "College of Pharmacists") released the Certified Pharmacist Prescriber Initiative Draft Framework ("Draft Framework") for public consultation. The Draft Framework proposes expanding pharmacists' scope of practice in BC to include the prescribing authority to initiate Schedule 1 drugs.[a](1)

The Draft Framework proposes the creation of a Certified Pharmacist Prescriber ("CPP") program. To become a CPP, a pharmacist registered with the College of Pharmacists will be required to complete an education program and assessment which will include testing on therapeutics, patient assessment, and the ordering and interpreting of laboratory tests. The Draft Framework also proposes CPP renewal requirements that include proof of an additional 15 units of continuing education in the area of prescribing, and an annual self-declaration. Limits on CPP prescribing include the requirement to obtain informed patient consent[b] and exclusion of pharmacy owners from CPP eligibility, in accordance with existing provincial legislation[c] which prohibits pharmacy owners from prescribing. The Draft Framework also provides a range of case illustrations, varying in medical complexity, for pharmacist prescribing in BC.

Doctors of BC values this opportunity to review and comment on the Draft Framework and welcomes any opportunities to work with the College of Pharmacists to improve patient and provider experience, improve the health of populations, and reduce the cost of health care.

Pharmacist Prescribing in Canada

In Canada, pharmacist prescribing authority varies across provinces. Pharmacists in Alberta have the widest prescribing authority, where pharmacists (with additional prescribing authorization) have the authority to independently initiate, manage or adapt any Schedule 1 drug. Currently, pharmacists in BC are not permitted to initiate Schedule 1 drugs in any situation but may sell non-prescription Schedule 2 and 3 drugs, refill and modify prescriptions, inject certain vaccines, sell emergency contraception without prescription, and dispense emergency supplies of drug therapy.(1)

The table below compiled by the Canadian Pharmacists Association provides a summary of pharmacists' scope of practice in Canada.(2)

[a] The proposed prescribing authority does not include controlled substances, such as opioids.

[b] Draft Framework proposes requiring CPP to advise patient that he or she may choose to have their prescription dispensed by another pharmacist or pharmacy.

[c] BC's Pharmacy Operations and Drug Scheduling Act prohibits pharmacy owners from prescribing.

Pharmacists' Scope of Practice in Canada

	Scope of Practice [1]	Province/Territory												
		BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	NWT	YT	NU
Prescriptive Authority (Schedule 1 Drugs) [1]	Independently, for any Schedule 1 drug	X	✓ [5]	X	X	X	X	X	X	X	X	X	X	X
	In a collaborative practice setting/agreement	X	✓ [5]	✓ [5]	✓ [5]	X	X	✓	✓	X	X	X	X	X
Initiate [2]	For minor ailments/conditions	X	✓	✓	✓ [5]	X	✓	✓	✓	✓ [5]	✓	X	X	X
	For smoking/tobacco cessation	X	✓	P	✓ [5]	✓	✓	✓	✓	✓ [5]	✓	X	X	X
	In an emergency	X	✓	✓	✓	X	X	✓	✓	✓	X	X	X	X
Adapt [3]/ Manage	Independently, for any Schedule 1 drug [4]	X	✓ [5]	X	X	X	X	X	X	X	X	X	X	X
	Independently, in a collaborative practice [4]	X	✓ [5]	✓ [5]	✓ [5]	X	X	✓	✓	X	X	X	X	X
	Make therapeutic substitution	✓	✓	✓	X	X	X	✓	✓	✓	✓	X	X	X
	Change drug dosage, formulation, regimen, etc.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X
	Renew/extend prescription for continuity of care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X
Injection Authority (SC or IM) [1,5]	Any drug or vaccine	X	✓	✓	✓	X [7]	X [7]	✓	X	✓	✓	X	X	X
	Vaccines [6]	✓	✓	✓	✓	X	X	✓	✓	✓	✓	X	X	X
	Travel vaccines [6]	✓	✓	✓	✓	P	X	✓	✓	✓	✓	X	X	X
	Influenza vaccine	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	X	X	X
Labs	Order and interpret lab tests	X	✓	P [8]	✓ [9]	X	✓	P	✓	P	X	X	X	X
Techs	Regulated pharmacy technicians	✓	✓	✓	✓ [10]	✓	X	✓	✓	✓	✓	X	X	X

1. Scope of activities, regulations, training requirements and/or limitations differ between jurisdictions. Please refer to the pharmacy regulatory authorities for details.
2. Initiate new prescription drug therapy, not including drugs covered under the *Controlled Drugs and Substances Act*.
3. Alter another prescriber's original/existing/current prescription for drug therapy.
4. Pharmacists independently manage Schedule 1 drug therapy under their own authority, unrestricted by existing/initial prescription(s), drug type, condition, etc.
5. Applies only to pharmacists with additional training, certification and/or authorisation through their regulatory authority.
6. Authority to inject may not be inclusive of all vaccines in this category. Please refer to the jurisdictional regulations.
7. For education/demonstration purposes only.
8. Ordering by community pharmacists pending health system regulations for pharmacist requisitions to labs.
9. Authority is limited to ordering lab tests.
10. Pharmacy technician registration available through the regulatory authority (no official licensing).

✓ Implemented in jurisdiction
P Pending legislation, regulation or policy for implementation
X Not implemented

Canadian Pharmacists Association / Association des pharmaciens du Canada

Doctors of BC Response to Draft Framework

Summary of Response

Doctors of BC considers pharmacists important members of multidisciplinary health care teams and supports efforts to enhance multidisciplinary care as an important solution to the challenges of chronic disease, an aging population and patient access. To ensure patient safety, Doctors of BC believes that any changes in health professionals' scopes of practice must be substantiated by sufficient evidence of training and demonstrated expertise; and are ethical, appropriate, and consistent with best available scientific evidence.(3) With this in mind, **Doctors of BC has deep reservations about the proposed CPP program and is unable to support the Draft Framework to expand pharmacist prescribing in BC.**

Doctors of BC reservations are discussed below and pertain to issues regarding:

- inter-professional collaboration,
- continuity of care (including duplication and fragmentation of care),
- clinical training in patient assessment and diagnosis, and
- conflict of interest.

To inform our response to the Draft Framework, Doctors of BC conducted an online member survey titled "Informing Doctors of BC Response to CPP" ("Doctors of BC Survey") which was open from June 16th- July 3rd, 2016. In total, 715 responses were received.

Doctors of BC Survey results indicate that members are overwhelmingly opposed to the Draft Framework to expand pharmacist prescribing in BC. In particular, physician members are concerned about how insufficient clinical training, conflicting prescriber and dispenser interests, and the fragmentation of care will compromise patient safety and increase health care costs.

Public support for expanding pharmacist prescribing also appears to be limited. A 2008 Ipsos Reid poll ("Ipsos 2008 Poll"), commissioned by Doctors of BC, found that 83% of British Columbians opposed allowing pharmacists to diagnose a new illness and to recommend a treatment plan, including prescription medication, without consulting a patient's doctor.(4)

Inter-professional Collaboration

One important solution for addressing challenges of patient access, chronic disease and an aging population is enhancing the delivery of multidisciplinary care. In recent years, local Divisions of Family Practice, Health Authorities and the BC Ministry of Health have worked together to implement various team-based care models in communities around BC. These initiatives emphasize stronger linkages and coordination between physicians and other health care professionals, including pharmacists.(5, 6)

As pharmacology experts, pharmacists (within current scope of practice) are well positioned to work with physicians, who are experts in patient assessment and diagnoses, to collectively improve patient care and safety. Many of our physicians strongly support opportunities to work with pharmacists, as part of a multidisciplinary team, to improve chronic disease management, prevent adverse drug events, and optimize other complex medication issues. This message came through clearly in the Doctors of BC Survey.

According to information provided by the Alberta Medical Association, physicians in Alberta have expressed concerns about the ways in which expanded pharmacist prescribing rights are deteriorating physician/pharmacist relationships in their province. More specifically, these physicians have noted that there is currently no mechanism for effective communication between pharmacists and physicians during the prescribing process nor is there a reasonable approach to dispute resolution when there is disagreement between physicians and pharmacists relating to a patient's prescription and treatment plan.(7)

Continuity of Care

There is considerable evidence that population health outcomes are better, and costs are lower, when patients' medical conditions are managed in the context of an ongoing relationship with a regular family doctor.(8-10) Rather than strengthening continuity of care, Doctors of BC is concerned that additional prescribers, such as CPPs, will further fragment patient care. Additional prescribers may also increase service duplication and lead to contradictory patient assessments and treatment plans. This is supported by data from the Doctors of BC Survey which showed that nearly all respondents viewed that CPPs, as currently outlined in Draft Framework, will fragment care for patients.

Doctors of BC disagrees with the Draft Framework's assertion that CPPs will improve health care efficiency by enabling physicians to focus on other medical issues and reducing the number of practitioners a patient must visit to be assessed and access drug therapy. First, even in the case of minor ailments, patients often raise more serious health concerns when seeking treatment for minor conditions and in these cases, it is more efficient to address all health concerns in a single visit. Second, many patients may still see a physician after visiting a CPP.

For instance, according to the Ipsos 2008 Poll, 73% of British Columbians reported that they would likely see a doctor to confirm after a pharmacist renewal or change of prescription.(4)

Clinical Training in Patient Assessment and Diagnosis

Doctors of BC is concerned that CPP training and education, as currently outlined in the Draft Framework, is unlikely to proficiently train a pharmacist to perform physical examinations and to diagnose patients. In the UK, where pharmacists are required to take additional training in diagnosis, one study indicates that while pharmacists' diagnostic accuracy was similar to GPs for some conditions, they were statistically different for other conditions and behind nurses' diagnostic scores.(11) Without sufficient training in patient assessment and diagnoses, pharmacists may have to rely more on patient self-assessments, which may be inaccurate. In fact, another UK study showed that patients often arrive to a pharmacy having already committed to a diagnosis.(12)

For the proposed CPP program, the Draft Framework does not provide sufficient detail about the length and rigour of proposed CPP training. According to the Doctors of BC Survey, nearly all respondents expressed that they do **not** believe that the training requirements, as outlined by the Draft Framework, will adequately train CPPs to perform their expanded roles. A typical family physician in Canada is required to attend four years of medical school plus a minimum of two years of residency (five years of residency for specialists). Nurse Practitioners, who also have prescribing authority (within scope), are required to complete a two year Master's program, in addition to completing a nursing degree.

Conflict of Interest

There is an inherent conflict of interest between a drug prescriber and dispenser. For this reason, most physicians in BC are prohibited from dispensing medication to patients due to their role as prescriber.[d](13)

The Draft Framework addresses conflict of interests by excluding pharmacy owners from CPP eligibility and by requiring informed patient consent. Despite these safeguards, Doctors of BC does **not** consider that the Draft Framework adequately mitigates potential conflict of interest between a pharmacist role as a prescriber and dispenser. This is strongly supported by data in the Doctors of BC survey, with many members expressing concerns that CPPs may nonetheless be influenced by pharmacy owners/employers or by other industry relationships. As for informed patient consent, the Draft Framework proposes requiring CPPs to advise patients that they may choose to have their prescription dispensed by another pharmacist or pharmacy. However, it seems unlikely that patients would choose to visit a different pharmacy or wait for another pharmacist (if available) to purchase their medication. For instance, the Ipsos 2008 Poll indicates that the most frequent reason for people choosing a pharmacy in BC is the convenience of location.

[d] Only certain physicians authorized by the College of Physicians and Surgeons of British Columbia are permitted to prescribe and dispense medications to their own patients. Most are physicians practicing in isolated communities that are not large enough to support a commercial pharmacy. Others are physicians involved in specialized infertility clinics who dispense medications based on a need for precise timing of administration.

Conclusion

As experts in pharmacology, pharmacists are well positioned to work with physicians, who are experts in patient assessment and diagnoses, to collectively improve patient care and safety. Doctors of BC believes that the knowledge and experience of pharmacists and physicians are different and complementary, and that overlapping prescribing authority may further fragment care, compromise patient safety, and increase cost to the health care system. In addition, Doctors of BC believes that issues of CPP training and conflict of prescriber/dispenser interests have not been adequately addressed in the Draft Framework.

Although Doctors of BC is unable to support the Draft Framework, Doctors of BC welcomes opportunities to work with the College of Pharmacists to explore ways in which pharmacists and physicians can work together to collectively address BC's health care challenges.

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Canadian Society of Hospital Pharmacists
Société canadienne des pharmaciens d'hôpitaux
British Columbia Branch
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Sept 13 2016

Dear College of Pharmacists of BC:

The Canadian Society of Hospital Pharmacists (CSHP) BC Branch would like to thank the College for presenting the Certified Pharmacist Prescriber Initiative Draft Framework (Feb 2016) to our executive council and allowing us opportunity for feedback.

CSHP BC Branch strongly supports the Certified Pharmacist Prescriber Initiative as it allows hospital pharmacists greater ability to provide best patient care. Pharmacist prescribing within an institutional setting (collaborative and independent prescribing) by hospital pharmacists already exist and this has clearly been shown to benefit hospital patients, physicians and the health care system. Pharmacist prescribing can further enhance medication reconciliation on admission and discharge, reduce the number of prescribing errors, reduce logistical burden to physicians and contribute towards timely and seamless hospital discharge. Formal recognition of prescribing by hospital pharmacists with the Certified Pharmacist Prescriber Initiative would greatly enhance provision of care to hospitalized patients as well as contribute to a more efficient and successful transition back into the community. As well, hospital pharmacists do not carry a conflict of interest with prescribing as their wages are salaried by the various health authorities and there is no profit generation with dispensing of medication within a hospital.

A common goal of both our organizations is to provide the best care to the patients of BC. We are very happy to work with the College in approving the Certified Pharmacist Prescriber Initiative.

Best Regards,

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July 12, 2016

Mr. Blake Reynolds, Chair
College of Pharmacists of BC
200 – 1765 West 8th Avenue
Vancouver, BC V6J 5C6

Mr. Bob Nakagawa, Registrar
College of Pharmacists of BC
200 – 1765 West 8th Avenue
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Dear Mr. Reynolds and Mr. Nakagawa:

Re: Certified Pharmacist Prescriber Initiative

We write on behalf of the College of Physicians and Surgeons of British Columbia (the "CPSBC") regarding your proposal to expand the scope of practice for pharmacists to include independent prescribing authority. We thank you for the opportunity to review your document "Certified Pharmacist Prescriber Initiative Draft Framework" and the opportunity to meet with you to discuss this in person. Our feedback is contextualized by our regulatory role. We have reviewed your proposal through the lens of our legislated mandate: to serve and protect the public, and to promote and enhance collaborative relations with other colleges established under the *Health Professions Act* (the *"HPA"*).

At the outset, we wish to be on record as supporting the role of the pharmacist in providing safe, quality, and effective medication therapy to patients. Pharmacists are highly trained health professionals and experts at dispensing drugs. Fundamentally, the separation of the professional activities of prescribing from dispensing is a cornerstone to safe, quality patient care. As a virtual or real member of the health care team, the pharmacist has a critical role in ensuring and confirming that the patient receives the right medication, has been counselled again regarding the administration/ storage/ side effects of the medication, and that possible drug interactions/ allergies have been reconsidered. This is why the CPSBC has been advocating that physician-only dispensing of mifegymiso is not in the patient's best interest, and we are very supportive of pharmacist-dispensing for this medication. We also believe this to be the reason why practitioner-dispensing of medications is prohibited under the *HPA* unless additional specific patient safety measures are in effect.

We have carefully considered the unique circumstances of hospital based pharmacists being granted prescribing authority. In this situation, the hospital pharmacist is part of an onsite collaborative team, and has ready access to a unified patient record that includes admitting history, physical examination assessments, investigations, consultations from other allied health providers, and progress notes. The patient in this circumstance has had the benefit of a medical

or nurse practitioner assessment, leading to a diagnosis and treatment plan. In the most complex situations, the pharmacist has been directly involved with medication review and management in a collaborative relationship with either the medical or nurse practitioner. The role of the hospital pharmacist is not one of providing an assessment, diagnosis, and prognosis: this role is provided by the attending physician and/or nurse practitioner, whose training and expertise is focused on assessment and diagnosis. It seems entirely appropriate for hospital pharmacists to provide prescriptions at time of discharge, having been engaged in the medication optimization and management during the patient's stay. The patient is free to obtain the medication(s) from a community pharmacist of their choice, who fulfills that independent role of dispensing, affording the patient the opportunity to receive the correct medication, along with additional advice and education.

After reflection, we believe that it would not be appropriate to grant community-based pharmacists an expanded scope of practice to include primary prescribing. Unlike the hospital-based pharmacist, the community pharmacist in your model must independently conduct a patient assessment. From a public protection and patient safety perspective, we are of the opinion that pharmacists are not adequately trained in patient assessment leading to diagnosis and prognosis. We note in the proposal that the community pharmacist must conduct a patient assessment that may include physical assessment, mental health assessment, laboratory values, and diagnostic information. The education and training that pharmacists receive leading to registration as a full pharmacist does not include the depth and breadth of training such as for physicians (a graduate degree with significant clinical exposure followed by a minimum of a two year residency focused entirely on clinical skill development) or for nurse practitioners (a graduate degree followed by two additional years of training focused on clinical skills). It is unclear to us from your proposal how 15 units of certified practice training will provide an adequate amount of education to support the proposed expanded scope of practice. A review of the literature identifies pharmacists in foreign jurisdictions who take on prescribing as a scope of practice must undergo significant clinical training, often measuring weeks or months in time. As you know, our society is suffering from the public health consequences resulting from inappropriate and overuse of prescription antibiotics. Similar examples also exist in the management of many psychiatric disorders. A holistic approach that considers non-pharmacologic therapy, counselling, cognitive behavioral therapy, etc. as well as pharmacotherapy is the preferred approach.

Furthermore, unlike the hospital-based pharmacist who assumes the role of the prescriber, and only the prescriber, the proposal identifies the community pharmacist as both prescriber and dispenser. We do not believe that this conflict can be addressed by an expectation that the pharmacist must act in the patient's interest. The principles supporting the separation of the professional activities of prescribing from dispensing must be maintained to ensure safe, effective pharmacotherapy. The situation would be quite different if the community pharmacist was part of a collaborative community team and their role was limited to prescribing as part of that team (a team in which medical and/or nurse practitioners would be providing patient assessment and diagnosis). Again, the dispensing would be provided by another pharmacist independent to that team.

We would view a community pharmacist as part of a primary care team having prescribing authority in a more favorable light. CPSBC's Board is on record as supporting reforms to

primary care that encourage more comprehensive care, with an emphasis on continuity and integration of care, over initiatives that encourage more fragmentation of care. We would point to care models in the USA and the UK where pharmacists have prescribing authority, and are part of teams of care. The actual dispensing of medication is a separate and distinct professional activity.

As you know, one of the emerging services that retail pharmacies are offering for sale is point of care testing (POCT). These are "kits" that can be purchased at a kiosk in a pharmacy and the patient provides a drop of blood and a result is provided back to the patient via an online report. As our two colleges have previously discussed, these POCT tests are not subject to proficiency testing or accreditation, nor are they provided to the patient with the benefit of pre or post-test counselling or follow-up. We see the potential for a series of perceived or real conflicts of interest if pharmacists are selling both lab tests and medications in the context of having primary prescribing authority.

In closing, we thank you for the opportunity to provide comment on your proposed scope of practice change for pharmacists, and trust that you have found our comments helpful in your deliberations.

Yours truly,

Heidi M. Oetter, MD
Registrar and CEO

Gerrard A. Vaughan, BSc, MD
President

HMO/sm

SGP
Society of General Practitioners of BC

Mr. Blake Reynolds, Chair
BC College of Pharmacists
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July 14, 2016

Dear Mr Reynolds

The Society of General Practitioners of BC represents GP members within Doctors of BC and works to ensure a strong future for family practice and the patients we serve. As such we are keenly interested in collaborating in system change initiatives to support high quality patient centered care.

Many of our members have told us of strong and satisfying collaborative relationships with pharmacists, working together in the best interests of patients. Members recognize that Pharmacists are well trained in pharmacology and medication management and value their expertise. So SGP was surprised and disappointed to find that the College of Pharmacists of BC Certified Pharmacist Prescriber Initiative focuses on expanding the scope of practice of pharmacists to include patient assessment, diagnosis and subsequent initiation of prescription medication, based on a purported "societal need." The Draft Framework document states that an aging population, increasing burden of chronic disease, a perceived shortage of physicians and "limited" access to primary care services, increasing prescription drug utilization, proliferation of new drug therapies, medication-related hospitalization and polypharmacy, all contribute to pressure on "traditional models of care with physician-dominated prescribing" which could somehow be solved by "expanding prescribing rights for pharmacists."

Rather than focusing on system change that would support all health care team members to work to their full scope of practice in an interdisciplinary patient centered model, the College of Pharmacists seeks to create an expanded scope of practice for pharmacists which will lead to further fragmentation of care with multiple prescribers sometimes working in isolation of each other. This is a recipe for medical error.

Instead SGP would like to see system change that supports physicians, pharmacists, and other allied health providers to collaborate on patient care. Each team member brings the specialized skill set of their individual training program to the provision of that care. Rather than trying to replace each other, they each play the appropriate position on the team, creating an opportunity for patients to truly receive comprehensive, collaborative team based care based on their individual needs.

SGP is working with GPSC, a joint collaborative committee of the MOH and Doctors of BC, to achieve the vision of the Patient Medical Home and to support the creation of Primary Care Homes. We know that the future lies in inter-professional team based care. The Patient Medical Home will support collaborative interdisciplinary team based care, none of which requires a change in scope of practice for the members of the team. Instead, each team member contributes his/her specific skills as appropriate to the patient centered care provided.

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SGP is very concerned that the Draft Framework is silent on what further education would be required by pharmacists who wish to prescribe, other than to say that the College will require "all pharmacists applying for prescribing authority to meet the educational program and assessment requirements recommended by the College's multidisciplinary Drug Administration Committee." SGP respectfully offers that the further education required to independently assess patients, make a diagnosis, and initiate treatment (pharmaceutical or otherwise) is already available – it is called medical school. Appendix 1 describes cases which include diagnosis, physical examination, and interpretation of lab investigations, all to be undertaken by Pharmacists who have completed an educational program which is not outlined and is left to the imagination of the reader.

The Draft Framework states that one of the expected benefits of Pharmacists prescribing will be increased patient access to health care services because other prescribers, such as MDs and NPs, can instead "focus on other medical issues." It also states that this would "reduce the number of practitioners a patient must visit to be assessed and if necessary access drug therapy." Following the same reasoning, why not just allow MDs and NPs to dispense medication? This would be a far simpler solution, if in fact, the reasoning of the College of Pharmacists is correct.

SGP argues the reasoning is faulty. The evidence shows that the best patient outcomes result when the primary care system meets all of the key attributes of primary care as articulated by Barbara Starfield: access, continuity, comprehensiveness, and co-ordination. Focusing on one or two, and ignoring others, is not the answer.

SGP encouraged its members to complete the College of Pharmacists on-line stakeholder consultation so the College will have the benefit of receiving physician feedback directly. In addition, we asked our members to let us know what they thought. Many of the responses expressed a desire for better collaborative working relationships with pharmacists. Expressed concerns included:

- inadequate training to ensure competent clinical diagnosis and physical exam
- fragmentation of care with increased risk of medical error
- duplication of care, resulting in increased costs
- clear conflict of interest that is not mitigated or adequately addressed in the draft framework

In summary, there was clear consensus within the SGP that the Certified Pharmacist Prescriber Initiative will not achieve the benefits it purports to bring to our health care system. It does not support the key attributes of primary care nor provide evidence it would achieve the IHI Triple Aim. Instead it brings clear risks in the form of fragmented care. Rather than supporting the move towards collaborative team based care it would result in a new silo of medical practice, increasing costs and utilization of health care services. SGP cannot support this Initiative, and would be happy to engage further with the College of Pharmacists in dialogue on how physicians and pharmacists can better work together, within their existing scopes of practice, to achieve a quality health care system for BC patients.

Yours truly,
SGP President

Dr. Ernie Chang

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Specialists of BC

Response regarding pharmacists prescribing June 27, 2016

Thank you for the opportunity to provide input on the BC College of Pharmacists Draft Framework. The Specialists of BC represent the interests of the almost 5300 medical, diagnostic and surgical specialists within the province.

We are surprised that a pharmacist college policy in development for many months is now distributed for feedback with a deadline of four weeks. There are very significant issues to consider. We strongly recommend that you extend your deadline and encourage all interested and affected parties to submit further information. Such an extension is particularly important given that the request came mid-June, at the start of the summer season when many stakeholders in BC take time off.

In that context, and in preliminary consultation with our specialty leads, we identify the following issues that represent immediate concerns; there may be others:

1. Competency/training
2. Conflict of interest for pharmacists who are employed by, are partners in or own pharmacies
3. Scope of practice
4. Fragmentation of care
5. Delays in appropriate care
6. Patient safety
7. Potential for missed or incorrect diagnoses
8. Duplication of services
9. Cost increases
10. Liability/duty of care

We respect the training and skill set of pharmacists which have allowed us to work together to achieve the highest quality patient care possible, but it is difficult for us to understand how the current pharmacy training curriculum could provide for the safe independent assessment and management of patients. Medical students spend years studying history taking, physical examination, ordering and interpretation of laboratory and imaging tests. By completion of their undergraduate education and postgraduate residency training they have assessed thousands of patients. We are not aware of any such comparable training in the pharmacy curriculum.

We do note that the Bachelor of Pharmacy degree has been discontinued, and Entry-to-Practice Doctor of Pharmacy degree introduced. This new training relies on having

completed two years of undergraduate course work, perhaps not dissimilar to some of the standard undergraduate requirements that medical students complete in three to four years of undergraduate training before entering medicine.

The 2016/2017 UBC Calendar lists available pharmacy courses per the appendix below. We do not see course work in History Taking, Physical Examination, Pathology, or Radiology. Nor do we note clinical clerkships dealing with Family Practice, Medicine, Surgery, Pediatrics, Obstetrics, etc. After completion of this so-called Doctor of Pharmacy undergraduate degree, we do not see any practical requirements such as the two-year family practice, or the four to six years of additional on-the-job training of medical, surgical, diagnostics residencies required to be considered full-fledged doctors of medicine.

In contrast, the preparation in Pharmacy and Pharmacology appears very thorough and complete. This portion of training looks to be considerably more indepth than what medical students obtain. It is no wonder that physicians value the input of our pharmacy colleagues in their pharmaceutical areas of expertise. We cannot imagine any physician feeling capable of stepping into the role of a pharmacist, given the relative dearth of pharmacy training they receive.

As the College of Pharmacists considers the future roles of its graduates, should any of them have a desire to practice medicine, that is independently assess patients, order tests, examine them, and prescribe treatments, we would encourage those pharmacy graduates to consider applying to medical school. In fact, there have been many pharmacists who have chosen this route and have become fine medical doctors. Similarly, should any of our physicians desire to begin a career as a pharmacist, we would encourage them to enroll in the Entry-to-Practice Doctor of Pharmacy program, and we are sure that they would make fine pharmacists.

Excepting physicians being trained in pharmacy, or pharmacists being trained in medicine, we think it would be unwise and unsafe for doctors to practice as pharmacists or pharmacists to practice as doctors.

Yours sincerely,

John Falconer MD, FRCPC
President

Appendix – Pharmacy Course Listing UBC Calendar 2016/17:

Faculty of Pharmaceutical Sciences
PHAR: Pharmaceutical Sciences
PHRM 100 (18) Foundations of Pharmacy Scientific concepts and pharmacy practice principles. Role of the pharmacist, patient assessment skills, professional identity, communication skills, and an understanding of legal and ethical responsibilities. *This course is not eligible for Credit/D/Fail grading.*
PHRM 111 (15) Medication Management I Modules and integration activities focusing on: an introduction to infectious diseases; musculoskeletal disorders; dermatology; eyes, ears, nose, and throat disorders; fluid and electrolytes, and hematology. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 100; *Corequisite:* PHRM 131.
PHRM 131 (2) Study Design and Interpretation I Principles of clinical study design, focusing on biostatistical foundations, randomized controlled trials, and systematic review of randomized controlled trials. *This course is not eligible for Credit/D/Fail grading. Corequisite:* PHRM 111.
PHRM 141 (2) Seminar: Pharmacists in Practice I Current and future roles for pharmacists and controversies in pharmacy practice. *This course is not eligible for Credit/D/Fail grading.*
PHRM 161 (2) Technology in Healthcare Knowledge and skills related to the role and applications of technology in health care. *This course is not eligible for Credit/D/Fail grading.*
PHRM 170 (1) Community Service Learning I Service learning activities with external community partner sites and members. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 171 (2) Introductory Pharmacy Practice Experience - Outpatient I Prescription processing, drug distribution systems, and select patient care activities in real world outpatient environments. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.* **PHAR 201 (3) Pharmacist, Patient and Society** The Canadian health care system, the pharmacist-patient relationship, and contemporary trends and standards in pharmacy practice. *This course is not eligible for Credit/D/Fail grading.* [3-0-0]
PHRM 211 (15) Medication Management II Modules and integration activities focusing on respirology and cardiovascular disorders. *Corequisite:* PHRM 231.
PHRM 212 (15) Medication Management III Modules and integration activities focusing on nephrology, endocrinology, and neurology. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 211; *Corequisite:* PHRM 231.
PHRM 221 (3) Nutrition for Pharmacists Foundations of nutrition, nutrition for healthy individuals through the lifespan, and selected clinical applications of nutrition in pharmacy practice. *This course is not eligible for Credit/D/Fail grading.*
PHRM 231 (2) Study Design and Interpretation II Principles of clinical study design, focusing on epidemiologic studies (cohort, case-control), pharmacoeconomic analyses, non-inferiority designs, clinical prediction rules, and guidelines. *This course is not eligible for Credit/D/Fail grading.*
Corequisite: All of PHRM 211, PHRM 212.
PHRM 241 (2) Seminar: Pharmacists in Practice II Current and future roles for pharmacists and controversies in pharmacy practice, focusing on the roles and training opportunities for pharmacists in specialty areas of outpatient and inpatient practice. *This course is not eligible for Credit/D/Fail grading.*
PHRM 251 (1) Institutional Practice Skills Preparation for experiential learning in the hospital setting. Focuses on enhancing familiarity with the care environment and developing skills suited for students to apply to patient care during institutional experiential rotations. *This course is not eligible for Credit/D/Fail grading.*
PHRM 270 (1) Community Service Learning II Service learning activities with external community partner sites and members. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 271 (2) Introductory Pharmacy Practice Experience - Outpatient II Prescription processing, drug distribution systems, and select patient care activities in real world outpatient environments. Focus on direct patient care activities. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 272 (1) Introductory Pharmacy Practice Experience - Inpatient Prescription processing, drug distribution systems, and select patient care activities in real world inpatient environments. Focus on direct patient care activities. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 311 (12) Medication Management IV Modules and integration activities focusing on psychiatry; gastroenterology; and obstetrics, gynecology, sexual health, and genito-urinary disorders. *This course is not eligible for Credit/D/Fail grading.*
PHRM 312 (12) Medication Management V Modules and integration activities focusing on special infectious diseases; toxicology; and oncology and palliative care. *This course is not eligible for Credit/D/Fail grading.*

Prerequisite: PHRM 311.
PHRM 341 (2) Seminar: Pharmacists in Practice III Current and potential roles for pharmacists, and contemporary issues in pharmacy practice. Focus on the role of pharmacists as patient educators, researchers and collaborators in interprofessional teams. *This course is not eligible for Credit/D/Fail grading.*
PHRM 351 (3) Practice Management and Leadership Application of management and leadership principles and skills to pharmacy operations. *This course is not eligible for Credit/D/Fail grading.*
PHRM 371 (4) Introductory Pharmacy Practice Experience - Outpatient III Direct patient care activities in an outpatient setting. Building on existing pharmaceutical knowledge and problem solving ability. Increased involvement in diverse patient care situations. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 441 (1) Seminar: Advanced Topics in Pharmacy Practice Roles and skills for pharmacists as preceptors, teachers and mentors; emerging issues in pharmacy practice. *This course is not eligible for Credit/D/Fail grading.*
PHRM 450 (2) Pharm.D. Seminar Seminar course about current and potential roles for pharmacists. Students will also deliver an individual and a group seminar. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 451 (4) Critical Appraisal of Pharmacotherapy Literature Principles of clinical study design, focusing on randomized controlled trials, systematic reviews, epidemiologic studies (cohort, case-control), pharmacoeconomic analyses, clinical prediction rules, and guidelines. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 452 (4) Patient Assessment Skills Principles and practices of patient assessment, applied to the monitoring of drug efficacy and toxicity. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 453 (3) Applied Pharmacokinetics and Pharmacogenomics Pharmacokinetic monitoring of drug therapy in common clinical situations with foundations for application to other drugs. Pharmacogenomics and personalized medicine principles and applications to practice. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 454 (2) Practice Management Values, concepts, issues and responsibilities of individuals exercising leadership and management roles in pharmacy practice and health care settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 461 (2) Pharmacotherapeutics 1 Therapeutic foundations. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 462 (2) Pharmacotherapeutics 2 Respirology, dermatology, and ears, eyes, nose, and throat. Pass/Fail. *This course is not eligible for Credit/D/Fail grading. Prerequisite:* PHRM 461.
PHRM 463 (2) Pharmacotherapeutics 3 Cardiovascular disorders. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 464 (2) Pharmacotherapeutics 4 Infectious diseases. Pass/Fail. *This course is not eligible for Credit/D/Fail grading. Prerequisite:* PHRM 461.
PHRM 465 (2) Pharmacotherapeutics 5 Neurology and psychiatry. Pass/Fail. *This course is not eligible for Credit/D/Fail grading. Prerequisite:* PHRM 461.
PHRM 466 (2) Pharmacotherapeutics 6 Gastroenterology and musculoskeletal disorders. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 467 (2) Pharmacotherapeutics 7 GU, OBS/GYN, endocrine, and renal. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 468 (2) Pharmacotherapeutics 8 Oncology, hematology, and toxicology. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 469 (2) Pharmacotherapeutics 9 Acute/critical care, neurology, cardiac, GI, infectious diseases, and respiratory. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 471 (16) Outpatient Advanced Pharmacy Practice Experience Application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in outpatient settings. Patient care will be provided for a wide range of therapeutic areas. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 472 (10) Inpatient Advanced Pharmacy Practice Experience Application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in inpatient settings. Patient care will be provided for a wide range of therapeutic areas. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*

PHRM 473 (5) Selected Advanced Pharmacy Practice Experience Required 4-week experiential clerkship in an area chosen by the student. Diverse options available in such domains as patient care (various settings), research, health policy, education, and others. The available placement options will vary from year to year depending on site/preceptor availability. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 481 (2) Healthcare Quality Improvement Builds on the foundation of patient care and management learning with knowledge about healthcare system improvement. Focuses on principles of quality measurement and quality improvement in health. *This course is not eligible for Credit/D/Fail grading.*
PHRM 491 (6) Experiential Rotation I Community Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in a variety of community settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 492 (6) Experiential Rotation II Inpatient Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in a variety of inpatient settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 493 (6) Experiential Rotation III Advanced Practice Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in specialized (advanced practice) settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 494 (6) Experiential Rotation IV Ambulatory/Primary Care Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in a variety of ambulatory or primary care settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 495 (6) Experiential Rotation V Community or Inpatient Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in community or inpatient settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 496 (8) Experiential Rotation VI Elective Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in community, inpatient, primary care, ambulatory care, or specialized (advanced practice) settings. This elective rotation requires Program Director approval. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 499 (1) Comprehensive Examination Assessment of skills in the clinical problem-solving process. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: Successful completion of all other coursework

College of Pharmacists of British Columbia

Certified Pharmacist Prescriber Engagement Report Review

Presented by:
Jeremy Walden, Public Board Member
Doreen Leong, Director of Registration, Licensure & PharmaNet
Gillian Vrooman, Director of Communications and Engagement

November 18, 2016

Progress to date

2010

- Jan – Board approved feasibility study for Advanced Pharmacist Practice (APP). APP Task Group formed to oversee feasibility study
- Sept – Board approves feasibility study directs to continue with business case analysis and discussion paper

2011

- Feb – Board approves recommendations from business case analysis submitted by Task Group
- Nov – established APP Steering Committee

2012

- Apr – Road map, action plan developed and endorsed by APP Steering Committee
- Jun – Board approved action plan
- Nov – Board approved APP Task Group Terms of Reference

2013

- Jan – Task Group to obtain stakeholder input in the development of the APP initiative
- Feb - Board directs Task Group to draft recommendations for APP initiative eligibility criteria, and assessment criteria
- Apr – Task Group report recommends stakeholder engagement

2014

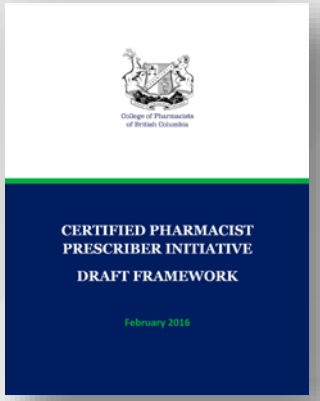
- Jun – APP initiative included in College's Strategic
- Aug – Stakeholder engagement conducted to support discussions with MoH on pharmacist prescribing
- Fall – Further stakeholder engagement with pharmacy groups

2015

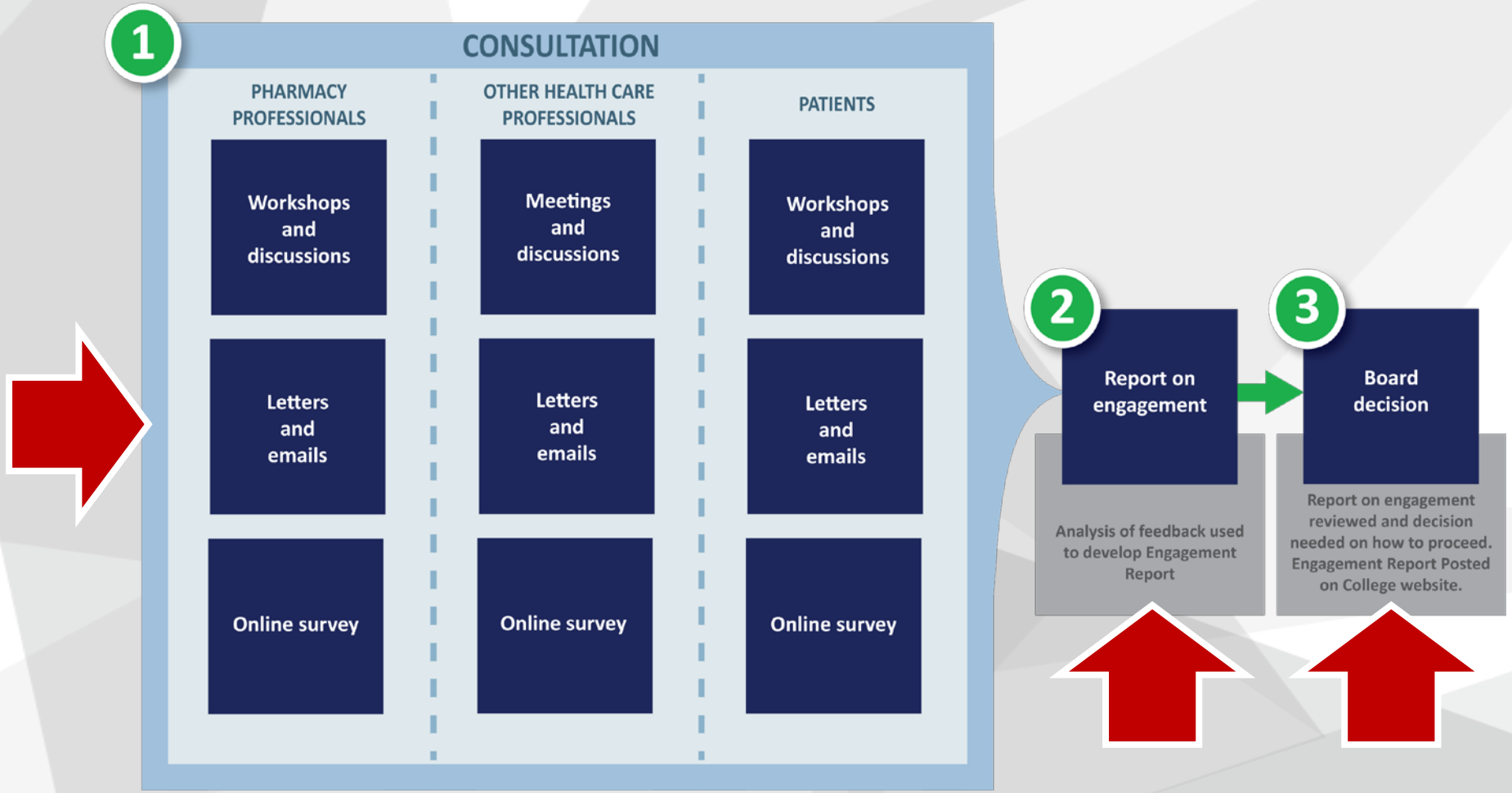
- Spring – MoH requests information on societal need, eligibility criteria, and managing perverse incentive to prescribe
- July/Aug/Oct – Workshops with Task Group to support draft framework development
- Sept – APP to Certified Pharmacist Prescriber approved by Board
- Nov – Certified Pharmacist Prescriber draft framework approved by Board for stakeholder engagement

2016

- Spring, Summer – Stakeholder engagement
- Summer, Fall – Analysis of feedback received



Engagement Process: Where We're At

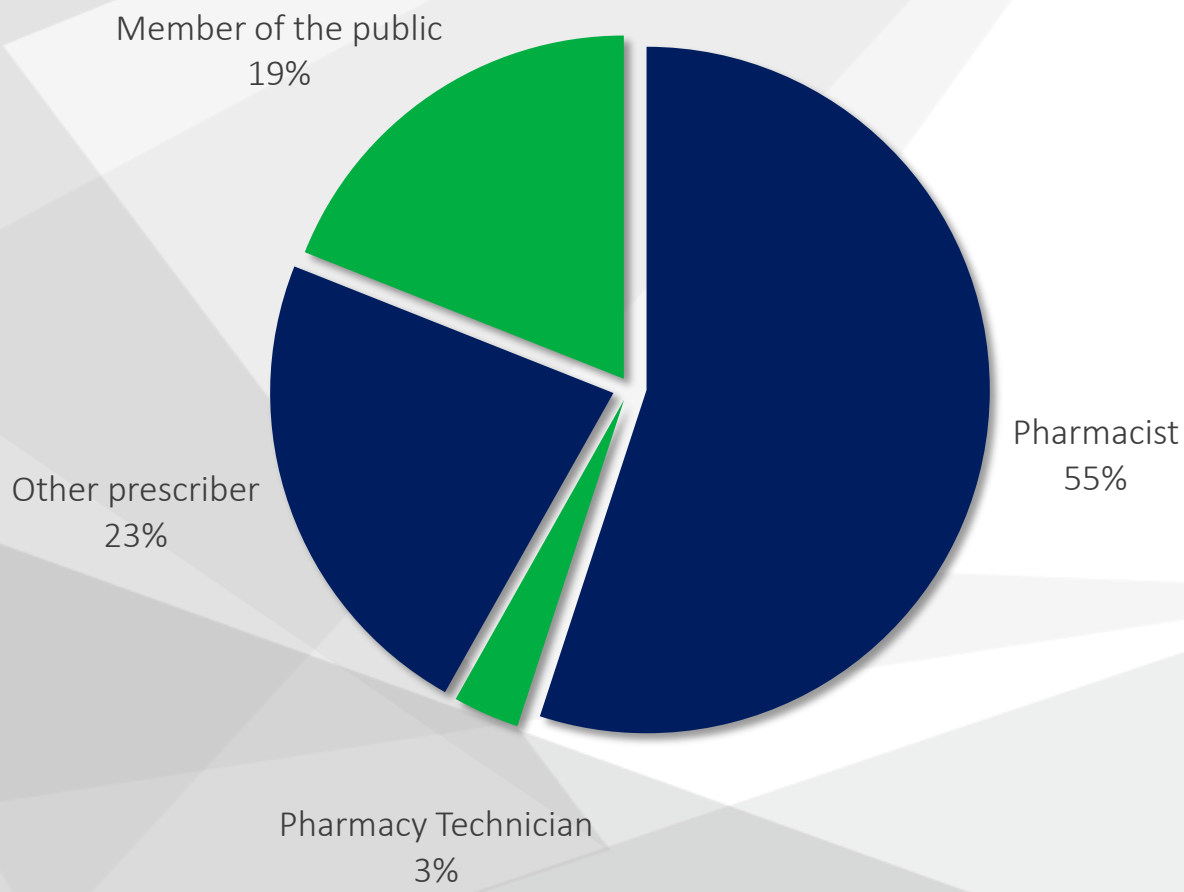


Who We Heard From

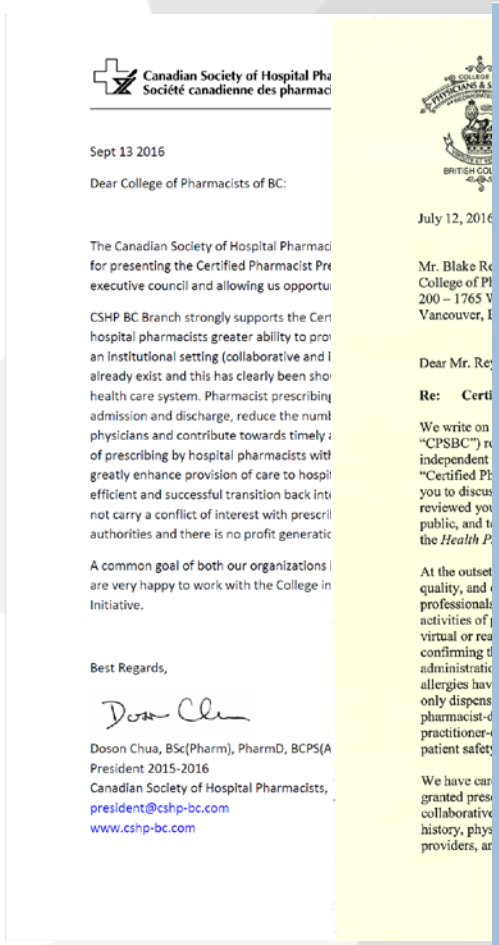
15 workshops and meetings with 200+ people

1,500+ survey responses

11,400+ comments



Who We Heard From


Canadian Society of Hospital Pha
Société canadienne des pharmaci

Sept 13 2016

Dear College of Pharmacists of BC:

The Canadian Society of Hospital Pharmaci
for presenting the Certified Pharmacist Pre
executive council and allowing us opportu

CSHP BC Branch strongly supports the Cert
hospital pharmacists greater ability to prov
an institutional setting (collaborative and i
already exist and this has clearly been sho
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not carry a conflict of interest with prescri
authorities and there is no profit generatio

A common goal of both our organizations
are very happy to work with the College in
Initiative.

Best Regards,

Doson Chua, BSc(Pharm), PharmD, BCPS(A
President 2015-2016
Canadian Society of Hospital Pharmacists,
president@cshp-bc.com
www.cshp-bc.com

July 12, 2016

Mr. Blake Ro
College of Ph
200 – 1765 W
Vancouver, B

Dear Mr. Rey

Re: Certi

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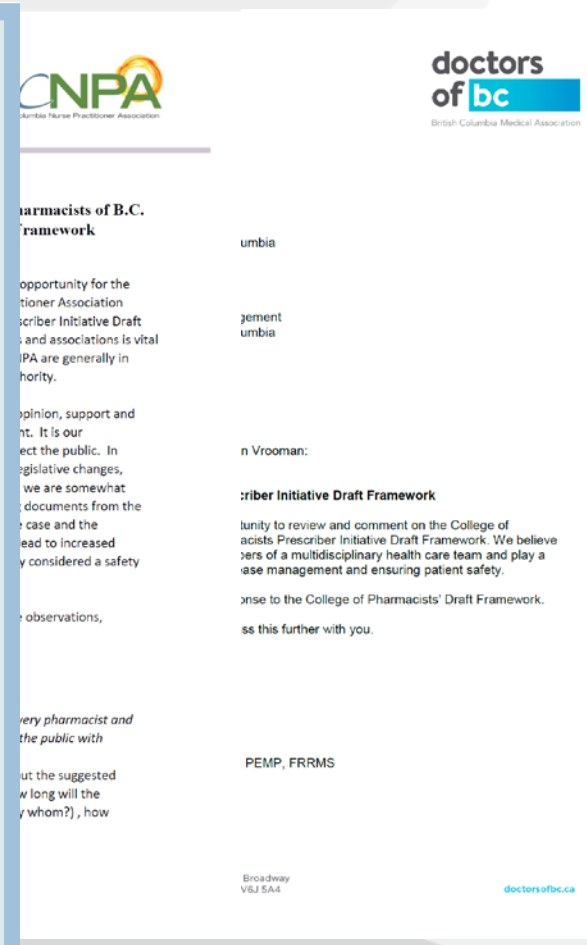
- Association of Registered Nurses of BC
- BC Pharmacy Association
- BC College of Family Physicians
- BC Health Authorities Pharmacy Directors
- BC Nurse Practitioner Association
- BC Psychiatric Association
- Best Medicines Coalition
- Better Pharmacare Coalition (BC)
- British Columbia Association for People on Methadone
- Canadian Arthritis Patient Alliance
- Canadian Society of Hospital Pharmacists of BC, BC Branch
- Canadian Council of the Blind
- College of Pharmacists of BC Hospital, Community and Residential Care Advisory Committees
- College of Registered Nurses of BC
- College of Naturopathic Physicians of British Columbia
- College of Physicians and Surgeons of BC
- Doctors of BC
- Gastrointestinal Society
- The Kidney Foundation of Canada BC & Yukon
- University of British Columbia – Faculty of Pharmaceutical Sciences
- Patient Voices Network (BC Patient Safety and Quality Council)
- Pharmacy Leaders of Tomorrow
- Society of General Practitioners of BC
- Specialists of BC
- Vancouver Area Network of Drug Users


CNPA
Columbia Nurse Practitioner Association

doctors of bc
British Columbia Medical Association

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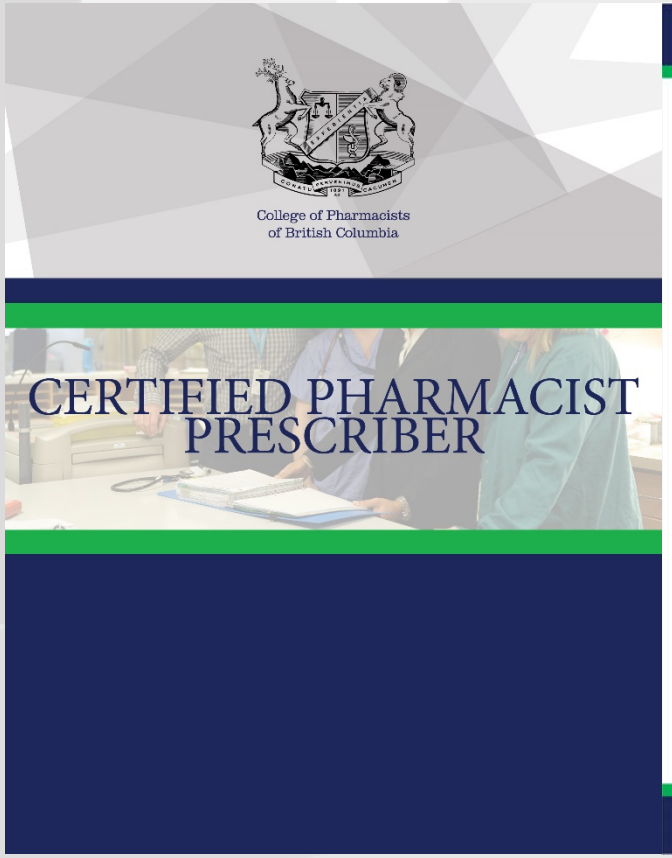
ss this further with you.

PEMP, FRRMS

Broadway
V6J 5A4

doctorsofbc.ca

Engagement Report

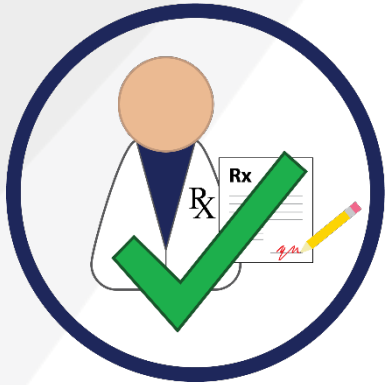


Feedback Themes

Confidence in Pharmacist Prescribing

Communication and Collaboration

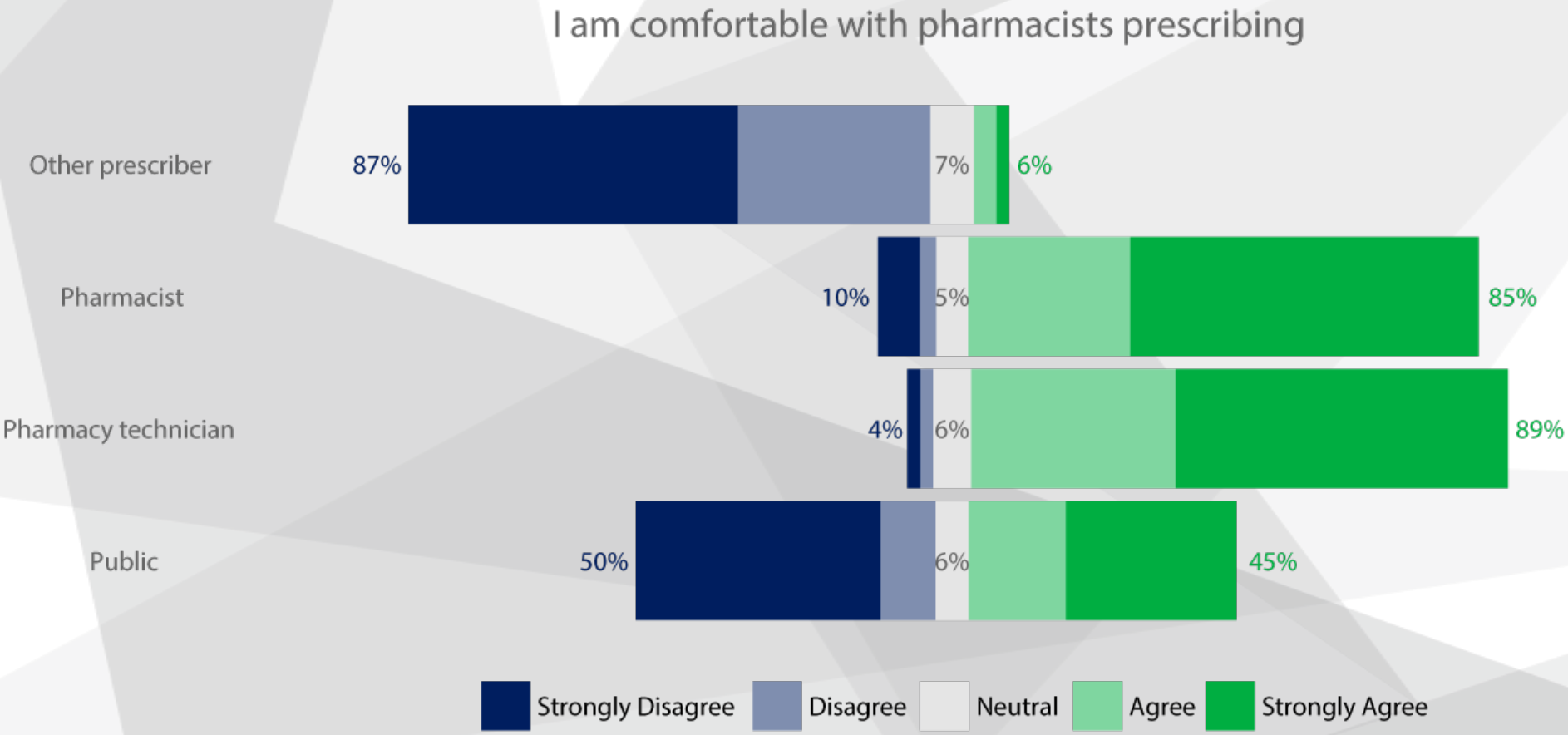
Improving Patient Care



Support for the Initiative

Confidence in Pharmacist Prescribing

Confidence in Pharmacist Prescribing



Confidence in Pharmacist Prescribing

PUBLIC RESPONDENT

Confusion is possible. There is a huge problem with discontinuity in health care - Walk in Clinic, MD office, Public health, Emergency, hospital, Naturopath, and now Pharmacist - it makes this worse.

"I won't need to make appointments way in advance to my doctor just to get a refill, and it will save me a lot of time since I don't need to wait in line for walk-in offices. I also would like that my pharmacist can be more involved in my meds. Right now I have to relate things my doctor tells me to my pharmacist, or he has to call my doctor and there's a delay."

PUBLIC RESPONDENT

Confidence in Minor Ailments

All respondent groups provided comments suggesting that pharmacist prescribing may be appropriate for minor ailments.

PUBLIC RESPONDENT

"Simple medical conditions would not require a visit to my doctor who is already overloaded with patients."

OTHER PRESCRIBING RESPONDENT

"It allows patient to avoid unnecessary doctor visits by accessing health care services and necessary information from a certified pharmacist prescriber. Moreover, it allows the certified pharmacist prescribers to deal with any patient prescription issues, which saves the unnecessary time waste from patient revisiting physicians for prescription issues, refills, or similar issues."

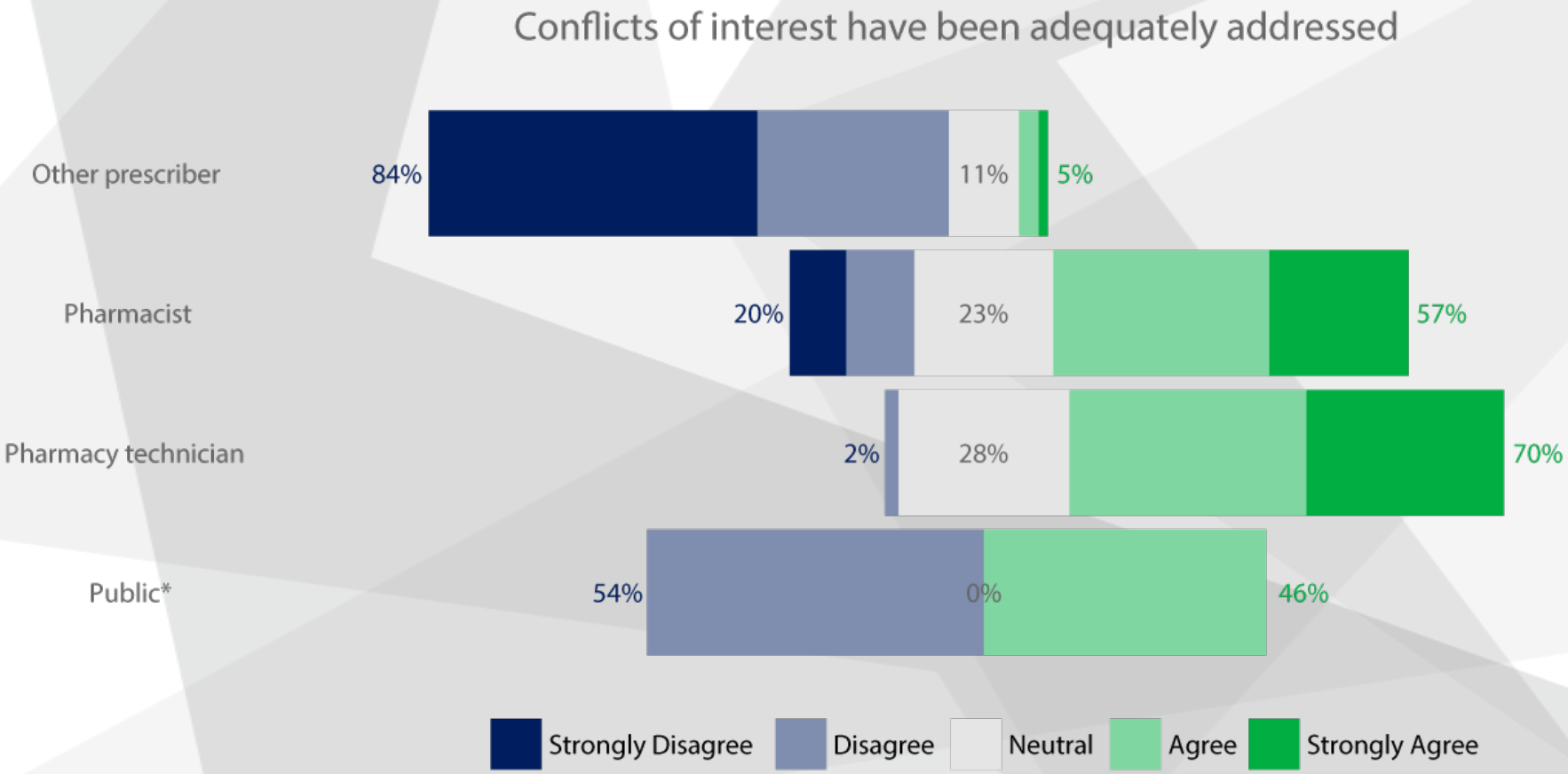
Confidence in with Pharmacist Prescribing in Collaborative Care Environments

Feedback from some pharmacists and other prescribers highlighted pharmacist prescribing might work best in a clinical setting.

Reasons include

- No business pressures/ conflict of interest
- Access to more patient information
- Access to labs
- Physicians or nurse practitioners provide the diagnosis

Conflicts of Interest



* Public respondents were asked a yes–no question. In the graph, 'Disagree' corresponds to 'No', and 'Agree' corresponds to 'Yes'.

Concerns about business interests

PHARMACIST RESPONDENT

"If we allow profit-focused entities to operate in the prescribe and dispense model, we would be only as good as the street dealer. Conflict of Interest both actual and perceived needs to be better addressed and more safeguards be put in place. Certified Pharmacist Prescribers must be independent of control by businesses."

OTHER PRESCRIBING RESPONDENT

"Unless pharmacists are removed from the profit motive of the store that they're working [at] there will be a complete conflict of interest… with any of this they have to not benefit from selling any drugs that they decide to dispense."

PUBLIC RESPONDENT

"I support this move. I just think if it passes, stores with pharmacies need to have some legislation around the pharmacist's work load and staffing. They ask them to do way too much alone and that can be dangerous. Please address this before making any changes. Be proactive-lives depend on it."

Conflicts of interest a focus of opposition for other prescribers

"The principles supporting the separation of the professional activities of prescribing from dispensing must be maintained to ensure safe, effective pharmacotherapy. The situation would be quite different if the community pharmacist was part of a collaborative community team and their role was limited to prescribing as part of the team (a team in which medical and/or nurse practitioners would be providing patient assessment and diagnosis). Again, the dispensing would be provided by another pharmacist independent to that team."

– Letter from the College of Physicians and Surgeons of British Columbia

Conflicts of Interest & Pharmacist Owners

- Pharmacists identified pharmacist prescribing could provide greater access to health care in smaller, rural and remote communities
- Excluding pharmacist owners who work in these communities could limit the benefits of pharmacist prescribing from reaching these communities
- Many respondents suggested the College better assess and protect pharmacist prescribers from business pressures and introduce mechanisms to better safeguard the profession as a whole from conflicts of interest
- Almost 20% of pharmacist respondents disagreed or were neutral towards pharmacist owners value in prescribing to specifically improve access to health services

Education and Training Requirements

Other prescribers and pharmacist respondents specified that pharmacists should have some practical, clinical training and experience.

Suggested knowledge, skills and abilities included

- diagnostics,
- differential diagnosis,
- prescribing responsibilities,
- physical assessment, and
- therapeutics

Education and Training Methods

Suggested approaches to providing education required included

- 1-2 year practicums
- Hospital residencies
- Existing clinical, diagnostic and physical assessment courses
- Comprehensive online modules
- Medical school

Unaddressed Risks

Common risks that respondents felt weren't adequately addressed in the Draft Framework included:

- Inadequate training to diagnose conditions
- Misdiagnosis which could potentially be harmful to patients
- Disruption and fragmentation of patient care
- Double-doctoring or too many prescribers
- Lack of access to lab test results
- Room for more errors in patient care

Collaboration & Communication

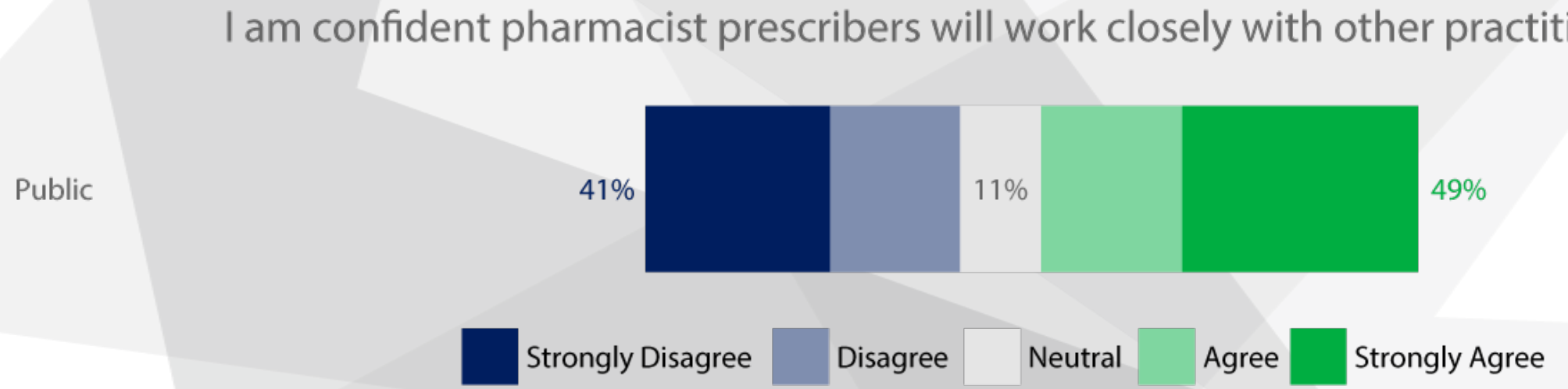
Collaboration & Communication

A greater focus on team-based care with more direct communication between pharmacists and physicians was frequently suggested.

Suggested additions to the Draft Framework to assist with communication and collaboration included:

- Guidelines on how pharmacist prescribers should communicate and follow-up with primary care providers and other health professionals
- Use case examples around communication in various situations and circumstances
- Guidance on communication methods and step-by-step processes to support collaboration and communication

Public Expectations for Collaboration



Public Expectations for Collaboration

PUBLIC RESPONDENT

"I'm not opposed to the investigation of the possible benefit of such an initiative. There is merit in this initiative if there is strong collaboration with physicians, appropriate training with strong oversight, and a phased in process to evaluate effectiveness.""

PUBLIC RESPONDENT

"As a mother my level of care and that of my kids would not change it would just be a more comprehensive team approach."

PUBLIC RESPONDENT

"Develop a framework that addresses the care team issues that already exist. Be the leaders in establishing an intelligent and bullet proof approach. The physicians have at times taken a lofty - we are untouchable - approach. This has at times crippled the management of the use of funds available for innovation and improvements to health care. Learn from their mistakes and demonstrate that by not making the same ones."

Better Solutions for Patient Information Sharing Needed

PHARMACIST RESPONDENT

"Our whole system is still archaically working with fax. It would be nice to have the pharmacy software integrated with physician communication, this would lessen the paperwork burden of documentation for the pharmacists."

OTHER PRESCRIBING RESPONDENT

"Multiple phone calls in the middle of a busy clinic would be disruptive. Ideally we could share an EHR that would provide immediate access to information as well as ways to communicate. It also would be ideal if the primary care providers and pharmacists in a defined community to get to know each other through combined CPD and other events."

OTHER PRESCRIBING RESPONDENT

"Simple problems will be taken away from GPs, leaving us with an even higher concentration of complex, multiple problems, including chronic pain which is such a huge issue. Can pharmacists get involved there? That would be extremely valuable collaboration, and true team-based care."

Additional Resources and Support Needed

Pharmacist respondents shared what they would need in their current practice to support pharmacist prescribing.

Respondents identified the following needs:

- additional and continuous education
- office space or a consultation room
- access to patient files, information, digital records
- access and ordering of lab tests
- supplementary staff
- necessary time to spend with patients

Pharmacy Technicians Role in Pharmacist Prescribing

Pharmacy technicians could help pharmacists find more time to spend with patients by working within their full scope of practice which is often underutilized.

TECHNICIAN RESPONDENT

"As the role of pharmacist continues to move more and more toward clinical services, I feel that pharmacy technicians will step more into the roles that we are trained for. Pharmacists will need technicians to help ease the workload as they are focused on providing essential clinical services to patients."

"This will create an even closer collaboration between pharmacists and technicians. They will need each other even more in order to provide better care. In order for the pharmacists to be able to successfully prescribe medications, the technician must gather all the necessary information from the patient…"

TECHNICIAN RESPONDENT

Access to Labs

Many pharmacists highlighted access to patient lab test results, as well as the opportunity to order lab tests to monitor patients as an important tool.

PHARMACIST RESPONDENT

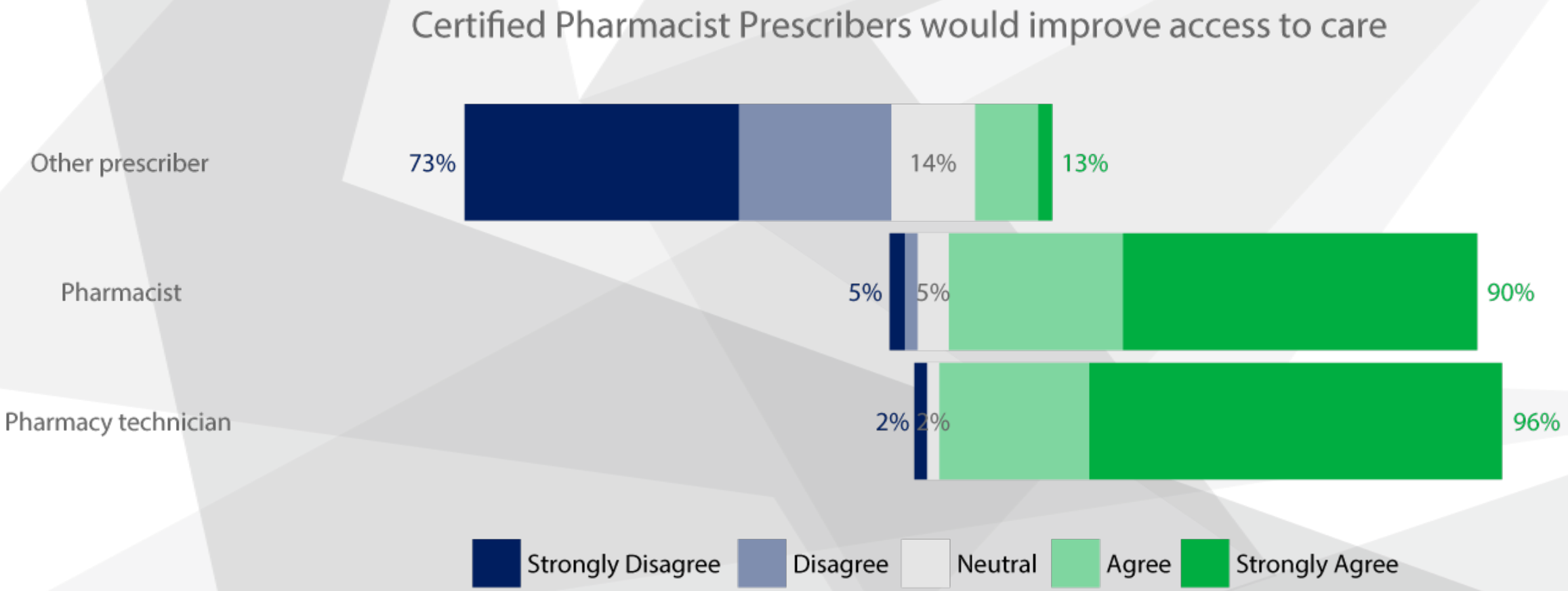
"I would hope that pharmacist can order lab work because questions about iron supplements are common in practice."

"I worked in Alberta for a year and [pharmacist prescribing] worked well out there- only thing is you really need access to labs (and should be able to order them as well)."

PHARMACIST RESPONDENT

Improving Patient Care

Improving Access to Care



Improving Access to Care

PUBLIC RESPONDENT

"This would reduce stress on walk-in clinics and seeing drs for easy prescription refills (ex. birth control)."

OTHER PRESCRIBING RESPONDENT

"Patients who don't have ready access to other PCP [primary care provider] will benefit from Pharmacists acting as their PCP (as their most responsible providers), when it's compared to lack of access."

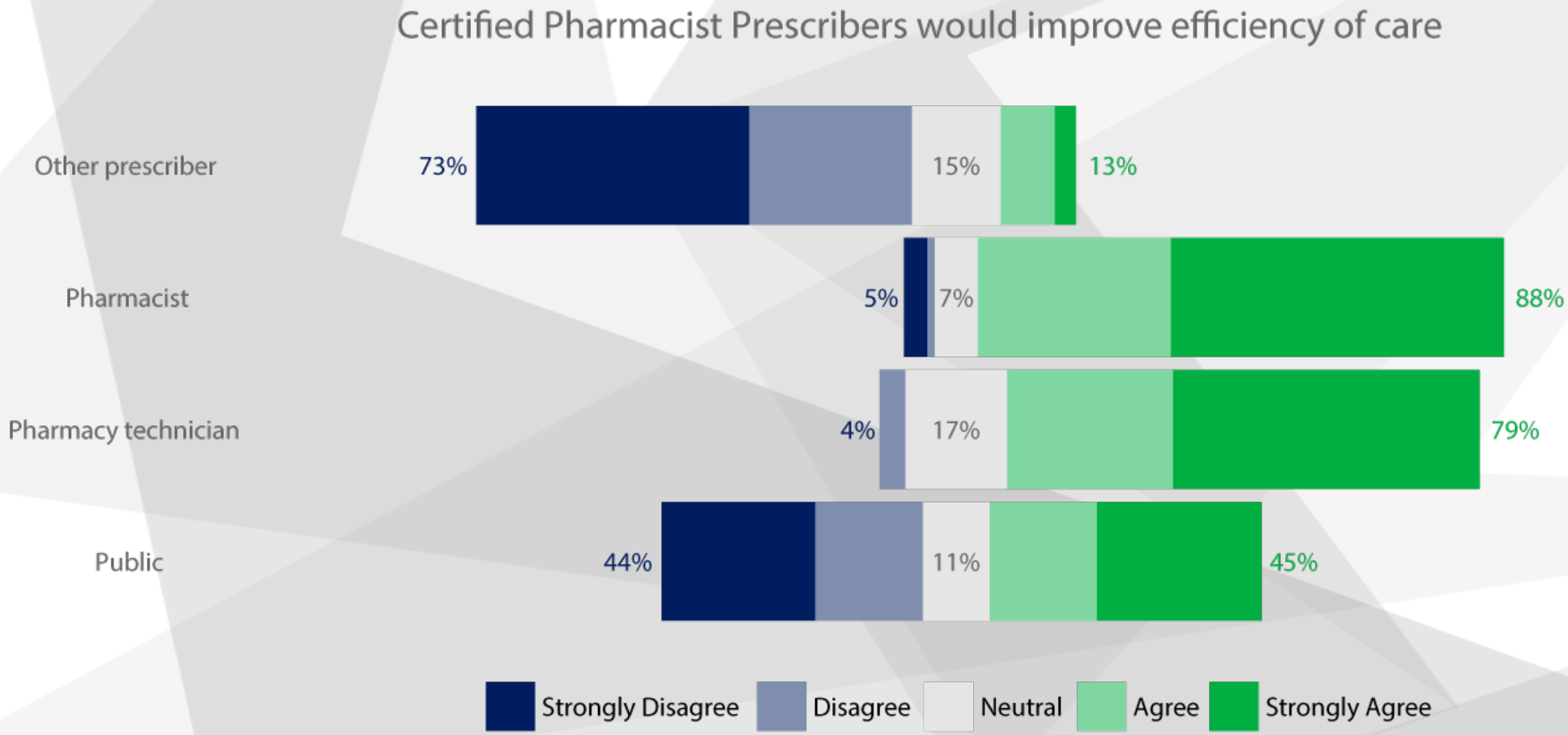
OTHER PRESCRIBING RESPONDENT

"It is another access point, but I would rather see more collaboration and less silos."

PUBLIC RESPONDENT

"I would assume that the strain on the health care providers would be lessened. Often the only reason a person goes to see their health care provider is to renew a prescription, think how much more efficient the whole system would be by streamlining the process to one."

Improving Care



Improving Care

TECHNICIAN RESPONDENT

"I honestly feel people would seek treatment earlier if they knew it was going to be convenient for them. No long wait at a walk-in clinic, or a weeks wait to see your doctor. I believe patients find pharmacists to be more accessible than a Doctor, and anything that makes healthcare more convenient will inevitably increase patient compliance."

PUBLIC RESPONDENT

"I feel I will be able to make more informed decisions, if I have a pharmacist prescriber on board…I think It will push my physician to really focus on primary care including accurate diagnosis and my overall health while having the pharmacist take care of my prescriptions."

PUBLIC RESPONDENT

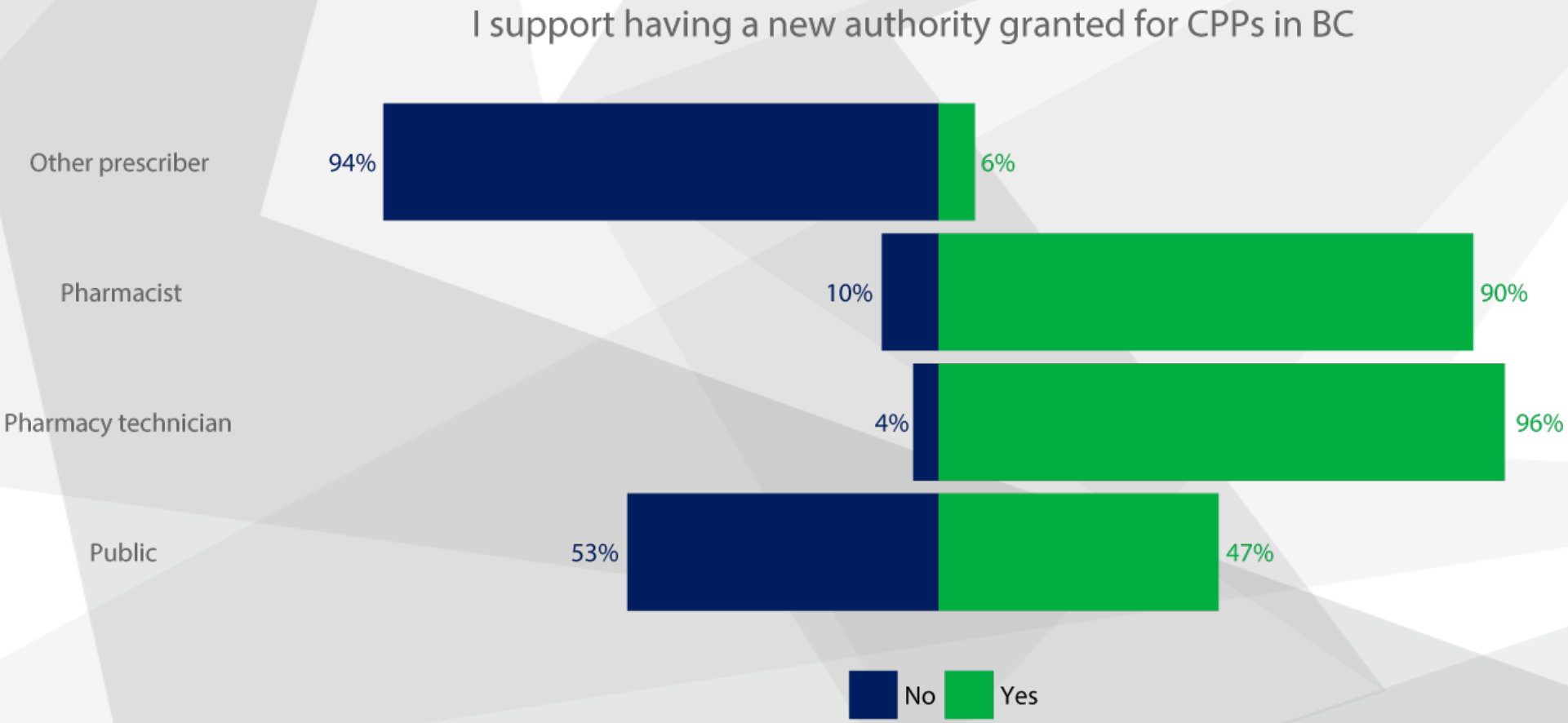
"I am quite concerned about this proposal…Allowing pharmacists to prescribe within the scope of their training seems potentially dangerous. I would ask the question, "How can you know what you don't know?""

OTHER PRESCRIBING RESPONDENT

"I am a supporter of expanding SOP of pharmacists as I believe that they are key to high quality care but we need to look at systems of care and how we all fit into new models of care. otherwise we continue to create more silos, more fragmentation…"

Support the Initiative

Levels of Support the Initiative



Recommendations for Next Steps

College Board Pharmacist Prescriber Ad-hoc Working Group

Anar Dossa, RPh
Vice-Chair,
District 6
Urban Hospitals

Frank Lucarelli, RPh
District 5
Northern BC

Arden Barry, RPh
District 7
Community Hospitals

Kris Gustavson, RN
Government
Appointee

Jeremy Walden
Government
Appointee

George Walton
Government
Appointee

Collaborative Practice Pharmacist Prescribing

Working groups suggests narrowing scope of Draft Framework to pharmacist prescribing within collaborative practice.

Pharmacist prescribing within collaborative practice settings would

- Take place in interdisciplinary team-based settings
- Have diagnosis provided by physicians and nurse practitioners
- Require access to electronic health records and diagnostics, including lab tests
- Restrict pharmacist prescribers from dispensing medications they prescribed for a patient

Collaborative Practice Pharmacist Prescribing

Reasons for restricting pharmacist prescribing to collaborative practice

- **Conflict of Interest** – separating pharmacist prescribing from dispensing and business interests removes concern for a potential business conflict of interest
- **Interdisciplinary Team-based Settings** – involves working closely in an interdisciplinary team to care for patients where physicians or nurse practitioners provide diagnosis
- **Access to patient health information and lab tests** – interdisciplinary practice settings provide access to patient health information and lab tests that are needed to provide safe and effective care

What About Minor Ailments and Refills?

Many identified opportunities for pharmacist prescribing to improve patient access to care for minor ailments, refills and renewals.

However, significant concerns were also raised, including:

- Lack of access to electronic health records
- Lack of access to and ability to order lab tests
- Conflict of interest and business pressure concerns (with lack of separation between prescribing and dispensing)
- Physicians or nurse practitioners not available to provide diagnosis

College could look at how authority in Professional Practice Policy 58 (adapting prescriptions) could help improve access to care.

Discussion

Recommendation

MOTION 1:

Direct the Registrar to amend the Certified Pharmacist Prescriber Draft Framework by narrowing the scope of pharmacist prescribing to within collaborative practice settings.

MOTION 2:

Direct the Registrar to develop a proposal for pharmacist prescribing within collaborative practice settings – based on the amended Draft Framework and results of the stakeholder engagement – to be brought to the Board for approval to submit to the Minister of Health for consideration.

Thank You to the Members of the Certified Pharmacist Prescriber Task Group

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

13. Practice Review Program: Phase 2 Implementation

DECISION REQUIRED

Recommended Board Motion:

Approve the policies, processes and implementation of PRP Phase 2 (hospital practice), as recommended by the Practice Review Committee as circulated.

4. Standards (d) Strengthen enforcement to improve compliance

Purpose

To approve the implementation of the Practice Review Program Phase 2 (hospital practice) brought forward by the Practice Review Committee.

Background

The Practice Review Program (PRP) redefines the current inspection process and enhances accountability and public safety by reviewing pharmacies and pharmacy professionals (pharmacists and pharmacy technicians).

The Board approved the direction to build upon existing inspection processes and made the following decisions to date:

- eliminated the use of the KA exam
- established the Practice Review Committee (PRC) to oversee the PRP
- determined that:
    - the PRP applies to all pharmacies and pharmacy professionals, to be reviewed at least once every six years
    - the reviews will be conducted by pharmacy professionals who are College staff (Compliance Officers)

The PRC has developed a program design that emphasizes the application of knowledge in practice and directly assesses the ability of pharmacy professionals to practice safely and effectively in Board-approved focus areas. This is the rationale and basis for the program, which utilizes observation and assessment to ensure that:

- Pharmacies or pharmacy premises meet legislated requirements
- Pharmacy professionals appropriately apply their knowledge, skills, and abilities to provide safe healthcare and improve patient outcomes by meeting standards set by the College.

The program was successfully implemented in community pharmacy practice in January 2015. Subsequent phases of the PRP (hospital and other speciality practice settings) were to be developed and brought to the Board for approval to implement.

Discussion

Multiple stakeholder engagement sessions were held, in-person and via email, prior to and during the development of Phase 2.

In May 2015 the College held a workshop where hospital pharmacy stakeholders with a wide range of expertise had the opportunity to provide input on the design of Phase 2.

In July 2015 the College led a two-day Joint Application Design (JAD) session engaging the PRP team, which consisted of the Director, Coordinator, two compliance officers, a business systems analyst, the project manager, as well as two subject matter expert consultants hired specifically for their knowledge and experience with hospital systems, workflow and processes.

In March 2016, the same hospital pharmacy stakeholders that attended the first workshop (plus others that were requested by Board members to attend) were invited back to a second workshop where they provided extensive feedback on the Hospital Pharmacy Professionals Review focus areas. PRC members, including public appointees, and Board members also attended this session. Feedback from this workshop informed the remaining pieces of Phase 2 to be developed, including drafting new standards for Patient Identification Verification and Prescription Product Preparation/Final Check to support the Board-directed focus areas.

The College consulted with the Hospital Pharmacy Advisory Committee (HPAC) and all hospital registrant members of all College committees continuously during the development of the new standards. In September 2016, the HPAC was given the opportunity to provide feedback on the complete Phase 2 package which included all proposed policies and processes.

The PRC has completed the design of PRP Phase 2 (hospital practice). Under the direction of the Board, the PRC was responsible for designing Phase 2 and is requesting Board approval for implementation at their November 2016 meeting.

College staff have defined all of the necessary components (personnel, communications, processes, policies and technology) to support PRP Phase 2 (hospital practice). The PRC reviewed these components in detail during a one-day workshop on October 4th, 2016. The PRC is now submitting and presenting this defined and documented program design for Board approval, in order to implement Phase 2 and once approved will meet the projected launch timeline of April 2017.

PROGRAM COMPONENTS:

- **Personnel**

  In July 2015, the College hired a pharmacy technician for the role of Hospital Practice Review Coordinator and Compliance Officer (CO). This staff member joined the existing PRP team to help with the development of Phase 2. The pharmacy technician CO will conduct pharmacy reviews and pharmacy technician reviews once the program is implemented.

  The existing pharmacist hospital inspector has transitioned into the role of a CO and has also helped with the development of Phase 2. The pharmacist CO will conduct pharmacy, pharmacist and pharmacy technician reviews.

  The College plans to hire a pharmacist for the role of Hospital Pharmacy Advisor which will help with program coordination, be trained as back-up to conduct on-site practice reviews and enhance clinical pharmacy expertise at the College.

  The hospital COs will be responsible for conducting practice reviews throughout BC for District 6 (urban hospitals) and District 7 (community hospitals).

- **Communications**

  A communications plan was developed with the Communications Department and is currently being executed. Registrants already receive regular updates through online articles, video clips, presentations, forums, and articles in professional publications for Phase 1. Multiple resources for registrant communication for Phase 2 have been developed and will be available once implementation is approved and prior to launch (similar to Phase 1). Public messaging will be tailored to emphasize the benefits of the PRP to patients, their families and caregivers.

- **Processes and Policies**

  - **Practice Review Scheduling and Administration**

    The College PRP Coordinator will schedule the Pharmacy Review and work with pharmacy manager's to schedule the Pharmacy Professionals Reviews to ensure that all pharmacies and pharmacy professionals are reviewed at least once every 6 years. Scheduling will be prioritized according to the following factors:

    - Program timeline –all hospital pharmacies will be reviewed at least once every 6 years, with the oldest date-of-last-inspection driving the priority.
    - Scheduling will be based on CO availability as well as seasonal travel restrictions, which will maximize travel and cost efficiency.
    - Hospital pharmacies will be notified 60 days in advance of their scheduled review. Pharmacy Managers will have the opportunity to request an adjustment to actual dates based on staff scheduling, or to delay a review for up to one calendar month for reasons of extended pharmacy manager vacations and/or medical leaves.
    - Pharmacy Managers will be notified of all review criteria in advance, and will complete a Hospital Pharmacy Pre-Review to maximize the effectiveness of actual on-site practice review visits and decrease repeat visits.
    - Pharmacy Managers will schedule all regulated staff for their Pharmacy Professionals Review once they have completed the Pre-Review and confirmed the exact dates of review with the PRP Coordinator.
    - Individual pharmacy professionals will also be notified of their scheduled review as well as the criteria within each focus area. The focus areas are Patient Identification Verification, Profile Check, Documentation and Counselling for pharmacists and Patient Identification Verification, Product Distribution, Collaboration and Documentation for pharmacy technicians.

  - **Performing Practice Reviews/ Results Delivery**

    Compliance Officers will visit each scheduled pharmacy and perform the Pharmacy Review first. A Pharmacy Review is the assessment of the site or facility and was created based on the past hospital pharmacy inspection process and current standards. Non-compliance items observed by the CO will be electronically documented and action items will be assigned to the Pharmacy Manager with a specified completion date, typically within 30 days.

    Next, the CO will perform the Pharmacy Professionals Reviews, observing each pharmacy professional in his or her own practice setting while concentrating on the four focus areas

specific to the registrant type. Again, non-compliance items observed by the CO will be electronically documented and action items will be assigned to the individual pharmacy professional with a specified completion date, typically within 30 days.

All review criteria are standardized and based on established College standards. Almost all action items to be assigned will be standardized and pre-coded. This level of standardization is designed to ensure consistency, defensibility and fairness of the PRP.

- **Action Item Management and Escalation**
  Compliance Officers will be responsible to monitor the progress of each assigned action item. Reminders will be sent via email and upon expiry of the completion date, outstanding action items will be escalated to the Director of the Program. The Director will issue further communications, advising the Pharmacy Manager and/or the pharmacy professional that the outstanding action items must be complete within 5 days. If the outstanding action items are not completed after 5 more days, the matter will be escalated to the Registrar's attention. A final communication will then be sent, advising that any outstanding action items beyond 2 more days will be forwarded to the Inquiry Committee for investigation as per usual College processes.

- **Technology**
  PRP Phase 1 was designed with standard web-based technology. The application (app) supports the PRP and will be integrated into the existing College business systems. The new system was developed in-house using dedicated resources and has been operating since April 2016. Phase 1 launched in January 2015 using an Excel spreadsheet to conduct reviews, as the app was not ready.

  Similar to Phase 1, Phase 2 will not be launching with this application, but there are plans to retrofit the hospital pharmacy item bank database into the app, post launch. Instead, the hospital COs will use an Excel spreadsheet to conduct reviews. The spreadsheet has been developed with the functionality to capture non-compliance items and assign action items in a standardized manner. All interactions with registrants and pharmacy managers, including practice review results will be done by standard email notifications.

- **Budget**
  The PRP is currently operating within the budget as approved by the Board. Current projections are that Phase 2 will successfully be implemented, within approved budget, by end of the fiscal year.

PRACTICE REVIEW PROGRAM POLICY RECOMMENDATIONS FOR BOARD APPROVAL:

Pharmacy Review Inclusion Policy:
All licensed hospital pharmacies in BC.

Pharmacy Professionals Review Inclusion Policy:
All registrants employed by and practicing in a licensed hospital pharmacy, where at least one of the following Pharmacy Professionals Review focus areas – Patient Identification Verification, Profile Check, Counselling, Product Distribution, or Documentation – applies to their job description.

Scheduling Policy:
The College will provide 60 calendar days of advance notice to pharmacy managers of the scheduled Practice Reviews. If the proposed scheduled date is inconvenient, the new date should be within the following month.

Prioritization Policy:
Cycle based - Reviews will be scheduled based on the last inspection date. Pharmacies with the oldest "last inspection date" will be prioritized.

Policy in regards to non-regulated pharmacy employees:
Where a non-regulated pharmacy employee is performing regulated activities, a Compliance Officer will observe the activities of that employee, and any observations (and action items resulting from those observations) will be recorded on the responsible pharmacy professional's review. That pharmacy professional will be responsible for corrections of those action items in order to be compliant.

On-site Review Period Policy
Each review period will be limited to 1 month. The compliance officers will review larger hospitals for a maximum of 1 month on site conducting reviews, followed by 1 month off, continuing until all Pharmacy Professional Reviews are complete.

Disclosure of Practice Review Results Policy:
Results of a Pharmacy Review will be disclosed by the Compliance Officer to the Pharmacy Manager only. Results of a Pharmacy Professional's Review will be disclosed by the Compliance Officer to that Pharmacy Professional only.

Any sharing (disclosure) of results between the Pharmacy Manager and the Pharmacy Professionals will be at the discretion of those parties, and the College will bear no responsibility for such disclosure, at least in the first phase of the Program.

If the non-compliance presents risk to public safety, follow-up will be immediate as per usual College processes.

Escalation Policy:
Pharmacy managers and pharmacy professionals have 30 calendar days for the correction of assigned action items; exception conditions as approved by the Director may override the 30 day standard response time.

After 30 days has expired without correction, an escalated notice will be sent to action item owner from Director, giving 5 more days to complete.
After the 5 days has expired without correction, an escalated notice is sent from Registrar, indicating if action item(s) not resolved in 2 days the issue will be forwarded to Inquiry Committee.

If unresolved after the 2 days (total 37 days), the issue will be forwarded to Inquiry Committee. Responsibility for forwarding to Inquiry Committee to be delegated by the PRC to the Director of Practice Reviews and Quality Assurance.

The College allows 10 business days (14 calendar days) in between each step of the escalation process.

Timeline

Dates	Activities
November 2016	• Board approval
November - January 2017	• New standards in force • Publish communications materials on CBPC website • Continue fine-tuning CO IT tool • Implement CO training
February 2017	• Hire/Train Hospital Pharmacy Advisor • Select first pharmacy
April 2017	• First on-site hospital review

Recommendation
That the Board approve the policies, processes and implementation of PRP Phase 2 (hospital practice), as recommended by the Practice Review Committee.

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Practice Review Program: Hospital Pharmacy Practice Implementation

Board Meeting:

November 18th, 2016

Presented By:

Michael Ortynsky

Chair of the Practice Review Committee (PRC)

Practice Review Program (PRP) Rationale

- Directed by the Board
- Directly assesses practice
- Focused on critical standards with greatest impact on public safety and quality enhancement
- Designed based on practice setting (Community/Hospital/Other)

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PRP Principles

- Comprehensive in scope
- Fair, equitable and consistent process
- Prioritized by known areas of need
- Demonstrated value
- Not unreasonably disruptive to pharmacy operations or the public
- Contributes to cohesive college processes

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PRP Overview

Pharmacy Review	Pharmacy Professionals Review
Built on pharmacy inspection	New for all pharmacy professionals
At least once every 6 years	
Advance notice and scheduling	
Pharmacy manager completes Pre-Review in advance	Pharmacy professionals can review criteria on College website in advance
Results (and action items) delivered to pharmacy manager immediately after review	Results (and action items) delivered to each pharmacy professional immediately after review
30 days to complete corrective actions	

Inclusion Criteria

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Pharmacy Review Inclusion Policy

All licensed hospital pharmacies in BC.

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Pharmacy Professionals Review Inclusion Policy

All registrants employed by and practicing in a licensed hospital pharmacy, where at least one of the following Pharmacy Professionals Review focus areas – Patient Identification Verification, Profile Check, Counselling, Product Distribution, or Documentation – applies to their job description.

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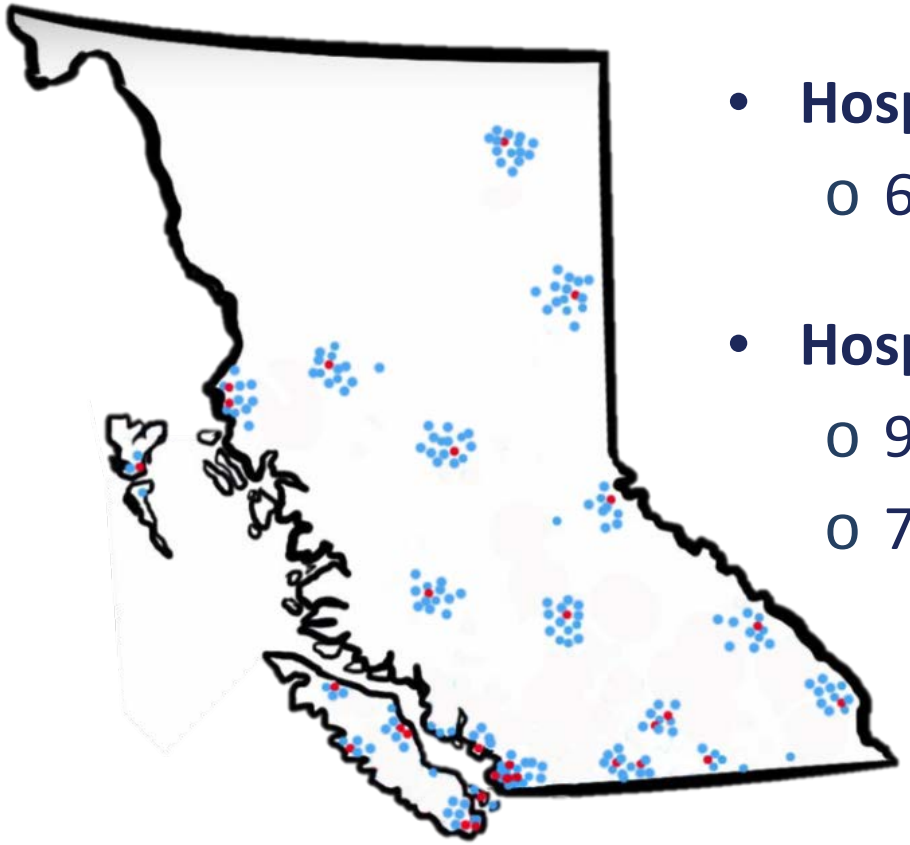
Prioritizing and Scheduling

Hospital Pharmacy Demographics



- **Hospital Pharmacies**
  - 69 (not including pharmacy satellites)
- **Hospital Pharmacy Professionals**
  - 900 Pharmacists
  - 700 Pharmacy Technicians

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As of February 2016

Prioritization Policy

Cycle based - Reviews will be scheduled based on the last inspection date. Pharmacies with the oldest “last inspection date” will be prioritized.

Scheduling Policy

The College will provide 60 calendar days of advance notice to pharmacy managers of the scheduled Practice Reviews. If the proposed scheduled date is inconvenient, the new date should be within the following month.

On-site Review Period Policy

Each review period will be limited to 1 month. The compliance officers will review larger hospitals for a maximum of 1 month on site conducting reviews, followed by 1 month off, continuing until all Pharmacy Professional Reviews are complete.

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Scheduling Process

CPBC notifies PM

- Includes review date range and estimated duration

PM completes Pre-Review

- Confirms availability
- Confirms pharmacy profile information
- Updates staff roster
- Regulated staff members to update information (if needed)

CPBC confirms review dates

- Based on availability
- Emails to be sent to PM and scheduled staff
- Hyperlinks to review forms provided to prepare for reviews

PM schedules staff

- Schedules 1 day for the Pharmacy Review and an additional ½ day for each satellite (if any)
- Schedules ½ day for each Pharmacy Professionals Review

On-site Practice Reviews

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On-site Practice Reviews

Pharmacy / Pharmacy Professionals Review conducted

- Compliance Officers (CO) will conduct reviews using electronic forms on their tablets
- CO will conduct the Pharmacy Review first followed by the Pharmacy Professionals Reviews

Summary results provided

- Once review conducted, summary results are provided
- Opportunity for clarification (if needed)

PM / Pharmacy Professionals acknowledge results

- Pharmacy Manager (PM) and Pharmacy Professionals will acknowledge their review results

Pharmacy Review Categories

- Security
- Equipment
- Drug Orders
- Confidentiality
- Inventory Management
  - Pharmacy
  - Nursing Units
- Narcotics and Controlled Drug Substances
- Dispensed Products
- Patient Records/Documentation
- After Hours Services
- Pharmacy Manager's Responsibilities
- Sterile Compounding
- Non-Sterile Compounding
- Telepharmacy
- Bulk Repackaging
- Residential Care

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Pharmacy Professionals Review: Focus Areas

Pharmacists	Pharmacy Technicians
Patient ID Verification	Patient ID Verification
Profile Check	Product Distribution
Counselling	Collaboration
Documentation	Documentation

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Methods of Assessment

1. **Observe (action)**
   - Watch work performed
   - Interact when clarification is needed

2. **Recall (case)**
   - "How did you?"
   - Review recent work (recall charts, orders, computer records, etc.)

3. **Describe (process)**
   - "How would you?"

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Monitoring Action Items

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Follow-up Process

Action items assigned

- Compliance Officers (CO) assign action items based on their findings
- results shared with each pharmacy professional
- Standardized action items used

30 days to complete

- Pharmacy professionals acknowledge review results and submit completed action items (and any required documentation)

within 30 days

COs monitor and follow-up

- COs monitor and track status of action items assigned until all are submitted and approved
- COs may conduct follow-up reviews in person, by phone or by email (if needed)

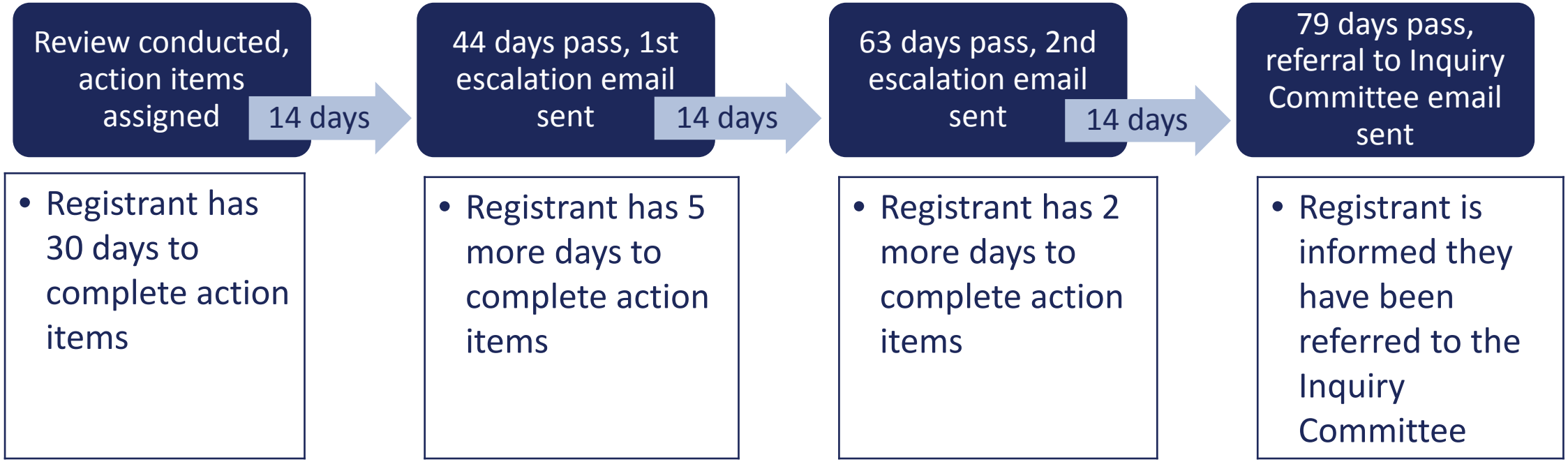
Review complete / referred

- Once action items complete, a notice of completion is issued
- If action items not completed, notice of non-completion is issued by the PRC and, if needed, review results will be referred to the Inquiry Committee or Quality Assurance Committee

Escalation Policy

Pharmacy managers and pharmacy professionals have 30 calendar days for the correction of assigned action items; exception conditions as approved by the Director may override the 30 day standard response time.
After 30 days has expired without correction, an escalated notice will be sent to action item owner from Director, giving 5 more days to complete.
After the 5 days has expired without correction, an escalated notice is sent from Registrar, indicating if action item(s) not resolved in 2 days the issue will be forwarded to Inquiry Committee.
If unresolved after the 2 days (total 37 days), the issue will be forwarded to Inquiry Committee. Responsibility for forwarding to Inquiry Committee to be delegated by the PRC to the Director of Practice Reviews and Quality Assurance.
The College allows 10 business days (14 calendar days) in between each step of the escalation process.

Escalation Process



Allow 10 business days (14 calendar days) in between each step of the escalation process.

Timeline

Dates	Activities
November 2016	• Board approval
November - January 2017	• New standards in force • Publish communications materials on CPBC website • Continue fine-tuning CO IT tool • Implement CO training
February 2017	• Select first pharmacy
April 2017	• First on-site hospital review

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Questions?

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Recommended Board Motion

"Approve the policies, processes and implementation of the Practice Review Program Phase 2 (hospital practice), as recommended by the Practice Review Committee as circulated."

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BOARD MEETING
November 18, 2016

14. Draft Strategic Plan

DECISION REQUIRED

Recommended Board Motion:

Approve the high level Draft Strategic Plan 2017-2020 as circulated.

Direct the Registrar to build the detailed Strategic Plan 2017-2020 based on the approved high level version, including budget and bring back to the February 2017 Board meeting for approval.

Purpose

Board members to review and provide approval in principle of the draft Strategic Plan to enable staff to build the detailed 3-year Strategic Plan and budget for full approval in February 2017.

Background

At the February 20th Board Strategic Planning Session, three broad themes were identified (Legislation / Standards Modernization, Professional Excellence, Drug Therapy access and monitoring). In addition there was a discussion about strengthening the "foundation" with the overall goal of Organization Excellence.

As discussed at the session, staff was asked to take the information from the day and develop a draft plan to bring back to the Board.

A draft plan is now presented, including budget and staffing implications for the Board's review. Once approval in principle is received, staff will build the detailed 3-year plan and include the budget considerations while preparing the 2017-18 annual budget.

Discussion

The College's Mission states: "The CPBC regulates the pharmacy profession in the public interest. We set and enforce standards and promote best practices for the delivery of pharmacy care in British Columbia."

The four Strategic Plan Goals discussed in February give direction towards achieving this Mission over the next three years.
Staff considered the objectives to implement in order to support these four goals, while taking into account the resources available and the demands of the day-to-day core work as directed at the planning session.
Some of these objectives will have significant budget and staffing implications which have been noted. Some of these objectives have been planned earlier and are carried over from the previous Strategic Plan, but are included in this one as they are significant plans and will contribute toward achieving these Goals.

Considerations / Budget impact

This Strategic Plan includes some major projects that will require significant multi departmental involvement and planning. Almost all of the projects will require significant IT involvement. However, these projects can be phased in over the three years, spreading out the budget impact. Some of the budget impact includes:

- Legal fees
- Project management fees
- Consulting fees
- IT development fees
- Additional staff

Once the draft strategic plan is approved, staff will review the timelines and prepare detailed budget forecasts for the three year plan.

Recommendation

To approve the high level Draft Strategic Plan to enable staff to develop detailed timelines and budgets.

Appendix	
1	Draft Strategic Plan 2017-2020

Draft Strategic Plan

Vision - Better health through excellence in pharmacy

Mission – The CPBC regulates the pharmacy profession in the public interest. We set and enforce standards and promote best practices for the delivery of pharmacy care in British Columbia.

Theme – Organizational Excellence?

Goal One

Legislative standards & Modernization

The College and the pharmacy profession have continued to evolve and increase in complexity, making it important to re-examine our legislative requirements and their effectiveness in protecting the public. The College will work to modernize the legislative requirements under the *Pharmacy Operations and Drug Scheduling Act* (PODSA) and the *Health Professions Act* (HPA), to ensure they are clear, consistent and enforceable.

Objectives	Key Results	Considerations
1. Develop and implement bylaws to operationalize the recent changes enacted by the provincial government regarding pharmacy ownership provisions under PODSA.	• New bylaws are in force by February 2018. • Key bylaws include: o Establishing an Application Committee. o Specifying the information required from pharmacy owners for licensure purposes. Pharmacy owners and directors understand and adhere to the bylaws.	• Must be integrated with IT system changes. • Potential resource requirements for staff and contractors.
2. Implement a comprehensive review and reform of legislative requirements under PODSA and the HPA.	• Bylaws are clearer and duplication in bylaws and policies is addressed. • Policies are standardized and transitioned to bylaw where needed. • Bylaws and policies have consistent writing style and structure.	• Multi-year project from March 2018 – 2020 (and beyond). • Subject to impact of other initiatives. • Potential resource requirements for staff and contractors.

Goal Two

Professional Excellence

Professional excellence involves ensuring that the practice of pharmacy meets or exceeds the standards set out to protect the public and maintain their trust.

Objectives	Key Results	Considerations
1. Extend the practice review program into hospitals and other practice settings.	• Pharmacy professionals and owners/directors understand and meet College standards of professional practice. • PRP - Hospital is implemented. • Targets: an average of 15 hospitals and 400 pharmacy professionals per year. • PRP – Other: Review of non-traditional areas of practice is researched and a plan is approved.	
2. Continue to implement the 2015-18 Methadone Action Plan to ensure that pharmacies providing methadone treatment to vulnerable populations meet the required standards for professionalism and patient safety.	• Pharmacies providing methadone therapy understand and meet College standards of professional practice. • Decreased complaints regarding MMT dispensing. • Target: 40 inspections of MMT dispensing pharmacies completed between 2015-18.	

Goal Three

Drug Therapy Access and Monitoring

The College will explore avenues that enhance the ability of pharmacy professionals to maximize the public's access to safe, high quality drug therapy.

Objectives	Key Results	Considerations
1. Recommend to the Minister of Health that pharmacists be granted the authority to prescribe.	• A comprehensive proposal is approved by the Board and delivered to the Minister of Health.	• There will be further budget and staffing impacts if the Board and Ministry approve the proposal. • Potential resource requirements for contractors.
2. Seek greater access to patient lab values to enhance pharmacists' ability to provide quality, timely service to patients.	• Pharmacists can access patient lab reports directly. • Pharmacists are using knowledge gained from lab results to provide an increased level of quality and timeliness to patients.	• Scope of this objective does not extend to ordering lab tests and being paid for them.

Goal Four

Organizational Excellence

The College has grown significantly over the last 10-15 years both in the number of registrants and pharmacies and in the staff required to govern them in the public interest. Over the next three years, the College will ensure that the efficiency and effectiveness of its foundational business processes and technological supports are upgraded to meet the ongoing needs of registrants, pharmacy owners and directors, staff and the public. It will also ensure that College governance and staffing are well organized and provided at the appropriate level to ensure the efficient and effective delivery of services to all stakeholders.

Objectives	Key Results	Considerations
1. Streamline the licensure business process to improve its efficiency and effectiveness.	• Updated business processes are in place. • Registrants report the processes are clearer and more understandable.	• This objective will start after the implementation of PODSA ownership bylaws (Goal 1). • This objective must be integrated with IT changes.
2. Update the College's information technology infrastructure to integrate and support the College's departments, programs and functions.	• Design and implementation plan completed. • Updates planned include: a. Key database modules b. Enhancing privacy and security	• Follows implementation of PODSA ownership bylaws. • Integrates with business process changes. • Potential resource requirements for staff and contractors.
3. Consider the Organization Review recommendations, which will inform a review of Board Policies and staffing levels and organization.	• Board policies are updated • Staffing levels and organization are reviewed and changes are implemented.	• Potential resource requirements for consulting and staffing.

College of Pharmacists of British Columbia

BOARD MEETING
November 18, 2016

4.b.x. PODSA Fee Increase Update

INFORMATION ONLY

Purpose

To update Board members as to the status of the request for a shortened posting period of the *Pharmacy Operations and Drug Scheduling Act* (PODSA) fees and potential consequences.

Background

At the September Board meeting, the Board approved PODSA fee increases and related form changes, to be effective January 1, 2017. These fee changes are:

- New Pharmacy application fee - $525.00 (for both Community and Hospital pharmacies)
- Increase Pharmacy annual license fee from $1,331.00 to $2,001.00 (for both Community and Hospital pharmacies)

In order for the PODSA fee increases to be effective in January 2017, the College required a shortened public posting period (the full public posting period is 90 days). In September, the Board also approved that the College request a shortened public posting period from the Minister of Health for these fees.

As a reminder, fee increases for registrants were also approved by the Board at their September 2016 meeting. However, those fees fall under the *Health Professions Act* (HPA). Section 19(6.2) of the HPA excludes the establishment of fees (amongst other bylaw making authorities) from a 90 day public posting period. Accordingly, once approved by the Board, the bylaws were sent to the Ministry of Health for filing. They will be in force by January 1, 2016.

Discussion

The College requested the shortened posting period and has been advised that the request is still with the Minister of Health for consideration. There is no clear timeframe when the Minister's decision will be made.

The College has explored potential scenarios with respect to the effective date of the PODSA fees and their financial implications, which are all dependent on the Minister's decision. These scenarios are:

Scenario One
The shortened public posting period is not granted, but the filing period is shortened (the full filing period is 60 days). The new fee schedule would likely be effective February 1, 2017. The loss of revenue by delaying the effective date is $52,930.

Scenario Two Neither public posting nor filing periods are shortened and the new fees are effective March 1, 2017. The loss of revenue would be $291,450.

Scenario Three
The public posting period (and, possibly, the filing period) is shortened, such that the new fees become effective January 1, 2017. This scenario grows increasingly unlikely, as time passes without a decision by the Minister.

Next Steps

College staff have engaged the Ministry of Health staff on this issue, and have raised the financial implications as a significant concern for the College. The College will continue to engage with Ministry staff and monitor the situation.