College of Pharmacists of British Columbia

Board Meeting
February 18th & 19th, 2016
Held at the College of Pharmacists of British Columbia
200-1765 West 8th Avenue, Vancouver, BC

MINUTES

Members Present:
Blake Reynolds, Chair & District 4 Board Member
Anar Dossa, 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
Bal Dhillon, District 8 Board Member
Norman Embree, Public Board Member
Kris Gustavson, Public Board Member (*absent for items 12, 13 and 14*)
Jeremy Walden, Public Board Member
George Walton, Public Board Member

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

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

Thursday, February 18th, 2016

1. **WELCOME & CALL TO ORDER**
   Chair Reynolds called the meeting to order at 9:08am on February 18th, 2016.

2. CONSENT AGENDA

a) Items for further discussion

None.

b) Approval of Consent Items (Appendix 1)

It was moved and seconded that the Board:

Approve the Consent Agenda as circulated.

CARRIED

3. CONFIRMATION OF AGENDA (Appendix 2)

It was moved and seconded that the Board:

Approve the February 18 & 19, 2016 Draft Board Meeting Agenda as amended by adding a new item 6(b) Indigenous Cultural Safety Training.

CARRIED

4. SEPTEMBER 2016 BOARD MEETING LOCATION

It was moved and seconded that the Board:

Approve the location of the September 15 & 16, 2016 Board Meetings to be in Kelowna, BC.

CARRIED

5. 125TH ANNIVERSARY WORKING GROUP

a) Terms of Reference (Appendix 3)

Board member and Chair of the 125th Anniversary Working Group Ming Chang presented.

It was moved and seconded that the Board:

That the Board approve the following change to the 125 Year Anniversary Working Group Terms of Reference membership requirements:

From:

Membership

- 4 additional members as appointed by the Board.

To:

Membership

- Additional members as appointed by the Board

CARRIED

b) Committee Appointment

Board member and Chair of the 125th Anniversary Working Group Ming Chang presented.

It was moved and seconded that the Board:

Appoint Aaron Sihota as a member of the working group as recommended by the 125 Year Anniversary Working Group.

CARRIED

c) Plan Update

It was moved and seconded that the Board:

Approve the 125 Year Anniversary Working Group recommendation to hold a destination celebration on September 17, 2016 in Kelowna, BC.

CARRIED

6. a) GOVERNANCE COMMITTEE

Board member and Chair of the Governance Committee Norman Embree presented information as distributed in the briefing package **(Appendix 4)**.

b) INDIGENOUS CULTURAL SAFETY TRAINING

Board member Kris Gustavson led a discussion about the Indigenous Cultural Safety (ICS) online training program developed by the Provincial Health Services Authority (PHSA) Aboriginal Health Program. More information specific to College registrant uptake of the ICS training program will be presented at a future Board meeting.

7. AUDIT AND FINANCE COMMITTEE – BUDGET PRESENTATION

Board member and Chair of the Audit and Finance Committee George Walton presented information as distributed in the briefing package **(Appendix 5)**.

It was moved and seconded that the Board:

Approve the 2016/17 budget totaling $10,298,048 as presented.

CARRIED

8. PRIORITIZING CE FOR NEXT FISCAL YEAR

Chair of the Quality Assurance Committee Gary Jung presented information **(Appendix 6)** as distributed in the briefing package **(Appendix 7)**.

It was moved and seconded that the Board:

Approve the following priorities for development of continuing education for the 2016/17 fiscal year based on the outcomes of the CPBC Learning Needs Survey for BC Pharmacy Professionals 2015:

1. *Expertise in Medications and Medication-use/Drug Distribution Systems*
   - *Knowledge/pharmacology based:*
     - *Diabetes, asthma, COPD, vaccines and mental health, OTC products, natural health products, wound care, ostomy supplies, chemotherapy*
   - *Skills/product preparation based:*
     - *Identifying and resolving drug therapy problems, developing follow-up and monitoring plan, interpreting lab values, pharmaceutical calculations, compounding (sterile, non-sterile, hazardous), preparation of parenteral medications*
   - *Pharmacy services based:*
     - *Medication reviews, immunization*
2. *Safety and Quality*
   - *Preventing and managing dispensing errors and incidents, patient safety and quality improvement, documentation skills and tools, handling hazardous drugs, identifying reliable references and resources, workflow management, hand hygiene*

CARRIED

9. PRACTICE REVIEW PROGRAM – PHASE I AND PHASE II UPDATE

Chair of the Practice Review Committee Mike Ortynsky presented information as distributed in the briefing package **(Appendix 8)**.

10. ITEMS BROUGHT FORWARD FROM THE CONSENT AGENDA

No items were brought forward from the Consent Agenda for further discussion.

11. DRUG SCHEDULE REGULATION AMENDMENT - NALOXONE

Board member and Chair of the Legislation Review Committee Bal Dhillon presented information as distributed in the briefing package **(Appendix 9, and Appendix 10)**.

It was moved and seconded that the Board:

Approve the following resolution on the condition that Health Canada confirms the amendments to the Prescription Drug List regarding Naloxone.

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.

CARRIED

12. CERTIFIED PHARMACIST PRESCRIBER UPDATE

Director of Communications and Engagement Gillian Vrooman presented the Board with an update of the Certified Pharmacist Prescriber initiative **(Appendix 11)**, the updated Draft Framework **(Appendix 12)** and the stakeholder engagement process **(Appendix 13)**.

13. POINT-OF-CARE HIV TESTING: COMMUNITY PHARMACY PILOT

Bob Rai from Medicine Shoppe Pharmacy, and Reka Gustafson Medical Health Officer with Vancouver Coastal Health presented **(Appendix 14)**.

14. IN-CAMERA SESSION

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

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

ADJOURN FOR THE DAY

The meeting adjourned for the day at 4:00pm.

Friday, February 19th, 2016

CALL TO ORDER

Chair Reynolds called the meeting to order at 9:02am on February 19th, 2016.

15. IN-CAMERA

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

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

It was moved and seconded that the Board:

Hereby approves the confidentiality commitment and authorizes the College Board Chair to sign that commitment on behalf of the College, as its authorized signatory. The Board further approves, under s. 53 of the Health Professions Act, of disclosure in the public interest of personal and other information to the United States Food and Drug Administration, pursuant to the confidentiality commitment given by the Food and Drug Administration to the College.

16. BC PHARMACY ASSOCIATION – PERSONALIZED MEDICATION IN OUR COMMUNITIES

President of the BC Pharmacy Association Allison Nourse presented **(Appendix 15)**.

17. OPTIMIZING PHARMACEUTICAL CARE FOR POST-TRANSPLANT AND CHRONIC KIDNEY DISEASE PATIENTS

Greg Wheeler, consultant to BC Transplant in the role of Community Pharmacy Project Manager presented **(Appendix 16)**.

18. METHADONE MAINTENANCE TREATMENT UPDATE

Deputy Registrar Suzanne Solven and Senior Investigator George Budd presented **(Appendix 17)**.

ADJOURNMENT

Chair Reynolds adjourned the meeting at 2:06pm.

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

2. Consent Agenda
b) Approval of Consent Items

DECISION REQUIRED

Recommended Board Motion:

That the Board approve the Consent Agenda as circulated or amended.

i. Chair's Report
ii. Registrar's Update
    a. Activity Report
    b. Action Items & Business Arising
    c. Strategic Plan **[DECISION]**
iii. November 20, 2015 Draft Board Meeting Minutes **[DECISION]**
iv. Media, Communications and Engagement Strategy **[DECISION]**
v. Finance Report (November Financials)
vi. Ethics Advisory Committee Update
vii. 2015 Draft Annual General Meeting Minutes **[DECISION]**

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

2.b.i. Chair's Report

INFORMATION ONLY

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

- Follow up calls with Board members
- Had discussions with Anar Dossa and Bob Nakagawa via our biweekly meetings
- January 21, 2016 attended PLOT meeting with 35 young and enthusiastic pharmacists
- January 22, 2016 meeting with Allison Nourse president of BCPhA to discuss strategic goals
- January 22, 2016 Governance Committee meeting
- January 22, 2016 strategic planning session with Paul Sacilotto, Mary O'Callaghan and Bob Nakagawa
- January 26, 2016 PRC meeting
- February 1 & 2, 2016 reply to incentives inquiries, complaint letters
- February 3, 2016 Audit and Finance Committee meeting
- February 4, 2016 Ethics Advisory Committee meeting and Physician Assisted Dying (PAD) presentation
- February 10, 2016 Certified Pharmacist Prescriber Initiative consultation with the Hospital Pharmacy Advisory Committee
- February 13, 2016 planning meeting for upcoming Strategic Planning Session
- February 16, 2016 meeting with the Registrar and Vice-Chair, and follow-up with Allison Nourse, President, BCPhA

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

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

INFORMATION ONLY

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

- BC Health Regulators meeting
- Attended meetings of the Chain Drug Store Association of BC
- Met with Michael McMillan, VP and Dana Cole, Pharmacy Director of Northern Health to discuss:
  - Role of the College
  - Upcoming issues
  - Practice Reviews – presence of the College compliance officers
  - Pharmacist prescribing – and how it could impact on health authorities
  - Sterile compounding – new NAPRA guidelines imminent
  - Technicians – bridging program ending, and the need for regulated technicians
  - Privacy issues – report to College if breach involves our registrants
- Meetings with the Chair and Vice-Chair
- Met with Julio Montaner and Irene Day to discuss HIV meds and PharmaNet
- Presented to the technicians education program at CDI College
- Attended the Court of Queen's Bench in Edmonton for their defence of their bylaw prohibiting pharmacies providing incentives in return for pharmacy goods and services
- 2 days of College of Pharmacists Leadership Team (CPLT) retreat
- Attended the BC Court of Appeal for our appeal of the Supreme Court decision to quash our bylaw prohibiting the provision of incentives in return for pharmacy goods and services
- Various staff and stakeholder Christmas events
- Networking with Dean Coughtrie, Dean McNeill, Health Profession Regulators, Aaron Sihota
- Participated in planning for the Thought Leadership Summit in June
- Toured the Medicine Shoppe to see Health Tab re: CPSBC concerns
- Discussed potential for College support of a Chair position at UBC
- Discussed potential role of the College in supporting pragmatic research to advance the quality of prescribing
- Meeting to discuss PharmaNet history and future development with Deb Shera, ADM Ministry of Health and Trevor Hodges, consultant
- Meeting with the leadership of the Cochrane Collaboration re: loss of federal funding
- Meeting with Health Canada to discuss scheduled drug and narcotic storage requirements in telepharmacy and kiosks
- Participated in the CPhA Medical Marijuana review
- As CPRC Chair, participated in the Specialization Task Group teleconference meeting
- Participated in the Pharmacy Leaders of Tomorrow meeting

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

2.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 the Registrar to draft bylaws regarding pharmacy security measures.	Sep 2015	IN PROGRESS
Motion: Direct the Registrar to engage with stakeholders on changing the College name. The Registrar is to report back on the outcome of this stakeholder engagement process by September 2016, at which time, the Board make consider a name change.	Sep 2015	IN PROGRESS
Motion: Directs the Quality Assurance Committee to change their policy for CE requirements for yearly registration renewal as follows: ***From:*** *Yearly completion of CE-Plus consists of:* • *A minimum of 15 hours of learning activities, documented on a minimum of 6 Learning Records with supporting documentation.* *a) All learning must have been completed within the 12 months prior to renewal date.* *b) CE-Plus Learning Records must be completed in English.* ***To:*** *Starting January 1, 2016 (for renewal deadline December 31, 2016) and onwards:* *Yearly completion of CE-Plus consists of:* • *A minimum of 15 hours of learning activities, documented on a minimum of 6 Learning Records with supporting documentation.* a) *A minimum of 5 hours of the learning activities must be accredited.* b) *All learning activities must have been completed within the 12 months prior to renewal date.*	Nov 2015	COMPLETED

MOTIONS/ACTION ITEMS	RELEVANT BOARD MEETING	STATUS UDPATE
Motion: Approve the Certified Pharmacist Prescriber Initiative Draft Framework, in principle, considering guidance from the Board.	Nov 2015	COMPLETED
Motion: Approve the 125th Anniversary Working Group communications plan, and host a signature gala event to celebrate the 125th anniversary of the College.	Nov 2015	IN PROGRESS
Motion: Direct the Registrar to subscribe to RxFiles for 12 months at a maximum cost of $17,000.	Nov 2015	COMPLETED

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

2.b.ii. Registrar's Update
c) Strategic Plan

DECISION REQUIRED

Recommended Board Motion:

That the Board approve the updated Three Year Strategic Plan & Detailed Operational Plan for 2014/15 to 2016/17 with the changes as circulated.

Purpose
To provide an update on the Strategic Plan, including some changes to timelines, wording and removing objectives that are outside of the College's legislative authority.

Background
The Board approved the 2014/15 to 2016/17 Strategic Plan in September 2013. Each year the College presents an update with modifications to the detailed operational plan. The update reflects timing changes, clearer wording, etc.

The changes included in this update are:

- Clarifying the descriptions of Milestones #2 and 3.
- Clarifying the descriptions of Milestones # 56 to 59.
- Removing Milestone #60 as the deliverable date is outside of this Strategic Plan.
- Removing Milestones #62 and 63 as they are captured by Milestones #20 and 21.
- Removing Milestones #76 to 80 as they are outside the legislative authority of the College.

This is the final year of the current Strategic Plan. As the scope of the various objectives have become clearer, some timelines have been moved to accommodate the time required to complete the projects. With some other objectives, the wording of the milestones was unclear or confusing. As the College explored the objective re: permitting the viewing of lab test results, it became clear that the College does not have the legislative authority to proceed with this objective.

Appendix	
1	Strategic Plan – tracked changes version
2	Strategic Plan – changes accepted version

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan
Fiscal Years: 2014/15 to 2016/17

Completed
On track
Delayed
On hold
Change

Strategic Plan Areas	Objectives	#	Reporting Milestones	Board Meeting (mmm-yy)	Status	Rationale for Delay	Previous Delay Date
1. Public Expectation	(a) Role and value of profession	1	Decision: Board review outcomes of roles and values analysis with pharmacy profession stakeholders	Apr-15	Completed		
		2	Update: Report on outcomes of networking meetings. ~~Decision: Board refine plan based on outcomes of 2nd year of networking meetings reviewing roles and values with pharmacy profession stakeholders~~	Feb-16	Feb-16	Change wording to 'Report on outcomes of networking meetings' to clarify the milestone is an update and not a decision.	
		3	Update: Report on outcomes of networking meetings. ~~Decision: Board refine plan based on outcomes of 2nd year of networking meetings reviewing roles and values with pharmacy profession stakeholders~~	Feb-17	On track	Change wording to 'Report on outcomes of networking meetings' to clarify the milestone is an update and not a decision.	
	(b) Public Awareness Strategy	4	Update: Results of baseline public awareness survey available for Board review	Sep-15	Completed		
		5	Decision: Board endorse plan for public awareness program in 16/17	Nov-15	Feb-16		
		6	Decision: Board approves launch of program	Feb-16	On track		
		7	Update: Results of public awareness survey available for Board review	Feb-17	On track		
2. Interdisciplinary Relationships	(a) Work with other regulated healthcare professionals to identify interdisciplinary opportunities for collaboration and improvement in healthcare services.	8	Update: Report on outcomes of collaborative opportunities program	Nov-14	Completed		
		9	Decision: Options presented to Board on refinements to program	Apr-15	Completed		
		10	Update: Report on APP Stakeholder Engagement Plan	Nov-14	Completed		
		11	Update: Report on outcomes of collaborative opportunities program	Nov-15	Completed		
		12	Decision: Options presented to Board on refinements to program	Feb-16	On track		
		13	Update: Report on outcomes of collaborative opportunities program	Nov-16	On track		
		14	Decision: Options presented to Board on refinements to program	Feb-17	On track		
	(b) Create opportunities for pharmacists and pharmacy technicians to improve and enhance their practice by establishing a means in which they can deepen their relationships and understanding of each other's role.	15	Update: Report on outcomes of pharmacist/pharmacy technician networking sessions	Apr-15	Completed		
		16	Update: Report on outcomes of pharmacist/pharmacy technician networking sessions	Feb-16	Apr-16		
		17	Update: Report on outcomes of pharmacist/pharmacy technician networking sessions	Feb-17	On track		
	(a)(i) Enhance availability of continuing education tools and programs	18	Decision: Report on survey of what new CE tools and programs required, decision on what tools and programs to prioritize for rest of year	Jun-14	Completed		
		19	Decision: Report on new CE tools and programs, decision on program direction for next fiscal year	Nov-14	Completed		
		20	Decision: Report on new CE tools and programs, decision on program direction for next fiscal year	Nov-15	Feb-16		
		21	Decision: Report on new CE tools and programs, decision on program direction for next fiscal year	Nov-16	On track		
	(a)(ii) Encourage BC pharmacists to enroll in programs that support best practices	22	Update: Report on numbers of pharmacists participating in clinical skills development programs	Nov-14	Completed		
		23	Update: Report on numbers of pharmacists participating in clinical skills development programs	Nov-15	On track		
		24	Update: Report on numbers of pharmacists participating in clinical skills development programs	Nov-16	On track		
	(a)(iii) Provide the University of BC faculty of pharmaceutical sciences and the BC pharmacy technician program institutions with feedback on jurisprudence exam results and changes to standards or scope of practice to help inform their curricula	25	Update: Report on process developed for tracking changes in legislation and jurisprudence exam results, and advising educational institutions	Jun-15	Completed		
		26	Update: Report on changes noted in legislation and jurisprudence exam results that will be communicated to educational institutions	Jun-16	On track		

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan
Fiscal Years: 2014/15 to 2016/17

Completed
On track
Delayed
On hold
Change

Strategic Plan Areas	Objectives	#	Reporting Milestones	Board Meeting (mmm-yy)	Status	Rationale for Delay	Previous Delay Date
3. Scope of Practice	(a)(iv) Encourage uptake of registered pharmacy technicians into community practice settings	27	Decision: Board reviews results of survey and decides on future regulation of technicians and how best to integrate registered technicians into community pharmacies and potentially registering pharmacy assistants (certified non-registrants) (N.B. Decision not made in Jun 14)	Jun-14	Completed		
		28	Decision: Board decides whether it wishes to pursue registration of all currently non-regulated pharmacy staff (i.e. all people who will touch drugs)	Apr-15	Completed		
		29	Decision: Board reviews/approves action plan for further registration	Nov-15	Completed (Sep-15)		
	(b)(i) Improve the quality of current adaptations by updating the standards, limits and conditions	30	Decision: Board approves updated standards, limits and conditions and policy changes (Phase 1)	Nov-15	On hold	On hold due to the review of policy and bylaw requirements/enforceability.	
		31	Update: Report on progress of Phase 1	Jun-16	On hold	On hold because it is linked to milestone 30.	
		32	Decision: Board approves updated standards, limits and conditions (including removal of restrictions on PPP58 adaptations)	Feb-17	On hold	On hold because it is linked to milestone 30.	
	(b)(ii) Changes to standards/limits/conditions for injection authority	33	Decision: Board approves public posting of proposed bylaw changes of updated standards, limits and conditions for injection authority that removes limitation to immunization only and provides guidance around injections of all appropriate drugs	Sep-15	Sep-16	Delayed because of the Ministry of Health's request to accommodate their bylaw backlog processing timelines. In addition, delayed because of the pharmacy security bylaw priority, and the review of policy and bylaw requirements/enforceability.	
		34	Decision: Board approves filing of bylaw changes	Jan-16	Feb-17	Delayed because it is linked to milestone 33.	
		35	Update: Legislation in force	Apr-16	Apr-17	Delayed because it is linked to milestone 33.	
	(b)(iii) Advanced Pharmacist Practice certification	36	Update: Report on updated project plan	Apr-15	Completed		
		37	Update: Report on Board Chair meeting with Minister of Health in Spring 2015 (to include proposed regulation submission)	Jun-15	Completed		
		38	Update: Results of request for regulation changes from MoH.	Nov-15	Jun-16	Delayed because the Ministry of Health identified a need for a fulsome description of the societal need, plans to address perverse incentives and certification requirements (eg. eligibility criteria, renewal requirements and SLC in order for it to be considered). In addition, there needs to be a consultation plan developed.	
		39	Decision: Board approve public posting of proposed bylaw changes supporting APP certification	Jun-16	Sep-16	Delayed because it is linked to milestone 38.	
		40	Update: Presentation of materials and planning supporting launch of APP certification	Sep-16	On track		
		41	Decision: Board approve filing of bylaw changes with MoH supporting APP certification	Feb-17	On track		
	(a) Review and map standards (HPA/PODSA/PPP/NAPRA) to ensure relevancy and consistency.	42	Decision: Board approve public posting of proposed bylaw changes supporting package of legislation updating 6 standards	Feb-15	Completed		
		43	Decision: Board approve filing of proposed bylaw changes updating 6 standards	May-15	Jun-16	Further delayed because of the Ministry of Health's request to accommodate their bylaw backlog processing timelines. In addition, delayed because of the pharmacy security bylaw priority, and the review of policy and bylaw requirements/enforceability.	Nov-15
		44	Update: Package of legislation in force	Sep-15	Aug-16	Further delayed because it is linked to milestone 43.	Mar-16
	(b) Develop a comprehensive, integrated policy guide that incorporates standards, guidelines and indicators of good practice and standards	45	Decision: Board approve policy guide for publication incorporating standards and indicators for standards of 4(a)	Sep-15	Sep-16	Further delayed because it is linked to Objective 4(a).	Nov-15
		46	Update: Report on Tools and communication plan developed to support standards of 4(a)	Feb-16	Feb-17	Delayed because it is linked to Objective 4(a).	

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan
Fiscal Years: 2014/15 to 2016/17

Completed
On track
Delayed
On hold
Change

Strategic Plan Areas	Objectives	#	Reporting Milestones	Board Meeting (mmm-yy)	Status	Rationale for Delay	Previous Delay Date
4. Standards	(c) Develop standards for pharmacy workload	47	Decision: Board approve public posting of proposed bylaw changes supporting standards for pharmacy workload	Feb-15	Completed		
		48	Decision: Board approve filing of bylaw changes of standards for pharmacy workload	May-15	Jun-16	Further delayed becaue of the Ministry of Health's request to accommodate their bylaw backlog processing timelines. In addition, delayed due to the pharmacy security bylaw priority, and the review of policy and bylaw requirements/enforceability.	Nov-15
		49	Update: Legislation in force for new standards for pharmacy workload	Sep-15	Aug-16	Delayed again because it is linked to milestone 48.	Mar-16
	(d) Strengthen enforcement to improve compliance	50	Update: Report on setting up of new Practice Review Program infrastructure	Jun-14	Completed		
		51	Update: Report on setting up of new Practice review Program infrastructure (Community compliance officers hired/trained, Oversight Committee in place, roll out of community communication plan, tools and processes in place)	Sep-14	Completed		
		52	Update: Confirmation of Community Pilot Program launch	Nov-14	Completed		
		53	Update: Results from Community Pilot Practice Reviews	Feb-15	Completed		
		54	Update: Launch of formal Community Practice Review program	Apr-15	Completed		
		55	Update: Practice Review Program results, metrics, learnings Update: Progress report on setting up of hospital Practice Review Program infrastructure (compliance officer hired/trained, roll out of communications plan, tools and processes in place, launch of pilot program)	Sep-15	Completed		
		56	Update: Confirmation of Hospital Pharmacy ~~Pilot~~ Program launch	Nov-15	Sep-16	Further delayed because Phase 1 is delayed; Phase 2 will be implemented in Q2 (June-August); removal of "pilot"	Feb-16
		57	Update: Report on Practice Review Program Phase 1 results, metrics, learnings ~~Report on results from Hospital Pharmacy Pilot Practice Reviews~~	Feb-16	Feb-17	Further delayed because it is linked to milestone 56; change milestone to be same as #58	Jun-16
		58	Update: Report on Practice Review Program Phase 1 results, metrics, learnings	Feb-16	On track		
		59	Update: Report on Practice Review Program Phase 1 results, metrics, learnings	Sep-16	On track		
		~~60~~	~~Update: Report on Practice Review Program results, metrics, learnings~~	~~Feb-17~~	~~Sep-18~~	Remove milestone because the date outside of current strat plan	
	(e) Align CE requirements with evolving practice and standards	61	Decision: Board prioritizes required CE tools and programs to support evolving practices and standards arising from new Practice Review Program	Sep-14	Completed		
		~~62~~	~~Decision: Board prioritizes required CE tools and programs to support evolving practices and standards arising from new Practice Review Program~~	~~Nov-15~~	~~Feb-16~~	Delayed because the Quality Assurance Committee needs to complete a learning needs survey prior to bringing recommendation to Board; remove this objective as it is already captured in 3(a)	
		63	Decision: Board prioritizes required CE tools and programs to support evolving practices and standards arising from new Practice Review Program	Nov-16	On track		
	(f) Prohibit tobacco products in premises where a pharmacy is located	64	Decision: Board approve public posting of proposed bylaw changes supporting prohibition of tobacco products in premises where a pharmacy is located	Jun-14	Completed		
		65	Decision: Board approve filing of bylaw changes with MoH supporting prohibition of tobacco products in premises where a pharmacy is located	Nov-14	Completed		
		66	Update: Legislation in place that prohibits tobacco products in premises where a pharmacy is located	Feb-15	On hold		

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan
Fiscal Years: 2014/15 to 2016/17

Completed
On track
Delayed
On hold
Change

Strategic Plan Areas	Objectives	#	Reporting Milestones	Board Meeting (mmm-yy)	Status	Rationale for Delay	Previous Delay Date
	(g) Prohibit use of loyalty programs related to the provision of pharmacy services	67	Update: Summary report on loyalty point prohibition complaints for 2015/16	Feb-15	N/A		
5. Technology	(a) Act as a key stakeholder in order to facilitate enhancements to the PNet database such that a more complete drug history is available for clinicians	68	Update: PNet Services contract signed;	Apr-15	Completed		
		69	Update: Report on status of request MoH for enhancements to PNet	Feb-15	Completed		
		70	Update: Report on status of request to MoH for enhancements to PNet	Apr-16	On track		
		71	Update: PNet profiles contract renewed	Feb-17	On track		
	(b) Provide e-access to current and comprehensive drug information	72	Decision: Board determines options for e-library resources	Jun-14	Apr-16	Further delayed because the College is researching more suitable resources.	Sep-15
		73	Decision: Board approves roll out of e-library (Phase 1)	Nov-14	Completed		
		74	Update: Report on results of survey on uptake and effectiveness of e-library. Review if any changes required	Nov-15	On track		
		75	Update: Report on results of survey on uptake and effectiveness of e-library. Review if any changes required	Nov-16	On track		
	(c) Access to view patient lab information	~~76~~	~~Update: Report summarizing need to provide access to lab data~~	~~Sep-14~~	~~Completed~~	Remove ojective as this is outside of the College's legislative authority	
		~~77~~	~~Update: Outcomes of discussions with MoH regarding access to lab data~~	~~Jun-15~~	~~Completed~~	Remove ojective as this is outside of the College's legislative authority	
		~~78~~	~~Decision: Board approve public posting of proposed bylaw changes supporting access to lab data~~	~~Apr-16~~	~~On track~~	Remove ojective as this is outside of the College's legislative authority	
		~~79~~	~~Decision: Board approve filing of bylaw changes with MoH supporting access to lab data~~	~~Sep-16~~	~~On track~~	Remove ojective as this is outside of the College's legislative authority	
		~~80~~	~~Update: Legislation in force granting access to laboratory data~~	~~Feb-17~~	~~On track~~	Remove ojective as this is outside of the College's legislative authority	

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan
Fiscal Years: 2014/15 to 2016/17

Completed
On track
Delayed
On hold

Strategic Plan Areas	Objectives	#	Reporting Milestones	Board Meeting (mmm-yy)	Status	Rationale for Delay	Previous Delay Date
1. Public Expectation	(a) Role and value of profession	1	Decision: Board review outcomes of roles and values analysis with pharmacy profession stakeholders	Apr-15	Completed		
		2	Update: Report on outcomes of networking meetings.	Feb-16	Feb-16		
		3	Update: Report on outcomes of networking meetings.	Feb-17	On track		
	(b) Public Awareness Strategy	4	Update: Results of baseline public awareness survey available for Board review	Sep-15	Completed		
		5	Decision: Board endorse plan for public awareness program in 16/17	Nov-15	Feb-16		
		6	Decision: Board approves launch of program	Feb-16	On track		
		7	Update: Results of public awareness survey available for Board review	Feb-17	On track		
2. Interdisciplinary Relationships	(a) Work with other regulated healthcare professionals to identify interdisciplinary opportunities for collaboration and improvement in healthcare services.	8	Update: Report on outcomes of collaborative opportunities program	Nov-14	Completed		
		9	Decision: Options presented to Board on refinements to program	Apr-15	Completed		
		10	Update: Report on APP Stakeholder Engagement Plan	Nov-14	Completed		
		11	Update: Report on outcomes of collaborative opportunities program	Nov-15	Completed		
		12	Decision: Options presented to Board on refinements to program	Feb-16	On track		
		13	Update: Report on outcomes of collaborative opportunities program	Nov-16	On track		
		14	Decision: Options presented to Board on refinements to program	Feb-17	On track		
	(b) Create opportunities for pharmacists and pharmacy technicians to improve and enhance their practice by establishing a means in which they can deepen their relationships and understanding of each other's role.	15	Update: Report on outcomes of pharmacist/pharmacy technician networking sessions	Apr-15	Completed		
		16	Update: Report on outcomes of pharmacist/pharmacy technician networking sessions	Feb-16	Apr-16		
		17	Update: Report on outcomes of pharmacist/pharmacy technician networking sessions	Feb-17	On track		
3. Scope of Practice	(a)(i) Enhance availability of continuing education tools and programs	18	Decision: Report on survey of what new CE tools and programs required, decision on what tools and programs to prioritize for rest of year	Jun-14	Completed		
		19	Decision: Report on new CE tools and programs, decision on program direction for next fiscal year	Nov-14	Completed		
		20	Decision: Report on new CE tools and programs, decision on program direction for next fiscal year	Nov-15	Feb-16		
		21	Decision: Report on new CE tools and programs, decision on program direction for next fiscal year	Nov-16	On track		
	(a)(ii) Encourage BC pharmacists to enroll in programs that support best practices	22	Update: Report on numbers of pharmacists participating in clinical skills development programs	Nov-14	Completed		
		23	Update: Report on numbers of pharmacists participating in clinical skills development programs	Nov-15	On track		
		24	Update: Report on numbers of pharmacists participating in clinical skills development programs	Nov-16	On track		
	(a)(iii) Provide the University of BC faculty of pharmaceutical sciences and the BC pharmacy technician program institutions with feedback on jurisprudence exam results and changes to standards or scope of practice to help inform their curricula	25	Update: Report on process developed for tracking changes in legislation and jurisprudence exam results, and advising educational institutions	Jun-15	Completed		
		26	Update: Report on changes noted in legislation and jurisprudence exam results that will be communicated to educational institutions	Jun-16	On track		
	(a)(iv) Encourage uptake of registered pharmacy technicians into community practice settings	27	Decision: Board reviews results of survey and decides on future regulation of technicians and how best to integrate registered technicians into community pharmacies and potentially registering pharmacy assistants (certified non-registrants) (N.B. Decision not made in Jun 14)	Jun-14	Completed		
		28	Decision: Board decides whether it wishes to pursue registration of all currently non-regulated pharmacy staff (i.e. all people who will touch drugs)	Apr-15	Completed		
		29	Decision: Board reviews/approves action plan for further registration	Nov-15	Completed (Sep-15)		
		30	Decision: Board approves updated standards, limits and conditions and policy changes (Phase 1)	Nov-15	On hold	On hold due to the review of policy and bylaw requirements/enforceability.	

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan

Fiscal Years: 2014/15 to 2016/17

Completed
On track
Delayed
On hold

Strategic Plan Areas	Objectives	#	Reporting Milestones	Board Meeting (mmm-yy)	Status	Rationale for Delay	Previous Delay Date
4. Standards	(b)(i) Improve the quality of current adaptations by updating the standards, limits and conditions	31	Update: Report on progress of Phase 1	Jun-16	On hold	On hold because it is linked to milestone 30.	
		32	Decision: Board approves updated standards, limits and conditions (including removal of restrictions on PPP58 adaptations)	Feb-17	On hold	On hold because it is linked to milestone 30.	
	(b)(ii) Changes to standards/limits/conditions for injection authority	33	Decision: Board approves public posting of proposed bylaw changes of updated standards, limits and conditions for injection authority that removes limitation to immunization only and provides guidance around injections of all appropriate drugs	Sep-15	Sep-16	Delayed because of the Ministry of Health's request to accommodate their bylaw backlog processing timelines. In addition, delayed because of the pharmacy security bylaw priority, and the review of policy and bylaw requirements/enforceability.	
		34	Decision: Board approves filing of bylaw changes	Jan-16	Feb-17	Delayed because it is linked to milestone 33.	
		35	Update: Legislation in force	Apr-16	Apr-17	Delayed because it is linked to milestone 33.	
	(b)(iii) Advanced Pharmacist Practice certification	36	Update: Report on updated project plan	Apr-15	Completed		
		37	Update: Report on Board Chair meeting with Minister of Health in Spring 2015 (to include proposed regulation submission)	Jun-15	Completed		
		38	Update: Results of request for regulation changes from MoH.	Nov-15	Jun-16	Delayed because the Ministry of Health identified a need for a fulsome description of the societal need, plans to address perverse incentives and certification requirements (eg. eligibility criteria, renewal requirements and SLC in order for it to be considered). In addition, there needs to be a consultation plan developed.	
		39	Decision: Board approve public posting of proposed bylaw changes supporting APP certification	Jun-16	Sep-16	Delayed because it is linked to milestone 38.	
		40	Update: Presentation of materials and planning supporting launch of APP certification	Sep-16	On track		
		41	Decision: Board approve filing of bylaw changes with MoH supporting APP certification	Feb-17	On track		
	(a) Review and map standards (HPA/PODSA/PPP/NAPRA) to ensure relevancy and consistency.	42	Decision: Board approve public posting of proposed bylaw changes supporting package of legislation updating 6 standards	Feb-15	Completed		
		43	Decision: Board approve filing of proposed bylaw changes updating 6 standards	May-15	Jun-16	Further delayed because of the Ministry of Health's request to accommodate their bylaw backlog processing timelines. In addition, delayed because of the pharmacy security bylaw priority, and the review of policy and bylaw requirements/enforceability.	Nov-15
		44	Update: Package of legislation in force	Sep-15	Aug-16	Further delayed because it is linked to milestone 43.	Mar-16
	(b) Develop a comprehensive, integrated policy guide that incorporates standards, guidelines and indicators of good practice and standards	45	Decision: Board approve policy guide for publication incorporating standards and indicators for standards of 4(a)	Sep-15	Sep-16	Further delayed because it is linked to Objective 4(a).	Nov-15
		46	Update: Report on Tools and communication plan developed to support standards of 4(a)	Feb-16	Feb-17	Delayed because it is linked to Objective 4(a).	
	(c) Develop standards for pharmacy workload	47	Decision: Board approve public posting of proposed bylaw changes supporting standards for pharmacy workload	Feb-15	Completed		
		48	Decision: Board approve filing of bylaw changes of standards for pharmacy workload	May-15	Jun-16	Further delayed becaue of the Ministry of Health's request to accommodate their bylaw backlog processing timelines. In addition, delayed due to the pharmacy security bylaw priority, and the review of policy and bylaw requirements/enforceability.	Nov-15
		49	Update: Legislation in force for new standards for pharmacy workload	Sep-15	Aug-16	Delayed again because it is linked to milestone 48.	Mar-16
	(d) Strengthen enforcement to improve compliance	50	Update: Report on setting up of new Practice Review Program infrastructure	Jun-14	Completed		
		51	Update: Report on setting up of new Practice review Program infrastructure (Community compliance officers hired/trained, Oversight Committee in place, roll out of community communication plan, tools and processes in place)	Sep-14	Completed		
		52	Update: Confirmation of Community Pilot Program launch	Nov-14	Completed		
		53	Update: Results from Community Pilot Practice Reviews	Feb-15	Completed		
		54	Update: Launch of formal Community Practice Review program	Apr-15	Completed		
		55	Update: Practice Review Program results, metrics, learnings Update: Progress report on setting up of hospital Practice Review Program infrastructure (compliance officer hired/trained, roll out of communications plan, tools and processes in place, launch of pilot program)	Sep-15	Completed		

COLLEGE OF PHARMACISTS OF BC

Three (3) Year Strategic Plan & Details Operational Plan

Fiscal Years: 2014/15 to 2016/17

Completed
On track
Delayed
On hold

Strategic Plan Areas	Objectives	#	Reporting Milestones	Board Meeting (mmm-yy)	Status	Rationale for Delay	Previous Delay Date
		56	Update: Confirmation of Hospital Pharmacy Program launch	Nov-15	Sep-16	Further delayed because Phase 1 is delayed; Phase 2 will be implemented in Q2 (June-August)	Feb-16
		57	Update: Report on Practice Review Program Phase 1 results, metrics, learnings	Feb-16	Feb-17	Further delayed because it is linked to milestone 56	Jun-16
		58	Update: Report on Practice Review Program Phase 1 results, metrics, learnings	Feb-16	On track		
		59	Update: Report on Practice Review Program Phase 1 results, metrics, learnings	Sep-16	On track		
		60	Removed Feb 2016				
	(e) Align CE requirements with evolving practice and standards	61	Decision: Board prioritizes required CE tools and programs to support evolving practices and standards arising from new Practice Review Program	Sep-14	Completed		
		62	Removed Feb 2016				
		63	Decision: Board prioritizes required CE tools and programs to support evolving practices and standards arising from new Practice Review Program	Nov-16	On track		
	(f) Prohibit tobacco products in premises where a pharmacy is located	64	Decision: Board approve public posting of proposed bylaw changes supporting prohibition of tobacco products in premises where a pharmacy is located	Jun-14	Completed		
		65	Decision: Board approve filing of bylaw changes with MoH supporting prohibition of tobacco products in premises where a pharmacy is located	Nov-14	Completed		
		66	Update: Legislation in place that prohibits tobacco products in premises where a pharmacy is located	Feb-15	On hold		
	(g) Prohibit use of loyalty programs related to the provision of pharmacy services	67	Update: Summary report on loyalty point prohibition complaints for 2015/16	Feb-15	N/A		
5. Technology	(a) Act as a key stakeholder in order to facilitate enhancements to the PNet database such that a more complete drug history is available for clinicians	68	Update: PNet Services contract signed;	Apr-15	Completed		
		69	Update: Report on status of request MoH for enhancements to PNet	Feb-15	Completed		
		70	Update: Report on status of request to MoH for enhancements to PNet	Apr-16	On track		
		71	Update: PNet profiles contract renewed	Feb-17	On track		
	(b) Provide e-access to current and comprehensive drug information	72	Decision: Board determines options for e-library resources	Jun-14	Apr-16	Further delayed because the College is researching more suitable resources.	Sep-15
		73	Decision: Board approves roll out of e-library (Phase 1)	Nov-14	Completed		
		74	Update: Report on results of survey on uptake and effectiveness of e-library. Review if any changes required	Nov-15	On track		
		75	Update: Report on results of survey on uptake and effectiveness of e-library. Review if any changes required	Nov-16	On track		
	(c) Access to view patient lab information	76	Removed Feb 2016				
		77	Removed Feb 2016				
		78	Removed Feb 2016				
		79	Removed Feb 2016				
		80	Removed Feb 2016				

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

2.b.iii. November 20, 2015 Board Meeting Minutes

DECISION REQUIRED

Recommended Board Motion:

That the Board approve the Draft November 20, 2015 Board Meeting Minutes as circulated.

Appendix	
1	Draft November 20, 2015 Board Meeting Minutes

College of Pharmacists of British Columbia

Board Meeting
November 20th, 2015
Held at the College of Pharmacists of British Columbia
200-1765 West 8th Avenue, Vancouver, BC

MINUTES

Members Present:
Blake Reynolds, Chair, District 4 Board Member
Anar Dossa, Vice-Chair, District 6 Board Member (*present for items 1-8*)
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
Bal Dhillon, District 8 Board Member
Norman Embree, Public Board Member
Kris Gustavson, Public Board Member
Jeremy Walden, Public Board Member
George Walton, Public Board Member

Staff:
Bob Nakagawa, Registrar
Suzanne Solven, Deputy Registrar
Mary O'Callaghan, Chief Operating Officer
Ashifa Keshavji, Director of Practice Reviews and Quality Assurance
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

---

1. WELCOME & CALL TO ORDER

Registrar Nakagawa called the meeting to order at 9:05am on November 20th, 2015.

2. ELECTION OF CHAIR

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

Registrar Nakagawa called for nominations:

- Blake Reynolds was nominated.

After no further nominations were made, Blake Reynolds was elected by acclamation as the new Board Chair for a 1-year term to conclude at the start of the November 2016 Board meeting.

3. ELECTION OF VICE-CHAIR

In accordance with HPA bylaw 12(4) Board members at the November Board meeting must elect a Vice-Chair.

Chair Reynolds called for nominations:

- Anar Dossa was nominated.

After no further nominations were made, Anar Dossa was elected by acclamation as the new Board Vice-Chair for a 1-year term to conclude at the start of the November 2016 Board meeting.

4. CONSENT AGENDA

a) Items for further discussion

The following items were removed from the Consent Agenda and placed onto the regular Agenda under '13. Items Brought Forward from the Consent Agenda':

- Item (ii) Board Meeting Schedule 2016, and
- Item (xiii) Board Self-Evaluation Tool Kit Results.

b) Approval of Consent Items (Appendix 1)

It was moved and seconded that the Board:

Approve the Consent Agenda as amended.

CARRIED

5. APPROVAL OF AGENDA (Appendix 2)

It was moved and seconded that the Board:

Approve the November 20, 2015 Draft Board Meeting Agenda as amended.

CARRIED

6. REQUIREMENT FOR ACCREDITED CE FOR YEARLY REGISTRATION RENEWAL

Gary Jung, Chair of the Quality Assurance Committee gave a presentation regarding the requirement for accredited continuing education (CE) for yearly registration renewal.

It was moved and seconded that the Board:

Directs the Quality Assurance Committee to change their policy for CE requirements for yearly registration renewal as follows:

From:
Yearly completion of CE-Plus consists of:

- *A minimum of 15 hours of learning activities, documented on a minimum of 6 Learning Records with supporting documentation.*
  - *a) All learning must have been completed within the 12 months prior to renewal date.*
  - *b) CE-Plus Learning Records must be completed in English.*

To:
Starting January 1, 2016 (for renewal deadline December 31, 2016) and onwards:
Yearly completion of CE-Plus consists of:

- *A minimum of 15 hours of learning activities, documented on a minimum of 6 Learning Records with supporting documentation.*
  - *a) A minimum of 5 hours of the learning activities must be accredited.*
  - *b) All learning activities must have been completed within the 12 months prior to renewal date.*

CARRIED

7. CERTIFIED PHARMACIST PRESCRIBER

a) Update

Information was provided in the briefing package **(Appendix 3)**.

b) Draft Framework

John Shaske and Steve Shalansky, Co-Chairs of the Certified Pharmacist Prescriber Task Group, presented the principles of the Certified Pharmacist Prescriber Initiative Draft Framework **(Appendix 4)**.

It was moved and seconded that the Board:

Approve the Certified Pharmacist Prescriber Initiative Draft Framework, in principle, considering guidance from the Board.

CARRIED

8. NON-REGULATED PHARMACY STAFF

Board member Jeremy Walden presented an update to the Board on the College's ongoing exploration of non-regulated pharmacy employee registration **(Appendix 5)**.

9. 125TH ANNIVERSARY CELEBRATION

Board member and Chair of the 125th Anniversary Working Group Ming Chang presented.

It was moved and seconded that the Board:

Appoint Leeann McKenzie as the pharmacy technician representative on the 125th Anniversary Working Group.

CARRIED

It was moved and seconded that the Board:

Approve the 125th Anniversary Working Group communications plan, and host a signature gala event to celebrate the 125th anniversary of the College.

CARRIED

10. SOLVING DRUG-RELATED PROBLEMS THROUGH INTERPROFESSIONAL COLLABORATION BETWEEN PHARMACISTS AND PHYSICIANS

Aaron Tejani and Tom Perry gave a joint presentation updating the College Board on the progress of the UBC, Faculty of Medicine research project entitled 'Solving Drug Related Problems through Interprofessional Collaboration between Pharmacists and Physicians' **(Appendix 6)** which the Board granted funds to at their November 2013 meeting. Dr. Tejani is a clinical assistant professor with the Faculty of Pharmaceutical Sciences (University of British Columbia) and Dr. Perry is a specialist in general internal medicine and clinical pharmacology, practicing in Vancouver.

11. E-REFERENCE FUNDING CONSIDERATION – RX FILES

Chief Operating Officer Mary O'Callaghan presented.

It was moved and seconded that the Board:

Direct the Registrar to subscribe to RxFiles for 12 months at a maximum cost of $17,000.

CARRIED

12. STRATEGIC PLAN 2017/18 – 2019/20

Chief Operating Officer Mary O'Callaghan presented **(Appendix 7)**.

13. ITEMS BROUGHT FORWARD FROM CONSENT AGENDA

The following items were removed from the Consent Agenda and placed on the regular Agenda for further discussion:

- Item (ii) Board Meeting Schedule 2016:

Thursday, February 18, 2016
Friday, February 19, 2016
Board Strategic Planning Session – February 19, 20, and 21, 2016

Thursday, April 14, 2016
Friday, April 15, 2016

Thursday, June 23, 2016
Friday, June 24, 2016

Thursday, September 15, 2016
Friday, September 16, 2016
Location/venue for this date to be considered at a future Board meeting

Thursday, November 17, 2016
Friday, November 18, 2016

CPBC Annual General Meeting
Saturday, November 19, 2016

It was moved and seconded that the Board:

Approve the 2016 Board Meeting Schedule as circulated.

CARRIED

- Item (xiii) Board Self-Evaluation Tool Kit Results **(Appendix 6)**.

14. DRUGSAFEBC IMPACT UPDATE

Director of Communications & Engagement, Gillian Vrooman, presented an update of the impact to date of the College's DrugSafeBC program **(Appendix 7)**.

15. IN-CAMERA

As per HPA Bylaws section 13(7)(f):
'instructions will be given to or opinions received from legal counsel for the college, the board, or a committee.'

16. ADJOURNMENT

Chair Reynolds adjourned the meeting at 3:40pm.

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

2.b.iv. Communications and Engagement Strategy

INFORMATION ONLY

Purpose

The College's current strategic plan identified the need for a public awareness strategy. The College will develop a Communications and Engagement Strategy that will address the need for a public awareness strategy, support the next strategic plan and guide all College communications and engagement with a cohesive and strategic approach.

Background

The College has established a strong and consistent brand presence and will further benefit from establishing a strategy with clear communications and engagement goals and approaches. As the Board develops the College's next strategic plan, this is an ideal time for the College's Communications Team to review the strengths, weaknesses, opportunities and threats of the College's current approach and review the communications and engagement expectations and preferences of our many stakeholders.

Developing the Communications and Engagement Plan

The plan to develop a Communications and Engagement strategy is described in Appendix **1** and includes:

- a SWOT analysis;
- audience analysis
- developing communications and engagement goals
- assessing the best approaches and tactics to be used
- identifying how we will measure success

The Communications Team will draw on the expertise of the College's Communications and Engagement Advisory Committee as well as established best practices in public sector marketing and engagement.

Preliminary Work

The College's Communications Team has already developed a draft Engagement Guide (see Appendix **2**) to support the College in conducting engagements using a consistent planning approach based on best practices. This guide is already being used by College staff to plan stakeholder engagement sessions.

The College is also already in the process of conducting audience analysis.

Next Steps

The Communications Team anticipates presenting a draft Communications and Engagement Strategy to the Board at the September 2016 meeting. This aligns with the approval timelines of the College's next strategic plan. However, the Communications Team will refine its approach based on the results of the research and analysis conducted as the strategy is developed.

Appendix	
1	Communications and Engagement Strategy Overview
2	Draft College of Pharmacists of BC Engagement Guide

College of Pharmacists of British Columbia

Communications and Engagement Strategy Overview

The College will develop a Communications and Engagement Strategy that will address the need for a public awareness strategy, support the next strategic plan and guide all College communications and engagement with a cohesive and strategic approach.

1 Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis

We will analyze the College's communications and engagement strengths, weaknesses, opportunities and threats as a first step to developing a Communications and Engagement Strategy. Communication challenges and opportunities are always evolving. This analysis will ensure we consider what's working well and what we can improve on in our plans moving forward.

2 Audience Analysis

We will analyze the College's communications and engagement strengths, weaknesses, opportunities and threats as a first step to developing a Communications and Engagement Strategy. Communication challenges and opportunities are always evolving. This analysis will ensure we consider what's working well and what we can improve on in our plans moving forward.

3 Develop Communications and Engagement Goals

We will establish clear communications goals for the College which the Communications Team will continue to address on an ongoing basis. These communications goals will be designed to support the College in meeting its strategic priorities in addition to its day to day operations and duty to protect the public.

To develop our communications and engagement strategy goals we will consider:

- the results of College's recent strategic planning engagement and the upcoming Board Strategic Planning Session
- the results of networking meetings between pharmacy professionals
- the need for greater public awareness of the role of the College and the role of pharmacy professionals
- the communications and engagement needs in the areas of registration, complaints, legislation, practice review, and professional development and assessment
- public entity best practices in public engagement and transparency

4 Approach, Tactics and Tools

With a deeper understanding of our strengths and weaknesses and our audiences' communication and engagement preferences we will assess the best approaches, tactics and tools to meet them. An approach may include a specific campaign (such as DrugSafeBC) designed to attract immediate attention, or it may include an ongoing approach intended to have continual impact.

5 Measuring Success

We will clearly outline how we can measure our success against each one of our communications and engagement goals. We will use a combination of marketing data and past College activities to set appropriate benchmarks.

(DRAFT) College of Pharmacists of BC Engagement Guide

Introduction - Planning your Engagement

There are many different ways for the public and stakeholders to engage with the College. This can include attending a face to face meeting, workshop or townhall, leaving a comment on a blog, tweeting an idea or sending a letter to the College or Board.

Engagement provides opportunities to inform, consult, involve, collaborate and empower stakeholders and the public. And it is an internationally recognized principle of Open Government. In an increasingly complex world, public and stakeholder input is a critical resource for policy-making. Good decision-making requires the knowledge, experiences, views and values of the public. Implementing difficult decisions depends on consent and support. Unless citizens and stakeholders understand and are engaged in the decision themselves, trust is easily lost.

As a result, public and stakeholder engagement is integral to the way the College approaches program and policy development. It helps the College find the "right touch" in regulation. And it helps build awareness and support for new College initiatives and programs.

The College of Pharmacists of BC Engagement Planning Guide was developed based on the Province of BC's Citizen Engagement Handbook, the International Association for Public Participation's Engagement Spectrum (IAP2 Spectrum), the Digital Sustainability Conversations Guide and the Open Government Guide.

This guide was developed to help College staff design public and stakeholder engagements. It may also be useful to others practicing in the open government and citizen engagement space.

We recommend working through the following engagement planning steps to plan an engagement with stakeholders or the public.

(DRAFT) College of Pharmacists of BC Engagement Guide

Contents

(DRAFT) College of Pharmacists of BC Engagement Guide

Determining Purpose

The first step in designing an engagement initiative is to clearly define what you want to achieve. What is your objective? What should the College gain from the engagement, what should participants gain? Whether it's input on a changing policy, gaining input in the development or implementation of a new program, ideas and issues to inform direction, or looking for suggestions to address complex problems, it is essential to clearly define your purpose.

Use the participation spectrum to assess the level of participation you require. The internationally recognized IAP2 Spectrum is applicable to both public and stakeholder engagement.

IAP2'S PUBLIC PARTICIPATION SPECTRUM

iap2 international association for public participation

The IAP2 Federation has developed the Spectrum to help groups define the public's role in any public participation process. The IAP2 Spectrum is quickly becoming an international standard.

INCREASING IMPACT ON THE DECISION

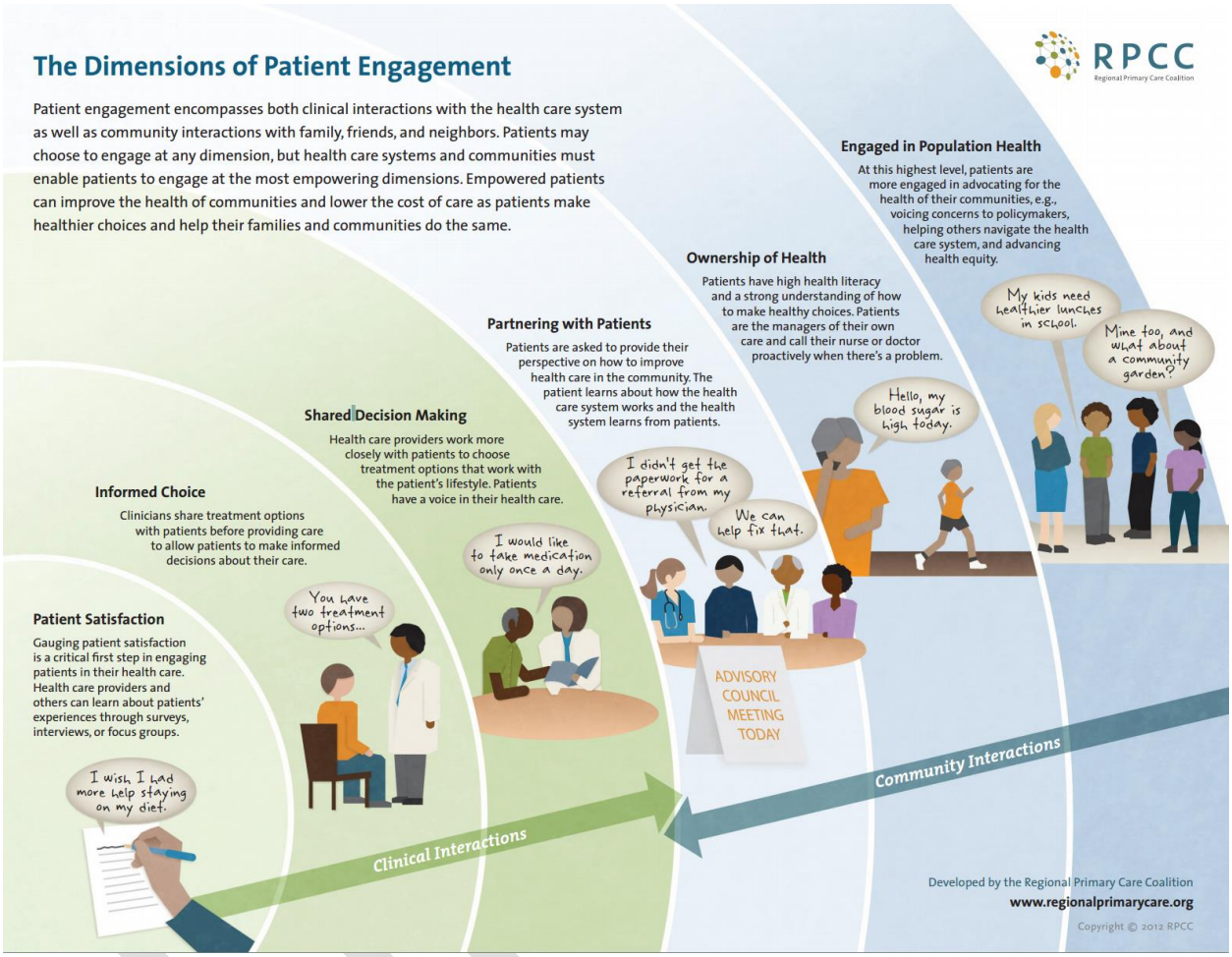
	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision. We will seek your feedback on drafts and proposals.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will work together with you to formulate solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

[Engagement Spectrum - International Association for Public Participation (IAP2 Spectrum)]

In the process of defining the purpose of your engagement, you may discover that you only need to "inform", or that you need to "involve" participants and draw on their input throughout the development process a program. Wherever you may land on the participation spectrum, having a clear purpose for your engagement is key to planning for success.

(DRAFT) College of Pharmacists of BC Engagement Guide

A patient engagement spectrum, the Continuum of Patient Engagement, was developed by the Regional Primary Care Coalition and can help guide patient specific engagements.



In using either the Participation Spectrum or Continuum of Patient Engagement, you need to consider the purpose of your engagement and the level of impact participants have on the end decision.

(DRAFT) College of Pharmacists of BC Engagement Guide

Determining Scope

What is the scope and limitation of the discussion? A clear understanding of what is needed from the discussion, and what decisions are likely to be influenced by the findings helps to keep the process relevant and avoid misunderstandings with stakeholders about possible outcomes that may be outside the scope of the process.

Depending on the purpose of your engagement, you may need to clearly identify specific areas that are out of scope for discussion. For example, these may be program objectives, or requirements set out in bylaws under the *Pharmacy Operations and Drug Scheduling Act* and the *Health Professions Act*.

Identifying out of scope topics that may be raised in the process of an engagement ahead of time is helpful in preparing facilitators and moderators in how to keep engagements focused. These topics should also be identified as part of assessing the risks of your engagement covered later in this document. Communicating an alternative method for participants to share their ideas or issues on out of scope topics if they come up in the course of discussion can help diffuse potential disruptions and keep the engagement on track.

Defining the timeframe for the engagement process is also an important part of determining the scope of your engagement. When will the engagement process begin and end? Are we talking to stakeholder or the public at the very beginning or 'scoping' stage of a project, or on a specific element of an overall plan? Are there key dates or deadlines to be considered? Are there decisions that will need to be made during the process?

(DRAFT) College of Pharmacists of BC Engagement Guide

Defining Audience

Defining the audience is an important component to planning an engagement. It is important to identify your desired audience, and how they prefer to provide input.

Some questions to ask are:

- Who is the primary audience? These are individuals and groups that you want to ensure you hear from.
- Who is the secondary audience? These are individuals and groups who would be beneficial to include.
- Is interdisciplinary discussion important?
- What is the key perspective of each audience?
- How large are each of the intended audiences?
- Have you engaged this audience previously? On what? What did you learn?
- How do you think your audience prefers to be engaged?
- How does our audience connect with you now? What are their issues?
- It is important to consider any geographical communities and communities of interest. You should create a list of specific people or groups that should be invited to participate.
- Are there other organizations, agencies or partners involved with this issue? For example, consultants, provincial and/or federal government representatives, other local government agencies etc.
- What are the perceptions/concerns/needs of your audience? A summary of your current knowledge can enhance the process by ensuring that you consider and/or address any perceptions or concerns that have already been expressed.

Successful community discussion relies on genuine efforts to inform all stakeholders about the process and to address barriers that may impact the community's active participation.

Once you have identified your desired audience, you will need to consider how they prefer to provide input.

Consider the following when identifying your audience and assessing the best engagement approach

College registrants

There are many different types of pharmacy professionals that are registered through the College. Depending on the purpose of your engagement you may need to focus on one particular group. For example, you may need to focus specifically on pharmacy technicians or pharmacists, hospital or community pharmacy professionals, pharmacy managers or pharmacy students. In other occasions it will be important to include a cross section of many different pharmacy professional roles.

(DRAFT) College of Pharmacists of BC Engagement Guide

Pharmacy professional students and recent graduates
Pharmacy professional students and recent graduates, may be especially interested in evolving patient care and collaborative pharmacy practice as a result of inclusion of these topics in Pharmaceutical Sciences. Students and recent grads are also among the demographics that frequently use social media to engage. Informal Meetup style events are also popular. Students may be difficult to engage during times of the year where exams and other work impact their availability.

Stakeholder groups
Consider reaching out to specific stakeholder groups - associations, regulatory bodies, health authorities, working groups, committees, patient groups and others. Advanced notice and time commitment requirements can help for these professional groups.

Patients and patient advocate groups
Engaged patients have better experiences, take ownership of their health, and are better able to navigate the health care system. Engaging all patients requires participation by a broad range of "stakeholders," including patients, their families, community members, health and social service providers, and patient advocate organizations. Psychographics need to be considered for different patient audiences. Patient advocate groups are typically very focused with key health outcome objectives. May patient advocate groups use social media effectively to engage patients and raise awareness of key topic areas.

First Nations
Consider talking with the First Nations Health Authority to determine how best you can connect with First Nations groups. Many first nations groups also experience rural challenges.

Rural areas
Brainstorm the unique ways you can connect with people outside of Metro Vancouver. Is there a local newspaper, a newsletter or a meeting taking place where you can let people know? Can you engage reach rural communities through online forums or social media?

Young families, single parent families
Consider using local schools and libraries for additional publicity. Connect with service providers to spread the world. Consider providing childcare or children's activities for meetings.

People who are unemployed or low income
May require assistance with transportation. Consider connecting with nonprofits working with the community you are looking for input from.

Youth
An innovative 'event based' consultation process is more likely to be successful. Consider using local high schools and youth networks for publicity and participation. This group may also require assistance with transportation. Social media channels popular with youth may also be effective environments to conduct engagements in.

Older people or people with a disability
Consider working with seniors groups to facilitate additional publicity and participation. Schedule meetings during the day. Participants may require assistance with transportation. Venues must have disabled access. Printed material should be appropriate for people with impaired vision.

(DRAFT) College of Pharmacists of BC Engagement Guide

Tools and Approach Planning

Once you have established your purpose and audience, you can start to think about the tools and approach you might use for the engagement.

INFORM

News Releases – use a news release (or news article) to build awareness of an issue or new initiative. Depending on the audience you are trying to reach, you might also distribute a news release media through a media distribution service. For example, the College distributed information to media and held a press conference to build awareness of DrugSafeBC with a broad audience.

Web Articles – write an article specifically for the web to build awareness of an issue or new initiative or program. Web articles need to use clear, simple and effective content, should be easy to read (plain language) and use a conversational-style where possible. Storytelling together with images, video, infographics or data visualizations are often used to create compelling content. Readlinks is an example of how the College uses web articles to inform on important topics.

Media / Guest Post Articles – suggest a story or article to a news media outlet, or other organization to build awareness of an issue or new initiative or program. Take you're the purpose or your engagement and desired audience into consideration to assess which media outlet or organization to submit to. These articles need to follow the same "writing for the web" best practices.

Webinar - host a short for Web-based seminar (webinar) that includes a presentation, lecture, workshop or seminar that is transmitted over the Web to inform on important topics.

Presentations – host an in-person presentation with one or more speakers to inform on important topics. Presentations can also be livestreamed to allow others to listen in online.

Panels – bring two or more people together at a meeting to provide different perspectives on specific issues. Panelists are often subject matter experts or individuals who have a valuable experience to share related to the topic. A moderator facilitates the panel with a series of questions for the panelists and inviting audience questions. The conversational style of panels often makes them more compelling than presentations. Presentations and panels can pair nicely together to provide an informative and compelling engagement to inform on important topics.

Meetups – popularized by Meetup.com, meetups are an informal meeting of people who share a particular interest and have connected with each other through a social-networking website. Meetups may include presentations and panels and provide informal and affordable professional development and networking. They are an effective way to engage a grass roots, or young professionals' community in learning about an important topic.

Slide Decks – share slide decks or embed them in a web article (using services like SlideShare) to provide information on an important issue.

Infographics and memes – use and infographic (such as a chart or diagram) to represent information or data on an important topic. Infographics are also effective for explaining processes. They can be provide added compelling content to slide decks and web articles. Memes are also effective in providing specific key messages, often with a sense of humor.

Videos – develop or share a video to inform participants on a topic or issue. For example, the College used a video to introduce the new practice review program.

Podcasts – produce or share a podcasts (digital audio recording) to provide input on an important issue. A RSS feed will send regularly updated or changing content to other web for podcast apps to stream.

Social Media – using social media channels to share information on important topics. Social media posts should typically include a visual (infographic, photo, meme, or video) and a link to more information. Special attention should be paid to using topic focused hashtags and engaging the relevant social media community members and champions for a topic.

(DRAFT) College of Pharmacists of BC Engagement Guide

CONSULT

Blogs – use blog posts that include engagement discussion material to invite input on a topic through the comments section. It is the interactivity, made possible through commenting, that distinguishes blogs from other web articles. The College's Readlink's articles include comment functionality and can be used to engage registrants, the public and other stakeholders.

Surveys (online) – use surveys conducted through the internet to solicit input on a series of topics or questions. Some surveys may be public facing, while others are delivered directly to participants.

Social Media – use social media platforms, such as Facebook, Twitter and LinkedIn, to solicit input through comments or replies.

Roundtables – use roundtables to discuss and debate important topics. Each person is given equal right to participate, as illustrated by the idea of a circular layout of the round table.

Interviews – use one on one interviews with a series of questions to gain input on a topic. This may be useful to solicit detailed input from key SMEs. However this limits the opportunity for input and ideas that is formed through discussion and debate.

Focus groups – use a focus group to test your message or idea with randomly selected members of your target audience.

Forums – use forum meeting where ideas and views on a particular topic or issue are shared.

Online Discussion Forums – online forums where ideas and views on a particular topic or issue are exchanged.

Town Halls (in person) – an informal public meeting, function, or event derived from the traditional town meetings of New England. Typically open to everybody in a community, attendees generally present ideas, voice their opinions, and ask questions of government or organizational leaders. If the turnout is large, and if the objective of the particular town hall meeting is to give as many people as possible an opportunity to speak, then the attendees can be broken down into smaller discussion groups. While they are intended to consult and involve participants they can also be used to inform.

Online Town Halls – an online implementation of a town hall using video conferencing and chat functionality to engage participants virtually. Online town halls may be an extension of an in person event, or may be run independently. In both cases, dedicated resources need to be assigned to engage the online community.

Twitter Town Halls – an online public forum and "twitter chat" focused around a topic #hashtag where participants tweet ideas, opinions, and questions of government or organizational leaders who respond via twitter in real time. Barak Obama brought twitter town halls into the spotlight after hosting a Whitehouse #AskObama chat. Twitter chats have also been used by the Province of BC for input on topics such as Climate Change, Education, Technology Strategy, Skills4BC and most recently for the. Collaboration between leaders, subject matter experts, and communications staff is essential to carry off an effective twitter town hall.

(DRAFT) College of Pharmacists of BC Engagement Guide

INVOLVE	**Workshops** – use a workshop to have your desired audience contribute to the development of a program or strategy. Workshops may include a presentations and exhibits but ends with interactive working groups. Participants work closely together towards an outcome. **Ideas sharing and prioritization platforms** – use a digital platform that allow participants to contribute and rank ideas on an important topic or issue. For example, the College used an ideas platform to engage registrants, the public and other stakeholder groups in sharing and prioritizing ideas and issues related to its strategic plan, and most recently to improve practice reviews.
COLLABORATE	**Innovation platforms –** use a digital innovation platform that harnesses the ideas and insights of a community to find opportunities to do things better. Participants are often involved in both contributing, ranking and discussing ideas and collaborating on solutions. **Crowdsourcing –** enlist the services of digital community, in solving problems, taking action, or working on a project. People from around the world collaborate and work together online to achieve a common goal. For example with Climate CoLab, participants work with people from all over the world to create proposals for what to do about climate change. **Working groups and task groups –** use a committee or task group to study and report on an important topics or issue and make recommendations based on findings. Working groups may also contribute to particular projects. For example, the College has a Certified Pharmacist Prescriber Task Group to guide and work on this initiative along with College staff. Some work groups and task groups may also include an advisory committee role.
EMPOWER	**Advisory Committees** – use a group of representative stakeholders to provide input into to the planning and direction of important initiatives and programs. Advisory committees are embowed to make decisions and steer direction. **Ballots and voting** – use online or offline voting to form a decision.

(DRAFT) College of Pharmacists of BC Engagement Guide

Framing the Discussion

Regardless of which tool you use, you will need to provide information to inform participants about the discussion. This is the background, history, proposal, research or other information presented to provide the context for the engagement.

This information can be presented in a variety of ways, for example:

- **Web page or dedicated websites** – one central online location with materials to frame discussion. For example, The City of Vancouver's TalkGreenToUs.ca website explained the rationale for being the greenest city in the world, provided background information about the ten goal areas, and collected public input
- **Discussion guides, white papers and draft proposals and plans –** a guide that sets the context for the discussion which includes relevant background information, an outline of key issues and areas of questioning. This guide may also include a proposal for discussion. For example, BC's climate action consultation included a discussion paper to frame the engagement on the Climate Action Plan (July 2015).
- **Research and reports** – providing additional information to frame the discussion through scientific papers or other research and reports.
- **Information packets** – materials shared prior to or at an engagement event (forum, focus group, workshop, or presentation). Consideration should be given to the amount of printed materials and where possible and appropriate for the audience, share materials digitally.
- **Presentations (and slide decks)** – presentations and supporting slide decks used to inform participants and to set the context of the discussion. Slide decks can also be shared separately with participates or embedded on websites (through services like SlideShare) to help frame the discussion.
- **Infographics** – using visuals to illustrate important information, processes or data that help set the context for the discussion. For example, the BC Liquor Policy Review used infographics as a way to explain things like the history of liquor laws in BC.
- **Videos** – videos that provide information and that help set the context for the discussion. For example, BC Housing used a series of videos to provide context around four topics in the Renewing Riverview Visioning Process engagement.
- **Data and maps** – using data and maps share important data sets or Geographical information that helps set the context for the discussion. See example of how the BC Liquor Policy Review used data and maps to present information about liquor licenses.

Selecting the proper approach above will help the community put the issue into perspective, determine their particular interest (if any) in the issue, set realistic expectations and, subsequently, facilitate informed discussion.

Managing Risk and Issues

When planning a citizen engagement initiative, there are some general questions to ask about risk:

- Could out of scope topics derail your engagement?
- Who are your most active critics?
- How do they contact you?
- What if no one supports the initiative?
- What is their message?
- How will the media report this?
- Are there situations where College staff may be put in danger?
- Are there any privacy concerns in the process you have designed? How will privacy be managed?
- Are there chances for blockades, protests, online petitions?

Work through the possible risks and determine your approach to handling each scenario if it comes up in the course of your engagement.

Out of Scope Risks

One of the most common risks is the likelihood that some participants may want to provide input on or express concerns about an out of scope topic or area of a program. Identifying these out of scope topics ahead of time is helpful in preparing facilitators and moderators in how to keep engagements focused. Communicating an alternative method for participants to share their ideas or issues on out of scope topics can help diffuse potential disruptions and keep the engagement on track. Clear explanations on why an area is out of scope is also helpful. Moderators and facilitators can be provided with key messages to address out of scope comments and questions to assist them in keeping the discussion on track.

(DRAFT) College of Pharmacists of BC Engagement Guide

Engaging Leadership

An authentic, visible leadership presence helps bring credibility to your engagement project. Leaders could include the College's Registrar, Board Members, educational institution representatives or other well-known subject matter experts.

The key is to create specific roles for your leaders involving low-barrier activities that connect them to the community. Customize your leadership strategy and support and promote your leaders' efforts. Be prepared to offer feedback on their contributions, and show them how their participation has impacted the community. Over time members will develop a relationship with the leaders. They will see that the goals of the leaders align with their own goals, which will serve to strengthen the community over all.

There are a number of considerations useful to consider when designing your leader's strategy, including:

- Focusing on consistency – find a method of participation that works for the leader, and make it part of their daily schedule.
- Acting as their partner and support them in their contributions.
- Guiding them through new technology - be prepared to act as a guide.
- Asking them to be promoters, as messages from leaders have a big impact.
- Using the leaders to recognize community members, identify stakeholders and help spread the word.

(DRAFT) College of Pharmacists of BC Engagement Guide

Spreading the Word

Some of most challenging work in any engagement is usually spreading the word and making sure your citizens know about the engagement.

Understanding how your desired audience prefers to communicate and engage is essential and will inform your approach.

Approaches to spreading the word include:

- Community marketing
- Conferences
- Email marketing
- Event listings
- Invitations from leadership (such as the College Registrar or Board Chair)
- Meetups
- Media articles, guest posts and media kits
- Newsletters
- News releases
- Panels and presentations
- Social media (earned)
- Social media (paid)
- TV and radio ads
- Videos and infographics
- Website articles and blog posts
- Word of mouth

(DRAFT) College of Pharmacists of BC Engagement Guide

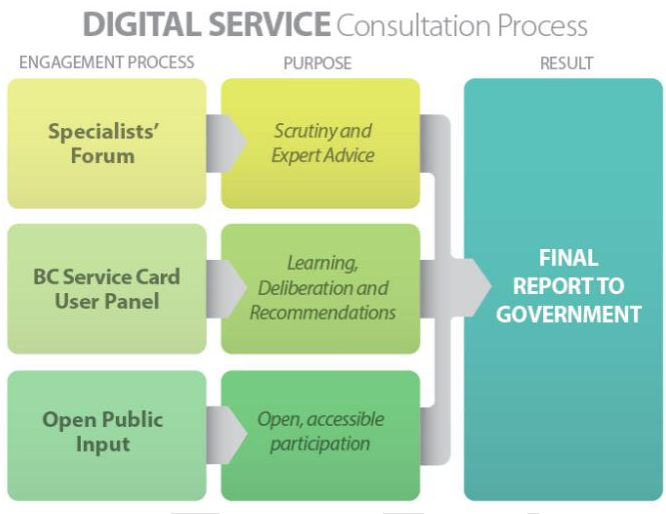
What Happens to the Feedback?

Early on, it is important to ask how you will collect, collate and evaluate feedback, information and ideas generated by the discussion and feedback? Meeting notes/minutes, comments on draft plans, feedback forms, attendance records and storyboards are all useful tools for this purpose.

Once you have received feedback and your engagement closes, new work begins. The next step is to begin to analyze the comments for sentiment, trends, ideas or solutions. However, it doesn't take long before you may find yourself awash in a sea of text.

Data and text analysis tools can help make the process of analyzing large volumes of input less onerous. It is helpful to determine the level of granularity you need to report on. You can structure discussions and surveys to support different levels of granularity.

Reporting back is an important part of any engagement. Participants need to understand the level of impact their input will have in decisions, and how their input will be used. You should clearly communicate the purpose of the engagement, how public and stakeholder input will be used, and what the next steps are (including reporting back) at the beginning of your engagement.



Infographic used to describe the Designing the Digital Service consultation process
http://www2.gov.bc.ca/local/haveyoursay/Docs/BC-Designing-the-Digital-Service-Consultation.pdf

(DRAFT) College of Pharmacists of BC Engagement Guide

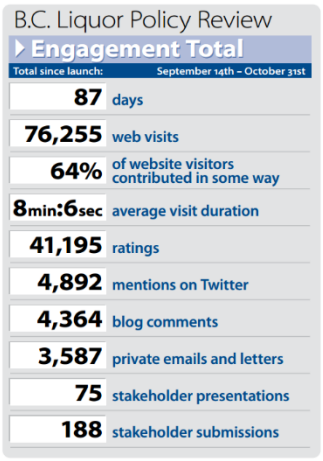
You will want to report the scale of your engagement (how many participated and through what methods), and the results of the input (common themes and ideas shared).

This can be done in a variety of ways. Consider the following:

- Publish a web article with a summary of the results (see BC Liquor Policy Review).
- Provide a summary of key points, issues and ideas that came out from the discussion
- Provide details on the outcome of the engagement – is a project moving forward, was a decision made? Next Steps?
- Use an infographic to show the scale of your engagement
- Use an infographic to illustrate key points, issues and ideas based on text analysis.
- Publish a report that summarizes the engagement including purpose, scope, scale of participation, key points, issues and ideas that came out from the discussion

You will want to report back to leadership involved in program, for example to the College Registrar, College Board or related Advisory Committees.

Wordle of Registrar's Message (http://www.bcpharmacists.org/readlinks/registrars-message-professionalism-rules-and-right-touch-regulation)



BC Liquor Policy Review scale of engagement (http://engage.gov.bc.ca/liquorpolicyreview/)

(DRAFT) College of Pharmacists of BC Engagement Guide

Measuring Success

Depending on which tool you are using, the measurement approach may be different.
Before getting into specific metrics, consider the overall goals of your project. Chances are, you're trying to achieve at least one of the following:

- Getting your message out to more people and gaining more exposure
- Building a positive reputation for your program or initiative
- Building a community
- Garnering rich feedback from stakeholders and the public

Once you've identified the goals of your project, you can start to think about specific metrics that will show you whether or not you're achieving those goals.

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

2.b.v. Finance Report (November Financials)

INFORMATION ONLY

Purpose

To report on the highlights of the November financial reports.

Background

The November financial reports reflect **nine months** activity, as our fiscal year ends February 29, 2016. 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 nine 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 $672,017 is sufficient to pay month end payroll and invoices.
Short Term Investments are still substantial at $8,398,797.
Payables and Accruals are $726,036. As some of the accruals will not impact cash flow for some time, we are in excellent cash position.

Revenue

Pharmacists and Pharmacy Technician fee projections are lower than anticipated in the budget. These are being monitored, as are expenses, so that expenditures can be adjusted, if needed. Pharmacist registration statistics are meeting budgeted estimates. However, some of the one-time fees, such as JE exams and injection fees are lower than anticipated. Pharmacy Technician registrations are lower than expected.
Grant revenues are lower primarily due to timing and should increase somewhat.

Expenses

With Revenues projected to be lower than budget, we are monitoring expenses closely. 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	$523,106	$381,269	The budget contains a contingency related to the loyalty points court case, which has not been used to date.
Grant distribution	$451,075	$81,700	Some contracts have recently been signed and one is still pending but anticipated to be signed before the end of January.
Registration & Licensure	$198,174	$159,457	This variance is primarily due to the delay in the Jurisprudence Exam review project.
Quality Assurance	$534,878	$363,018	The budget includes funding for the expansion of e-library services. One proposal was approved in November and College staff will be looking at another one early in November. However, there will be a surplus at the end of the year, which will offset some of the revenue shortfall.
Practice Review (Inspections)	$147,900	$131,673	Compliance Officer travel costs have not been as costly as anticipated.
Complaints Resolution (Discipline and Investigations)	$464,889	$283,441	Legal and outside contractors' fees depend upon the timing of Discipline Hearings.
Policy and Legislation	$65,711	$45,000	Due to timing of legal expenditures.
Hospital Pharmacy & Practice (Pharmacist Prescriber)	$316,290	$400,263	Outside consulting fees are higher than budget due to the amount of time and work involved with the Pharmacist Prescriber project.

Public Engagement (Communications)	$401,400	$301,467	This surplus is due to changing priorities and Communications staffing availability.
Finance and Administration	$1,015,820	$1,103,299	The higher than anticipated expenses came from three areas. Some staff were contracted through a temp agency, resulting in fees from the agency rather than salaries and benefits. Legal fees were higher than budgeted, both for HR and for FOI. The Registration Database software (iMIS) upgrade was moved up in timing.
Salaries and benefits	$3,307,035	$3,210,481	Some timing factors and some classification factors - see temporary agency note above.
Amortization	$216,492	$164,190	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 November 30, 2015

Assets	**$**
Current	
Cash	672,017
Short term investments	8,398,797
Receivables	239,352
Prepaids and deposits	341,864
Investment in Joint Venture	1,594,976
	11,247,006
Development costs	162,059
Property and equipment	825,835
	12,234,900

Liabilities and Net Assets	**$**
Liabilities	
Current	
Payables and accruals	726,036
Current portion of capital lease obligations	5,430
Deferred revenue	2,697,165
Unearned revenue	366,685
	3,795,316
Capital lease obligations	80,850
	3,876,166
Net Assets	
Closing Balance	8,358,733
	12,234,900

College of Pharmacists of BC

Statement of Revenue and Expenditures

For the nine months ended November 30, 2015

	2015/16 YTD BUDGET	2015/16 YTD ACTUAL	Variance (BUD vs. ACT) $	Variance (BUD vs. ACT) %
	9 months	9 months	9 months	9 months
REVENUE				
Licensure	**4,414,756**	**4,154,565**	**(260,191)**	**(6%)**
Non Licensure	**1,781,524**	**1,597,781**	**(183,742)**	**(10%)**
Total Revenue before transfer from balance sheet	**6,196,279**	**5,752,346**	**(443,933)**	**(7%)**
Transfer from Balance Sheet	**1,432,495**	**1,432,495**	**-**	**0%**
TOTAL REVENUE	**7,628,774**	**7,184,841**	**(443,933)**	**(6%)**
TOTAL EXPENSES BEFORE AMORTIZATION	**7,426,277**	**6,461,067**	**965,209**	**13%**
NET SURPLUS (DEFICIT) BEFORE THE FOLLOWING:	**202,497**	**723,774**	**521,276**	
Amortization expenses	216,492	164,190	52,302	24%
TOTAL EXPENSES AFTER AMORTIZATION	**7,642,769**	**6,625,257**	**1,017,512**	13%
NET SURPLUS(DEFICIT)	**(13,995)**	**559,584**	**573,579**	

College of Pharmacists of BC

Statement of Revenue and Expenditures

For the nine months ended November 30, 2015

	2015/16 YTD BUDGET	2015/16 YTD ACTUAL	Variance (BUD vs. ACT) $	Variance (BUD vs. ACT) %
	9 months	9 months	9 months	9 months
REVENUE				
Licensure				
Pharmacy Fees	1,335,825	1,344,727	8,902	1%
Pharmacist Fees	2,563,925	2,474,241	(89,684)	(3%)
Pharmacy Technician Fees	515,006	335,597	(179,409)	(35%)
	4,414,756	**4,154,565**	**(260,191)**	**(6%)**
Non Licensure				
Other revenue	1,124,735	1,145,008	20,273	2%
Grant revenue	289,082	101,000	(188,082)	(65%)
Investment Income - GIC	180,207	168,026	(12,181)	(7%)
Investment Income - JV	187,500	183,747	(3,753)	(2%)
	1,781,524	**1,597,781**	**(183,742)**	**(10%)**
Total Revenue before transfer from balance sheet	**6,196,279**	**5,752,346**	**(443,933)**	**(7%)**
Transfer from Balance Sheet	**1,432,495**	**1,432,495**	**-**	**0%**
TOTAL REVENUE	**7,628,774**	**7,184,841**	**(443,933)**	**(6%)**

College of Pharmacists of BC

Statement of Revenue and Expenditures

For the nine months ended November 30, 2015

	2015/16 YTD BUDGET	2015/16 YTD ACTUAL	Variance (BUD vs. ACT) $	Variance (BUD vs. ACT) %
	9 months	9 months	9 months	9 months
EXPENSES				
Board & Registrar's Office	523,106	381,269	141,837	27%
Grant Distribution	451,075	81,700	369,375	82%
Registration and Licensing	198,174	159,457	38,717	20%
Quality Assurance	534,878	363,018	171,859	32%
Inspections	147,900	131,673	16,227	11%
Discipline and Investigations	464,889	283,441	181,448	39%
Legislation	65,711	45,000	20,711	32%
Hospital Pharmacy and Practice	316,290	400,263	(83,973)	(27%)
Public Accountability and Engagement	401,400	301,467	99,933	25%
Finance and Administration	1,015,820	1,103,299	(87,479)	(9%)
Salaries and Benefits	3,307,035	3,210,481	96,554	3%
TOTAL EXPENSES BEFORE AMORTIZATION	**7,426,277**	**6,461,067**	**965,209**	**13%**
NET SURPLUS (DEFICIT) BEFORE THE FOLLOWING:	**202,497**	**723,774**	**521,276**	
Amortization expenses	216,492	164,190	52,302	24%
TOTAL EXPENSES AFTER AMORTIZATION	**7,642,769**	**6,625,257**	**1,017,512**	13%
NET SURPLUS(DEFICIT)	**(13,995)**	**559,584**	**573,579**	

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

2.b.vi. Ethics Advisory Committee Update

INFORMATION ONLY

Purpose

To provide the Board with a brief update on the topics going to the Ethics Advisory Committee on February 4, 2016 for discussion.

Background

The Ethics Advisory Committee is meeting on February 4, 2016 to discuss the following topics:

- Health Canada's recent approval of Mifegymiso®, the abortion-inducing drug commonly known as RU-486.
- The decriminalization of physician assisted dying.

Please see Appendices 1 and 2 for the information briefing notes for each of the foregoing topics.

Next Steps

An update of the discussion and outcome from the February 4, 2016 Ethics Advisory Committee meeting will be provided to the Board at the April meeting.

Appendix	
1	Information Briefing Note: Mifegymiso®
2	Information Briefing Note: Physician Assisted Dying

College of Pharmacists of British Columbia

Ethics Advisory Committee
February, 04, 2016

##. Mifegymiso®

INFORMATION ONLY

Purpose

To provide information on Health Canada's recent approval of the abortion-inducing drug commonly known as RU-486, along with the impact of this approval on the College of Pharmacists of BC (the College) and its registrants.

Background

The RU-486 drug has been approved for prescription use in Canada. The drug will be marketed as Mifegymiso® in Canada; it is manufactured by Linepharma International Limited and it will be distributed by Celopharma Inc.

The Mifegymiso® drug provides a medical abortion regimen rather than a surgical procedure to induce an abortion. The treatment consists of a combination drug product of mifepristone and misoprostol. It is to be used sequentially for the termination of a developing intra-uterine pregnancy up to a gestational age of 49 days.

Canada has no legal restriction on abortions. Nevertheless, Health Canada has been reviewing the Drug Submission for Mifegymiso®since 2012 in an effort to determine the safety, efficacy, and quality of the product. The decision to authorize Mifegymiso® for the Canadian market was approved July 29, 2015.

To support the safe and effective use of Mifegymiso®, Linepharma International Limited agreed to implement a number of different risk management conditions. Most noteworthy of these conditions is the requirement for physician only dispensing. Other conditions include the development of an education and registration program for prescribers and a post-approval observational safety study. Essentially, there is no immediate role for the College and both pharmacists and pharmacy technicians regarding the approval of Mifegymiso®.

Patients in Canada will need to see their doctors to obtain a prescription for Mifegymiso® and it will involve two visits to the doctor. On the first visit, the patient takes one mifepristone-misoprostol combination pill under doctor supervision. At home, they take four more within 12 to 24 hours. The patient returns to their doctor for a post-treatment examination within one to two weeks.

Discussion

- This type of medical abortion regimen has been available in France since 1988, approved by Great Britain and other European countries during the 1990's and in 2000 in the United States. In most of these jurisdictions, pharmacists do not have a role in the distribution of products required for medical abortions as the medication is provided directly to the patient from a medical clinic. However, in Australia and some Scandinavian countries, medication required for medical abortions is dispensed by pharmacists.
- The Canadian Pharmacists Association issued a statement on July 30, 2015 stating they support Health Canada's approval of Mifegymiso®. However, they are disappointed that access will be limited through physician only dispensing. The Association argues that community pharmacists should dispense and counsel for medical abortion, in collaboration with the prescribing physician. They purport authorizing this type of medical service will support greater accessibility to medical abortion services.
- Action Canada for Sexual Health and Rights stated it hopes Canada will eventually follow the World Health Organization's recommendation that health-care providers other than doctors such as midwives and nurse practitioners should be allowed to provide Mifegymiso®.
- The *Health Professions Act Bylaws*, Schedule A outlines the Code of Ethics for registrants and Standard 1(g) (iii) states the framework regarding conscientious objection. Conscientious objection is defined as "a sincerely held belief that the provision of a particular product or service will cause the registrant to contravene their personal moral or religious value system." A registrant may object to the provision of a product or service, however they must follow a set of conditions (See Appendix 1 for a copy of the Code of Ethics).[1] The definition and conditions for conscientious objection are similar amongst other Canadian jurisdictions. This provision is not relevant to Mifegymiso® as registrants will not be dispensing or counselling on this type of medical regimen.

Options (if needed)

No options needed.

Next Steps

The College will be monitoring any updates to the conditions set out by Health Canada, particularly if the restrictions on physician only dispensing expands to include other regulated health professionals. Additionally, the College will be providing an information update to registrants regarding this product.

Appendix	
1-1	HPA, Schedule A, Code of Ethics, Standard 1(g) (iii)

[1] Professional Practice Policy 35 "Pharmacists Refusal to Provide a Product or Service for Moral or Religious Reasons" summarizes Standard 1(g) (iii) from the Code of Ethics.

Code of Ethics - Detailed
College of Pharmacists of British Columbia

Responsibility to Patients

Standard 1: Registrants Protect and Promote the Health and Well-Being of Patients

Guidelines for Application

a) Registrants are committed first and foremost to protecting and promoting the health and well-being of their patients.

b) Registrants practice only within the scope of their education, training and competence.

c) Registrants are aware of the limitations of their knowledge and expertise and refer as necessary and appropriate.

d) Registrants are knowledgeable of, and adhere to, national and provincial legislation, standards of practice and policies relevant to the practice of pharmacy.

e) Registrants maintain appropriate resources to facilitate their efforts to deliver services according to the standards of practice.

f) Registrants dispense, distribute, recommend and advertise drugs and health-related products that are approved by Health Canada.

g) Registrants must provide pharmacy services requested by patients and may only refuse to provide these services for any of the following reasons:

   i. the drug or product requested is not available

   ii. the registrant does not possess the knowledge, skills and abilities to provide the service or product

   iii. the registrant objects to the provision of the product or service on the basis of conscientious objection (a sincerely held belief that the provision of a particular product or service will cause the registrant to contravene their personal moral or religious value system). In the event of a conscientious objection to the provision of a product or service, registrant must ensure the following;
      - that they have informed and explained to their pharmacy manager and employer their conscientious objection before they accept employment.
      - that if the belief is formed after employment is accepted, they inform the pharmacy manager and employer at the earliest opportunity
      - that they do not, at any time, express their conscientious objection directly to the prescriber or the patient
      - that they, in goodwill, participate in the development and delivery of a system designed to respect the patient's right to receive products and

services in a timely and convenient manner which minimizes suffering and hardship to the patient
- that should the system developed to ensure the timely delivery of the product or service fail the registrant, not withstanding their conscientious objection, has a duty to the patient to provide the product or service requested
- that they do not utilize an appeal to conscientious objection in order to discriminate against any patient on morally irrelevant grounds including those outlined in *Standard 3, Guideline g* of this Code.

iv. the patient is unable or unwilling to provide payment for the requested pharmacy service or product

v. the patient is abusive physically or mentally to the registrant

Note: In the case of the above (g) the registrant must refer the patient as appropriate.

h) Registrants must provide essential pharmacy care throughout the duration of any job action or pharmacy closure.

i) In the event of either a patient emergency or a public emergency, registrants take appropriate action to provide care within their professional competence and experience.

Standard 2: Registrants Protect the Best Interests of their Patients In Achieving their Chosen Health Outcome

Guidelines for Application

a) Registrants utilize their professional judgment to protect the best interests of their patients in achieving their chosen health outcome.

b) Pharmacists support patients in making informed choices about their medical care by providing them with the benefits and risks associated with medication therapy. Risks are defined as the most frequent and serious adverse effects.

c) Pharmacists provide information that is evidence based, relevant, up-to-date and consistent with the standard of care.

d) Registrants provide information in an understandable and sensitive manner and respond to patients' questions.

e) Registrants respect their patient's right to accept or refuse any drug or health product related recommendation.

f) Registrants ensure that they obtain the patient's informed, implied or expressed and voluntary consent prior to the provision of pharmacy services.

g) Registrants recognize and respect the autonomy of a competent minor to provide informed consent and make decisions about their healthcare.

h) Registrants recognize and respect persons authorized either through personal directives or proxy designations to act as surrogate decision-makers in the case of incompetent patients.

Standard 3: Registrants Practice Respect for Patients

Guidelines for Application

a) Registrants respect the value and dignity of patients.

b) Registrants respect the patient's autonomy and freedom of choice.

c) Registrants recognize the power imbalance inherent in professional relationships (registrant-patient relationship) and maintain appropriate professional boundaries.

d) Registrants act in the best interests of their patients and do not exploit the professional relationship for any personal, physical, emotional, financial, social or sexual gain.

e) Registrants treat patients with sensitivity, caring, courtesy and respect.

f) Registrants provide pharmacy care that is respectful of the values, customs and beliefs of patients.

g) Registrants ensure that their personal beliefs and values do not prejudice patient care and do not engage in discrimination based on age, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, lifestyle, disability, socio-economic status or any basis proscribed by law.

Standard 4: Registrants Protect the Right to Confidentiality of their Patients

Guidelines for Application

a) Registrants respect their patient's right to privacy and confidentiality.

b) Registrants do their utmost to protect patient confidentiality when they share patient information with colleagues or other healthcare professionals.

c) Registrants do not disclose confidential information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

d) Registrants maintain confidentiality in creating, storing, accessing, transferring and disposing of records they control.

Standard 5: Registrants Participate in Ethically Valid Research

Guidelines for Application

a) Registrants ensure that any research they participate in is evaluated both ethically and scientifically and is approved by a research ethics board that meets applicable standards recognized by National Council on Ethics and Human Research (NCEHR) requirements for research involving human participants. (http://www.pre.ethics.gc.ca/policy-politique/tcps-eptc/docs/TCPS%20October%202005_E.pdf)

b) Registrants ensure that before proceeding with their research study they have obtained the informed consent of the patient or proxy and advised the patient that they have the right to withdraw from the study at any time without penalty.

c) Registrants inform the patient of the purpose of the study, its source of funding, the risks of harm and benefits, and the nature of their participation including any applicable compensation.

d) Registrants ensure that they inform research participants that all participant information will be kept confidential and not disclosed without the participants approval and consent.

Responsibility to Society

Standard 6: Registrants are Committed to Benefiting Society

Guidelines for Application

a) Registrants have an ethical duty to uphold public trust and confidence in the profession by acting with honesty and integrity.

b) Registrants have a responsibility to report incompetent or unethical behavior by colleagues or other healthcare professionals to the appropriate regulatory authority.

c) Registrants recognize the professions' responsibility to society to participate in*:
   i. advocacy
   ii. research
   iii. public education programs

d) Registrants endeavor to advance the quality of pharmacy services and care provided to the public

e) Registrants contribute to the future of the profession by participating in student, intern and resident education including multidisciplinary and collaborative experiences as appropriate.

f) Registrants ensure that they maintain appropriate professional boundaries in pharmacy student/instructor and supervisor/subordinate relationships.

g) Registrants recognize the responsibility of the profession to provide access to pharmacy services and resources.

h) Registrants have a responsibility for ensuring the provision of cost-effective pharmacy services in overall healthcare delivery.

i) Registrants provide safe disposal of drugs and health related products and support environmentally friendly practices.

*It is understood that this is not an obligation of all individual registrants but rather a responsibility of the profession as a whole.

Responsibility to the Profession

Standard 7: Registrants are Committed to Personal and Professional Integrity

Guidelines for Application

a) Registrants have an ethical duty to act conscientiously and avoid unethical behavior.

b) Registrants act with honesty and integrity in all professional relationships and fulfill their responsibilities as described in the Code of Ethics and companion documents: Conflict of Interest Standards and Patient Relations Program.

c) Registrants uphold the spirit of the Code of Ethics and its intent as well as its written articulation.

d) Registrants comply with legislation, standards of practice and accepted best practice guidelines.

e) Registrants do not justify unethical behavior by rationalizing that such behavior is not explicitly captured in a standard or guideline and therefore ethically permissible.

f) Registrants shall resist any influence or interference that could undermine their professional integrity.

g) Registrants have a responsibility to protect and maintain their physical and mental health and well-being and seek care and support as appropriate.

h) Registrants must discontinue the provision of professional services if their physical or mental health poses a risk of harm.

i) Registrants take appropriate steps to prevent and report the misuse or abuse of substances by patients, colleagues, other healthcare professionals or other pharmacy employees.

j) Registrants recognize that professional obligations override management policies, and take all reasonable steps to resolve situations where management policies and professional obligations are in conflict.

k) Registrants report any policies, systems or working conditions to the College that pose a risk of harm to the public.

l) Registrants cooperate with investigations into their own or another healthcare professionals' fitness to practice and abide by undertakings or limitations and conditions placed on their practice.

m) Registrants enter only into relationships, contracts and agreements in which they can maintain their professional integrity and safeguard the interests of their patients.

Standard 8: Registrants are Sensitive to and Avoid Conflict of Interest

Guidelines for Application

a) Registrants must consider first the health and well-being of the patient and avoid situations that are, or may reasonably be perceived to be, a conflict of interest.

b) Registrants abide by and conscientiously follow the Code of Ethics companion document, Conflict of Interest Standards.

c) Registrants inform relevant parties, if they are involved in a real, perceived, or potential, conflict of interest scenario and resolve the situation as outlined in the Conflict of Interest Standards.

d) Registrants avoid dual or multiple relationships and other situations which may present a conflict of interest and potentially reduce their ability to be objective and unbiased in their professional judgment.

Standard 9: Registrants Participate in Ethical Business Practices

Guidelines for Application

a) Registrants do not participate in, condone, or are associated with dishonesty, fraud, misrepresentation or any other kind of unethical or illegal behavior.

b) Registrants do not make false, deceptive or fraudulent statements concerning their training, experience, competence, academic degrees or credentials, affiliations, services, research, fees, etc.

c) Registrants conform to legal and professional norms that support the integrity and dignity of the profession.

d) Registrants use only truthful, accurate, fully informative and non-deceptive information in their marketing and public education programs.

e) Registrants do not make false claims for any purpose.

f) Registrants are transparent in the fees they charge, consider the ability of the patient to pay and discuss options with the patient.

g) Registrants ensure that any comparison to the business services of competitors is fair and accurate.

h) Registrants only enter relationships with industry which are appropriate and in compliance with the Code of Ethics and Conflict of Interest Standards and maintain the integrity of the fiduciary relationship between the registrant and the patient.

i) Registrants refrain from participating in activities that could undermine patient trust in registrants and society's trust in the pharmacy profession.

Standard 10: Registrants are Committed to Professional Development

Guidelines for Application

a) Registrants keep up to date with new pharmacy knowledge and practices by participating in continuous lifelong learning.

b) Registrants participate in continuous evaluations of their practice and are responsive to the outcomes of evaluations and reviews by undertaking constructive change or further training if necessary.

c) Registrants endeavour to advance the knowledge and skills of the profession and make relevant information available to patients, colleagues and the public.

d) Registrants participate in professional development opportunities that support learning in professional ethics and the development of sound professional judgment in ethical decision making.

e) Registrants develop, promote and participate in quality assurance and accountability processes.

College of Pharmacists of British Columbia

Ethics Advisory Committee
February, 04, 2016

##. Physician Assisted Dying

INFORMATION ONLY

Purpose
To provide information on the recent decision by the Supreme Court of Canada (SCC) to decriminalize physician assisted dying (PAD), along with its impact on the College of Pharmacists of BC (the College) and its registrants.

Background
Last year, on February 6, 2015, the SCC unanimously ruled in *Carter v. Canada* that the federal *Criminal Code* prohibitions on PAD infringe the *Charter of Rights and Freedoms*, particularly the rights to life, liberty, and security. The SCC's ruling states the decriminalization of PAD will be in effect one year later on February 6, 2016. The SCC's intention to provide a 12 month period before decriminalizing PAD was in an effort to provide time for both the Federal and Provincial governments to develop a legislative framework along with regulatory authorities and associations to develop corresponding policies and guidelines.

However, on December 3, 2015, the Federal government requested a six month extension and on January 11, 2016 the SCC compromised, granting four months, albeit allowing exemptions for Quebec and on an individual basis. Essentially, PAD will be a legal health service in Canada as of June 6, 2016.

<u>Quebec</u>
In June 2014, Quebec passed Bill 52 '*An act respecting end of life care*' in order to address PAD. The *Act* establishes the rights of patients and limits PAD to only being administered by a physician in a context of end-of-life care. It came into force on December 10, 2015.

There was litigation regarding the validity of Quebec's legislation as it came into effect before the SCC's initial decriminalization effective date of February 6, 2016. However, on December 22, 2015, Quebec's Court of Appeal confirmed the validity of the legislation.

Moreover, regulatory authorities in Quebec issued practice guidelines for PAD.[1] The document outlines specific guidelines for both physicians and pharmacists while also emphasizing a collaborative approach across different health professions. There are specific sections of the document articulating the role of pharmacists. Generally, pharmacists must dispense the medication regimen for PAD with limited exceptions, namely conscientious objection.

[1] As of January 25, 2016, the document is not public.

More specifically, PAD kits will be prepared by pharmacists based on a physician's prescription. Each kit will contain enough drugs and injection equipment for two PAD procedures, in the event a backup set is needed. Physicians are required to return any unused medication to the pharmacy.

Discussion

- BC is the only province to act as an observer rather than an active participant on the Ontario-initiated *Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying*. The coalition published a Final Report on November 30, 2015 with 43 recommendations that support a uniform system of end-of-life care services, across the country. See Appendix 1 for a copy of the report.
    - Recommendations 7-9 request the Federal government to amend the *Criminal Code* to ensure clarity on including a team-based approach to the provision of PAD. There is also a need to examine any regulatory barriers that may prevent health care professionals from providing PAD and to determine if they are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide PAD.
    - At this time, there is no indication from the Federal government on their commitments to amend legislation.
- During October 2015, BC's majority government voted down the PAD recommendations of its own Select Standing Committee on Health. The recommendations suggest BC work with other provinces and territories to "ensure interjurisdictional harmonization" of PAD.[2] The Province's response to its Committee's recommendations is indicative of the Province's position to wait for direction from the Federal government.
- Some Colleges and medical associations are in the process of developing, or have already developed, policies and guidance documents on PAD. For example, the College of Physicians and Surgeons of BC has released an interim guidance document for its registrants. The material aligns with the conditions regarding the patient, which are contained in *Carter v. Canada*. For example, the patient must be a competent adult with a grievous and irremediable medical condition causing enduring suffering consenting to termination of life with physician assistance. See Appendix 2 for a copy of the Interim Guidance document.
- The Canadian Pharmacists Association has been working with its members to ensure that pharmacists' views and perspectives are represented in any future Federal legislation. A survey conducted by the Association in October 2015 indicated pharmacists perceive their profession to have a significant role in PAD, yet there is a strong concern about protecting conscientious objection. The Association also participated in the *Expert Panel* consultations to offer input into the development of legislation as it pertains to pharmacy practice. See Appendix 3 for a copy of the submission.
- Overall, the specific role of pharmacists in the provision of PAD within BC is unknown. It appears, that the BC Government's recent decision on Committee recommendations regarding PAD, signalled that they are deferring to the Federal government. Given the 4

[2] https://www.leg.bc.ca/parliamentary-business/committees-reports/13

month extension, there may be limited action from the Federal government before June. Nonetheless, it is likely that there may be an expectation of the Provinces to legislate and regulate the delivery of PAD as a health care service by June, too. Anecdotally, the Federal government has praised Quebec's legislative framework on PAD (discussed above).[3] Potentially, Quebec's lead and more particularly their guideline documents may serve as a foundation for BC's framework, in which pharmacists will have a significant role and the College may need to take action and work collaboratively with other regulatory authorities (particularly the College of Physician and Surgeons of BC) in order to develop standards of practice for its registrants. Conversely, as the BC Provincial government has autonomy on the delivery of the service, they may legislate the service in a particular way which remains to be seen.

- The *Health Professions Act Bylaws*, Schedule A outlines the Code of Ethics for registrants. Standard 1(g) (iii) outlines the framework regarding conscientious objection. Conscientious objection is defined as "a sincerely held belief that the provision of a particular product or service will cause the registrant to contravene their personal moral or religious value system." A registrant may object to the provision of a product or service, however they must follow a set of conditions (See Appendix 4 for a copy of the Code of Ethics).[4] The definition and conditions for conscientious objection are similar amongst other Canadian jurisdictions.

Options (if needed)

No options are needed at this time.

Next Steps

The legislative framework regarding PAD is evolving; it is expected that some direction will be provided by both the Federal and Provincial government before the June 6, 2016 federal decriminalization date. This note is going to the Ethics Advisory Committee for discussion and possible direction.

Appendix	
2-1	Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying Final Report
2-2	College of Physicians and Surgeons of BC Interim Guidance for physician-assisted dying
2-3	Canadian Pharmacists Association's Submission to the External Panel on Legislative Response to Carter v. Canada 2015
2-4	HPA, Schedule A, Code of Ethics, Standard 1(g) (iii)

[3] http://www.huffingtonpost.ca/2015/12/11/trudeau-and-couillard-hail-era-of-co-operation-after-meeting_n_8788060.html

[4] Professional Practice Policy 35 "Pharmacists Refusal to Provide a Product or Service for Moral or Religious Reasons" summarizes Standard 1(g) (iii) from the Code of Ethics.

College of Physicians and Surgeons of British Columbia

Interim Guidance

Physician-assisted Dying

Preamble

On February 6, 2015, the Supreme Court of Canada (SCC) in *Carter v. Canada* struck down the provisions in the Criminal Code prohibiting physician-assisted dying (PAD) (sections 241(b) and section 14). However, the SCC suspended the decision for a period of 12 months. On January 15, 2016 the SCC extended the suspension for an additional four months from February 6, 2016 to June 6, 2016.

The SCC decision establishes PAD as a charter right for "a competent adult person who clearly consents to the termination of life and has a grievous and irremediable medical condition (including an illness, disease or disability) that causes suffering that is intolerable to the individual." The decision allows both assisted suicide, where the patient is provided assistance in intentionally ending his or her own life, and voluntary euthanasia, where a physician directly administers a lethal dose of medication in accordance with the wishes of the patient. The SCC also stated that "nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying."

The SCC, in its decision to extend the suspension to June 6, 2016 also granted an exemption to the suspension. The exemption permits individuals who wish to seek PAD in accordance with the criteria established by the SCC in *Carter* to apply to the Supreme Court of British Columbia for approval relief during the four-month extension.

Registrants are expected to be aware of and comply with their legal, professional and ethical obligations and are encouraged to seek the guidance of legal counsel, or medical legal advice from the Canadian Medical Protective Association (CMPA). Registrants may also contact a member of registrar staff at the College to discuss professional and ethical obligations.

The College recognizes that there may be federal and/or provincial legislation in the near future that will address PAD. In the interim, the College acknowledges that it is in the public interest and in the interest of registrants to establish a process for physicians to follow when PAD issues arise. When legislation relating to PAD is enacted, the provisions of the legislation will take priority over the provisions of this document.

Carter Decision

In its decision, the SCC established certain requirements that must be met in order for a physician to assist a patient to die:

A. The patient must be an adult.

B. The patient must consent.

   The SCC used the phrase a "competent adult person who clearly consents." PAD cannot be provided to patients who cannot provide consent.

C. The patient must have a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the patient.

   The SCC did not limit PAD only to patients who have a terminal illness. The term medical condition would include an illness, disease or disability. Nor is the patient required to undertake treatments that are not acceptable to the individual.

Rights and Autonomy

Patients have the right to make decisions about their bodily integrity (autonomy) and to have access to unbiased and accurate information about relevant medical issues and treatments. Physicians have an obligation to provide their patients with health information and health services in a non-discriminatory fashion and an obligation not to abandon their patients.

Physicians have the right to decide whether or not to perform physician-assisted dying.

Conscientious Objection

Physicians may make a personal choice not to assess patients for and/or perform PAD, based on their values and beliefs. The College expects the physician to provide patients with enough information and assistance to allow them to make informed choices for themselves. This includes consulting with other experts on relevant medical facts and when needed competency assessment.

Physicians who object to PAD on the basis of their values and beliefs are required to provide an effective transfer of care for their patients by advising patients that other physicians may be available to see them, suggesting the patient visit an alternate physician or service and, if authorized by the patient, transferring the medical records as required.

Where needed, physicians must offer assistance to the patient and must not abandon the patient. While a physician is not required to make a formal referral on behalf of their patient, they do have a duty of care that must be continuous and non-discriminatory.

Physicians should not discuss in detail their personal beliefs and should not pressure patients to disclose or justify their own beliefs. In all cases, physicians must practise within the confines of the legal system, and provide compassionate, non-judgemental care according to the CMA *Code of Ethics*.

Process

The process respecting PAD involves the opinion of two physicians, the attending physician and the consulting physician, and the patient's consistent expression of a desire for PAD over a reasonable period of time.

1. Both the attending and consulting physician in a situation of physician-assisted dying must:

   a. have the appropriate competencies, qualifications, experience and training to render a diagnosis and prognosis of the patient's condition, together with the

appropriate technical knowledge and competency to provide PAD in a manner that is respectful to the patient

b. have a complete and full discussion about PAD with the patient; physicians are expected to provide patients with all the information required to make informed choices about treatment and to communicate the information in a manner that is easily understood by the patient

2. The attending and consulting physician must agree that the patient meets the criteria as set out by the SCC:

    a. the patient has a grievous medical condition

    b. the condition must not be remediable using treatment that the patient is willing to accept

    c. the patient's suffering must be intolerable to the patient

    Physicians must assess a patient's suitability for PAD against the above criteria. A request for PAD is contextual to the patient's medical condition, its natural history and prognosis, treatment options, and the risks and the benefits associated with each option. Both the attending and consulting physician are responsible to ensure that the patient understands such factors, and is able to communicate a reasoned decision based on that understanding. When it is unclear whether these criteria have been met, a psychiatric or a registered psychologist's consult is required to evaluate the patient's decision-making capacity (or limitations) in greater detail.

3. Both the attending and consulting physician must be licensed for independent practice in their respective Canadian jurisdictions, and at least one physician must be licensed in British Columbia. The attending and consulting physician must not be related to the patient.

4. The attending and consulting physician should be independent of each other (for example, not be in the same practice group), recognizing that in small, rural or remote communities that this may not be possible.

5. Either the attending physician or the consulting physician, but not both, may provide their opinion by videoconferencing provided that there is a physician or nurse in physical attendance with the patient. At least one of the attending or consulting physicians must meet with the patient in person.

6. The patient must be an adult and eligible for publicly funded health care services.

7. The patient must be competent and able to give free and informed consent.

    a. Both the attending physician and consulting physician must be satisfied that the patient is

        i. mentally capable of making a free and informed decision at the time of the request and throughout the process, and

        ii. capable of giving free and informed consent to PAD.

    b. If either physician is unsure whether the patient has the capacity to consent, the patient must be referred to a physician with special expertise in capacity assessments, such as a psychiatrist, neurologist or geriatrician, for further capacity assessment.

c. The patient must maintain mental capacity for PAD to proceed. If at any time during the progression of the patient's condition, the patient loses the mental capacity to rescind his or her decision, PAD ceases to be an option.

d. PAD cannot be provided to patients who are not able to give consent including when consent is given by an alternate or substitute decision-maker, or through a personal advance directive.

8. The consent must be voluntarily given by the patient.

    a. Both the attending and consulting physician must be satisfied on reasonable grounds that

        i. the patient's decision to undergo PAD has been made freely, without coercion or undue influence from family members, health-care providers or others,

        ii. the patient has a clear and settled intention to end his or her life after making an informed decision, and

        iii. the patient has requested PAD himself or herself, thoughtfully and repeatedly in a free and informed manner.

9. The patient must be informed by the attending and consulting physician of the following and the information must be included in the patient's medical record with a copy provided to the patient:

    a. patient's diagnosis and prognosis

    b. feasible alternatives (including comfort care, hospice care and pain control)

    c. option to rescind the request for PAD at anytime

    d. risks of taking the prescribed medication

    e. probable outcome/result of taking the medication

    f. recommendation to seek legal advice on life insurance implications

    In addition, the following information also needs to be included in the patient's medical record:

    a. all written and oral requests for PAD and a summary of the discussion

    b. confirmation that, after the completion of all documentation the patient was offered the opportunity to rescind the request

    c. a note from the physician who prescribes/administers the medication that all the requirements have been met, including the steps taken and the medication prescribed

    d. a copy of the medical certificate of death

10. The physicians must ensure that the patient has consistently expressed a desire for PAD over a reasonable period of time. What is a reasonable period of time will depend on the patient's medical condition and circumstances. In most situations, 15 days would be a reasonable period of time.

11. After the reasonable waiting period and following the completion of all documentation the patient is to be offered the opportunity to confirm or rescind the request.

12. The patient's decision to proceed with PAD requires a formal request which may be written by the patient or be oral and transcribed by another party. Both the attending and the consulting physician must obtain the written request from the patient. The request should confirm that the patient has given free and informed consent to PAD and that the requirements for PAD have been met. The written request must be dated, signed by the patient, and include the signature of a witness attesting to the identity of the patient. In both cases, the witness should not be: the attending or consulting physician; a relative; entitled to any portion of the estate; or an owner, operator, or employee of a health care facility where the patient is receiving treatment.
13. The medical certificate of death should indicate PAD arising out of the underlying grievous and irremediable medical condition.

Approved by Board January 21, 2016
Effective February 6, 2016

CANADIAN PHARMACISTS ASSOCIATION
ASSOCIATION DES PHARMACIENS DU CANADA

Submission to the External Panel on Options for a Legislative Response to *Carter v. Canada*

2015

Canadian Pharmacists Association

Contents

Pharmacy in Canada

Pharmacists in Canada

Canada has approximately 39,000 licensed pharmacists. Of those, 27,500 work in 9600 community pharmacies and 6500 work in hospitals. Almost 5000 pharmacists work in other settings such as the pharmaceutical industry, governments, associations, colleges and universities.

What Can Pharmacists Do In Canada?

Today's pharmacists are highly respected as the medication management experts of the health care team. They collaborate with patients, their families and other health care providers to benefit the health of Canadians. The pharmacist's traditional role is expanding, and pharmacists across Canada deliver a range of innovative services, including medication reviews, chronic disease management, immunization services and wellness programs. Most provincial governments have approved pharmacist prescribing with varying scopes of authority, a service that complements the care provided by a doctor and can result in more convenient refills, less time spent dealing with prescription changes and collaborative medication management.

About the Canadian Pharmacists Association

The Canadian Pharmacists Association was founded in 1907 and is the national professional voluntary association providing leadership to pharmacists in all areas of practice. Our members are active in community and hospital pharmacies, long-term care facilities, home care, academia and industry. In addition to advocacy, CPhA also publishes therapeutic guides and delivers continuing education courses to empower pharmacists in providing optimal patient-centred care.

Our Mission
Advancing the health and well-being of Canadians through excellence in pharmacist care.

Our Vision
Pharmacists providing world-class pharmacy leadership.

How CPhA Helps Pharmacists
We help pharmacists and achieve our mission and vision by collaborating with our member organizations, pharmacists and key stakeholders through:

- Speaking as the national voice for the profession.
- Leading practice advancement to enable pharmacists to utilize the full extent of their knowledge and skills in providing health care.
- Protecting the safety, security and integrity of the medication system through the development of and participation in medication safety and quality improvement initiatives.
- Supporting pharmacists in providing medication management, health promotion and disease prevention services.
- Collaborating with other health care providers and key stakeholders to optimize health outcomes for Canadians.
- Being the trusted source of education, information, tools and resources to support safe and effective medication use and optimal drug therapy outcomes.

Introduction

CPhA's submission is informed by the Panel's request for input, through the lens of Canadian pharmacy practice. Specifically, this submission highlights the pharmacy community's views on eligibility criteria and definition of key terms, and safeguards to address risks and procedures for assessing requests for assistance in dying (for pharmacists) and the protection of physicians' – and pharmacists' – freedom of conscience. While CPhA does not yet have a formal policy position on assisted dying, and therefore does not offer specific recommendations to the Panel, this submission seeks to highlight early considerations in the development of legislation as it pertains to pharmacy practice.

Depending upon the scenario, there will be a role to play for hospital and community pharmacists. In jurisdictions where assisted dying is legal, experience shows there are profound implications for pharmacy practice. In the case of physician-assisted suicide[1], a patient is provided with a prescription at a high enough dosage to cause their death. This would require a community pharmacist to fill the prescription and may necessitate pharmacist counseling. In the case of voluntary euthanasia[2], a doctor could inject the patient with a lethal dose of medication. This would require a hospital or community pharmacist to fill the prescription, and may also necessitate pharmacist counseling.

While it is difficult to predict the impact of assisted dying legislation in Canada, jurisdictions where assisted dying is legal indicate potential practice issues for the pharmacy profession. For example, research shows that most pharmacists in the Netherlands are directly affected by assisted dying. Results of a survey published in 2000 show that 78% of community pharmacists had received at least one request to dispense drugs for euthanasia or physician-assisted suicide in the years 1991-93 and 11% received at least one request in 1993.[3] While assisted dying is less common in other jurisdictions which allow it, a defined role for pharmacy has emerged in government legislation and formal guidance from professional and regulatory pharmacy bodies. See Appendix 2 (Pharmacy Involvement Where Assisted Suicide and Euthanasia Are Permitted) for a complete overview of international assisted dying legislation as it pertains to pharmacy, and a description of practice guidance issued by pharmacy regulators in other jurisdictions. See Appendix 3 for more information about existing policies which govern a pharmacist's refusal to fill a prescription for moral or religious reasons.

[1] CPhA notes that the term 'physician-assisted suicide' is politically sensitive. It is employed in this submission in accordance with the consultation materials produced by the Panel.
[2] CPhA notes that the term 'voluntary euthanasia' is politically sensitive. It is employed in this submission in accordance with the consultation materials produced by the Panel.
[3] Lau HS, Riezebos J, Abas V, Porsius AJ, De Boer A. A nationwide study on the practice of euthanasia and physician-assisted suicide in community and hospital pharmacies in the Netherlands. Pharmacy World and Science 2000; 22: 3-9.

Pharmacist Survey on Assisted Dying: Early Considerations for Pharmacy Practice

CPhA does not hold a formal position on assisted dying as it relates to pharmacy practice. As a first step toward the development of a policy, CPhA surveyed nearly 1000 individual members of the Canadian pharmacy community to seek their input on assisted dying. Respondents shared diverse views on a contentious and emotional issue, including protection of conscience, pharmacist participation, pharmacist counseling and drug information issues. The survey garnered 978 individual responses, the majority from community hospital pharmacists representing every province and territory. While these findings are preliminary, pharmacists from across Canada expressed their concerns clearly on a number of key issues.

1. Protection of Conscience

The Supreme Court of Canada's decision in *Carter v Canada* noted that a physicians' decision to participate in assisted dying is a matter of conscience, and in some cases, religious belief, and that nothing in its decision would compel physicians to provide assistance in dying.[4] Pharmacists agreed overwhelmingly that there must be equal consideration given to the role of pharmacists, who must not be compelled to dispense lethal medication for the purpose of assisted dying. Pharmacists believe strongly that any federal legislation which protects physicians' freedom of conscience should apply equally to pharmacists. Similar to other health care professionals, pharmacists are divided on the obligation to refer to another pharmacist who is willing to fill a prescription for the purpose of assisted dying. Many respondents referenced provincial pharmacy regulators' existing policies on refusal to fill for moral or religious reasons (see Appendix 2) which were introduced to respond to concerns from pharmacists who do not wish to dispense emergency contraception.

2. Pharmacist Counseling

In certain jurisdictions where assisted dying is legal, pharmacists are not only asked to dispense lethal drugs, but they can be expected to offer advice to patients and physicians. For example, in the state of Oregon, community pharmacists may dispense lethal doses of medication to a physician, patient or family member.[5] Pharmacists are also required by law to offer oral medication counseling to the patient or patient's agent.[6] CPhA's survey found that Canadian pharmacists favour a requirement for pharmacist counseling to the patient, physician, or patient's family as part of dispensing lethal medication. However, many pharmacists expressed concerns about the need for training in order to dispense prescriptions intended for assisted dying, and to provide appropriate counselling.

[4] Carter *v.* Canada (Attorney General), 2015 SCC 5, [2015] 1 S.C.R. 331
[5] Meek, C. Pharmacy involvement where assisted suicide and euthanasia are permitted. The Pharmaceutical Journal 2006.
[6] Ibid.

3. Drug Information Issues

In dispensing a prescription, a pharmacist assumes a proportion of the responsibility for that prescription and therefore must be assured that it is entirely appropriate for the patient. The same principle would apply for prescriptions use in assisted dying. In the absence of a specific requirement, pharmacists may not be privy to certain aspects of the doctor/patient relationship which plays an essential role in the end-of-life decision process. Given that there are currently no medications that are uniquely indicated for physician-assisted suicide, and that dispensing pharmacists may be unaware of the intended purpose of a prescription, pharmacists strongly agree that they should have full access to the patient's diagnosis and care plan when filling prescriptions intended for the purpose of assisted dying.

4. Additional Considerations

Pharmacists volunteered a number of additional considerations in addition to the questions posed by the survey:

- Pharmacists expressed concern that they presently lack the training to dispense prescriptions for lethal medication and provide appropriate counseling.
- Pharmacists highlighted the need to consider the unique practice environments of hospital and community pharmacists.
- Pharmacists expressed concerns about limiting liability associated with their participation in assisted dying.
- Pharmacists were divided on whether or not a requirement to refer is adequate protection for those who object to participate for reasons of conscience.

Next Steps

CPhA has convened an Assisted Dying Policy Working Group to review the survey results and develop a formal policy position. Membership includes community and hospital pharmacists, and experts in the fields of palliative and end-of-life care. CPhA will keep the External Panel apprised of policy developments on this file.

Appendix 1: CPhA Pharmacist Survey on Assisted Dying

1. The Supreme Court of Canada's decision in *Carter v. Canada* noted that a physician's decision to participate in assisted dying is a matter of conscience and in some cases religious belief, and that nothing in its decision would compel physicians to provide assistance in dying.

To what extent do you agree with the following statement?

Pharmacists should be obligated to participate in assisted dying.

Total Response Count	**978**	
Answer	**Count**	**Percent**
Strongly Disagree	549	56.13%
Disagree	131	13.39%
Neutral	103	10.53%
Agree	94	9.61%
Strongly Agree	92	9.41%
Prefer Not To Say	9	0.92%

2. The Panel is seeking input from stakeholders on "safeguards to address risks and procedures for addressing requests for assistance in dying and the protection of physicians' freedom of conscience."

To what extent do you agree with the following statement?

CPhA should advocate that safeguards in legislation should apply equally, where appropriate, to pharmacists.

Total Response Count	**978**	
Answer	**Count**	**Percent**
Strongly Disagree	36	3.68%
Disagree	14	1.43%
Neutral	46	4.70%
Agree	126	12.88%
Strongly Agree	734	75.05%
Prefer Not To Say	22	2.25%

3. Assuming that conscience protections will apply equally to pharmacists in legislation, to what extent do you agree with the following statement?

If a pharmacist does not wish to participate in any aspect of assisted dying, they must refer the patient and/or physician to another pharmacist who will fulfill the request.

Total Response Count	**978**	
Answer	**Count**	**Percent**
Strongly Disagree	177	18.10%
Disagree	58	5.93%
Neutral	78	7.98%
Agree	128	13.09%
Strongly Agree	518	52.97%
Prefer Not To Say	19	1.94%

4. Do you have any additional comments with respect to conscientious objection by pharmacists as it relates to a federal legislative framework for physician-assisted dying? If so, please describe below.

Pharmacists answered individually and provided a range of comments.

5. Where assisted dying is legal, pharmacists are not only asked to dispense lethal drugs, but they can be expected to offer advice to patients and physicians.

In the case of physician-assisted suicide, to what extent do you agree with the following statement?

A federal legislative framework for assisted dying should require pharmacist counseling as part of dispensing lethal medications to physicians, patients or family members.

Total Response Count	**978**	
Answer	**Count**	**Percent**
Strongly Disagree	204	20.86%
Disagree	56	5.73%
Neutral	111	11.35%
Agree	180	18.40%
Strongly Agree	379	38.75%
Prefer Not To Say	48	4.91%

6. In dispensing a prescription, a pharmacist assumes a proportion of the responsibility for that prescription and therefore must be assured that it is entirely appropriate for the patient. The same principle would apply for prescriptions used in assisted dying. In the absence of legislation, pharmacists may not be privy to certain aspects of the doctor/patient relationship which plays an essential role in the end-of-life process.

Given that there are currently no medications that are uniquely indicated for physician-assisted suicide, and that dispensing pharmacies may be unaware of the intended purpose of a prescription, to what extent do you agree with the following statement:

If pharmacists are to participate in dispensing prescriptions for use in assisted dying, legislation should require that pharmacists have full access to the patient's diagnosis and assisted dying care plan.

Total Response Count	**978**	
Answer	**Count**	**Percent**
Strongly Disagree	45	4.60%
Disagree	21	2.15%
Neutral	44	4.50%
Agree	114	11.66%
Strongly Agree	694	70.96%
Prefer Not To Say	60	6.13%

7. Do you have any additional comments with respect to safeguards to address risks and procedures for assessing requests for assistance in dying as they relate to a federal legislative framework for physician-assisted dying? If so, please describe below.

Pharmacists answered individually and provided a range of comments.

8. Which occupation best describes your pharmacy background?

Total Response Count	**971**	
Answer	**Count**	**Percent**
Community Pharmacist	686	70.65%
Hospital Pharmacist	179	18.43%
Pharmacy Technician	10	1.03%
Academic / Research	25	2.57%
Advocacy / Public Affairs	9	0.93%
Other	62	6.39%

9. What is your province or territory of practice?

Answer	Count	Percent
Alberta	258	26.41%
British Columbia	265	27.12%
Manitoba	36	3.68%
New Brunswick	39	3.99%
Newfoundland	28	2.87%
Nova Scotia	43	4.40%
Northwest Territories	4	0.41%
Nunavut	1	0.10%
Ontario	183	18.73%
Prince Edward Island	4	0.41%
Quebec	7	0.72%
Saskatchewan	105	10.75%
Yukon	4	0.41%

Appendix 2: Pharmacy involvement where assisted suicide and euthanasia are permitted

The Netherlands

The Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act, which came into force in 2002, codified requirements that have evolved in case law and medical ethics since 1973 and defines the conditions that doctors must satisfy in order to perform euthanasia or PAS without prosecution. For example, doctors must be satisfied that the patient has made a voluntary and considered request, and be satisfied the patient's suffering is unbearable and there is no prospect of improvement. The doctor must also consult a colleague who has seen the patient.

Under the Act, an advance directive counts as a well-considered request for euthanasia, meaning that treatment can be withdrawn from a patient who is unable to consent. The Act does not cover neonates but, with additional safeguards, the law is not limited to adults and the patient does not have to be terminally ill.

Pharmacy practice and Dutch law Research shows that most pharmacists in the Netherlands are directly affected by PAS or euthanasia. Results of a survey published in 2000 show that 78 per cent of community pharmacies had received at least one request to dispense drugs for euthanasia or PAS in the years 1991–93 and 11 per cent received between six and 10 requests. The same research found that 88 per cent of the hospital pharmacies received at least one request in 1993.[1]

Despite pharmacists' involvement, the Act does not explicitly refer to their role. If a doctor is prosecuted for illegal euthanasia, however, the pharmacist who supplied the drugs will not be prosecuted under normal circumstances. The pharmaceutical inspectorate holds the position that although the pharmacist and doctor should discuss the prescription, the pharmacist does not have to investigate whether the doctor is conforming with legal requirements.

The Royal Dutch Pharmaceutical Society (KNMP) has issued guidance for pharmacists on dispensing drugs for euthanasia and PAS. These state, for example, that pharmacists have a right to refuse to dispense. Practice protocols in hospitals and the community setting also exist for co-operation between pharmacists and doctors. One local protocol has made standard packages of drugs available (an intravenous one for performing euthanasia and an oral one for performing assisted suicide) and detailed technical guidelines exist on the drugs that should be used for the purposes of euthanasia and PAS.

Despite these efforts to ensure best practice there is some research to show that GPs do not always adhere to KNMP guidance on administration. One study published in 1992 found that GPs sometimes used inappropriate drugs (for example, a combination of morphine and brallobarbital or insulin) or dosages that were too low. Sometimes drugs were administered in inappropriate ways (for example, rectally or subcutaneously). In 12 per cent of cases there were complications such as the drug not leading to death or doing so too slowly.[2] Four years on from the introduction of the Act, Royal Dutch Medical Association says that its focus of policy development is now on the improvement of the quality of medical decision-making in cases of euthanasia and assisted suicide.

There is also evidence to show that the role pharmacists play in reality is often different to the role that is defined in the professional guidance. The KNMP guidelines state that written requests for drugs for euthanasia must comply with requirements for opioid drug prescriptions, yet one study has found that more than 40 per cent of requests that are dispensed by community and hospital pharmacists do not comply.

The KNMP guidelines also state that requests from doctors must be made in writing and pharmacy technicians should not be involved. But this study also found that 26 per cent of honoured requests were not made in writing (to community pharmacists) and pharmacy technicians were involved in 6 per cent of cases in the community and 31 per cent of cases in hospitals.[1]

Switzerland

The Swiss penal code states that a person who assists someone else to commit suicide will only be punished if that person is motivated by self-interest. This is the legal basis for PAS. However, this penal code provision is qualified by a number of other laws that impact on a physician's ability to assist a suicide. For example, the civil code states that if a person lacks capacity then his or her request for PAS has no legal validity. Furthermore, under the Swiss penal code, euthanasia remains a crime.

Pharmacy practice and Swiss law Pharmacists in Switzerland are rarely involved in PAS for three reasons. First, it is estimated that the number of physician-assisted deaths amounts to only 0.2 per cent of all deaths. Secondly, most PAS cases are carried out by voluntary organisations such as EXIT. These organisations offer services to people who want to commit suicide including facilities where the suicide can take place. Although the Swiss Academy of Medical Sciences has set out strict guidance for doctors on PAS, most suicides are not directly supervised by doctors. Lastly, according to the Swiss Law on Pharmaceutical Products, pharmacists cannot dispense drugs that may result in death. The one exception to that general rule permits the prescription of lethal barbiturates to relieve pain. This means that pharmacists who work with doctors in institutions such as hospitals and hospices can dispense barbiturates according to strict end-of-life protocols.

Pharmacists are not mentioned in the various relevant laws that make PAS legal in Switzerland and the Swiss Association of Pharmacists (SAP) has not issued any guidance to the profession about PAS. SAP says, however, that local protocols between doctors and pharmacists probably exist. Pharmacists who ask the association for advice when they receive prescriptions for drugs that may be lethal are advised not to dispense because they cannot check whether the patient is terminally ill or has legal capacity.

Pharmacists have no right to a conscience clause. On the contrary, they must dispense products requested in a prescription unless they suspect that the prescription may result in the death of a patient.

Belgium

Belgium's Euthanasia Act of May 2002 is similar to the one in place in the Netherlands and details how doctors can perform euthanasia without being prosecuted. The Belgian Act differs from the law in the Netherlands (and that in place in Oregon and Switzerland) because PAS remains illegal.

Pharmacy practice and Belgian law As in the Netherlands, many pharmacists in Belgium are directly affected by the legislation. Officially, PAS or euthanasia accounted for 0.6 per cent of all deaths in 2004. A study in 1998, however, looked at 1,925 deaths and the authors concluded that 1.3 per cent of all deaths in the country occurred as a result of PAS or euthanasia. It is predicted that the official figure of 0.6 per cent will rise sharply as more doctors comply with the new law.[3]

Pharmacists in Belgium are given good protection from prosecution. Revisions to the law on euthanasia in 2004 state that the pharmacist who dispenses a lethal drug does not commit any offence if the doctor states on the prescription that he or she is acting in accordance with the law. The pharmacist must deliver the drugs for euthanasia in person to the requesting doctor.

The Belgian Pharmaceutical Association (APB) has finalised guidance for pharmacists on the Euthanasia Act and this describes in detail how drugs for euthanasia should be prescribed, delivered, administered and returned if they are not used. It also includes information on how the products should be ordered and priced.

Prescriptions must make the intended use of the drug clear. This gives pharmacists the opportunity to refuse to participate and that right is legally protected. If the pharmacist is suspicious that the intended use of a prescription is for euthanasia, but the prescription does not make this clear, then the pharmacist can refuse to dispense. Many hospitals also have their own protocols and guidance for euthanasia.

Since the Euthanasia Act is so young it is difficult to know if Belgian pharmacists are deviating from their own guidelines. The APB, however, states that the current law is strictly observed.

Oregon

Under the Oregon Death with Dignity Act that came into force in 1997 a physician can help a patient commit suicide without fear of prosecution as long as strict conditions are met. For example, patients must make one written request to die (signed in front of two witnesses) and two oral requests to die separated by at least 15 days, and two doctors must independently judge that the patient has six months or less to live and determine whether the patient is capable. The Act legalises PAS, but prohibits euthanasia and any lethal drugs that are prescribed must be self-administered. Those eligible must be 18 years of age or older, capable, be a resident of Oregon and have a terminal disease (this must be incurable and irreversible and expected to lead to death within six months).

Pharmacy practice and Oregon law Any pharmacist can receive a prescription for a lethal drug but, in reality, only a small number are asked to dispense as PAS accounts for less than 0.1 per cent of all deaths in the state.

In 1999 the Act was amended to ensure that pharmacists are told about the intended use of the drug and physicians and pharmacists are under no obligation to take part. PAS is monitored by the Oregon Department of Human Services through a system of physician and pharmacist compliance reports, death certificate reviews and follow-up interviews. Pharmacists and physicians must take part in the official reporting procedure if they honour a PAS request.

Most drugs for PAS cases are dispensed by pharmacists who are members of the American Society of Health-System Pharmacists. Professional guidance from this body, however, represents “guiding principles” for pharmacists’ participation in the legal and ethical debate about PAS rather than best practice advice.

Rules for doctors have a big impact on the way pharmacists and physicians communicate when a patient makes a request for PAS. Doctors must personally find out if the pharmacist is willing to dispense drugs for the purposes of PAS. This Board of Medical Examiners’ rule also states that physicians must personally issue prescriptions for lethal drugs to pharmacists. This rule is also intended to encourage co-operation and communication between pharmacists and physicians.

There are no standard recommendations for drugs for assisted suicide. The Department of Human Services has said that neither the Board of Pharmacy nor the pharmacists’ body in Oregon was willing to make recommendations on drugs for assisted suicide because of the fear of litigation. The ASHP has not issued any guidance on which drugs should be used for PAS and how they should be administered.

Statement This article was commissioned by Eileen Neilson, head of policy development, Royal Pharmaceutical Society, on behalf of the Society’s Law and Ethics Committee.

References

1. Lau HS, Riezebos J, Abas V, Porsius AJ, De Boer A. A nationwide study on the practice of euthanasia and physician-assisted suicide in community and hospital pharmacies in the Netherlands. Pharmacy World and Science 2000;22:3–9.

2. Onwuteaka-Philipsen BD, Muller MT, Van Der Wal G. Euthanatics: implementation of a protocol to standardise euthanatics among pharmacists and GPs. Patient Education and Counselling 1997;31:131–7.

3. Deliens L, Mortier F, Bilsen J, Cosyns M, Stichele RV, Vanoverloop J et al. End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey. Lancet 2000;356:1806–11.

Appendix 3: Regulatory and Practice Guidance (Refusal to Fill)

Most provincial and territorial pharmacy bodies already have policies in place which outline the circumstances under which a pharmacist is permitted to decline providing certain pharmacy products or services if it appears to conflict with the pharmacist's view of morality or religious beliefs and if the pharmacist believes that his or her conscience will be harmed by providing the product or service.

Pharmacists shall hold the health and safety of the public to be their first consideration in the practice of their profession. Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared to explain the basis of their objections. Objecting pharmacists have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services.

British Columbia College of Pharmacists: Professional Practice Policy 35 – Refusal to Provide a Product or Service for Moral or Religious Reasons

Alberta College of Pharmacists: Code of Ethics

Saskatchewan College of Pharmacists: Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons

College of Pharmacists of Manitoba: Standards of Practice – Pharmacist's Responsibilities in the Refusal to provide Products or Services for Moral or Religious Reasons

Ontario College of Pharmacists: Position Statement on Refusal to Fill for Moral or Religious Reasons

New Brunswick College of Pharmacists: Code of Ethics – Statement V

Nova Scotia College of Pharmacists: Code of Ethics – Value V – Responsibility to the Patient

Prince Edward Island College of Pharmacists: Code of Ethics – Value V – Respect the patient's right to receive care

The Newfoundland and Labrador Pharmacy Board: Pharmacy Practice Manual – Guidelines for Application – Registrants respect the patient's right to receive care

Code of Ethics - Detailed
College of Pharmacists of British Columbia

Responsibility to Patients

Standard 1: Registrants Protect and Promote the Health and Well-Being of Patients

Guidelines for Application

a) Registrants are committed first and foremost to protecting and promoting the health and well-being of their patients.

b) Registrants practice only within the scope of their education, training and competence.

c) Registrants are aware of the limitations of their knowledge and expertise and refer as necessary and appropriate.

d) Registrants are knowledgeable of, and adhere to, national and provincial legislation, standards of practice and policies relevant to the practice of pharmacy.

e) Registrants maintain appropriate resources to facilitate their efforts to deliver services according to the standards of practice.

f) Registrants dispense, distribute, recommend and advertise drugs and health-related products that are approved by Health Canada.

g) Registrants must provide pharmacy services requested by patients and may only refuse to provide these services for any of the following reasons:

   i. the drug or product requested is not available

   ii. the registrant does not possess the knowledge, skills and abilities to provide the service or product

   iii. the registrant objects to the provision of the product or service on the basis of conscientious objection (a sincerely held belief that the provision of a particular product or service will cause the registrant to contravene their personal moral or religious value system). In the event of a conscientious objection to the provision of a product or service, registrant must ensure the following;
      - that they have informed and explained to their pharmacy manager and employer their conscientious objection before they accept employment.
      - that if the belief is formed after employment is accepted, they inform the pharmacy manager and employer at the earliest opportunity
      - that they do not, at any time, express their conscientious objection directly to the prescriber or the patient
      - that they, in goodwill, participate in the development and delivery of a system designed to respect the patient's right to receive products and

services in a timely and convenient manner which minimizes suffering and hardship to the patient
- that should the system developed to ensure the timely delivery of the product or service fail the registrant, not withstanding their conscientious objection, has a duty to the patient to provide the product or service requested
- that they do not utilize an appeal to conscientious objection in order to discriminate against any patient on morally irrelevant grounds including those outlined in *Standard 3, Guideline g* of this Code.

iv. the patient is unable or unwilling to provide payment for the requested pharmacy service or product

v. the patient is abusive physically or mentally to the registrant

Note: In the case of the above (g) the registrant must refer the patient as appropriate.

h) Registrants must provide essential pharmacy care throughout the duration of any job action or pharmacy closure.

i) In the event of either a patient emergency or a public emergency, registrants take appropriate action to provide care within their professional competence and experience.

Standard 2: Registrants Protect the Best Interests of their Patients In Achieving their Chosen Health Outcome

Guidelines for Application

a) Registrants utilize their professional judgment to protect the best interests of their patients in achieving their chosen health outcome.

b) Pharmacists support patients in making informed choices about their medical care by providing them with the benefits and risks associated with medication therapy. Risks are defined as the most frequent and serious adverse effects.

c) Pharmacists provide information that is evidence based, relevant, up-to-date and consistent with the standard of care.

d) Registrants provide information in an understandable and sensitive manner and respond to patients' questions.

e) Registrants respect their patient's right to accept or refuse any drug or health product related recommendation.

f) Registrants ensure that they obtain the patient's informed, implied or expressed and voluntary consent prior to the provision of pharmacy services.

g) Registrants recognize and respect the autonomy of a competent minor to provide informed consent and make decisions about their healthcare.

h) Registrants recognize and respect persons authorized either through personal directives or proxy designations to act as surrogate decision-makers in the case of incompetent patients.

Standard 3: Registrants Practice Respect for Patients

Guidelines for Application

a) Registrants respect the value and dignity of patients.

b) Registrants respect the patient's autonomy and freedom of choice.

c) Registrants recognize the power imbalance inherent in professional relationships (registrant-patient relationship) and maintain appropriate professional boundaries.

d) Registrants act in the best interests of their patients and do not exploit the professional relationship for any personal, physical, emotional, financial, social or sexual gain.

e) Registrants treat patients with sensitivity, caring, courtesy and respect.

f) Registrants provide pharmacy care that is respectful of the values, customs and beliefs of patients.

g) Registrants ensure that their personal beliefs and values do not prejudice patient care and do not engage in discrimination based on age, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, lifestyle, disability, socio-economic status or any basis proscribed by law.

Standard 4: Registrants Protect the Right to Confidentiality of their Patients

Guidelines for Application

a) Registrants respect their patient's right to privacy and confidentiality.

b) Registrants do their utmost to protect patient confidentiality when they share patient information with colleagues or other healthcare professionals.

c) Registrants do not disclose confidential information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

d) Registrants maintain confidentiality in creating, storing, accessing, transferring and disposing of records they control.

Standard 5: Registrants Participate in Ethically Valid Research

Guidelines for Application

a) Registrants ensure that any research they participate in is evaluated both ethically and scientifically and is approved by a research ethics board that meets applicable standards recognized by National Council on Ethics and Human Research (NCEHR) requirements for research involving human participants. (http://www.pre.ethics.gc.ca/policy-politique/tcps-eptc/docs/TCPS%20October%202005_E.pdf)

b) Registrants ensure that before proceeding with their research study they have obtained the informed consent of the patient or proxy and advised the patient that they have the right to withdraw from the study at any time without penalty.

c) Registrants inform the patient of the purpose of the study, its source of funding, the risks of harm and benefits, and the nature of their participation including any applicable compensation.

d) Registrants ensure that they inform research participants that all participant information will be kept confidential and not disclosed without the participants approval and consent.

Responsibility to Society

Standard 6: Registrants are Committed to Benefiting Society

Guidelines for Application

a) Registrants have an ethical duty to uphold public trust and confidence in the profession by acting with honesty and integrity.

b) Registrants have a responsibility to report incompetent or unethical behavior by colleagues or other healthcare professionals to the appropriate regulatory authority.

c) Registrants recognize the professions' responsibility to society to participate in*:
   i. advocacy
   ii. research
   iii. public education programs

d) Registrants endeavor to advance the quality of pharmacy services and care provided to the public

e) Registrants contribute to the future of the profession by participating in student, intern and resident education including multidisciplinary and collaborative experiences as appropriate.

f) Registrants ensure that they maintain appropriate professional boundaries in pharmacy student/instructor and supervisor/subordinate relationships.

g) Registrants recognize the responsibility of the profession to provide access to pharmacy services and resources.

h) Registrants have a responsibility for ensuring the provision of cost-effective pharmacy services in overall healthcare delivery.

i) Registrants provide safe disposal of drugs and health related products and support environmentally friendly practices.

*It is understood that this is not an obligation of all individual registrants but rather a responsibility of the profession as a whole.

Responsibility to the Profession

Standard 7: Registrants are Committed to Personal and Professional Integrity

Guidelines for Application

a) Registrants have an ethical duty to act conscientiously and avoid unethical behavior.

b) Registrants act with honesty and integrity in all professional relationships and fulfill their responsibilities as described in the Code of Ethics and companion documents: Conflict of Interest Standards and Patient Relations Program.

c) Registrants uphold the spirit of the Code of Ethics and its intent as well as its written articulation.

d) Registrants comply with legislation, standards of practice and accepted best practice guidelines.

e) Registrants do not justify unethical behavior by rationalizing that such behavior is not explicitly captured in a standard or guideline and therefore ethically permissible.

f) Registrants shall resist any influence or interference that could undermine their professional integrity.

g) Registrants have a responsibility to protect and maintain their physical and mental health and well-being and seek care and support as appropriate.

h) Registrants must discontinue the provision of professional services if their physical or mental health poses a risk of harm.

i) Registrants take appropriate steps to prevent and report the misuse or abuse of substances by patients, colleagues, other healthcare professionals or other pharmacy employees.

j) Registrants recognize that professional obligations override management policies, and take all reasonable steps to resolve situations where management policies and professional obligations are in conflict.

k) Registrants report any policies, systems or working conditions to the College that pose a risk of harm to the public.

l) Registrants cooperate with investigations into their own or another healthcare professionals' fitness to practice and abide by undertakings or limitations and conditions placed on their practice.

m) Registrants enter only into relationships, contracts and agreements in which they can maintain their professional integrity and safeguard the interests of their patients.

Standard 8: Registrants are Sensitive to and Avoid Conflict of Interest

Guidelines for Application

a) Registrants must consider first the health and well-being of the patient and avoid situations that are, or may reasonably be perceived to be, a conflict of interest.

b) Registrants abide by and conscientiously follow the Code of Ethics companion document, Conflict of Interest Standards.

c) Registrants inform relevant parties, if they are involved in a real, perceived, or potential, conflict of interest scenario and resolve the situation as outlined in the Conflict of Interest Standards.

d) Registrants avoid dual or multiple relationships and other situations which may present a conflict of interest and potentially reduce their ability to be objective and unbiased in their professional judgment.

Standard 9: Registrants Participate in Ethical Business Practices

Guidelines for Application

a) Registrants do not participate in, condone, or are associated with dishonesty, fraud, misrepresentation or any other kind of unethical or illegal behavior.

b) Registrants do not make false, deceptive or fraudulent statements concerning their training, experience, competence, academic degrees or credentials, affiliations, services, research, fees, etc.

c) Registrants conform to legal and professional norms that support the integrity and dignity of the profession.

d) Registrants use only truthful, accurate, fully informative and non-deceptive information in their marketing and public education programs.

e) Registrants do not make false claims for any purpose.

f) Registrants are transparent in the fees they charge, consider the ability of the patient to pay and discuss options with the patient.

g) Registrants ensure that any comparison to the business services of competitors is fair and accurate.

h) Registrants only enter relationships with industry which are appropriate and in compliance with the Code of Ethics and Conflict of Interest Standards and maintain the integrity of the fiduciary relationship between the registrant and the patient.

i) Registrants refrain from participating in activities that could undermine patient trust in registrants and society's trust in the pharmacy profession.

Standard 10: Registrants are Committed to Professional Development

Guidelines for Application

a) Registrants keep up to date with new pharmacy knowledge and practices by participating in continuous lifelong learning.

b) Registrants participate in continuous evaluations of their practice and are responsive to the outcomes of evaluations and reviews by undertaking constructive change or further training if necessary.

c) Registrants endeavour to advance the knowledge and skills of the profession and make relevant information available to patients, colleagues and the public.

d) Registrants participate in professional development opportunities that support learning in professional ethics and the development of sound professional judgment in ethical decision making.

e) Registrants develop, promote and participate in quality assurance and accountability processes.

College of Pharmacists of British Columbia

BOARD MEETING
February 18 & 19, 2016

2.b.vii. 2015 Draft Annual General Meeting Minutes

INFORMATION ONLY

The draft minutes from the 2015 College of Pharmacists Annual General Meeting are attached for information purposes only.

Appendix	
1	2015 Draft Annual General Meeting Minutes

2015 Annual General Meeting Minutes
Vancouver, British Columbia
November 21, 2015

CALL TO ORDER AND INTRODUCTIONS OF BOARD

College Chair Blake Reynolds called the 124th Annual General Meeting of the College of Pharmacists of British Columbia to order at 9:50 a.m. Chair Reynolds welcomed attendees to the meeting and introduced himself as the new Chair.

The College's vision, and mission were read aloud by Chair Reynolds:

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.

Chair Reynolds introduced Board members in attendance, College Registrar Bob Nakagawa, Deputy Registrar Suzanne Solven, and other College staff in attendance.

Chair Reynolds noted that notice of the AGM was sent out on October 19, 2015, thus meeting the three week bylaw requirement. He also confirmed that the required quorum of 25 registrants had been met, and the meeting was duly convened.

MINUTES OF PREVIOUS MEETING – NOVEMBER 22, 2014

The November 22, 2014 Annual General Meeting Minutes were approved by consensus.

FINANCIAL STATEMENTS AND AUDITOR'S REPORT

Chair Reynolds reminded registrants that the audited and Board approved financial statements were available for review on the College website and asked if there were any comments or questions pertaining to them. Hearing no questions, Chair Reynolds noted the financial statements will be placed on file.

CHAIR'S REPORT

Chair Reynolds read the following report on behalf of Past Chair, Anar Dossa who was unable to attend:

Anar would like to thank the outgoing Board members and welcome the four new Board members who will no doubt bring new perspectives to the team.

The College has been busy at work this past year, building upon many of the initiatives set out in its strategic plan. These initiatives include promoting interdisciplinary relationships within the pharmacy and across the larger health care team.

To that end, the College offered a series of free online collaborative practice modules in partnership with the UBC College of Health Disciplines. More than 350 pharmacy professionals have enrolled, and many attended the full-day workshops that were held in February.

The College also partnered with the Canadian Pharmacists Association to provide BC registrants with free access to e-Therapeutics Complete now known as RxTx, an evidence-based, reliable Canadian drug and therapeutic online database.

The College also launched the Practice Review Program in community practice and will now be visiting pharmacies in person to review each practice setting and each pharmacy professional that works there.

Compliance Officers will ensure that pharmacies meet College standards and that pharmacy professionals are appropriately applying their knowledge, skills, and abilities to deliver safe and effective pharmacy care.

The year ahead promises to be a busy one. There is renewed interest in the Pharmacist Prescriber initiative and Anar looks forward to help move this initiative forward.

Anar would like to acknowledge those of you who volunteer your time on many of our committees.

Committees accomplish very important work, and the College recently established two new committees to meet the changing needs of pharmacy practice, the Technology Advisory Committee, and the Interdisciplinary Relationships Advisory Committee.

Thank you for your dedication to the profession and your hard work.

REGISTRAR'S REPORT

There continues to be a lot happening in pharmacy practice, and this has a huge impact on the College. It doesn't seem to matter how bad the economy is, or what the pressures are on the professions, the number of pharmacies and pharmacy professionals continues to increase.

The leadership of our dynamic and action-oriented Board, the dedication of College staff, and the hard work of registrants across the province have allowed us to accomplish much this year. We are all dedicated to providing better health through excellence in pharmacy.

I'm proud of what the College was able to accomplish this year:

- Practice Review Program
    - Launch of Phase I; over 400 pharmacy professional reviews and over 180 pharmacy reviews conducted
    - Began development of Phase II
- Methadone Maintenance Treatment
    - Board approved a four year action plan to address serious issues and concerns as identified by the College's complaints resolution department, recent media reports, the College's MMT patient liaison working group, and Ministry of Health findings
- Grant awarded to PainBC towards Chronic Pain Management Education for Community Pharmacy Professionals
- The College also provided a clinical skills grant to PainBC towards the development of a new continuing education program for community pharmacists to better evaluate and manage long-term pain
- Launch of DrugSafeBC
    - Includes security measures such as the use of time-delay lock safes and displaying standardized signage in all community pharmacies in BC,
    - Media launch event included TV, radio and newspaper ads, digital marketing and social media.

- Growth
  - 55 new community pharmacies,
  - Over 5700 registered pharmacists,
  - Almost 1000 registered pharmacy technicians, and
  - Over 3400 pharmacists authorized to administer injections.
- 125-Year Anniversary
  - A working group has been established to plan a celebration of the 125 years that the College has been working with registrants to provide safe and effective pharmacy care across BC.
- Strategic Planning
  - The College will be engaging with registrants for input on pharmacy care in BC early next year to help inform our next strategic plan for 2017/18 – 2020/21.

I look forward to working together with registrants and the Board in the year ahead. Please continue to share your ideas and feedback with us. It is an honour and a privilege to serve as Registrar of the College. I would also like to thank my staff who were introduced earlier for their support and dedication in ensuring the College continues to move forward with its important work.

Registrar Nakagawa noted the following statistics from the College's Annual Report:

- **Community Pharmacies:** 75 opened / 17 closed
  Hospital: 0 opened / 0 closed
  TOTAL: 1202 community pharmacies and 69 hospital pharmacies

- **Registered Pharmacists**
  5,434 in 2013-14 a net increase over the previous year.
  * Due to change in reporting statistics based on payment date, there are variances between previous fiscal year end count and current fiscal year begin count.

- **Pharmacy Technicians**
  661 pharmacy technicians were registered, 1179 were pre-registered.

REPORT OF BOARD ELECTIONS

Registrar Nakagawa reported the results for the elections held in the fall:

Mona Kwong was elected in District 1
Tara Oxford was elected in District 3
Frank Lucarelli was elected in District 5
Arden Barry was acclaimed in District 7

At the November 20, 2015 Board meeting Blake Reynolds was elected as Chair and Anar Dossa was elected as Vice-Chair.

ADJOURNMENT

Chair Reynolds thanked the assembly for attending the meeting and adjourned the 124th meeting of the College of Pharmacists of British Columbia at 10:19 a.m.

College of Pharmacists of British Columbia

Board Meeting

Thursday, February 18, 2016

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

AGENDA

DAY 1 - THURSDAY, FEBRUARY 18, 2016

9:00-9:15am	**1.**	Welcome & Call to Order	Chair Reynolds
	2.	Consent Agenda a) Items for further discussion b) Approval of Consent Items **[DECISION]**	Chair Reynolds
	3.	Confirmation of Agenda **[DECISION]**	Chair Reynolds
9:15 - 9:20	**4.**	September 2016 Board Meeting Location	Registrar Nakagawa
9:20 - 9:30	**5.**	125th Anniversary Working Group a) Terms of Reference **[DECISION]** b) Committee Appointment **[DECISION]** c) Plan Update **[DECISION]**	Ming Chang
9:30 - 10:00	**6.**	a) Governance Committee b) Indigenous Cultural Safety Training	Norm Embree Kris Gustavson
10:00 - 10:15		***BREAK***	
10:15 - 11:15	**7.**	Audit and Finance Committee - Budget Presentation **[DECISION]**	George Walton
11:15 - 11:35	**8.**	Prioritizing CE for next fiscal year **[DECISION]**	Gary Jung
11:35 - 12:00	**9.**	Practice Review Program - Phase I and Phase II Update	Mike Ortynsky
12:00 - 1:00		***LUNCH***	
1:00 - 1:20	**10.**	Items brought forward from Consent Agenda	Chair Reynolds
1:20 - 1:30	**11.**	Drug Schedule Regulation Amendment - Naloxone **[DECISION]**	Bal Dhillon
1:30 - 2:00	**12.**	Certified Pharmacist Prescriber Update	Gillian Vrooman
2:00 - 2:45	**13.**	Point-of-Care HIV Testing: Community Pharmacy Pilot	Bob Rai / Reka Gustafson
2:45 - 3:00		***BREAK***	
3:00 - 4:00	**14.**	Legal Advice - IN CAMERA:	Registrar Nakagawa
4:00pm		***ADJOURN FOR THE DAY***	Chair Reynolds

College of Pharmacists of British Columbia

Board Meeting

Friday, February 19, 2016

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

AGENDA

DAY 2 - FRIDAY, FEBRUARY 19, 2016

9:00am		Call to Order	Chair Reynolds
9:00 - 10:00	**15.**	Legal Advice - In Camera:	Deputy Registrar Solven
10:00 - 10:20	**16.**	BC Pharmacy Association - Personalized Medication in Our Communties	Allison Nourse
10:20 - 10:30		***BREAK***	
10:30 - 11:15	**17.**	Optimizing Pharmaceutical Care for Post-Transplant and Chronic Kidney Disease Patients	Greg Wheeler / Damen Man / Marnie Mitchell
11:15 - 12:45	**18.**	Methadone Maintenance Treatment Update	Suzanne Solven / George Budd
		CLOSING COMMENTS, ROUND TABLE EVALUATION OF MEETING, AND ADJOURNMENT	Chair Reynolds
12:45 - 1:30		***LUNCH***	
1:30-4:30pm		***Board Session***	

125TH ANNIVERSARY WORKING GROUP
TERMS OF REFERENCE

Background

2016 is the 125th anniversary of pharmacy regulation in the province of British Columbia. The 125th anniversary is an opportunity for the College to celebrate this milestone, while providing a legacy to both registrants and the public that we serve.

Authority

Board motion.

Mandate

The Working Group will:

- Develop a plan for celebrations for Board approval for November, 2015 including:
  - a schedule of events.
  - a communication plan
  - a proposed budget
- Coordinate 125th anniversary celebration activities; and
- Research and make recommendations to the Board on partnership or sponsorship by other agencies or partners.

Reporting relationship

The Working Group reports through the Chair to the Board.

Membership

- 1 member of the Board to serve as Chair of the Working Group.
- Additional members as appointed by the Board

Term of appointment

Until December 31, 2016 or the end of 125th anniversary activities, whichever comes first.

Voting rights

Each member is entitled to one vote on all matters.

Meeting procedures

Schedule: To be determined by the Working Group

Format: In person or by teleconference.

Agenda: To be developed by staff in consultation with the Chair.

Attendees: Only Working Group members and invited guests are permitted to attend meetings.

Quorum: A majority of the Working Group.

Minutes: Drafted by staff for review and approval by the Chair or Vice Chair; filed at the College office.

Secretariat support: Provided by the College including meeting coordination, preparation and distribution of materials and drafting meeting minutes.

Conflict-of-interest disclosure

Members must declare conflicts of interest prior to the discussion of individual files.

A conflict of interest refers to situations in which personal, occupational or financial considerations may affect or appear to affect the objectivity or fairness of decisions related to the Working Group activities. A conflict of interest may be real, potential or perceived in nature. Individuals must declare potential conflicts to the Chair of the Working Group and must either absent themselves from the discussion and voting, or put the decision to the Working Group on whether they should absent themselves.

Remuneration

Working Group members may claim honoraria and expense reimbursement in accordance with the Board's policy and guidelines for claiming expenses.

College of Pharmacists
of British Columbia

Governance Committee Meeting

January 22, 2015 @ 3:30pm

Held by Teleconference

Members Present:

Norman Embree, Chair
Bal Dhillon, Vice-Chair
Blake Reynolds
Anar Dossa

College Staff:

Bob Nakagawa, Registrar (ex-officio)
Suzanne Solven, Deputy Registrar (staff resource)
Lori Tanaka, Board & Legislation Coordinator (Board support)

---

1. **Governance Committee (*'the Committee'*) Terms of Reference** (Appendix 1)

    - Terms of reference documents for the following organizations were circulated to the Committee prior to the meeting:
        - CPBC Governance Committee
        - Crown Agencies
        - Interior Health Authority
        - Manitoba College of Pharmacists
        - Northern Health Authority
        - Vancouver Coastal Health Authority
        - Fraser Health Authority
    - After discussion, committee members agreed that the current Board approved Governance Committee Terms of Reference is currently adequate for the committee to complete its work. The Committee will review the terms of reference on an ongoing basis and propose changes as necessary for approval by the Board.

2. Committees

a) Review of legislated and non-legislated committees

- The Committee did a general review of all CPBC committees looking specifically whether or not the committee was grounded in legislation or bylaw, the purpose and relevance of each committee, and the frequency each committee meets.
- After thoughtful discussion, the Committee will be recommending the following at the April 2016 Board meeting:
    1. To dissolve the following committees:
        i. Communications and Engagement Advisory Committee
        ii. Interdisciplinary Relationships Advisory Committee
        iii. Technology Advisory Committee
    2. That the following committees be re-structured as 'ad hoc' committees of the Board:
        i. Community Pharmacy Advisory Committee
        ii. Ethics Advisory Committee
        iii. Hospital Pharmacy Advisory Committee
        iv. Residential Care Advisory Committee
    3. All committees must provide a report to the Board at least annually, and all committees except 'ad-hoc' committees must update the Board at every Board meeting.

b) Committee re-appointments for April 2016

- It is the responsibility of the Committee to make recommendations on the appointment of committee members.
- As the Committee was only established in November 2015, it is the recommendation of the Committee to extend all committee membership terms to April 2017, from April 2016, to allow the Committee time to establish a recruitment and appointment process going forward.
- CPBC staff resources for all committees to gain consent from committee members to extend membership on respective committees.

c) Future review of committee terms of reference

- Review of all committee terms of reference will begin in February and will be considered at a future Governance Committee meeting.

3. Comprehensive Annual Board Calendar (Appendix 2)

- A Comprehensive Annual Board Calendar was circulated to the Committee and will be continuously updated and provided to the Board via the Board Portal.
- Lori Tanaka to explore option of putting all calendar events into an Outlook calendar.

4. Presentation to the Board (February 2016)

- The Committee Chair, Norm Embree, will present an overview of the Governance Committee meeting at the February 2016 Board meeting

5. Future Governance Committee Meeting Dates:

- Lori Tanaka will send out a doodle poll to establish dates of future Governance Committee meetings for the following weeks:

    1. Week of March 7th, 2016 @ 3:30pm
    2. Week of May 16th, 2016 @ 3:30pm
    3. Week of August 15th, 2016 @3:30pm
    4. Week of October 10th, 2016 @ 3:30pm

GOVERNANCE COMMITTEE

Background

The Board has established the Governance Committee.

Authority

Health Professions Act (HPA); HPA Bylaws.

Mandate

To provide recommendations to the Board on matters relating to Board governance.

Responsibilities

- Review Board policies and manuals and recommend revisions to these documents.
- Review and make recommendations regarding Board member orientation and ongoing development.
- Review and make recommendations on policies and practices related to the recruitment, election and/or appointment of Board and committee members.
- Provide advice and guidance on Board evaluations, including Board meeting evaluations.
- Assess and make recommendations regarding the governance-related needs of the Board.

Reporting relationship

The committee as a whole reports through the chair to the Board. The committee must submit a report of its activities to the Board annually.

Membership

- At least 3 but no more than 5 Board members appointed by the Board.
- Must include at least one Board public member.

Term of appointment

Appointments are determined by the Board and will not exceed 2 years. Appointees are eligible for reappointment by the Board but may not serve more than 3 consecutive terms.

Any committee member may resign upon written notification to the committee chair.

Committee officers

Board appoints a committee chair and vice-chair from among the members of the committee.

Voting rights

Each committee member is entitled to one vote on all matters coming before the committee.

Meeting procedures

Schedule:	At least three times annually to fulfill its mandate and responsibilities.
Format:	In person, by teleconference or by videoconference.
Agenda:	Developed by College staff in consultation with the committee chair with input from committee members.
Attendees:	Only Governance Committee members and College staff are entitled to attend committee meetings, with the exception of invited guests.
Quorum:	A majority of the committee.
Minutes:	Drafted by College staff for review and approval at next committee meeting; filed at the College office.
Secretariat Support:	Provided by the College, including meeting coordination, preparation and distribution of materials and drafting meeting minutes.

Conflict-of-interest disclosure

Members must declare conflicts of interest prior to the discussion of issues or at any time a conflict of interest or potential conflict of interest arises.

A conflict of interest refers to situations in which personal, occupational or financial considerations may affect or appear to affect the objectivity or fairness of decisions related to the committee activities. A conflict of interest may be real, potential or perceived in nature. Individuals must declare potential conflicts to the chair of the committee and must either absent themselves from the discussion and voting, or put the decision to the committee on whether they should absent themselves.

Confidentiality

Each committee member must sign a confidentiality agreement at the time of each appointment indicating their agreement to maintain the confidentiality, security and integrity of all materials during and after their term on the committee.

Remuneration

Committee members may claim honoraria and expense reimbursement in accordance with the Board's policy and guidelines for claiming committee expenses.

Amendment to terms of reference

The Board may amend committee terms of reference at any time and from time to time.

Comprehensive Annual Board Calendar (2016)

	Board Meetings	Committee Meetings	CPBC Stakeholder Engagement	Pharmacy Events	External Factors
January		Discipline - Jan 21 @ 1pm Quality Assurance - Jan 21 @ 6:30pm Governance - Jan 22 @ 3:30pm Practice Review - Jan 26 @ 6:30pm Interdisciplinary Relationships - TBD	Certified Pharmacist Prescriber - Feb to May Pharmacy Security Bylaws - Jan 19, 22, 26		
February	Board Meeting - Feb 18 & 19 Fiscal Budget Strategic Planning - Feb 20 & 21	Audit and Finance - Feb 3 @ 9am Ethics Advisory - Feb 4 @ 10am Community Advisory - TBD Hospital Advisory - TBD Residential Care - TBD			
March		Audit and Finance Governance - w/o Mar 7 Legislation Review			
April	Board Meeting - Apr 14 & 15 Committee Appointments Committee Annual Reports				
May		Audit and Finance Governance - w/o May 16 Legislation Review		BCPhA Annual Conference 2016 May 26 - 28, Kelowna, BC	Provincial General Election - May 9, 2017
June	Board Meeting - Jun 23 & 24 Auditors Report			Canadian Pharmacists Conference 2016: Co-hosted with Alberta College of Pharmacists Jun 24 - 27, Calgary, AB	
July					
August		Audit and Finance Governance - w/o Aug 15 Legislation Review			
September	Board Meeting - Sep 15 & 16 (offsite)			125th Anniversary Celebration (TBD)	
October		Audit and Finance Governance - w/o Oct 10 Legislation Review		11th Annual Pharmacy Technician Conference: Oct 28 & 29, River Rock Casino, Richmond	
November	Board Meeting - Nov 17 & 18 Board Orientation New Board Members (Oath of Office) Election of Chair and Vice-Chair Board Meeting Schedule (2017) Board Member Photos Annual General Meeting - Nov 19			NAPRA Board Meeting: Nov 9 & 10, Saskatchewan	
December					

College of Pharmacists of BC

Fiscal Budget 2016/17

	2015/16 BUDGET	2015/16 FORECAST	FY 2016/17 BUDGET	Fiscal Budget 2016/17	
				RECURRING	ONE-TIME
	12 months	12 months	12 months	12 months	12 months
REVENUE					
Licensure					
Pharmacy Fees	1,781,100	1,807,306	**1,854,394**	1,854,394	-
Pharmacist Fees	3,418,567	3,346,237	**3,373,555**	3,373,555	-
Pharmacy Technician Fees	686,674	496,990	**572,397**	572,397	-
	5,886,341	**5,650,533**	**5,800,346**	**5,800,346**	**-**
Non Licensure					
Other revenue	1,499,646	1,444,384	**1,682,875**	1,682,875	-
Grant revenue	457,855	320,635	**235,238**	135,000	100,238
Investment Income - GIC	240,276	221,340	**158,372**	158,372	-
Investment Income - JV	250,000	250,000	**250,000**	250,000	-
	2,447,777	**2,236,359**	**2,326,485**	**2,226,247**	**100,238**
Total Revenue	**8,334,118**	**7,886,892**	**8,126,831**	**8,026,593**	**100,238**
Transfer from Balance Sheet	1,909,993	1,709,993	**2,171,217**	**-**	**2,171,216**
TOTAL REVENUE	**10,244,111**	**9,596,885**	**10,298,048**	**8,026,593**	**2,271,454**
EXPENSES					
Board and Registrar	705,601	570,950	**538,616**	523,616	15,000
Grant Distribution	655,185	326,585	**443,237**	-	443,237
Registration, Licensing and Pharmanet	451,052	458,435	**259,005**	165,135	93,870
Quality Assurance	713,170	499,376	**586,960**	260,160	326,800
Practice Reviews	420,200	428,714	**295,250**	129,000	166,250
Complaints Resolution	623,626	420,123	**387,433**	267,433	120,000
Policy and Legislation	87,614	79,540	**172,200**	72,200	100,000
Communications and Engagement	535,200	367,621	**504,660**	219,660	285,000
Finance and Administration	1,354,426	1,605,937	**1,562,126**	1,283,181	278,945
Salaries and Benefits	4,409,380	4,489,096	**5,136,433**	4,887,082	249,351
TOTAL EXPENSES BEFORE AMORTIZATION	**9,955,455**	**9,246,378**	**9,885,921**	**7,807,468**	**2,078,453**
NET SURPLUS (DEFICIT) BEFORE THE FOLLOWING:	**288,656**	**350,507**	**412,126**	**15,834,061**	**4,349,907**
Amortization expenses	288,656	291,220	**412,127**	412,127	-
TOTAL EXPENSES AFTER AMORTIZATION	**10,244,111**	**9,537,597**	**10,298,048**	**8,219,595**	**2,078,453**
NET SURPLUS(DEFICIT)	**(0)**	**59,288**	**(0)**	**(193,001)**	**193,001**

8. Prioritizing CE for next Fiscal Year (2016/17)

Gary Jung

Chair, Quality Assurance Committee

Background

CPBC Learning Needs Survey for BC Pharmacy Professionals 2015

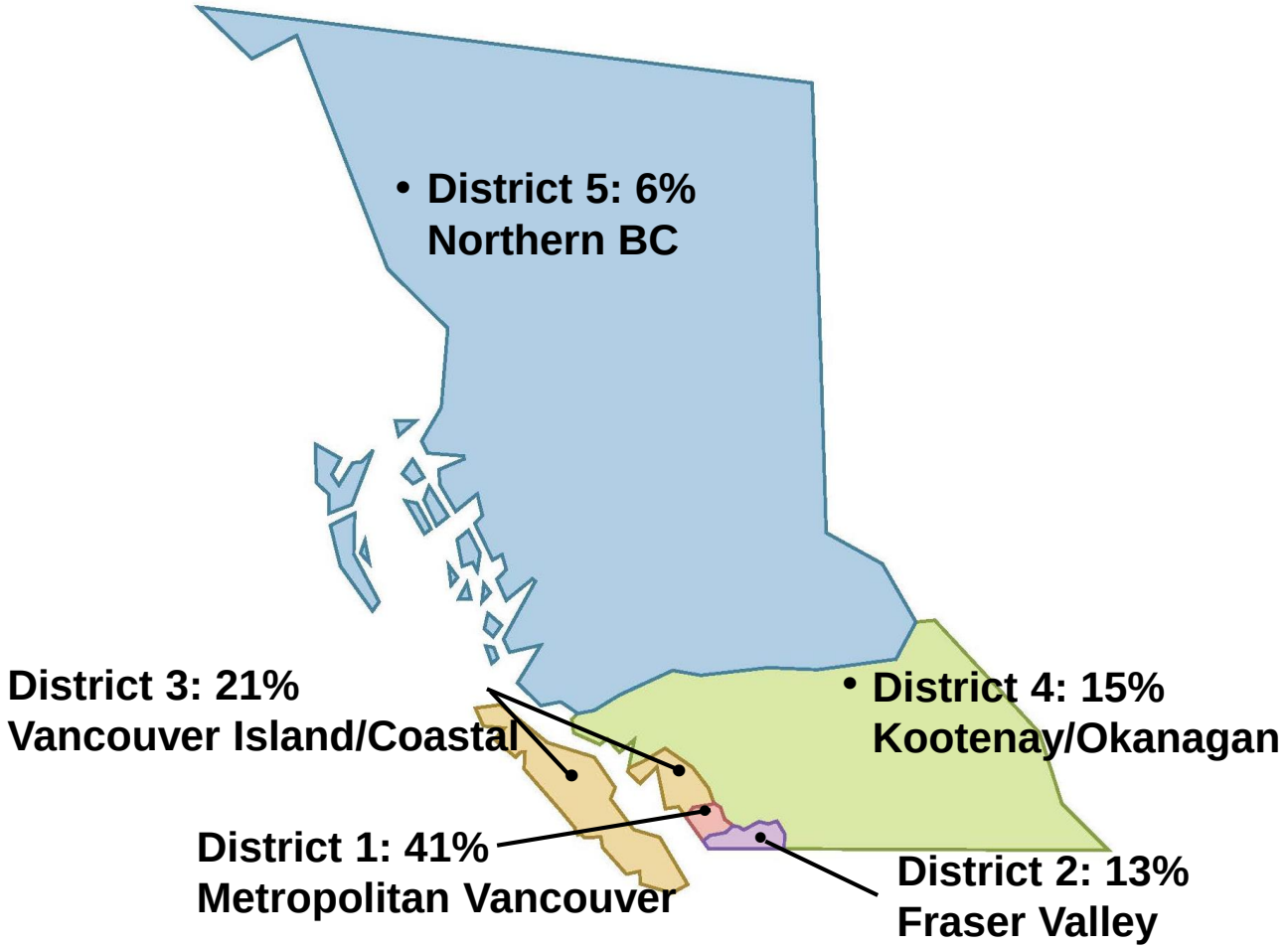
In order to prioritize the development of CE tools and programs for 2016/17 fiscal year, the Quality Assurance Committee conducted a learning needs survey:

- sent to all College registrants
- opened on November 16th, 2015
- closed on December 15th, 2015

Survey Response Rate

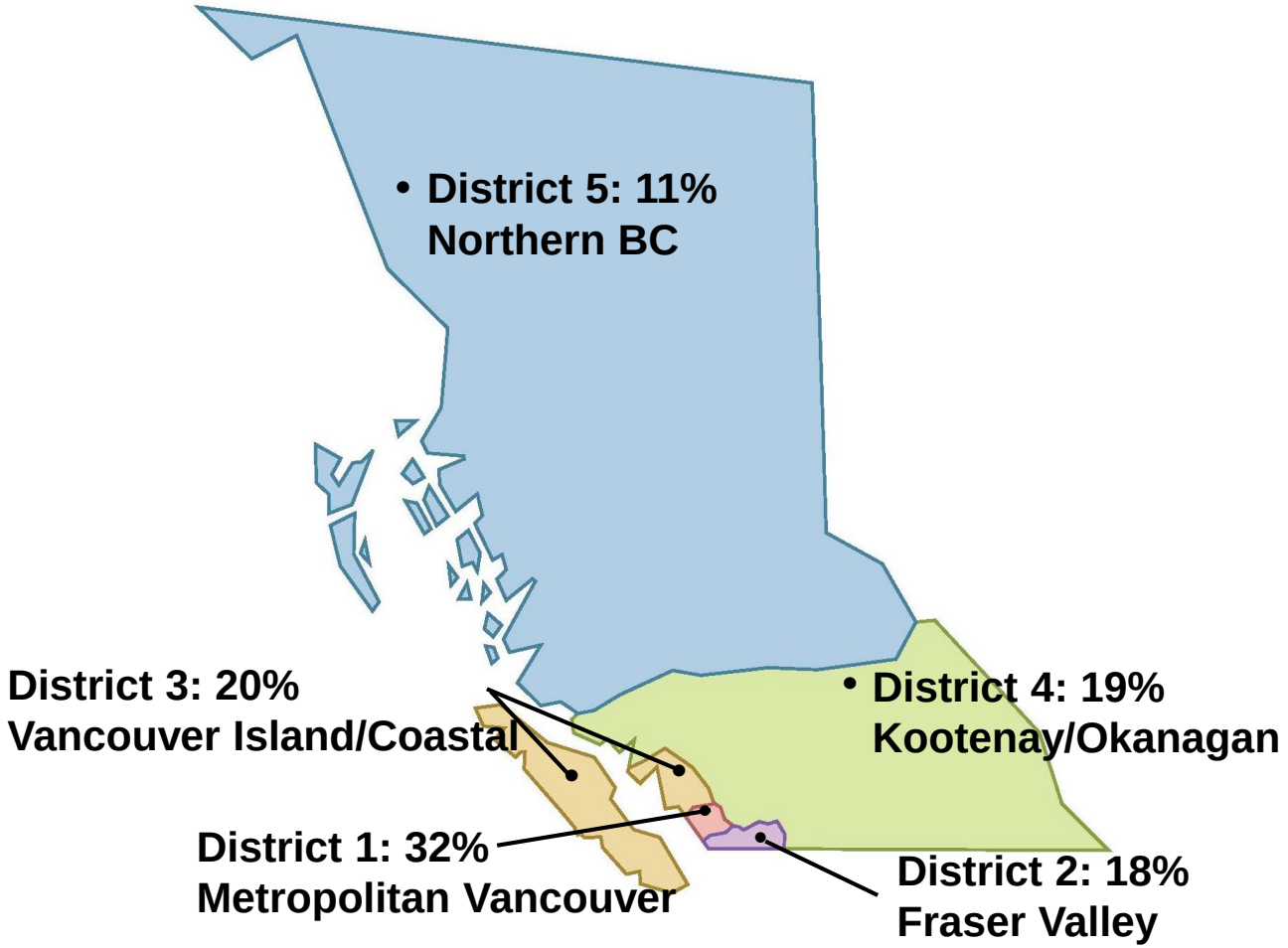
	Total Registrants	Total Responses	Response Rate
Pharmacists	5768	839	14.5%
Pharmacy Technicians	1160	198	17.1%
Others	-	32	-
TOTAL	**6928**	**1069**	**15.4%**

Geographic Location: Pharmacists



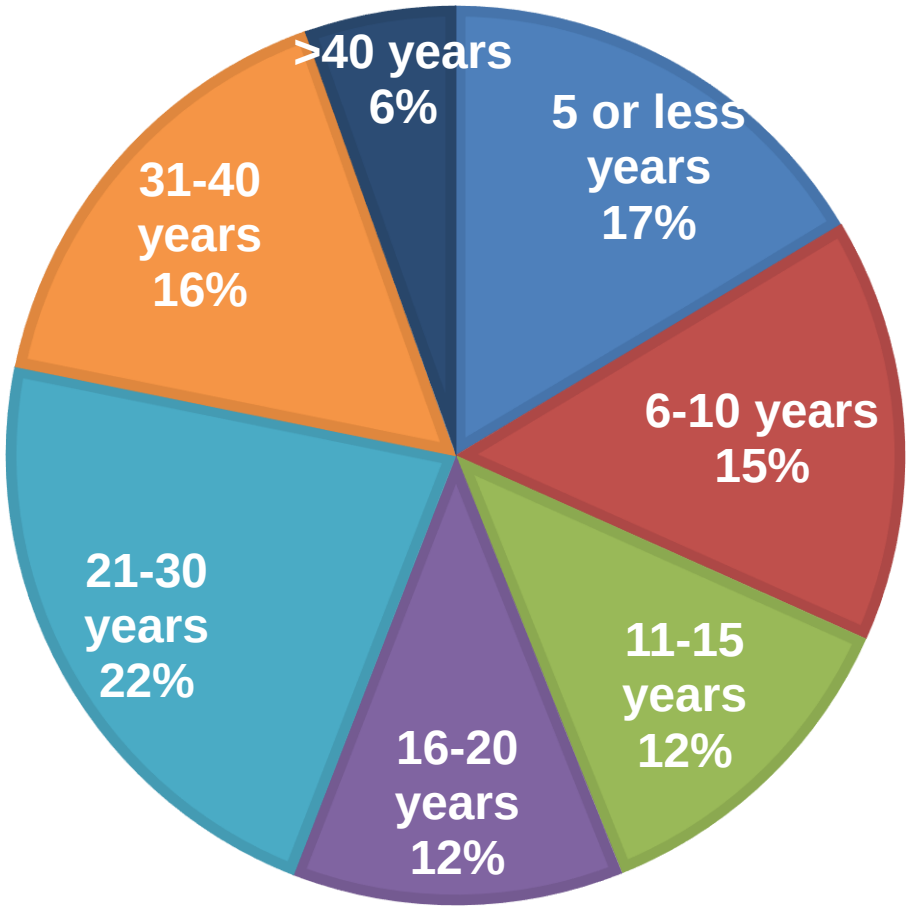
College of Pharmacists of British Columbia

Geographic Location: Pharmacy Technicians



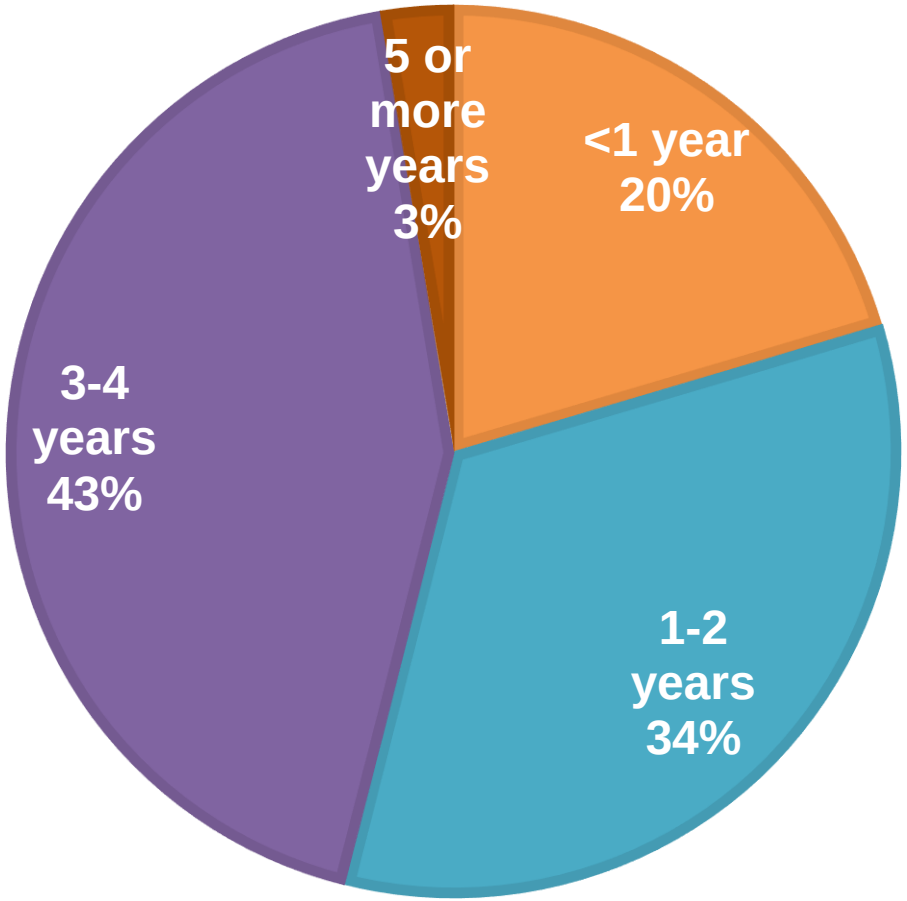
College of Pharmacists of British Columbia

Years of Practice: Pharmacists



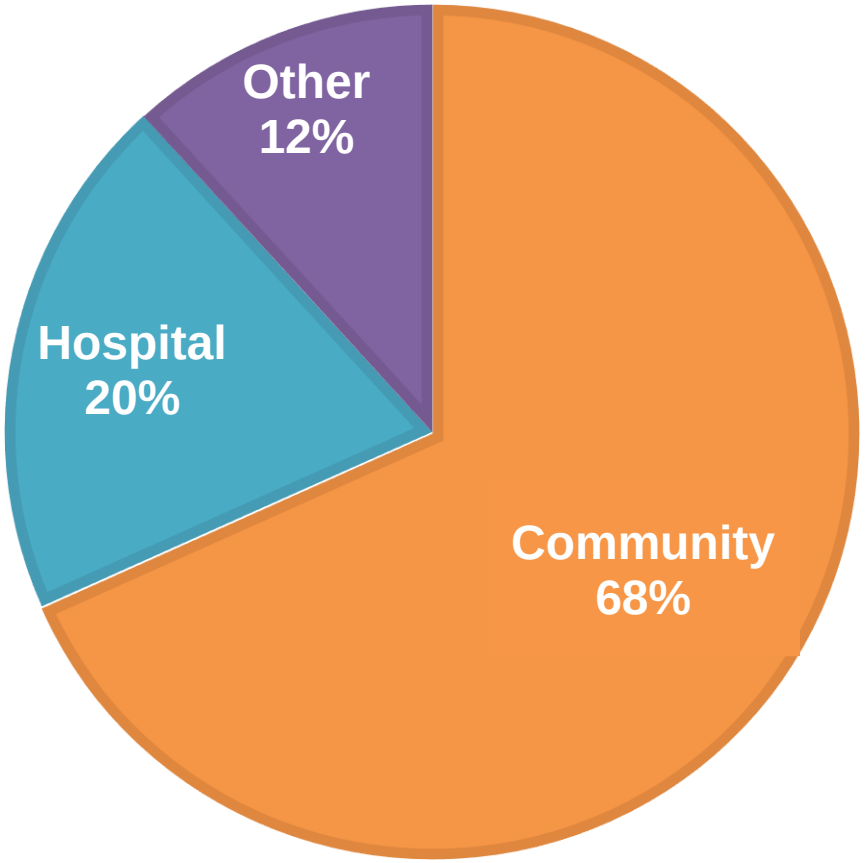
College of Pharmacists of British Columbia

Years of Practice: Pharmacy Technicians

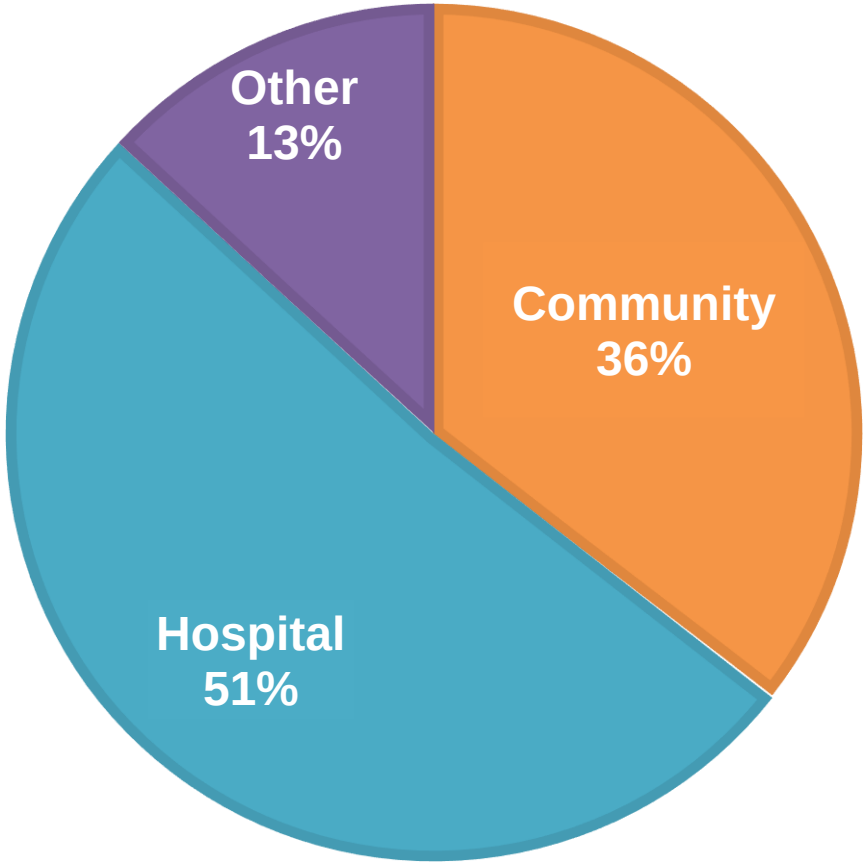


College of Pharmacists of British Columbia

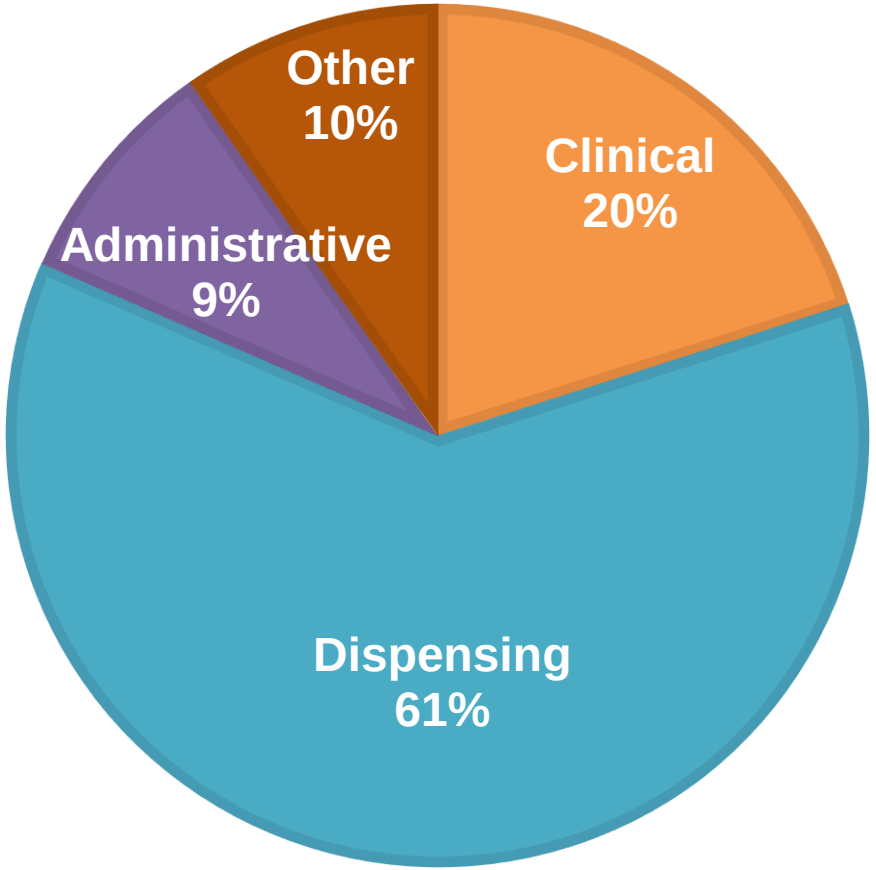
Practice Setting: Pharmacists



Practice Setting: Pharmacy Technicians

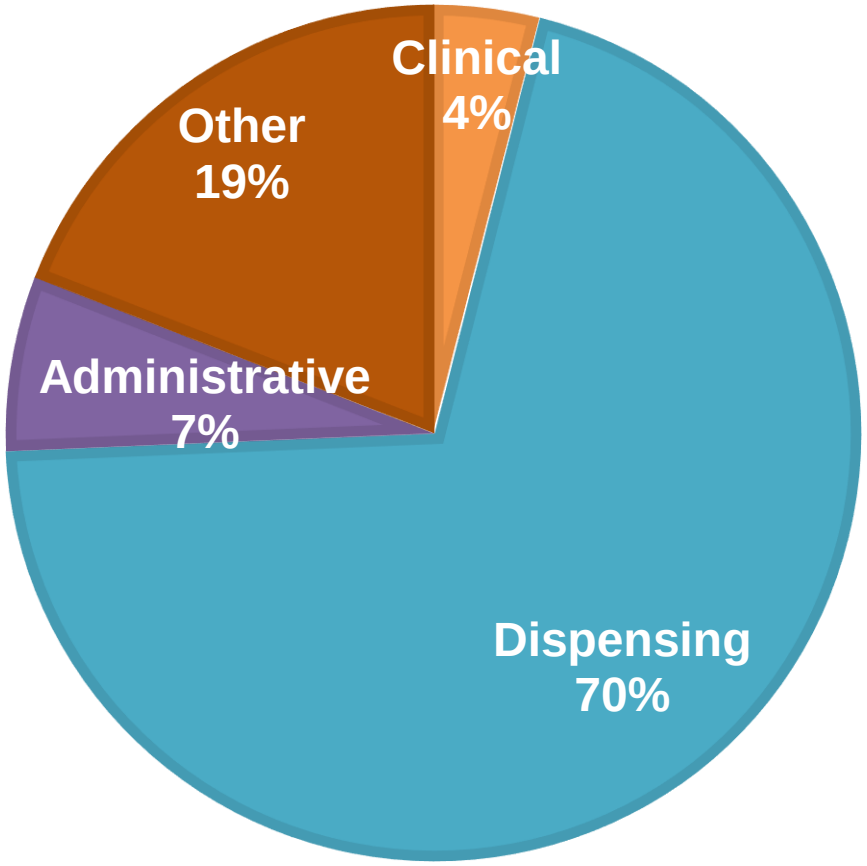


Primary Role: Pharmacists



College of Pharmacists of British Columbia

Primary Role: Pharmacy Technicians



College of Pharmacists of British Columbia

Priority Areas Identified

	All	Pharmacists	Pharmacy Technicians
Expertise in Medications and Medication-use / Drug Distribution Systems	**34.6%**	**35.8%**	**29.6%**
Collaboration	16.6%	17.0%	14.8%
Safety and Quality	**27.4%**	**26.2%**	**32.6%**
Professionalism and Ethics	21.5%	21.1%	23.0%

8. Prioritizing CE for next Fiscal Year (2016/17)

MOTION:

That the Board approves the following priorities for development of continuing education for the 2016/17 fiscal year based on the outcomes of the CPBC Learning Needs Survey for BC Pharmacy Professionals 2015:

1. Expertise in Medications and Medication-use/Drug Distribution Systems

- ***Knowledge/pharmacology based:***

  Diabetes, asthma, COPD, vaccines and mental health, OTC products, natural health products, wound care, ostomy supplies, chemotherapy

8. Prioritizing CE for next Fiscal Year (2016/17)

1. Expertise in Medications and Medication-use/Drug Distribution Systems (cont'd)

- ***Skills/product preparation based:***

  Identifying and resolving drug therapy problems, developing follow-up and monitoring plan, interpreting lab values, pharmaceutical calculations, compounding (sterile, non-sterile, hazardous), preparation of parenteral medications

- ***Pharmacy services based:***

  Medication reviews, immunization

2. Safety and Quality

- *Preventing and managing dispensing errors and incidents, patient safety and quality improvement, documentation skills and tools, handling hazardous drugs, identifying reliable references and resources, workflow management, hand hygiene*

College of Pharmacists
of British Columbia

CPBC LEARNING NEEDS SURVEY FOR BC PHARMACY PROFESSIONALS 2015

January 2016

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Table of Contents

Background

The College of Pharmacists of BC (CPBC) regulates the pharmacy profession in the public interest by setting and enforcing standards and promoting best practices for the delivery of pharmacy care in British Columbia.

In September 2013, the Board of the College approved strategic goals and objectives for the next three years. With input from many stakeholders, the Board created a three-year strategic plan that focuses on improvements and initiatives in the following areas:

1. Public Expectations
2. Interdisciplinary Relationships
3. Scope of Practice
4. Standards
5. Technology

With respect to the third goal identified above, CPBC has determined the need to advance the profession by supporting pharmacists and pharmacy technicians to practice to their current scope of practice through enhancing availability of continuing education (CE) tools and programs. In order to determine new CE tools and programs, the first step is to identify the educational needs and priorities for pharmacy professionals registered in British Columbia.

As a result, a voluntary, anonymous online survey was emailed to all registrants licensed in BC in November 2015. The survey results will assist the Quality Assurance Committee (QAC) to make recommendations to the Board for prioritization and development of CE tools and programs that will support practices of our registrants for the next fiscal year.

Survey Development

The online survey was developed using FluidSurveys in October 2015. The previous year's learning needs survey – drafted and sent by UBC Continuing Pharmacy Professional Development - was used as a reference. In late October, the first draft of the survey was sent to members of the Quality Assurance Committee, Community Pharmacy Advisory Committee, Hospital Pharmacy Advisory Committee, and Residential Care Advisory Committee, as well as registrant staff at CPBC. Some questions in the survey were subsequently revised based on the feedback received.

Survey Structure

Participants were first asked to identify their registration type, the number of years of pharmacy practice their geographic region of primary practice, type of primary practice setting, and primary role in current workplace.

Next participants were asked a series of questions about their educational needs for potential continuing professional development topics/programs in each of the four domains of standards of practice of their profession as set by NAPRA.

Three of the four NAPRA domains are the same for both pharmacists and pharmacy technicians. The four domains for each profession are:

Pharmacists[1] [PS]:

1. Expertise in Medications and Medication-Use
2. Collaboration
3. Safety and Quality
4. Professionalism and Ethics

Pharmacy Technicians[2] [PT]:

1. Expertise in drug distribution system
2. Collaboration
3. Safety and Quality
4. Professionalism and Ethics

In addition, participants were asked to rate their learning needs with respect to clinical pharmacy services specific to BC, such as immunization, medication review, methadone maintenance program, and prescription adaptation.

They were also asked what method(s) and providers they used, as well as what other pharmacy continuing education they would like to see in BC.

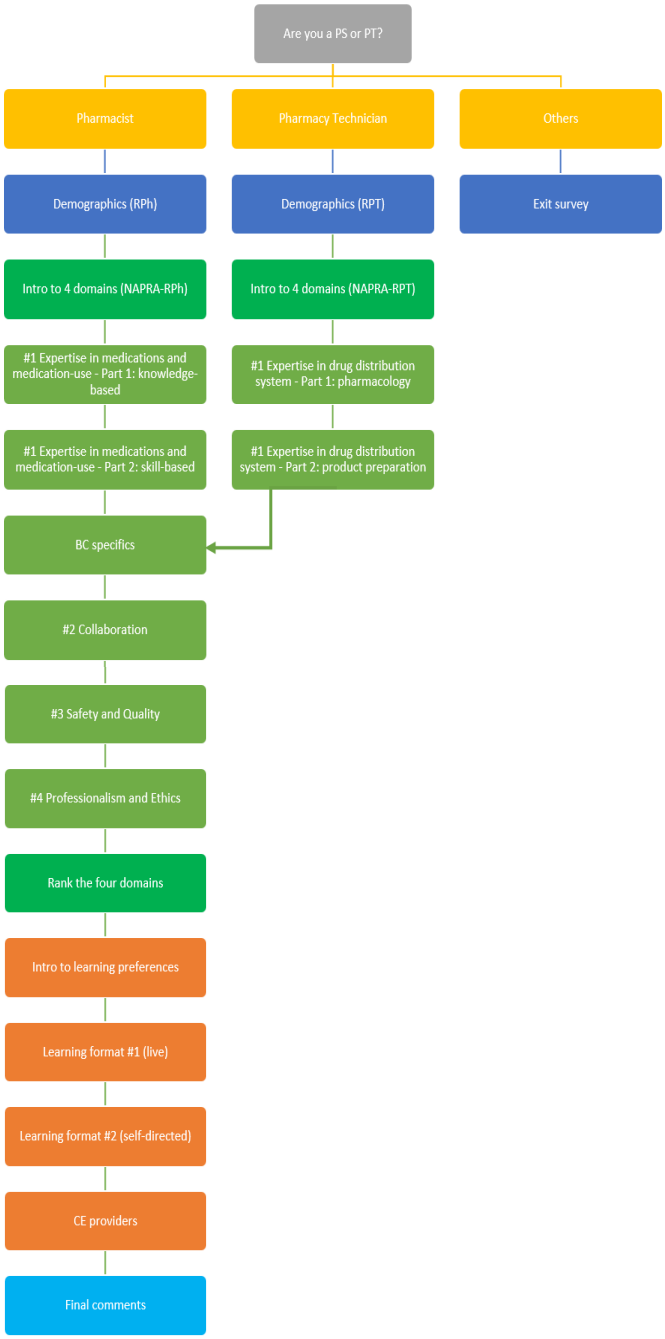


FIGURE 1 STRUCTURE OF SURVEY

[1] The National Association of Pharmacy Regulatory Authorities (2009). *Model Standards of Practice for Canadian Pharmacists*. Retrieved from http://napra.ca/Content_Files/Files/Model_Standards_of_Prac_for_Cdn_Pharm_March09_Final_b.pdf

[2] The National Association of Pharmacy Regulatory Authorities (2011). *Model Standards of Practice for Canadian Pharmacy Technicians*. Retrieved from http://napra.ca/content_files/files/model_standards_of_prac_for_cdn_pharmtechs_nov11.pdf

Survey Deployment

The survey was available between November 16 and December 15, 2015. It was emailed to 6842 pharmacy professionals on November 16, 2015 and two reminder emails were sent on December 1 and 11, 2015 respectively. See Table 1 for a breakdown of the email open rates.

TABLE 1 EMAIL NOTIFICATION

	Date Sent	Total Sent	Total Opened	Total Click
1st Email	16 NOV 2015	6842	3756 (55.3%)	414 (11.0%)
Reminder email #1	1 DEC 2015	6838*	3700 (54.5%)	308 (8.3%)
Reminder email #2	11 DEC 2015	6838*	3618 (53.3%)	374 (10.3%)

*Difference of four was due to email bounce-back or unsubscribing.

Note: As of November 16, 2015 there was a total of 6928 registrants registered with the College. However, 86 registrants had unsubscribed from the College's email system. These registrants were then informed of the requirement to receive emails from the College of Pharmacists of BC in accordance with section 21(2)(f) of the *Health Professions Act*.

Response Rate & Completion Rate

A total of 1069 responses were collected. There were 780 completed responses, 287 partially completed responses, and 2 disqualified responses (i.e. test responses). The response rate appears to be low however given the email's open rate was 53-55% (Table 1), the click-through rates are more indicative of the total responses received (both completed and non-completed) at 1096.

TABLE 2 RESPONSE RATE IN 2014 AND 2015

	Total Registrants 2015	Total Responses 2015	Response Rate 2015	Total Registrants 2014	Total Responses 2014	Response Rate 2014
Pharmacists	5768	839	14.5%	5591	1389	24.8%
Pharmacy Technicians	1160	198	17.1%	811	231	27.7%
Others	-	32	-	1211*	217*	17.3%*
TOTAL	**6928**	**1069**	**15.4%**	**7613**	**1823**	**23.9%**

* Pharmacy Assistant (PA) in the process of becoming a regulated Technician

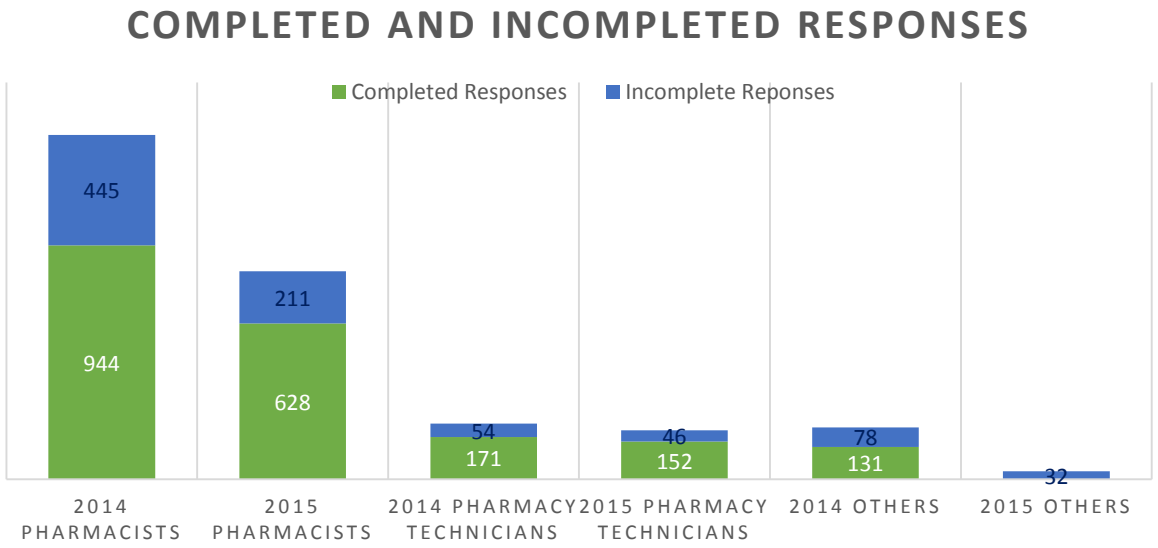
TABLE 3 COMPLETION RATE 2015

	Total Registrants Notified	Total Completed Responses	Total Incomplete Responses	Total Terminated Responses

Pharmacists	5768 (83.3%)	628 (80.5%)	211 (73.5%)	-
Pharmacy Technicians	1160 (16.7%)	152 (19.5%)	46 (16%)	-
Not identified	-	-	30	2
TOTAL	**6928 (100%)**	**780 (100%)**	**287 (100%)**	**2 (100%)**

A number of factors may have caused a lower response rate for 2015 than 2014. First, the 2014 survey was sent between September and October, whereas the 2015 survey was sent between November and December, which are known as the busiest months of the year in a pharmacy. Secondly, 3 reminder emails were sent in 2014, whereas only 2 reminder emails were sent in 2015. Lastly, ten $50 gift cards was offered as prizes for the 2014 survey, whereas no incentive was offered in 2015. On the other hand, the 2014 survey had proportionally more incomplete responses than 2015 survey (see Figure 1).

To ensure the validity and reliability of the survey results, only completed responses were used in the analysis as incomplete responses may contain duplication (e.g. same person attempting the survey half way at different times because they did not save the link to continue on a later day). Despite a smaller sample size among the completed responses, the distribution between two professions relatively reflects the actual population at ~80% vs 20% See Table 3). In order to have a confidence level of 95%, a population of 7000 will require a minimum sample size of 364, which is achieved with the sample size of this survey.



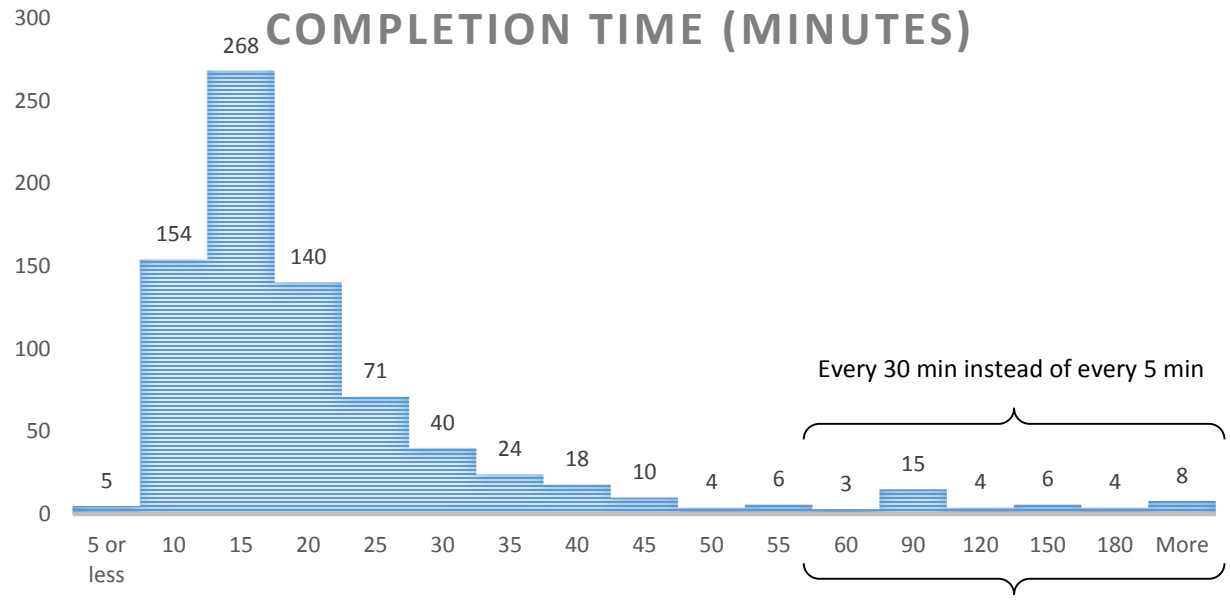
Completion Time

The 2014 survey was identified to be too long, so there was an concerted effort to shorten the 2015 survey. More than half of the participants submitted the survey in under 20 minutes. See Table 4 for information about completion time:

TABLE 4 COMPLETION TIME

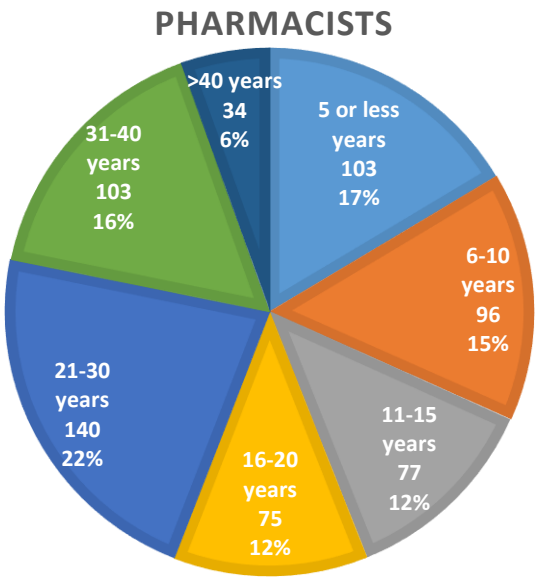
Data Description	Duration
Minimum	3 min 50 sec
Average	28 min 13 sec
Median	14 min 25 sec
Maximum	46 hours 16 seconds

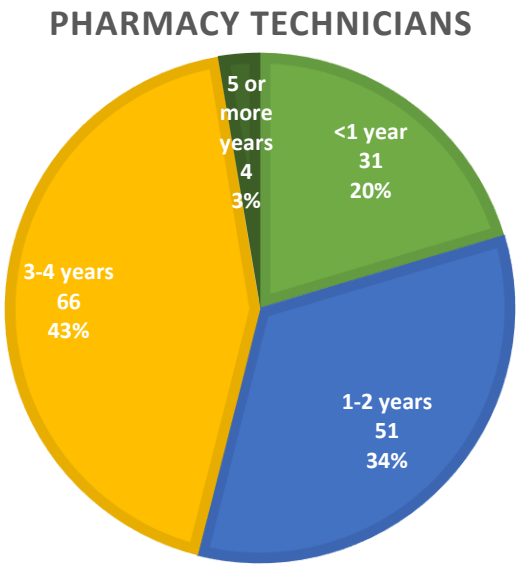
Note: The timer on FluidSurveys does not track the amount of time a person actually spent completing the survey. Rather, the timer starts when the person first launches the website and ends when the survey is submitted. If a registrant attempts to complete the survey during work and encounters interruptions when completing the survey, the timer will continue to track the idle time spent on the survey. Therefore, the data here does not truly reflect the actual amount of time participants spent on completing the survey, especially considering the average time when the 6 longest durations are: 4 hours 15 minutes, 8 hours 19 minutes, 11 hours 28 minutes, 11 hours 36 minutes, 24 hours 21 minutes, and 46 hours. Therefore, the median value would be an indicator that is more appropriate to use than the average value.



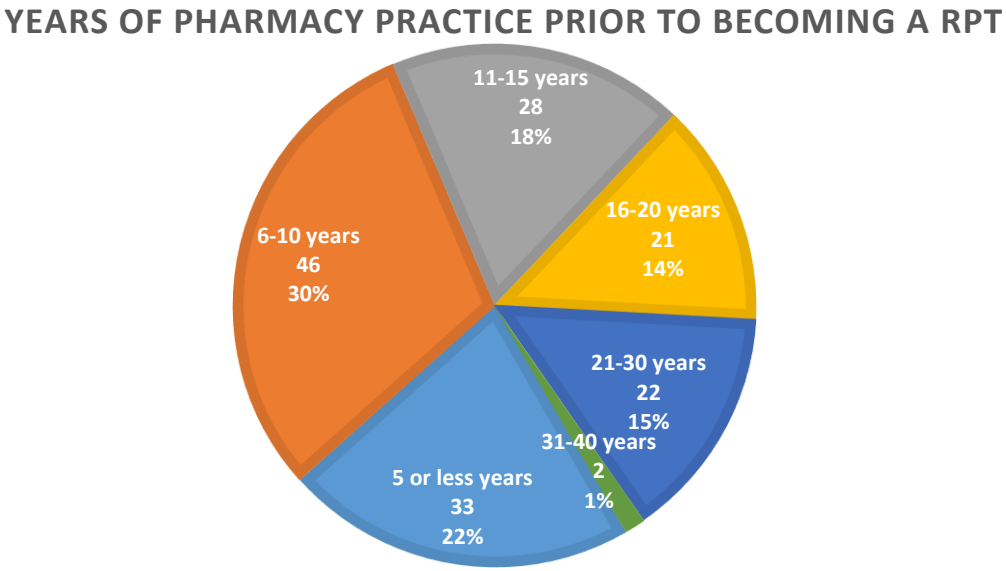
Demographics of Participants

Participants were asked for the number of years that they have been registered in Canada. The sample size of pharmacists contains a fairly equal distribution of registered years. On the other hand, as pharmacy technician is a new type of health care professionals starting in 2010, there were very few pharmacy technicians who identified themselves as having 5 or more years of registration.

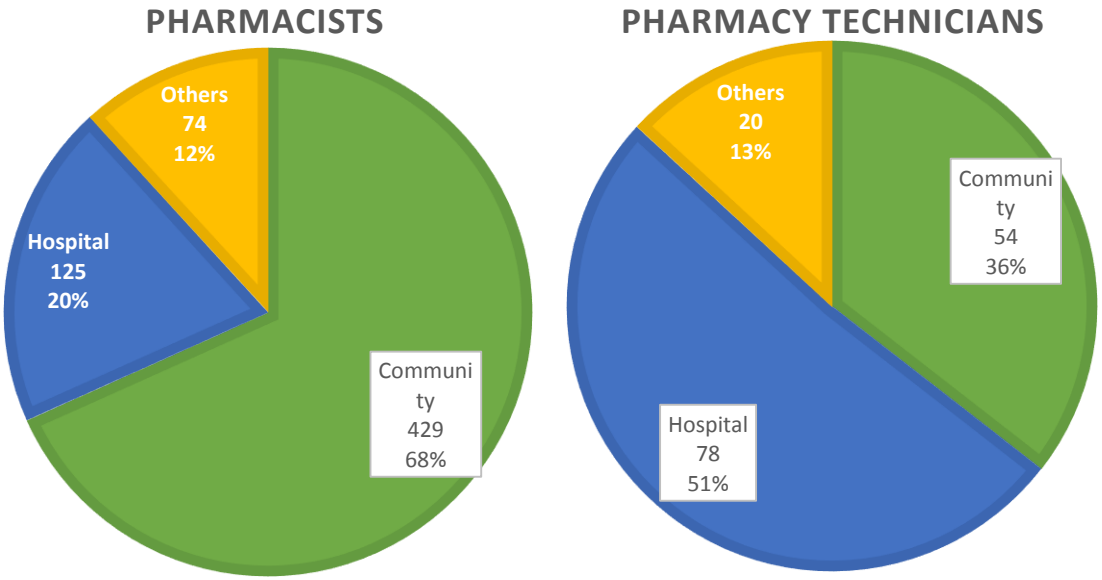




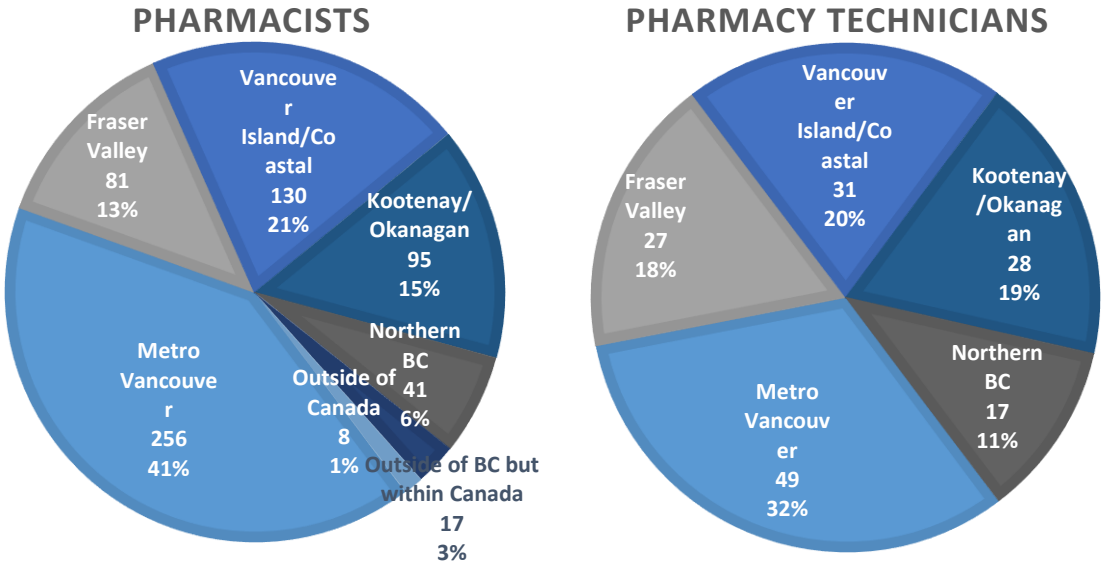
In addition, pharmacy technicians were asked for their number of years of pharmacy experience before they became registered.



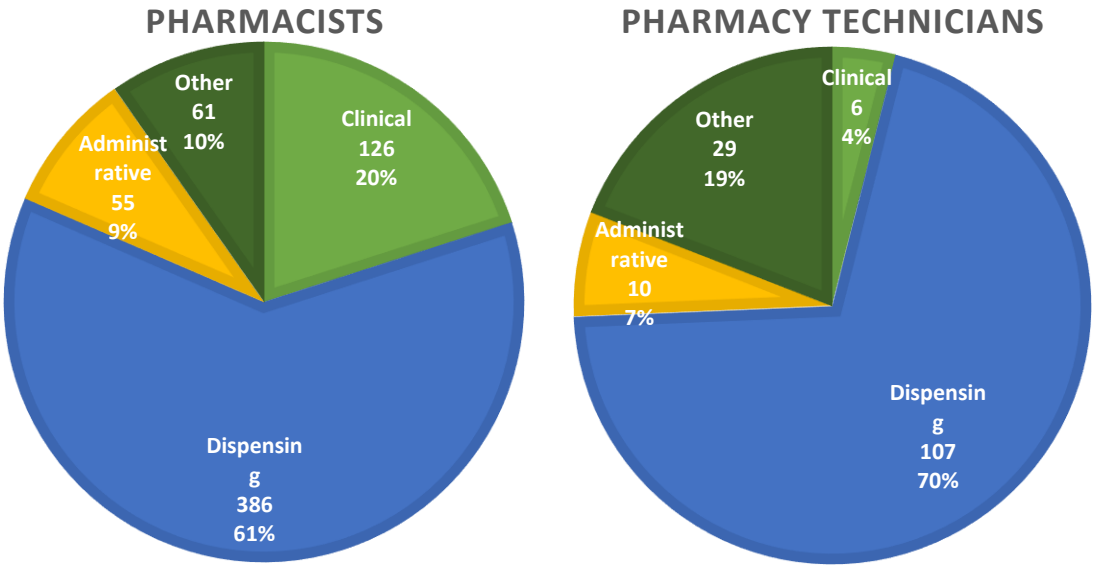
Next, participants were asked about their primary practice setting. Again, the results reflect a similar distribution of the pharmacy population as it is well known that there are more community pharmacists than hospital pharmacists, and more hospital pharmacy technicians than community pharmacy technicians in BC. For those who answered "other", most pharmacists were in hospital administration or government, whereas a few worked in outpatient clinics including BC Cancer Agency and long term care pharmacies. There were also pharmacist representatives from head offices, DPIC, BCPhA, central fill, and academia. For pharmacy technicians, they were mostly employed in long term care pharmacies. The rest were from outpatient clinics, central fill, and provincial corrections.



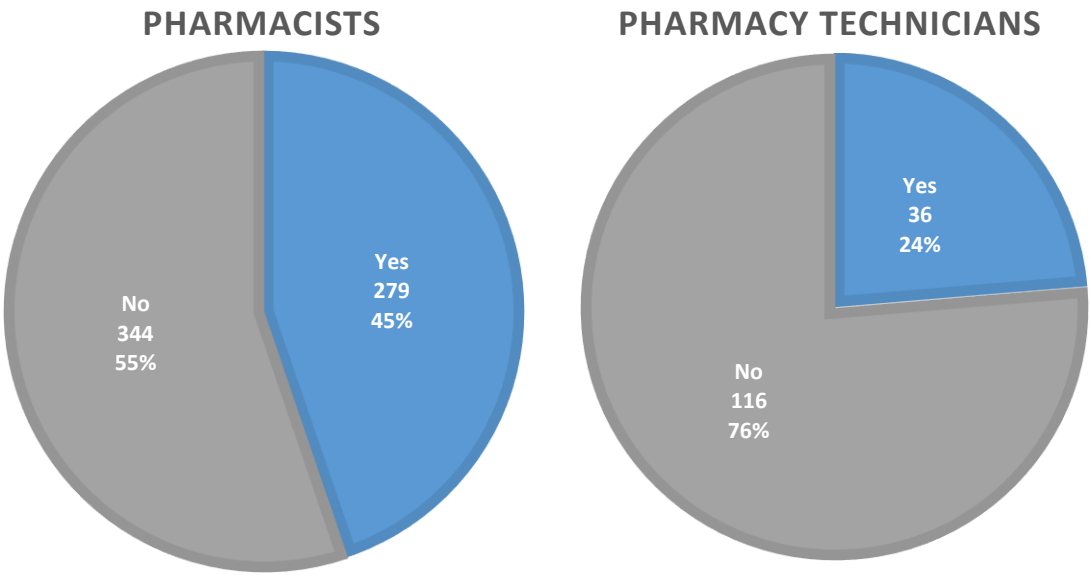
With respect to geographic locations, there is a relatively similar distribution of pharmacists and pharmacy technicians in each district.



Participants were asked for their primary role at their primary practice setting. Like the previous question, there is a very similar distribution of pharmacists and pharmacy technicians. Most participants who selected "other" indicated that they were involved in more than one area. A few participants who selected "other" indicated themselves as owners or in management, which technically should fall under "administration".



The last question in this section asked the participants whether they played a supervisory role at their primary practice setting.



Methods

Throughout the survey, participants were asked to rate their values of educational need for each CE topic/area using a scale of “not important”, “somewhat important”, and “very important”. In order to turn these qualitative responses into a quantitative measurement, a numerical value was assigned to each rating during survey analysis:

	Score = 1	Score = 2	Score = 3	
Variable	Not important	Somewhat important	Very important	
Ethics & Conflict of Interest	61 *7.8%*	261 *33.2%*	463 *59.0%*	*Total:* 785
Legislation & Standards Governing Pharmacy Practice	46 *5.9%*	251 *32.0%*	488 *62.2%*	*Total:* 785
Privacy & Confidentiality	67 *8.5%*	213 *27.1%*	505 *64.3%*	*Total:* 785
Roles & Responsibilities of Pharmacy Staff	72 *9.2%*	256 *32.6%*	457 *58.2%*	*Total:* 785
Scopes of Practice	41 *5.2%*	203 *25.9%*	541 *68.9%*	*Total:* 785

The total score of each question was used to determine the priorities of each CE topic/area in each domain. To calculate the total score of each question, the total number of responses for each rating was multiplied by its assigned score and then added together. In the example above, the total score for “Ethics & Conflict of Interest” will be: (61 x 1) + (261 x 2) + (463 x 3) = 1972. The same procedure was repeated for all the CE topics/areas in the same domain. The CE topics/areas with the highest scores represent in the highest priorities.

Domain #1: Expertise in…

Pharmacists and pharmacy technicians have a different focus in the first domain. Pharmacists' first domain is called "Expertise in Medications and Medication-Use", whereas pharmacy technicians' is "Expertise in Drug Distribution System". This domain has been divided again for each profession into two different subsections.

Pharmacists: Expertise in Medications and Medication-Use

The two subsections in this domain for pharmacists are knowledge-based and skill-based topics.

In the knowledge-based section, the top 5 areas that pharmacists ranked as important were (in order):

1. Medical topics on chronic diseases
2. Medical topics on acute diseases
3. Geriatrics
4. Mental health
5. Medical topics on preventative diseases

Because of the dominated responses from community pharmacists, we have stratified the results by primary practice settings. There is a difference in the results for each of the two major practice settings: community and hospital (i.e. excluded those who selected "other" in the question of primary practice settings in the demographics section). Medical topics on chronic diseases, acute diseases, and geriatrics still fell within the top 5 for community and hospital, but community pharmacists valued medical topics on minor ailments, preventable diseases and mental health, whereas hospital pharmacists valued knowledge with respect to special populations such as renal and hepatic impairment and immunocompromised patients (see Figure 2). .

Community pharmacists value…

1. Medical topics on chronic diseases
2. Medical topics on acute diseases
3. Geriatrics
4. Medical topics on minor ailments
5. Medical topics on preventative diseases & mental health

Hospital pharmacists value…

1. Medical topics on chronic diseases
2. Medical topics on acute diseases
3. Knowledge related to kidney & liver impairment
4. Geriatrics
5. Knowledge related to immunocompromised diseases/patients

Topics	All RPh (max 1896)		Comm RPh (max 1296)		Hospital RPh (max 378)	
Medical topics (acute diseases)	#2	1740	#2	1211	#2	346
Medical topics (chronic diseases)	#1	1811	#1	1261	#1	349
Medical topics (minor ailments)	#7	1573	#4	1164	#9	247
Medical topics (rare diseases)	#13	1201	#13	832	#11	236
Medical topics (preventable diseases)	#5	1613	#5	1152	#8	286
Natural health products	#11	1418	#10	1020	#13	233
Pharmacokinetics	#12	1315	#12	872	#6	303
Special populations (geriatrics)	#3	1674	#3	1168	#4	320
Special populations (kidney and liver impairment)	#6	1576	#9	1055	#3	334
Special populations (immunocomprised)	#8	1482	#11	1009	#5	305
Special populations (mental health)	#4	1630	#5	1152	#7	297
Special populations (pregnancy and lactation)	#9	1476	#7	1084	#10	243
Special populations (pediatrics)	#10	1455	#8	1071	#12	234
Other (please specify topics below)	#14	382	#14	250	#14	78

FIGURE 2 PHARMACISTS: EXPERTISE IN MEDICATIONS AND MEDICATION-USE (KNOWLEDGE-BASED)

Participants provided specific topics that were important in terms of need and/or educational value. Among the 328 responses received, the top 5 specific topics were:

1. Diabetes (79)
2. Asthma (67)
3. COPD (55)
4. Vaccines (42)
5. Mental health (34)

In the skill-based section, the top 3 areas that pharmacists ranked as important were (in order):

1. Identifying & resolving drug therapy problems
2. Developing follow-up & monitoring plans
3. Interpreting laboratory values

Community and hospital pharmacists equally valued the importance of learning the same 3 topics, but they ranked the last two topics differently (see Figure 3).

Topics	All RPh (max 1896)		Comm RPh (max 1296)		Hospital RPh (max 378)	
Critical literature appraisal	#4	1441	#5	942	#4	317
Using physical assessment techniques & tools	#5	1402	#4	981	#5	261
Interpreting laboratory values	#3	1625	#3	1080	#2	352
Identifying & resolving drug therapy problems	#1	1794	#1	1245	#1	354
Developing follow-up & monitoring plans	#2	1642	#2	1122	#3	338
Other (please specify topics below)	#6	191	#6	125	#6	38

FIGURE 3 PHARMACISTS: EXPERTISE IN MEDICATIONS AND MEDICATION-USE SKILL-BASED)

Pharmacy Technicians: Expertise in Drug Distribution System

The two subsections in this domain for pharmacy technicians are pharmacology-related and product preparation-related topics.

In the pharmacology section, the top 5 areas that pharmacy technicians ranked as important were (in order):

1. Medical topics on chronic diseases
2. Medical topics on acute diseases
3. Medical topics on preventative diseases
4. Drug delivery devices
5. Medical topics on minor ailments

As over half of the responses were from hospital pharmacy technicians, the results were also stratified by primary practice settings. There was no major difference between the two major practice settings (community and hospital) although the ranking was different. In addition, community pharmacy technicians valued home monitoring devices, whereas hospital pharmacy technicians valued medical topics on minor ailments.

Community pharmacy technicians valued …

1. Medical topics on chronic diseases
2. Drug delivery devices
3. Home monitoring devices
4. Tie:
    a. Medical topics on acute diseases
    b. Medical topics on preventative disease

Hospital pharmacy technicians valued …

1. Medical topics on acute diseases
2. Medical topics on chronic diseases
3. Medical topics on preventative diseases
4. Drug delivery devices
5. Medical topics on minor ailments

Participants provided specific topics that were important in terms of need and/or educational value. The top 5 topics were (in no particular order):

- OTC products
- Natural health products
- Wound care
- Ostomy supplies
- Chemotherapy

Topics	All RPT (max 459)		Comm RPT (max 162)		Hospital RPT (max 237)	
Medical topics (acute diseases)	#2	390	#4	140	#1	203
Medical topics (chronic diseases)	#1	405	#1	151	#2	202
Medical topics (minor ailments)	#5	346	#6	133	#5	172
Medical topics (rare diseases)	#9	297	#10	101	#6	159
Medical topics (preventable diseases)	#3	380	#4	140	#3	192
Natural health products (e.g. vitamins, herbals, homeopathy etc)	#7	321	#8	122	#7	158
Drug delivery devices (e.g. MDI, eye/ear drops)	#4	377	#2	142	#4	184
Home monitoring devices (e.g. BP/BG monitors)	#6	331	#3	141	#8	144
Medical supplies & equipment (e.g. syringes, compression stocking, cane, walker)	#8	307	#7	126	#9	137
Screening tests (e.g. pregnancy test, ovulation test)	#10	277	#9	111	#10	129
Other (please specify topics below)	#11	98	#11	41	#11	47

FIGURE 4 PHARMACY TECHNICIANS: EXPERTISE IN DRUG DISTRIBUTION SYSTEM (PHARMACOLOGY)

In the product preparation section, the top 3 areas that pharmacy technicians ranked as important were (in order):

1. Pharmaceutical calculations
2. Non-sterile compounding
3. Compounding hazardous drugs

However, there was a major split when the two major practice settings are looked at individually. The difference was most likely because of the nature of their job.

Community pharmacy technicians valued …

1. Pharmaceutical calculations
2. Non-sterile compounding
3. Compounding hazardous drugs

Hospital pharmacy technicians valued…

1. Sterile compounding
2. Compounding hazardous drugs
3. Preparation of parenteral medications

Topics	All RPT (max 459)		Comm RPT (max 162)		Hospital RPT (max 237)	
Compounding hazardous drugs	#3	378	#3	103	#2	226
Non-sterile compounding	#2	401	#2	142	#5	210
Pharmaceutical calculations	#1	413	#1	150	#4	212
Preparation of parenteral medications (e.g. TPNs, IV admixture compatibility)	#5	352	#6	87	#3	222
Specialty compounding (hormones, troches)	#6	301	#4	99	#6	161
Sterile Compounding (e.g. aseptic technique, infection control, USP 797)	#4	371	#5	93	#1	230
Other (please specify topics below)	#7	56	#7	21	#7	28

FIGURE 5 PHARMACY TECHNICIANS: EXPERTISE IN DRUG DISTRIBUTION SYSTEM (PRODUCT PREPARATION)

BC Specific Learning Topics

Among all pharmacy professionals, medication review and immunization are two of the areas of clinical pharmacy services specific to BC that were important (see Figure 6). These were also the same top two priorities for pharmacists regardless of practice settings (see Figure 7). However, pharmacy technicians were split on the priorities based on community and hospital practice (see Figure 8). For those who selected "other", responses were mostly related to third party audits.

Topics	Ranking	Total Score (max 2355)
Immunization	#2	1930
Medication review	#1	2023
Methadone maintenance treatment	#4	1758
Prescription adaptation	#3	1867
Other (please specify topics below)	#5	213

FIGURE 6 BC SPECIFIC TOPICS (ALL PHARMACY PROFESSIONALS)

Topics	All RPh (max 1896)		Comm RPh (max 1296)		Hospital RPh (max 378)	
Immunization	#2	1577	#1	1158	#2	250
Medication review	#1	1640	#2	1152	#1	315
Methadone maintenance treatment	#4	1420	#4	1059	#4	213
Prescription adaptation	#3	1527	#3	1127	#3	237
Other (please specify topics below)	#5	165	#5	113	#5	27

FIGURE 7 BC SPECIFIC TOPICS (ALL PHARMACISTS)

Topics	All RPT (max 459)		Comm RPT (max 162)		Hospital RPT (max 237)	
Immunization	#2	353	#2	135	#3	170
Medication review	#1	383	#3	132	#1	200
Methadone maintenance treatment	#4	338	#4	121	#2	172
Prescription adaptation	#3	340	#1	137	#4	158
Other (please specify topics below)	#5	48	#5	25	#5	20

FIGURE 8 BC SPECIFIC TOPICS (ALL PHARMACY TECHNICIANS)

Domain #2: Collaboration

In this domain, the top 5 areas that pharmacy professionals ranked as important were (in order):

1. Critical-thinking/Problem-solving skills
2. Working with other healthcare professionals
3. Counseling skills (for pharmacists)/Patient teaching skills (for pharmacy technicians)
4. Ethical decision-making
5. Verbal communication skills

Topics	Ranking	Total Score (max 2355)
Counseling skills (for pharmacists)/Patient teaching skills (for pharmacy technicians)	**#3**	**2067**
Critical-thinking/Problem-solving skills	**#1**	**2173**
Dealing with patient diversity	#8	1928
Dealing with workplace and interprofessional conflicts	#9	1906
Ethical decision-making	**#4**	**2026**
Leadership and preceptorship	#11	1874
Patient interviewing skills	#6	1981
Team building	#10	1880
Verbal communication skills (e.g. use of empathy, strategies for language barriers)	**#5**	**2003**
Working with other healthcare professionals	**#2**	**2097**
Written communication skills	#7	1978
Other (please specify topics below)	#12	208

FIGURE 9 DOMAIN #2: COLLABORATION (ALL PHARMACY PROFESSIONALS)

The top five topics that pharmacists ranked as important were:

1. Critical thinking/Problem-solving skills
2. Counseling skills
3. Working with other healthcare professionals
4. Patient interviewing skills
5. Ethical decision-making

While critical thinking/problem-solving skills, working with other healthcare professionals, and patient interviewing skills remained as three of the top five areas across practice settings, community and hospital pharmacists had two different priorities. Community pharmacists found it very important to learn more on counseling skills and quite important on ethical decision-making skills, whereas hospital pharmacists found it important to learn more on general communication skill (verbal and written).

Community pharmacists valued…

1. Counseling skills
2. Critical thinking/Problem-solving skills
3. Working with other healthcare professionals
4. Patient interviewing skills
5. Ethical decision-making skills

Hospital pharmacists valued…

1. Critical thinking/Problem-solving skills
2. Working with other healthcare professionals
3. Written communication skills
4. Verbal communication skills
5. Patient interviewing skills

Topics	All RPh (max 1896)		Comm RPh (max 1296)		Hospital RPh (max 378)	
Counseling skills (for pharmacists)/Patient teaching skills (for pharmacy technicians)	#2	1684	#1	1201	#6	309
Critical-thinking/Problem-solving skills	#1	1741	#2	1190	#1	356
Dealing with patient diversity	#8	1547	#7	1073	#10	292
Dealing with workplace and interprofessional conflicts	#9	1495	#9	1021	#9	295
Ethical decision-making	#5	1604	#5	1113	#7	305
Leadership and preceptorship	#10	1485	#11	1007	#8	301
Patient interviewing skills	#4	1616	#4	1139	#5	310
Team building	#11	1472	#10	1009	#11	291
Verbal communication skills (e.g. use of empathy, strategies for language barriers)	#6	1591	#6	1100	#4	311
Working with other healthcare professionals	#3	1678	#3	1144	#2	335
Written communication skills	#7	1569	#8	1061	#3	322
Other (please specify topics below)	#12	166	#12	107	#12	27

FIGURE 10 DOMAIN #2: COLLABORATION (PHARMACISTS)

The top five topics that pharmacy technicians ranked as important were:

1. Critical thinking/Problem-solving skills
2. Ethical decision-making
3. Working with other healthcare professionals
4. Verbal communication skills
5. Dealing with workplace and interprofessional conflicts

While the first four topics mentioned above remain as four of the top 5 across practice settings, similar to pharmacists' preferences, patient teaching skills was the most important area for community pharmacy technicians, whereas written communication was important for hospital pharmacy technicians. For those who selected "other", responses were mostly related to conflict management and team building (which were already in the questions).

Community pharmacy technicians valued…

1. Patient teaching skills
2. Critical thinking/Problem-solving skills
3. Ethical decision-making skills
4. Working with other healthcare professionals
5. Verbal communication skills

Hospital pharmacy technicians valued…

1. Critical thinking/Problem-solving skills
2. Working with other healthcare professionals
3. Tie:
    a. Ethical decision-making skills
    b. Written communication skills
5. Verbal communication skills

Topics	All RPT (max 459)		Comm RPT (max 162)		Hospital RPT (max 237)	
Counseling skills (for pharmacists)/Patient teaching skills (for pharmacy technicians)	#9	383	#1	155	#9	179
Critical-thinking/Problem-solving skills	#1	432	#2	154	#1	222
Dealing with patient diversity	#10	381	#6	149	#10	177
Dealing with workplace and interprofessional conflicts	#5	411	#7	147	#6	206
Ethical decision-making	#2	422	#3	152	#3	212
Leadership and preceptorship	#8	389	#11	133	#8	203
Patient interviewing skills	#11	365	#10	142	#11	174
Team building	#7	408	#8	144	#6	206
Verbal communication skills (e.g. use of empathy, strategies for language barriers)	#4	412	#5	150	#5	208
Working with other healthcare professionals	#3	419	#4	151	#2	213
Written communication skills	#6	409	#9	143	#3	212
Other (please specify topics below)	#12	42	#12	16	#12	20

FIGURE 11 DOMAIN #2: COLLABORATION (PHARMACY TECHNICIANS)

Domain #3: Safety and Quality

In this domain, the top 5 areas that pharmacy professionals ranked as important were (in order):

1. Preventing and managing dispensing errors and incidents
2. Patient safety and quality improvement
3. Documentation skills and tools
4. Identifying reliable references and resources
5. Workflow management

Topics	Ranking	Total Score (max 2355)
Documentation skills and tools (e.g. BPMH*, MAR)**	**#3**	**2029**
Drug disposal	#10	1684
Emergency preparedness	#9	1751
Hand hygiene	#8	1812
Reporting adverse drug reactions and medical device problems	#6	1866
Handling hazardous drugs	#7	1854
Identifying reliable references and resources	**#4**	**2003**
Inventory management	#11	1670
Patient safety and quality improvement	**#2**	**2103**
Performance reviews	#12	1631
Preventing and managing dispensing errors and incidents	**#1**	**2119**
Workflow management	**#5**	**1937**
Other (please specify topics below)	#13	205

FIGURE 12 DOMAIN #3: SAFETY AND QUALITY (ALL PHARMACY PROFESSIONALS)

The top five topics that pharmacists ranked as important were:

1. Preventing and managing dispensing errors and incidents
2. Patient safety and quality improvement
3. Documentation skills and tools
4. Identifying reliable references and resources
5. Workflow management

Overall, pharmacists had the same top 5 areas as all pharmacy professionals. However, when stratified by practice setting, there was a split on the 5th priority where community pharmacists valued workflow management, whereas hospital pharmacists valued reporting adverse drug reactions and medical device problems. For those who selected "other", responses were mostly related to technology, such as MAR, drug verification system, and informatics. The rest of the responses were related to stress management and LEAN.

Community pharmacists valued…

1. Preventing and managing dispensing errors and incidents
2. Patient safety and quality improvement
3. Documentation skills and tools
4. Identifying reliable references and resources
5. Workflow management

Hospital pharmacists valued…

1. Preventing and managing dispensing errors and incidents
2. Patient safety and quality improvement
3. Documentation skills and tools
4. Identifying reliable references and resources
5. Reporting adverse drug reactions and medical device problems

Topics	All RPh (max 1896)		Comm RPh (max 1296)		Hospital RPh (max 378)	
Documentation skills and tools (e.g. BPMH*, MAR**)	#3	1626	#4	1121	#1	319
Drug disposal	#10	1292	#10	951	#11	204
Emergency preparedness	#9	1356	#9	968	#9	238
Hand hygiene	#8	1390	#8	992	#8	256
Reporting adverse drug reactions and medical device problems	#6	1469	#6	1031	#5	276
Handling hazardous drugs	#7	1425	#7	1000	#6	272
Identifying reliable references and resources	#4	1606	#3	1123	#3	305
Inventory management	#12	1270	#11	945	#12	200
Patient safety and quality improvement	#2	1662	#2	1164	#2	312
Performance reviews	#11	1285	#12	919	#10	229
Preventing & managing dispensing errors & incidents	#1	1674	#1	1197	#4	299
Workflow management	#5	1511	#5	1089	#7	265
Other (please specify topics below)	#13	161	#13	115	#13	21

FIGURE 13 DOMAIN #3: SAFETY AND QUALITY (PHARMACISTS)

The top five topics that pharmacy technicians ranked as important were:

1. Preventing and managing dispensing errors and incidents
2. Patient safety and quality improvement
3. Handling hazardous drugs
4. Workflow management
5. Hand hygiene

Pharmacy technicians had the same top two learning priorities as pharmacists. While preventing and managing dispensing errors and incidents, patient safety and quality improvement, workflow management, and hand hygiene remained as four of the top five areas across practice settings, community pharmacy technicians found it more important to learn on reporting adverse drug reactions and medical device problems and inventory management, whereas hospital pharmacists found it very

important to learn more on handling hazardous drugs. "Other" responses included: review of drug errors, time management, and even violence prevention education.

Community pharmacy technicians valued…

1. Tie:
    a. Preventing and managing dispensing errors and incidents
    b. Patient safety and quality improvement
3. Workflow management
4. Tie:
    a. Hand hygiene
    b. Reporting adverse drug reactions and medical device problems
    c. Inventory Management

Hospital pharmacy technicians valued…

1. Handling hazardous drugs
2. Preventing and managing dispensing errors and incidents
3. Patient safety and quality improvement
4. Hand hygiene
5. Workflow management

Topics	All RPT (max 459)		Comm RPT (max 162)		Hospital RPT (max 237)	
Documentation skills and tools (e.g. BPMH*, MAR**)	#6	403	#11	131	#6	217
Drug disposal	#11	392	#10	133	#7	206
Emergency preparedness	#10	395	#9	137	#7	206
Hand hygiene	#5	422	#4	145	#4	225
Reporting adverse drug reactions and medical device problems	#8	397	#4	145	#11	199
Handling hazardous drugs	#3	429	#8	142	#1	233
Identifying reliable references and resources	#8	397	#7	143	#9	204
Inventory management	#7	400	#4	145	#10	202
Patient safety and quality improvement	#2	441	#1	154	#3	230
Performance reviews	#12	346	#12	119	#12	177
Preventing & managing dispensing errors & incidents	#1	445	#1	154	#2	231
Workflow management	#4	426	#3	149	#5	219
Other (please specify topics below)	#13	44	#13	11	#13	23

FIGURE 14 DOMAIN #3: SAFETY AND QUALITY (PHARMACY TECHNICIANS)

Domain #4: Professionalism and Ethics

In this domain, the top 3 areas that pharmacy professionals ranked as important were (in order):

1. Scopes of practice
2. Legislation & standards governing pharmacy practice
3. Privacy & confidentiality

Topics	Ranking	Total Score (max 2355)
Ethics & Conflict of Interest	#4	1972
Legislation & Standards Governing Pharmacy Practice	**#2**	**2012**
Privacy & Confidentiality	**#3**	**2008**
Roles & Responsibilities of Pharmacy Staff	#5	1955
Scopes of Practice	**#1**	**2070**
Other (please specify topics below)	#6	193

FIGURE 15 DOMAIN #4: PROFESSIONALISM AND ETHICS (ALL PHARMACY PROFESSIONALS)

Scope of practice and privacy & confidentiality remained as two of the top 3 areas for both pharmacists and pharmacy technicians across practice settings. Community pharmacists and pharmacy technicians found it important to learn about legislation & standards governing pharmacy practice, whereas hospital pharmacists and pharmacy technicians found it more important to learn about ethics & conflict of interest and roles and responsibilities of pharmacy staff.

Topics	All RPh (max 1896)		Comm RPh (max 1296)		Hospital RPh (max 378)	
Ethics & Conflict of Interest	#4	1038	#5	1079	**#3**	**294**
Legislation & Standards Governing Pharmacy Practice	**#3**	**1125**	**#1**	**1139**	#5	278
Privacy & Confidentiality	**#2**	**1146**	**#3**	**1110**	**#2**	**297**
Roles & Responsibilities of Pharmacy Staff	#5	987	#4	1084	#4	279
Scopes of Practice	**#1**	**1212**	**#2**	**1126**	**#1**	**314**
Other (please specify topics below)	#6	63	#6	110	#6	22

FIGURE 16 DOMAIN #4: PROFESSIONALISM AND ETHICS (PHARMACISTS)

Topics	All RPT (max 459)		Comm RPT (max 162)		Hospital RPT (max 237)	
Ethics & Conflict of Interest	#4	420	#4	150	#4	214
Legislation & Standards Governing Pharmacy Practice	#5	416	#2	154	#5	206
Privacy & Confidentiality	#3	427	#3	151	#3	219
Roles & Responsibilities of Pharmacy Staff	#2	432	#5	149	#2	226
Scopes of Practice	#1	443	#1	159	#1	228
Other (please specify topics below)	#6	44	#6	18	#6	17

FIGURE 17 DOMAIN #4: PROFESSIONALISM AND ETHICS (PHARMACY TECHNICIANS)

Ranking the Four Domains

In addition to determining the priorities of CE topics in each domain, it was also critical to determine the priorities of the four domains for each registration type.

Participants ranked the four domains in the order of importance: “least important”, “somewhat important”, “important” and “very important”. In order to turn these qualitative responses into a quantitative measurement, a numerical value was assigned:

	Score = 4	Score = 3	Score = 2	Score = 1	
Variable	▲ Very important	Important	Somewhat important	Least important	
Expertise in medications and medication-use (RPh)/Expertise in drug distribution systems (RPT)	29 *36.7%*	25 *31.6%*	17 *21.5%*	8 *10.1%*	*Total:* 79
Collaboration	4 *5.1%*	5 *6.3%*	19 *24.1%*	51 *64.6%*	*Total:* 79
Safety and Quality	36 *45.6%*	33 *41.8%*	8 *10.1%*	2 *2.5%*	*Total:* 79
Professionalism and Ethics	10 *12.7%*	16 *20.3%*	35 *44.3%*	18 *22.8%*	*Total:* 79

The total score of each domain was used to determine its rank. To calculate the total score of each domain, the total number of responses for each rating was multiplied by its assigned score and then added together. Then, to determine its weight among the four domains, the total score was divided by the maximum total score. The maximum total score was calculated by the maximum score times the total number of responses.

In the example above, the total score for “Collaboration” is: (4 x 4) + (5 x 3) + (19 x 2) + (51 x 1) = 120. The maximum number of score in that domain is: 79 x 4 = 316. The weight is: 120/316 = 15.2%.

The same procedure was repeated for the other 3 domains. The one with the highest score represents the domain in highest priority.

In the survey, we found that pharmacy professionals ordered learning priorities as follows:

1. Expertise in medications and medication-use (RPh)/Expertise in drug distribution systems (RPT)
2. Safety and Quality
3. Professionalism and Ethics
4. Collaboration

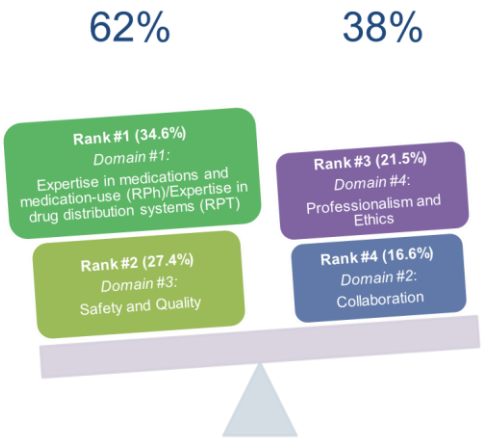


FIGURE 18 RANK OF DOMAINS (ALL PHARMACY PROFESSIONALS)

When the results were stratified by registration type, pharmacists have the same priorities as above. When stratified by practice setting, community pharmacists also have the same priorities above, but hospital pharmacists ranked Domain #2 collaboration higher than in Domain #4 professional and ethics.

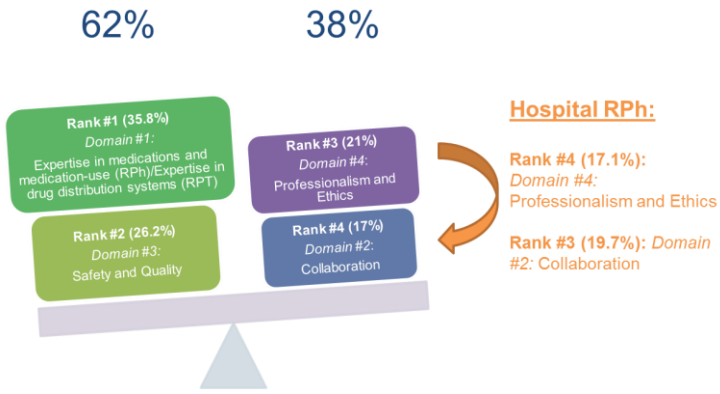


FIGURE 19 RANK OF DOMAINS (ALL PHARMACY PROFESSIONALS & PHARMACISTS)

Pharmacy technicians ranked the learning priorities a bit differently compared to pharmacists. The top priority for pharmacy technicians was Domain #3 safety and quality, whereas the top priority for pharmacists was Domain #1 expertise in medications and medication-use.

1. Safety and Quality
2. Expertise in drug distribution systems (RPT)
3. Professionalism and Ethics
4. Collaboration

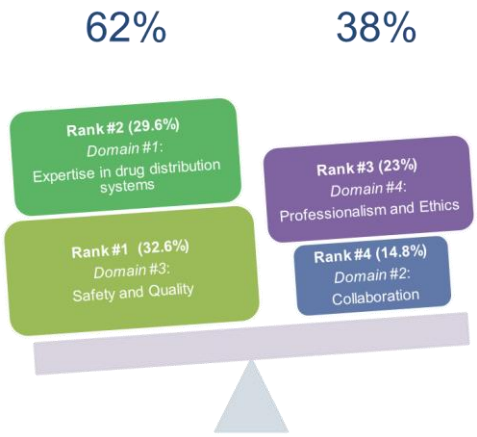


FIGURE 20 RANK OF DOMAINS (PHARMACY TECHNICIANS)

TABLE 5 RANK OF DOMAINS (ALL PHARMACY PROFESSIONALS & PHARMACISTS)

	All (PS + PT)		All PS		Community PS		Hospital PS	
Expertise in drug distribution systems (RPT)	**#1**	**2718 (34.6%)**	**#1**	**2265 (35.8%)**	**#1**	**1579 (36.4%)**	**#1**	**456 (36.2%)**
Collaboration	#4	1302 (16.6%)	#4	1076 (17.0%)	#4	679 (15.7%)	#3	248 (19.7%)
Safety and Quality	#2	2157 (27.4%)	#2	1658 (26.2%)	#2	1117 (25.8%)	#2	340 (27.0%)
Professionalism and Ethics	#3	1687 (21.5%)	#3	1335 (21.1%)	#3	959 (22.1%)	#4	216 (17.1%)

TABLE 6 RANK OF DOMAINS (ALL PHARMACY PROFESSIONALS & PHARMACY TECHNICIANS)

	All (PS + PT)		All PT		Community PT		Hospital PT	
Expertise in drug distribution systems (RPT)	**#1**	**2718 (34.6%)**	#2	453 (29.6%)	#2	170 (31.5%)	#2	233 (29.5%)
Collaboration	#4	1302 (16.6%)	#4	226 (14.8%)	#4	70 (13.0%)	#4	120 (15.2%)
Safety and Quality	#2	2157 (27.4%)	**#1**	**499 (32.6%)**	**#1**	**175 (32.4%)**	**#1**	**261 (33.0%)**
Professionalism and Ethics	#3	1687 (21.5%)	#3	352 (23.0%)	#3	125 (23.1%)	#3	176 (22.3%)

Learning Preferences

Participants were asked for their methods of accessing and obtaining information for their continuing professional development by estimating how and where they gathered their learning hours. The purpose was to determine implied preferences although it may not be entirely accurate as these parameters could be determined by the availability of the programs.

To determine which learning format (live vs self-directed), learning method, and CE provider was highly utilized, the minimum number of learning hours in each category was used to calculate the minimum number of learning hours per registrant for each variable. For example, in the category of "0.25 to 5 hours", 0.25 hrs was used for that category in the calculation. The minimum number of learning hours per registrant for each variable was calculated this way:

1. Multiply the minimum number of learning hours by the number of responses in that category
2. Add up the total number of hours per category for the same variable
3. Divide the number by the total number of registrants in that sample (i.e. # of respondents)

Variable	Hrs = 0 0 hours	Hrs = 0.25 0.25 to 5 hours	Hrs = 5.25 5.25 to 10 hours	Hrs = 10.25 10.25 to 15 hours	Hrs = 15.25 >15 hours	
Case study/problem-based learning	184 *23.4%*	348 *44.3%*	124 *15.8%*	68 *8.7%*	61 *7.8%*	*Total:* 785
Conferences (multiple lectures)	218 *27.8%*	254 *32.4%*	193 *24.6%*	66 *8.4%*	54 *6.9%*	*Total:* 785
Journal club	525 *66.9%*	173 *22.0%*	49 *6.2%*	22 *2.8%*	16 *2.0%*	*Total:* 785
Lecture (one topic)	211 *26.9%*	425 *54.1%*	106 *13.5%*	24 *3.1%*	19 *2.4%*	*Total:* 785
One-on-one sessions (peer mentoring)	540 *68.8%*	186 *23.7%*	36 *4.6%*	11 *1.4%*	12 *1.5%*	*Total:* 785

In the example above, the minimum total learning hours "Case study/PBL" is:

184 x 0 + 348 x 0.25 + 124 x 5.25 + 68 x 10.25 + 61 x 15.25 = 2365.25 hours

The size of this sample is 785 registrants. Therefore, the average minimum number of learning hours is:

2365.25 hrs/785 registrants = average 3.01 hrs/registrant.

The areas with the highest learning hours represent the methods or providers that were most used.

Learning Format #1: Live Programs

The top 3 live learning methods for pharmacy professionals were:

1. Conferences
2. Case studies (multiple lectures)
3. Lectures (single topic)

Topics	Ranking	Min Learning Hrs per registrant
Case study/problem-based learning	**#2**	**3.01**
Conferences (multiple lectures)	**#1**	**3.28**
Journal club	#5	0.98
Lecture (one topic)	**#3**	**1.53**
One-on-one sessions (peer mentoring)	#8	0.68
Online live webinars	#4	1.34
Role playing	#11	0.24
Teleconference	#10	0.41
Video-conference	#9	0.52
Workshop with small group discussions	#7	0.82
Other (please specify below)	#6	0.86

FIGURE 21 LEARNING FORMAT #1: LIVE PROGRAMS (ALL PHARMACY PROFESSIONALS)

Generally speaking, pharmacists had the same usage, but community pharmacists obtained more hours of learning by using case studies, whereas hospital pharmacists obtained more hours of learning through conferences.

Topics	All RPh (n = 632)		Comm RPh (n = 432)		Hospital RPh (n =126)	
Case study/problem-based learning	**#2**	**3.14**	**#1**	**3.25**	**#2**	**3.06**
Conferences (multiple lectures)	**#1**	**3.60**	**#2**	**3.05**	**#1**	**4.83**
Journal club	#5	1.16	#5	1.16	#4	1.46
Lecture (one topic)	**#3**	**1.71**	**#3**	**1.59**	**#3**	**2.32**
One-on-one sessions (peer mentoring)	#8	0.68	#8	0.53	#7	0.91
Online live webinars	#4	1.49	#4	1.57	#6	1.06
Role playing	#11	0.28	#9	0.35	#11	0.13
Teleconference	#10	0.48	#11	0.32	#10	0.84
Video-conference	#9	0.61	#10	0.34	#5	1.19
Workshop with small group discussions	#6	0.87	#6	0.75	#8	0.90
Other (please specify below)	#7	0.72	#7	0.74	#8	0.90

FIGURE 22 LEARNING FORMAT #1: LIVE PROGRAMS (PHARMACISTS)

Similar to pharmacists, pharmacy technicians also obtained more hours of learning through case studies and conferences. However, community pharmacy technicians obtained more hours of learning through peer mentoring, whereas hospital pharmacy technicians obtained more hours of learning by attending lecturers.

Note: While "Other" is rated as one of the top 3, most of the text responses were invalid because participants were naming providers or methods related to self-directed programs (i.e. not live programs).

Topics	All RPT (n = 153)		Comm RPT (n = 54)		Hospital RPT (n = 79)	
Case study/problem-based learning	#1	2.50	#1	3.32	#2	1.88
Conferences (multiple lectures)	#2	1.96	#3	1.24	#1	2.25
Journal club	#8	0.24	#6	0.41	#10	0.11
Lecture (one topic)	#4	0.77	#8	0.38	#4	0.93
One-on-one sessions (peer mentoring)	#6	0.66	#4	0.65	#6	0.73
Online live webinars	#5	0.72	#5	0.50	#7	0.57
Role playing	#11	0.07	#9	0.13	#11	0.03
Teleconference	#9	0.14	#11	0.02	#8	0.18
Video-conference	#10	0.12	#10	0.02	#9	0.13
Workshop with small group discussions	#7	0.61	#7	0.39	#5	0.75
Other (please specify below)	#3	1.45	#2	2.30	#3	1.11

FIGURE 23 LEARNING FORMAT #1: LIVE PROGRAMS (PHARMACY TECHNICIANS)

Learning Format #2: Self-Directed Programs

The top three self-directed learning methods for pharmacy professionals regardless of registration type and practice setting were:

1. Online text-based learning
2. Printed materials
3. Online interactive modules requiring the use of a web-based Learning Management System

At the same time, it was found that online text-based learning and printed materials were used more often than live programs such as conferences and case studies based on the numbers of the minimum learning hours per registrant.

Topics	Ranking	Min Learning Hrs per registrant
DVDs	#6	0.73
Online interactive modules requiring the use of a web-based Learning Management System (e.g. Blackboard Learn or Moodle)	**#3**	**1.49**
Online text-based learning	**#1**	**4.48**
Printed material (e.g. journals, newsletters, pamphlets, workbooks)	**#2**	**3.87**
Podcasts (audio) streaming directly from a website	#5	0.89
Recorded presentations (video+audio) streaming directly from a website	#4	1.27
Other (please specify below)	#7	0.28

FIGURE 24 LEARNING FORMAT #2: SELF-DIRECTED PROGRAMS (ALL PHARMACY PROFESSIONALS)

Topics	All RPh (n = 632)		Comm RPh (n = 432)		Hospital RPh (n =126)	
DVDs	#6	0.78	#6	0.86	#6	0.58
Online interactive modules requiring the use of a web-based Learning Management System (e.g. Blackboard Learn or Moodle)	**#3**	**1.60**	**#3**	**1.72**	**#3**	**1.39**
Online text-based learning	**#1**	**4.60**	**#1**	**5.05**	**#2**	**3.69**
Printed material (e.g. journals, newsletters, pamphlets, workbooks)	**#2**	**4.09**	**#2**	**4.07**	**#1**	**4.16**
Podcasts (audio) streaming directly from a website	#5	0.98	#5	1.06	#5	0.72
Recorded presentations (video+audio) streaming directly from a website	#4	1.40	#4	1.48	#4	1.36
Other (please specify below)	#7	0.28	#7	0.18	#7	0.57

FIGURE 25 LEARNING FORMAT #2: SELF-DIRECTED PROGRAMS (PHARMACISTS)

Topics	All RPT (n = 153)		Comm RPT (n = 54)		Hospital RPT (n = 79)	
DVDs	#5	0.50	#6	0.41	#5	0.43
Online interactive modules requiring the use of a web-based Learning Management System (e.g. Blackboard Learn or Moodle)	**#3**	**1.07**	**#3**	**1.28**	**#3**	**0.84**
Online text-based learning	**#1**	**4.01**	**#1**	**5.12**	**#1**	**2.94**
Printed material (e.g. journals, newsletters, pamphlets, workbooks)	**#2**	**2.95**	**#2**	**2.87**	**#2**	**2.56**
Podcasts (audio) streaming directly from a website	#6	0.49	#7	0.34	#6	0.31
Recorded presentations (video+audio) streaming directly from a website	#4	0.74	#5	0.57	#4	0.63
Other (please specify below)	#7	0.30	#4	0.76	#7	0.00

FIGURE 26 LEARNING FORMAT #2: SELF-DIRECTED PROGRAMS (PHARMACY TECHNICIANS)

CE Providers

Pharmacy professionals used the following CE providers the most:

1. Canadian Healthcare Network
2. Workplace Learning
3. Canadian Council on Continuing Education in Pharmacy (CCCEP)

The top 10 CE providers for pharmacy professionals is seen in Figure 27.

Topics	Ranking	Min Learning Hrs per registrant
Canadian Healthcare Network	#1	3.39
Workplace Learning	#2	2.79
Canadian Council on Continuing Education In Pharmacy (CCCEP)	#3	2.74
RxBriefcase	#4	1.90
Pharmacist's Letter/Pharmacy Technician's Letter	#5	1.90
Canadian Pharmacists Association (CPhA) [e.g. ADAPT, e-therapeutics highlights]	#6	1.60
British Columbia Pharmacy Association (BCPhA)	#7	1.20
Drug Manufacturers including TechTalk	#8	1.13
Canadian Society of Hospital Pharmacists (CSHP)	#9	0.69
Medscape Pharmacists	#10	0.64

FIGURE 27 TOP 10 CE PROVIDERS UTILIZED BY ALL PHARMACY PROFESSIONALS

Topics	Ranking	Min Learning Hrs per registrant
UBC Faculty of Pharmaceutical Sciences/UBC-CPPD (Continuing Pharmacy Professional Development)	#11	0.59
Provincial Pharmacy Regulatory Bodies [e.g. CPBC, Alberta College of Pharmacists]	#12	0.58
Pear Health eLearning	#12	0.58
UBC Therapeutics Initiative [e.g. Therapeutics Letters]	#14	0.48
American Society of Health System Pharmacists (ASHP)	#15	0.46
UBC Faculty of Medicine/UBC-CPD (Continuing Professional Development)	#15	0.46
Institute For Safe Medication Practices (ISMP)	#17	0.38
Other (please specify below)	#17	0.38
Canadian Association of Pharmacy Technicians (CAPT)	#19	0.35
Universities outside of Canada	#20	0.29
Universities outside of BC but within Canada	#21	0.28
Board of Pharmacy Specialties (BPS)	#22	0.25
Pharmacy Technician Society of BC (PTSBC)	#23	0.21
UBC College of Health Disciplines	#24	0.21

FIGURE 28 OTHER CE PROVIDERS

Community pharmacists mainly utilized CCCEP (3.77 hrs/PS) and Canadian Healthcare Network (3.74 hrs/PS), whereas hospital pharmacists used workplace learning very heavily (5.34 hrs/PS) for their CE learning. On the other hand, both community and hospital pharmacy technicians mainly used Canadian Healthcare Network (5.59 hrs/PT vs 4.33 hrs/PT) and Tech Talk (4.49 hrs/RPT vs 3.12 hrs/RPT) for their CE learning.

All RPh (n = 632)			Community RPh (n = 432)			Hospital RPh (n = 126)		
Canadian Council on Continuing Education In Pharmacy (CCCEP)	#1	3.15	Canadian Council on Continuing Education In Pharmacy (CCCEP)	#1	3.77	Workplace Learning	#1	5.34
Canadian Healthcare Network	#2	3.02	Canadian Healthcare Network	#2	3.74	Canadian Society of Hospital Pharmacists (CSHP)	#2	2.63
Workplace Learning	#3	2.86	RxBriefcase	#3	2.70	Canadian Healthcare Network	#3	1.53
RxBriefcase	#4	2.14	Pharmacist's Letter/Pharmacy Technician's Letter	#4	2.68	Canadian Council on Continuing Education In Pharmacy (CCCEP)	#4	1.53
Pharmacist's Letter/Pharmacy Technician's Letter	#5	2.10	Canadian Pharmacists Association (CPhA) [e.g. ADAPT, e-therapeutics highlights]	#5	2.13	Canadian Pharmacists Association (CPhA) [e.g. ADAPT, e-therapeutics highlights]	#5	1.07
Canadian Pharmacists Association (CPhA) [e.g. ADAPT, e-therapeutics highlights]	#6	1.85	British Columbia Pharmacy Association (BCPhA)	#6	1.71	RxBriefcase	#6	0.99
British Columbia Pharmacy Association (BCPhA)	#7	1.32	Workplace Learning	#7	1.66	Other (please specify below)	#7	0.90
Canadian Society of Hospital Pharmacists (CSHP)	#8	0.81	Pear Health eLearning	#8	0.84	Pharmacist's Letter/Pharmacy Technician's Letter	#8	0.88
Medscape Pharmacists	#9	0.77	Medscape Pharmacists	#9	0.81	American Society of Health System Pharmacists (ASHP)	#9	0.83
UBC Faculty of Pharmaceutical Sciences/UBC-CPPD (Continuing Pharmacy Professional Development)	#10	0.67	Provincial Pharmacy Regulatory Bodies [e.g. CPBC, Alberta College of Pharmacists]	#10	0.77	UBC Faculty of Medicine/UBC-CPD (Continuing Professional Development)	#10	0.83

FIGURE 29 TOP 10 CE PROVIDERS (PHARMACISTS)

All RPT (n = 153)			Community RPT (n = 54)			Hospital RPT (n = 79)		
Canadian Healthcare Network	#1	4.93	Canadian Healthcare Network	#1	5.59	Canadian Healthcare Network	#1	4.33
Drug Manufacturers including TechTalk	#2	3.78	Drug Manufacturers including TechTalk	#2	4.49	Drug Manufacturers including TechTalk	#2	3.12
Workplace Learning	#3	2.48	Pharmacist's Letter/Pharmacy Technician's Letter	#3	2.10	Workplace Learning	#3	2.49
Canadian Association of Pharmacy Technicians (CAPT)	#4	1.16	Workplace Learning	#4	2.02	Pharmacy Technician Society of BC (PTSBC)	#4	1.08
Pharmacist's Letter/Pharmacy Technician's Letter	#5	1.09	Canadian Council on Continuing Education In Pharmacy (CCCEP)	#5	1.61	Canadian Association of Pharmacy Technicians (CAPT)	#5	0.76
Canadian Council on Continuing Education In Pharmacy (CCCEP)	#6	1.08	RxBriefcase	#6	1.58	Canadian Council on Continuing Education In Pharmacy (CCCEP)	#6	0.70
RxBriefcase	#7	0.94	Canadian Association of Pharmacy Technicians (CAPT)	#7	1.55	British Columbia Pharmacy Association (BCPhA)	#7	0.61
Pharmacy Technician Society of BC (PTSBC)	#8	0.89	Canadian Pharmacists Association (CPhA) [e.g. ADAPT, e-therapeutics highlights]	#8	0.82	RxBriefcase	#8	0.59
British Columbia Pharmacy Association (BCPhA)	#9	0.71	British Columbia Pharmacy Association (BCPhA)	#9	0.79	Institute For Safe Medication Practices (ISMP)	#9	0.37
Canadian Pharmacists Association (CPhA) [e.g. ADAPT, e-therapeutics highlights]	#10	0.58	Provincial Pharmacy Regulatory Bodies [e.g. CPBC, Alberta College of Pharmacists]	#10	0.55	Canadian Pharmacists Association (CPhA) [e.g. ADAPT, e-therapeutics highlights]	#10	0.34

FIGURE 30 TOP 10 CE PROVIDERS (PHARMACY TECHNICIANS)

Top Considerations When Choosing a Learning Activity

Participants were asked to select their top 3 considerations when choosing a learning activity. The top 5 considerations for pharmacy professionals were:

1. Accreditation
2. Topic
3. Costs
4. Location (live)/Accessibility (self-directed)
5. Learning format (live/self-directed)

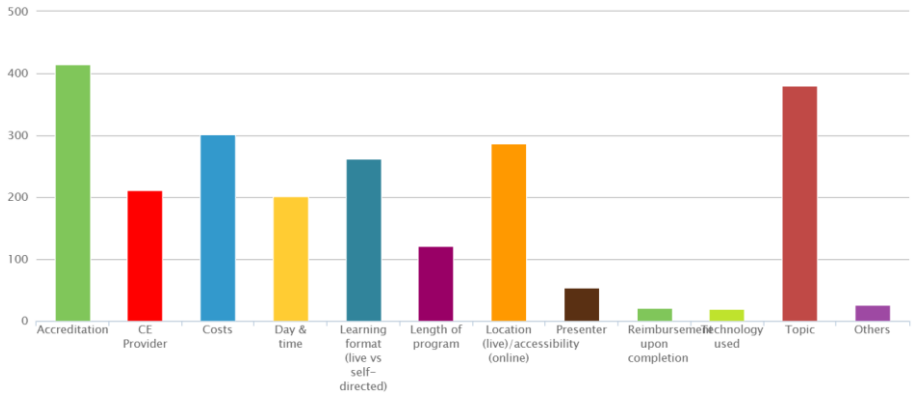


FIGURE 31 TOP CONSIDERATIONS WHEN CHOOSING A LEARNING ACTIVITY (ALL PHARMACY PROFESSIONALS)

These are also the same order of top 5 considerations by registration type (see Figure 32 and 33).

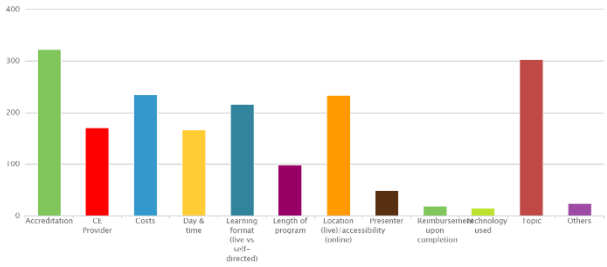


FIGURE 33 TOP CONSIDERATIONS WHEN CHOOSING A LEARNING ACTIVITY (PHARMACISTS)

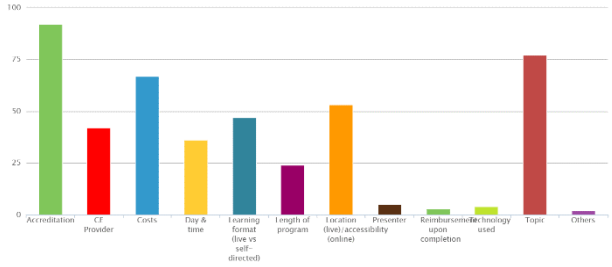


FIGURE 32 TOP CONSIDERATIONS WHEN CHOOSING A LEARNING ACTIVITY (PHARMACY TECHNICIANS)

The top 5 considerations remained the same by practice setting, however hospital pharmacy professionals had a different ranking for these 5 considerations. The top 5 considerations for hospital pharmacy professionals were as follows (see Figure 34 and 35):

1. Topic
2. Accreditation
3. Location (live)/Accessibility (self-directed)
4. Costs
5. Learning format (live/self-directed)

The top 5 considerations remained the same by location, however pharmacy professionals practicing

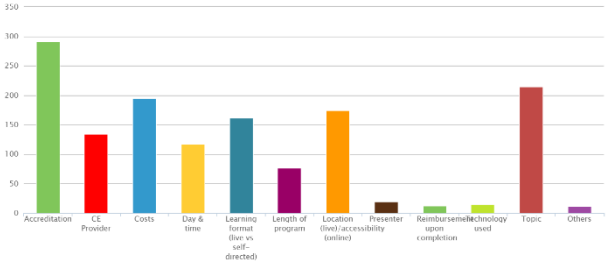


FIGURE 35 TOP CONSIDERATIONS WHEN CHOOSING A LEARNING ACTIVITY (COMMUNITY)

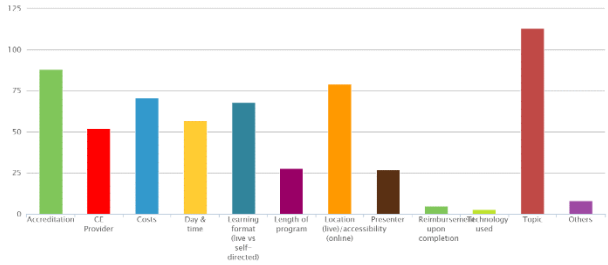


FIGURE 34 TOP CONSIDERATIONS WHEN CHOOSING A LEARNING ACTIVITY (HOSPITAL)

outside Lower Mainland (i.e. districts 3, 4, and 5) ranked location (live)/accessibility (self-directed) higher than those practicing in Lower Mainland (i.e. districts 1 and 2). The top 5 considerations for pharmacy professionals practicing outside Lower Mainland were as follows:

1. Accreditation
2. Topic
3. Location (live)/Accessibility (self-directed)
4. Costs
5. Learning format (live/self-directed)

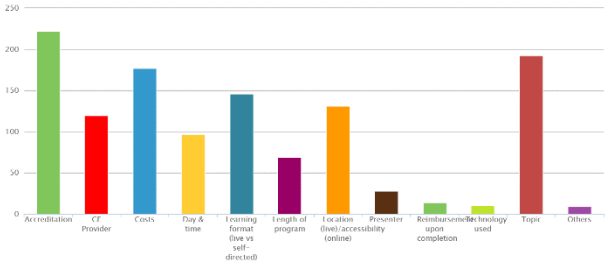


FIGURE 37 TOP CONSIDERATIONS WHEN CHOOSING A LEARNING ACTIVITY (LOWER MAINLAND)

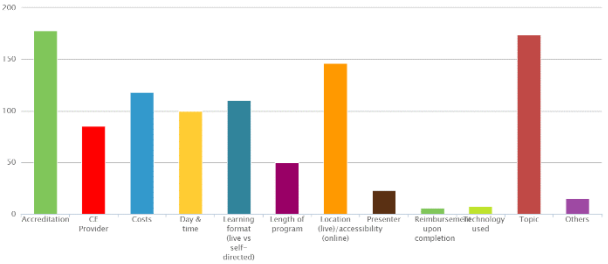


FIGURE 36 TOP CONSIDERATIONS WHEN CHOOSING A LEARNING ACTIVITY (OUTSIDE LOWER MAINLAND)

Learning Needs Met? How to Improve Learning Needs?

Participants were asked if their completed learning activities met their learning needs for their current practice.

A *Chi* test was run to determine whether there were significant differences to each group of responses among the two registration types. Among those who answered "yes", it was found that there was a significant difference ($p < 0.05$) between the two registration types. Among those who answered "somewhat", it was found that there was a very weak significant difference ($p \sim 0.05$) between the two registration types. Among those who answered "no", there was no significant difference.

A *Chi* test was also run to determine whether there are significant differences to each response among two geographical groups: "Lower Mainland" (districts 1 and 2) and "outside Lower Mainland" (districts 3 to 5). No differences were found among all 3 responses.

Based on this finding, there is a need to increase CE programs that will meet the need of pharmacy technicians.

YES	Community	Hospital	ALL
RPh	88.7%	84.8%	87.7%
RPT	77.4%	75.9%	75.0%
ALL	87.5%	81.4%	85.2%

SOMEWHAT	Community	Hospital	ALL
RPh	10.1%	14.4%	11.4%
RPT	18.9%	22.8%	22.4%
ALL	11.1%	17.6%	13.5%

NO	Community	Hospital	ALL
RPh	1.2%	0.8%	1.0%
RPT	3.8%	1.3%	2.6%
ALL	7.0%	1.0%	1.3%

FIGURE 38 DID THE LEARNING ACTIVITIES THAT YOU COMPLETED MEET YOUR LEARNING NEEDS FOR YOUR CURRENT PRACTICE?

For those who selected "somewhat" or "no", they were asked to describe what else could be done to meet their learning needs.

Pharmacists wanted more CEs that are:

- Diverse in topics…[and] more topics…more specific topics…new medications…new treatment protocols…[but also] review of diseases & treatments
- Relevant to their needs, practice, and/or role
- Web-based learning…[and] live presentations/conferences/workshops in their local areas…more free ones…and frequently held…held at times that suit their work and live schedules
- Delivered in a way that the registrants can retain the information after 6 months…[e.g.] have written learning summaries
- Delivered using user-friendly technology
- Comprehensive on broad disease states, drug therapies (old and new), their place in treatment, and how to improve the life of the individual patient with this disease state…
- Evidence-based, concise, bias-free articles

Pharmacy technicians wanted more CEs that are:

- accredited and specific for pharmacy technicians
- relevant to and will enhance their scope of practice and/or role
- hospital-based topics or journal articles…[such as] sterile compounding and safety
- web-based learning…[and] live presentations/conferences/workshops in their local areas…at a reasonable cost

To close the survey, participants were also asked about what pharmacy continuing education they would like to see more of in BC.

Pharmacists want to see more CE that is:

- More live presentations/workshops/seminars/ webinars/interactive sessions with group discussion and learning… in the evening…[or] day-long in length… in local areas…out of Vancouver…[including] the Island…the Okanagan-Kootenays…Northern BC….and the rural areas
- Live presentations that are also recorded and able to be completed online later
- Case studies…from BC pharmacists
- In-depth programs…[like] specialized programs…certificate programs…[for] advanced practices
- Programs organized/offered by the College…like those offered by OCP and ACP
- Preferably free…[or] at an affordable…reasonable cost
- Self-directed studies: easily accessible, time independent, preferably free, unbiased online learning…practical and case based studies that can be applied in the workplace
- [Non-clinical pharmacy practice topics]…hospital: drug distribution, automation, technology, safety, risk management, project management…regulatory and government…business management: human resources, time efficiencies, workflow issues…team building

Note: The first bullet point is the most important point as it is a recurring theme among the 240 text responses received.

Pharmacy technicians want to see more CE that is

- More technician-specific, in-depth information and topics…more Tech Talks…more hospital-based ones
- More live presentation/workshops/conferences for technicians…[especially] on the island…
- More free, accredited CEs for technicians
- More interactive learning with other technicians
- Support from workplace for learning
- More pharmacist/technician joint courses
- More online (longer duration, more CEU's per lesson)…easy to access
- Compounding

Note: The first bullet point is the most important point as it is a recurring theme among the 46 text responses received.

Conclusion

The survey results identified that pharmacists and pharmacy technicians have different focus areas of their learning priorities. Pharmacists found it very important to learn more about topics related to the first domain "Medications and Medication-use", whereas pharmacy technicians found it very important to learn more about topics related to the third domain "Safety and Quality". Unfortunately, among the four domains of standards of practice set forth by NAPRA, both types of registrants value collaboration as the least important learning priority.

For pharmacists, their highest priority is to learn more about chronic diseases and identifying and resolving drug therapy problems as these two topics have the highest scores in the first domain and among all the CE topics throughout the survey. The top five chronic diseases that pharmacists want to learn more of are: diabetes, asthma, COPD, vaccines, and mental health. On the other hand, pharmacy technicians found it very important to learn more about preventing and managing dispensing errors and incidents.

It was also identified that pharmacists and pharmacy technicians have different learning priorities based on their practice setting. The differences are assumed to be related to their roles and responsibilities of their positions, as well as the type of patients they provide care for. For example, with respect to the second domain "Collaboration", community pharmacists found it very important to learn more about counseling skills, whereas hospital pharmacists found it important to learn about communication skills in general. Another example with respect to the third domain "Safety and Quality" is that community pharmacy technicians found it important to learn more about inventory management, whereas hospital pharmacy technicians found it extremely important to learn more about handling hazardous drugs.

Both types of registrants spent most hours for continuing professional development through self-directed programs. The top 3 learning formats for all registrants in order are: online text-based learning (self-directed), printed materials (self-directed), conferences (live). With regards to CE providers, hospital registrants utilized workplace learning more frequently than their community peers, and pharmacy technicians utilized Canadian Healthcare Network and Tech Talks much more frequently than pharmacists most likely because they are most familiar with these two providers from their educational programs prior to licensing.

Accreditation, topic, costs, location/accessibility, and learning formats are the top 5 considerations for all registrants regardless of practice type, practice setting, and geographic location although hospital registrants value location/accessibility over costs than community registrants, and so are registrants who practice outside lower mainland when compare with those who practice within the lower mainland.

Overall, registrants want to see more live programs offered in their geographic regions. In essence, the survey results have identified that there is a crucial need to increase the availability of continuing education programs specific for pharmacy technicians in BC. Therefore, as a first priority, it is recommended that the College invests more resources on funding continuing education programs for pharmacy technicians in order to support their practices and their learning needs.

In general, it is recommended that all future College-funded CE programs should contain a few highly-scored CE topics in the four domains that were identified in this survey. For example, a live CE program on diabetes may have 2 different streams in addition to some shared subtopics. The pharmacist's stream may include other components directly or indirectly related to interpreting laboratory values, identifying and resolving drug therapy problems, counseling, critical thinking, and identifying reliable references and resources, whereas the pharmacy technician's stream may include components directly or indirectly related to home monitoring devices, patient teaching skills, patient safety and quality improvement, and roles and responsibilities of pharmacy staff.

9. Practice Review Program – Phase I and Phase II Update

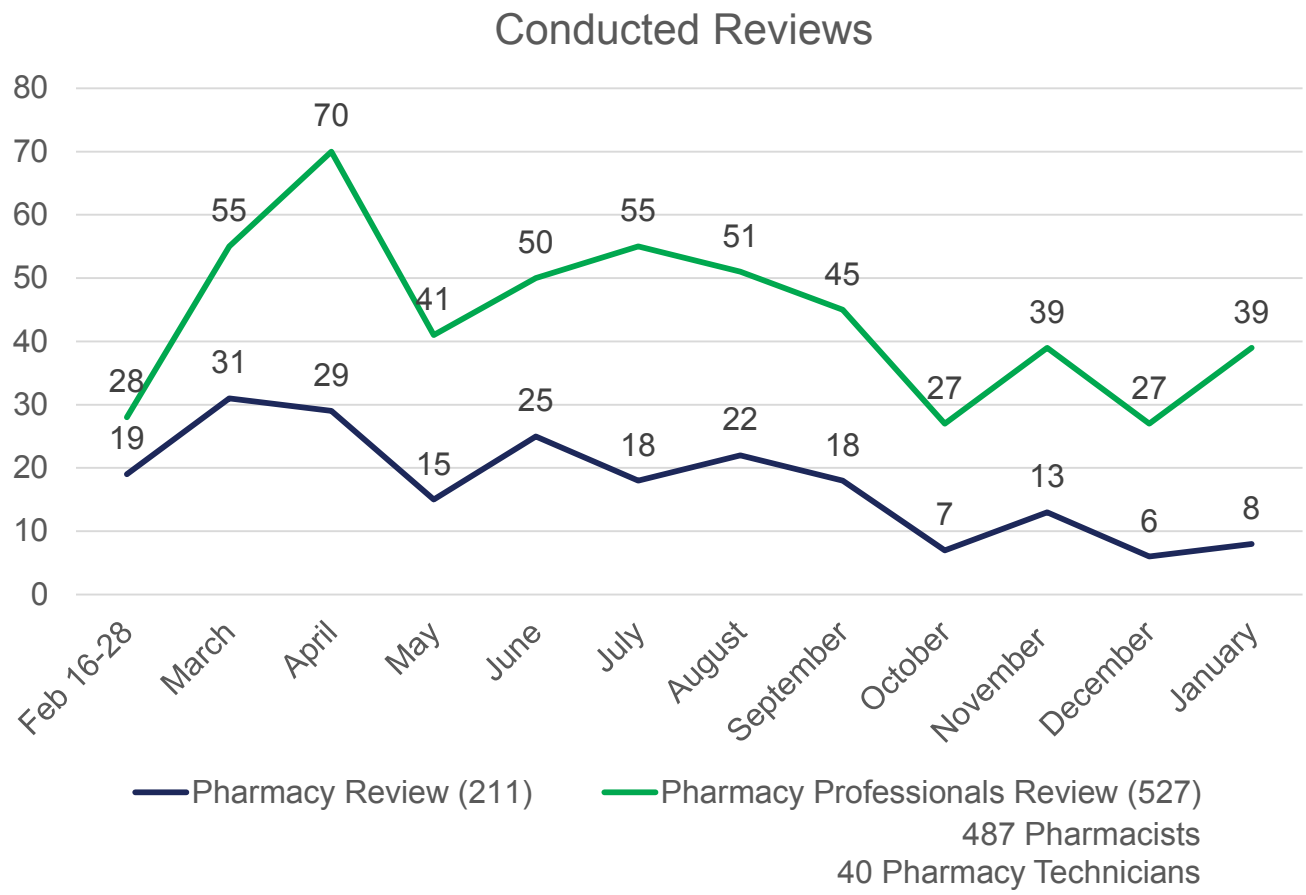
Michael Ortynsky

Chair, Practice Review Committee

Phase I – Community Practice Update

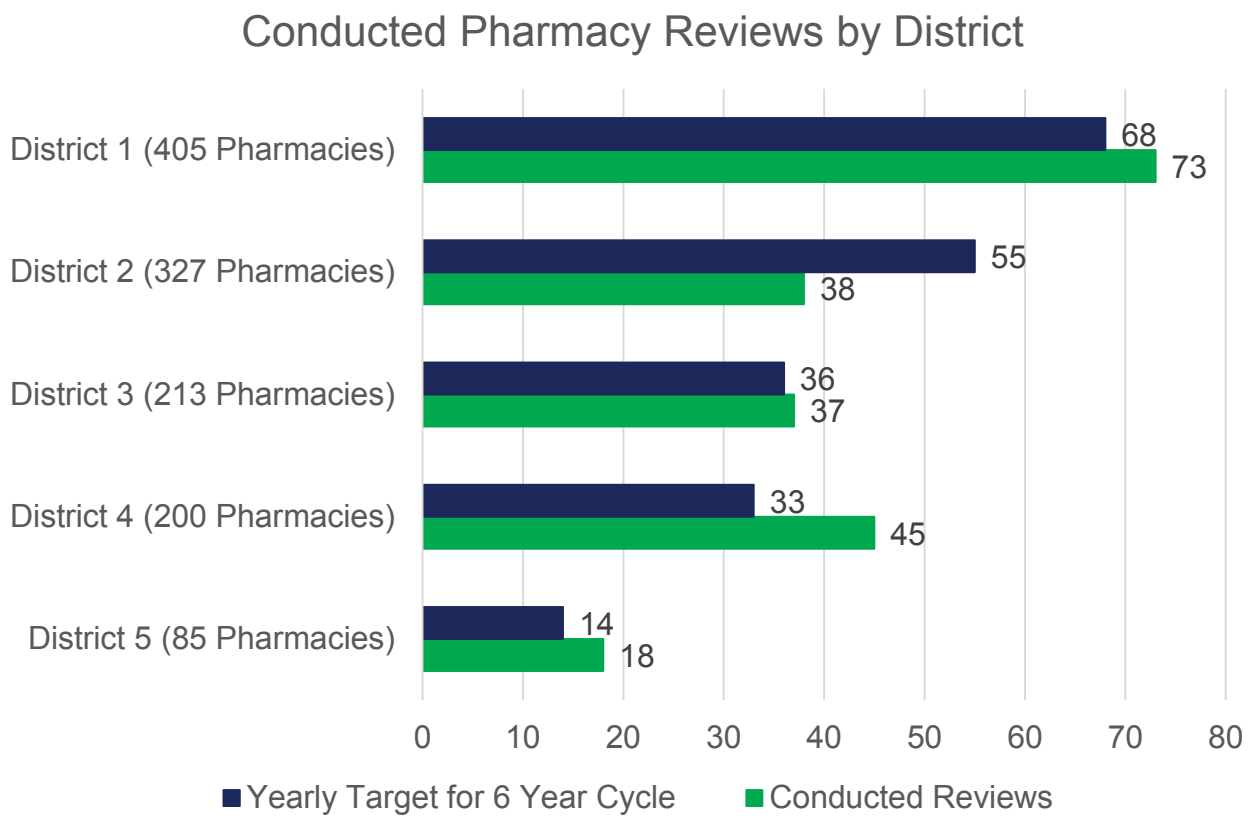
- Conducting Pharmacy Reviews and Pharmacy Professionals Reviews as scheduled
  - On target for 6 year cycle
- Providing feedback on findings via ongoing PRP Insights articles in ReadLinks
- Enhancing Pharmacy Professionals Reviews for Pharmacy Technicians
- Developing additional Pharmacy Review forms
  - Methadone, Residential Care services and compounding

Phase I – Community Practice Statistics



College of Pharmacists of British Columbia

Phase I – Community Practice Statistics



***As of January 31st, 2016**

College of Pharmacists of British Columbia

Phase II – Hospital Practice Update

- Developing review forms based on standards
  - Pharmacy Review and Pharmacy Professionals Review
- Engaging with registrants and other stakeholders
  - Health Authorities
  - Canadian Society of Hospital Pharmacists
  - March 8th, 2016 Forum / Workshop

Feedback

- Distributing anonymous feedback survey to those who have undergone Phase 1 reviews and completed all their assigned action items
  - To be collated and reported to the Board as a 1 year report
  - Concerns addressed when possible on an ongoing basis

- Other registrant feedback

Questions?

11. Drug Schedule Regulation Amendment – Naloxone

Bal Dhillon

Chair, Legislation Review Committee

Drug Schedule Regulation Amendment - Naloxone

Background

- Health Canada is proposing a change to the federal Prescription Drug List (PDL) to allow for non-prescription naloxone use in opioid overdose emergencies outside of hospital
- This is in response to the increases in fatal overdoses across Canada
- Consultation is underway until mid-March; unless significant issues are raised, Health Canada anticipates making the change to PDL by early April
- Naloxone is currently only available in Canada via intra-muscular injection

Drug Schedule Regulation Amendment - Naloxone

The BC Approach

- CPBC has worked in partnership with Health Canada; BCCDC; Ministry of Health; First Nations Health Authority; CPSBC; CRNBC to ensure BC is ready once the anticipated change to the PDL is made

- A consultation session was held on February 2, 2016. Recommendation from participants was to change the DSR to move naloxone to Schedule II – for the specific use in opioid overdose emergencies outside of hospital

- Recommendation was made considering one primary factor – the current delivery method (ampoule and IM injection)

- Schedule II would require the pharmacist to provide counselling, orientation and education to the purchaser of naloxone

Drug Schedule Regulation Amendment - Naloxone

The BC Approach – Continued

- Stakeholders in BC as well as Health Canada are working together to meet the aggressive timeline of early April
- This requires the CPBC, Health Canada and the Ministry of Health to work outside of the normal regulation change process
- Health Canada has committed to waiving the normal 60 day period of appeal
- The Ministry of Health has committed to fast-tracking the change through the legal review and tagging stage of their process

Drug Schedule Regulation Amendment - Naloxone

The BC Plan

- While the regulatory work is underway, BCCDC will be developing a module to train registrants who would be providing counselling, orientation, and education to persons purchasing the drug
- This will be delivered in four to five live sessions throughout BC
- A session will also be available on the CPBC website
- BCCDC will develop materials for registrants to provide when selling the drug

Drug Schedule Regulation Amendment - Naloxone

MOTION:

That the Board approve the following resolution on the condition that Health Canada confirms the amendments to the Prescription Drug List regarding naloxone.

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

(a) by striking out the following:

1 Naloxone and its salts***, and***

(b) by adding the following:

1 Naloxone and its salts (except when used for opioid overdose emergencies outside hospital settings)

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

12. Certified Pharmacist Prescriber Update

Gillian Vrooman

Director of Communications and Engagement

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

College of Pharmacists of British Columbia

Updates to Draft Framework

- Expanded sections (i.e. Issue and Societal Need) for greater clarity
- Added supporting evidence throughout the document
- Addressed inconsistency with prescribing and dispensing
- Expanded case scenarios to include additional details on:
  - patient assessment
  - synthesis
  - actions
  - monitoring plan
  - benefits

Draft Framework Ready for Stakeholder Engagement

College of Pharmacists
of British Columbia

Stakeholder Engagement

Stakeholder engagement is an essential part of moving the Certified Pharmacist Prescriber Initiative forward.

Stakeholder Engagement

(DRAFT) College of Pharmacists of BC Engagement Guide

Contents

College of Pharmacists of British Columbia

Purpose

The stakeholder engagement is intended to:

- Build awareness and indications of support from pharmacy professionals, other prescribing health care providers and patients for the new prescribing authority
- Gather input from pharmacists on how prescribing could work in their practice
- Gather input from pharmacists and other prescribing healthcare providers on the possible issues and risks and identity possible solutions
- Gather input from patients on their interest and concerns about pharmacist prescribing authority

Understanding the Range of Use Cases

Participation Spectrum

INCREASING IMPACT ON THE DECISION

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision. We will seek your feedback on drafts and proposals.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will work together with you to formulate solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

RPCC
Regional Primary Care Coalition

Appendix 11

The Dimensions of Patient Engagement

Patient engagement encompasses both clinical interactions with the health care system as well as community interactions with family, friends, and neighbors. Patients may choose to engage at any dimension, but health care systems and communities must enable patients to engage at the most empowering dimensions. Empowered patients can improve the health of communities and lower the cost of care as patients make healthier choices and help their families and communities do the same.

Engaged in Population Health

At this highest level, patients are more engaged in advocating for the health of their communities, e.g., voicing concerns to policymakers, helping others navigate the health care system, and advancing health equity.

Ownership of Health

Patients have high health literacy and a strong understanding of how to make healthy choices. Patients are the managers of their own care and call their nurse or doctor proactively when there's a problem.

Partnering with Patients

Patients are asked to provide their perspective on how to improve health care in the community. The patient learns about how the health care system works and the health system learns from patients.

Shared Decision Making

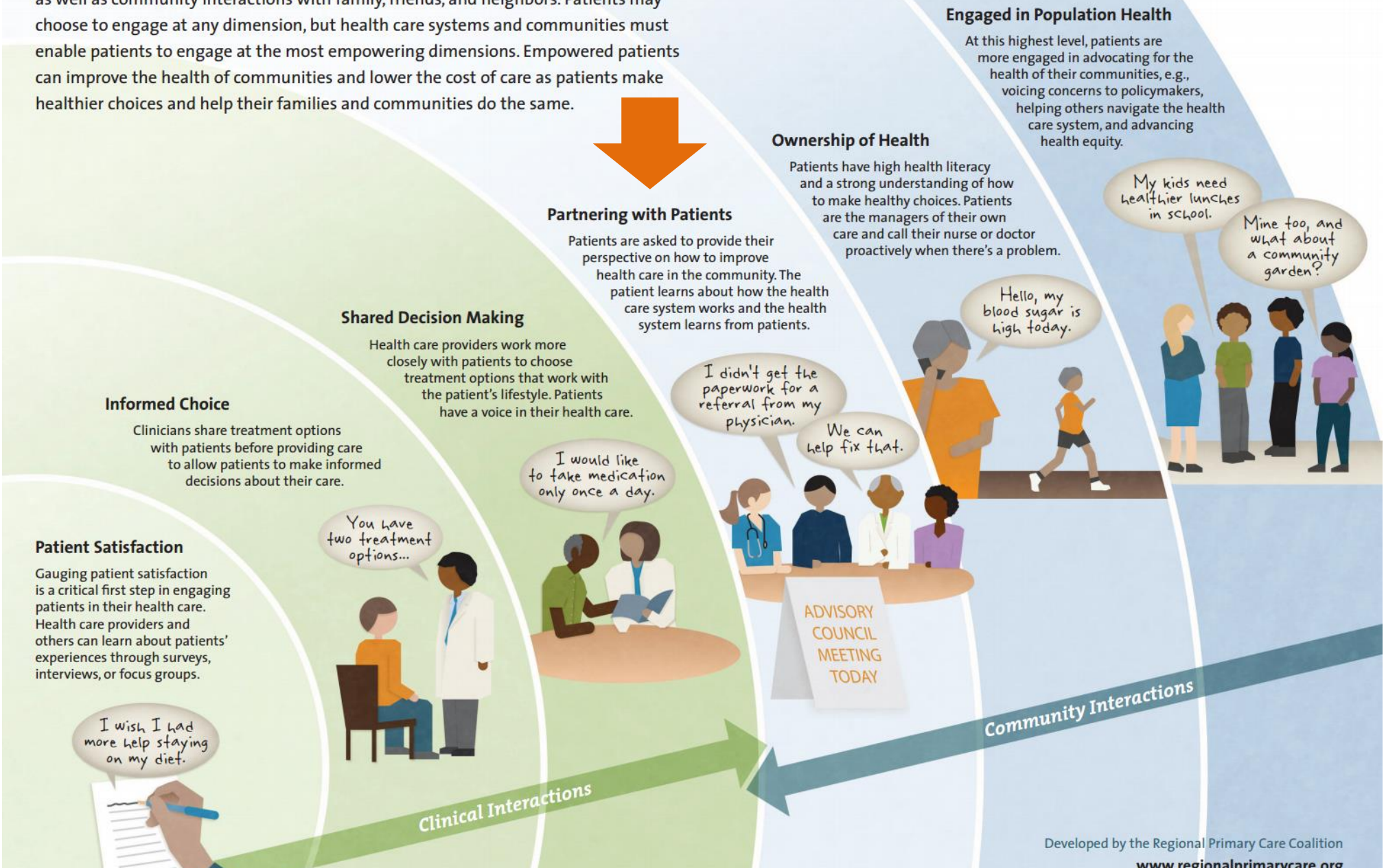
Health care providers work more closely with patients to choose treatment options that work with the patient's lifestyle. Patients have a voice in their health care.

Informed Choice

Clinicians share treatment options with patients before providing care to allow patients to make informed decisions about their care.

Patient Satisfaction

Gauging patient satisfaction is a critical first step in engaging patients in their health care. Health care providers and others can learn about patients' experiences through surveys, interviews, or focus groups.

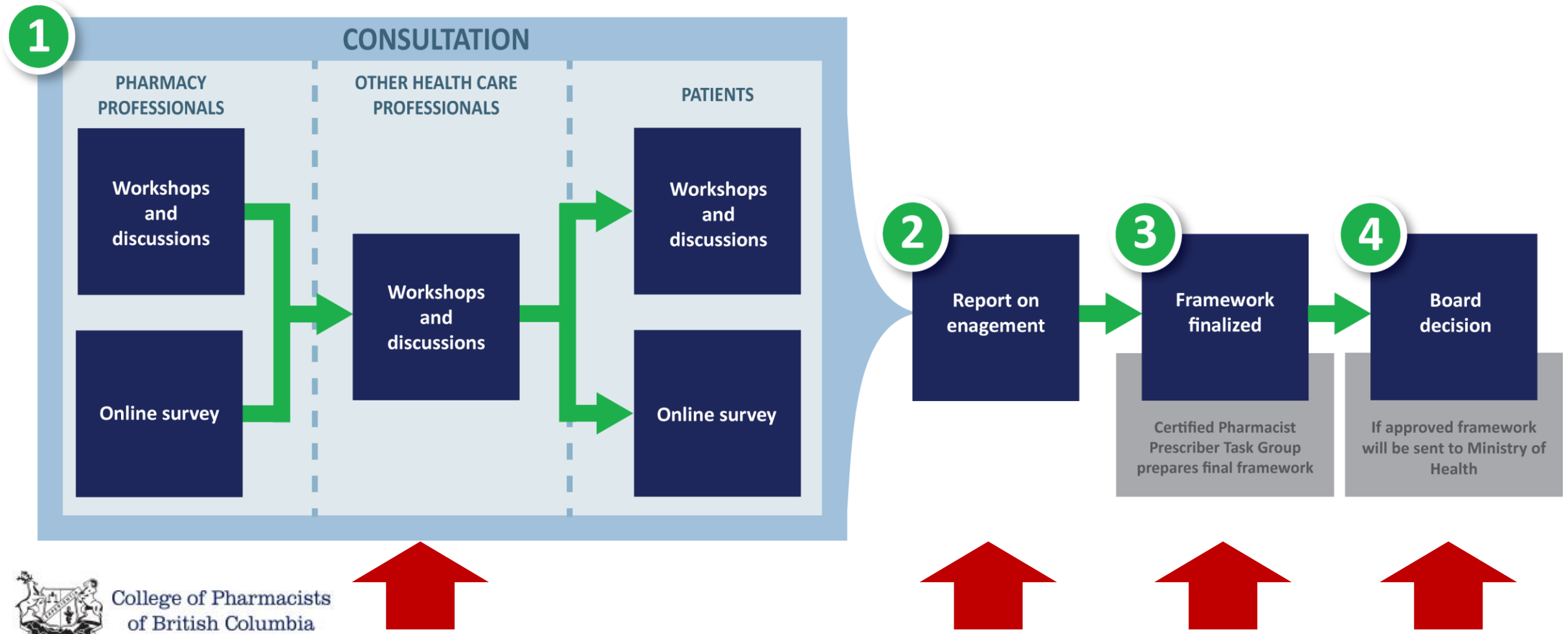


Developed by the Regional Primary Care Coalition
www.regionalprimarycare.org

Out of Scope Topics

- Ordering and accessing laboratory tests
- The Alberta pharmacist prescribing model
- Reimbursement for pharmacist prescribers

Engagement Process



College of Pharmacists of British Columbia

Stakeholder Engagement Report

The stakeholder engagement report will include:

- Purpose of engagement
- Scale of engagement
- Summary of what we heard
- Conclusion
- Next steps

Next Steps

- Consultation with College Advisory Committees
  - Hospital, community and residential care
- Discussions with pharmacist managers and executives
- Discussions with pharmacists actively interacting with patients
- Online survey of registered pharmacists across BC

Questions

College of Pharmacists of British Columbia

CERTIFIED PHARMACIST PRESCRIBER INITIATIVE

DRAFT FRAMEWORK

February 2016

Table of Contents

Acronyms and Abbreviations

ACP	**Alberta College of Pharmacists**
ARNBC	**Association of Registered Nurses of BC**
BC	**British Columbia**
CPhA	**Canadian Pharmacists Association**
College	**College of Pharmacists of BC**
CPSBC	**College of Physicians and Surgeons of BC**
CRNBC	**College of Registered Nurses of BC**
MoH	**Ministry of Health**
UK	**United Kingdom**
USA	**United States of America**

1.0 Purpose

This Certified Pharmacist Prescriber Initiative Draft Framework (draft framework) sets the parameters of the initiative. The Certified Pharmacist Prescriber Initiative is set out in the College's Strategic Plan, and is a priority for the Board. Previously known as the Advanced Practice Pharmacist Initiative, the title was updated and approved by the Board in September 2015 to better reflect the scope of the initiative. This draft framework outlines the societal need for the initiative, and includes an environmental scan of expanded scope of practice for pharmacists in other jurisdictions as well as other non-medical prescribers in British Columbia (BC). It outlines the proposed eligibility criteria, renewal requirements as well as the standards, limits and conditions to qualify as a Certified Pharmacist Prescriber. The College, with direction from the Certified Pharmacist Prescriber Task Group, developed this document for Board approval for the purposes of stakeholder engagement. Stakeholder engagement planning began in Winter 2015 and feedback will be gathered on the draft framework. The stakeholder engagement results will inform the final framework, which will be developed with direction from the Task Group. The report on stakeholder engagement will be shared with the Board in June 2016. The final Certified Pharmacist Prescriber Framework will be submitted to the Board in September 2016 for approval.

2.0 Issue

Traditional models of care with physician-dominated prescribing have come under pressure due to the combined effects of an expanding aging population, increasing burden of chronic diseases, physician shortages, limited access to primary care services, increasing prescription drug utilization, proliferation of new drug therapies, medication-related hospitalization and polypharmacy.

This growing pressure has led to expanding prescribing rights for pharmacists and other health care professionals to address the drug therapy needs of the population. The health care system is evolving to make better use of highly qualified health care professionals that results in a better team dynamic and partnerships among providers.[1] [2] Health care quality is getting the right care to the right patient at the right time from the right health care professional.[3] [4]

Prescribing allows pharmacists to play a greater role in optimizing patients' drug therapy, helping patients achieve their health goals, and improving patients' quality of life, while ensuring the quality of the medication use system, in collaboration with other health care providers.[5]

Prescribing rights vary for pharmacists across Canada; all provinces currently allow pharmacists to initiate Schedule I prescriptions, except BC.

Pharmacists are trained to prevent, identify, and resolve drug therapy problems. They have the knowledge, skills, and abilities to initiate, monitor and adjust drug therapy. Without the authority to prescribe, pharmacists make recommendations to an authorized prescriber and wait for the prescription

[1] Health Council of Canada. 2005. Primary Health Care: Background Paper.
[2] Health Council of Canada. 2008. Sustainability in Public Health Care: What Does It Mean? A Panel Discussion Report.
[3] BC Patient Safety and Quality Council. 2016. Frequently Asked Questions.
[4] Ontario Ministry of Health and Long-Term Care. 2012. Ontario's Action Plan for Health Care.
[5] Canadian Institute for Health Information. 2011. Health Care Cost Drivers: The Facts.

to be authorized, or not. As a result, patients may face delays in treatment and timely access to medications. Pharmacist prescribing would allow timely interventions to initiate, modify, and discontinue therapies.

Pharmacist prescribing is not new in BC, but it is limited and restrictive. BC pharmacists:

- have been assessing patients and prescribing Schedule II and III drugs for years
- became the first in Canada to be formally granted independent authority for emergency contraceptives
- prescribe emergency supplies of drug therapy
- continue (refilling) and adapt (modifying) prescriptions written by authorized prescribers

The College presents evidence which supports an expanded scope of practice for BC pharmacists to prescribe Schedule I drugs based on the following factors (a) a patient-centred multidisciplinary collaborative approach in the delivery of health care services, especially patients with chronic diseases, (b) the need for timely access to primary care due to an expanding aging population and rising burden of chronic disease, (c) the need for timely access to medications for patients in the acute and inpatient settings, outpatient clinics, community-based primary care, and during transitions in care, (d) pharmacist expertise in medication use, (e) pharmacist experience with assessing patients and prescribing (although limited to Schedule II and III drugs and adaptations of prescriptions), (f) the College's role of ensuring patient safety throughout the continuum of care, and (g) significant expansion in pharmacist scope of practice nationally and internationally. A prescribing pharmacist would require College certification as a Certified Pharmacist Prescriber (see Appendix 1 for Certified Pharmacist Prescriber case scenarios).

3.0 Background

3.1 Societal need for pharmacist prescribing

At one time, prescribing was limited largely to physicians. However, growing pressure on the health care system, including limited access to primary care services, increasingly important roles for other health professionals, recognition of this expertise, and an increasing focus on a multidisciplinary collaborative approach in the delivery of health care services, especially with chronic diseases, have led to expansion of prescribing rights for other health care professionals including pharmacists. Expanded roles for health care professionals provide opportunities to fill gaps in the health care system when physicians are unavailable, to improve efficiency and access to care by enabling qualified non-physician providers to assess patients and provide care, and to better utilize health care professionals in multidisciplinary collaborative patient-centred health care environments to address patient population needs.

Effective drug therapy management is a key health care need. Canadians spent approximately $25 billion on prescription drugs in 2009, over half of which was spent on chronic use drugs such as those to

manage cardiovascular risk factors and disease; however, medication adherence can be suboptimal,[6] [7] complicated by challenges accessing primary care.[8] Individuals with chronic conditions of medium or high complexity use a greater number of health services, including drug therapies, and 50% of British Columbians are taking one or more prescription medications.[9,10] People living in rural and remote areas face additional challenges as they tend to have poorer health status and limited access to health care services.[11]

Inadequate drug therapy management can result in a number of complications, including drug-related hospitalization, sub-optimal drug therapy, over-prescribing, and other adverse incidents. A study of internal medicine units of Vancouver General Hospital found that about 25% of patients were hospitalized for drug-related causes, and over 70% were deemed preventable.[12]

The need for effective drug therapy management will continue to increase as BC's population ages. BC has the fastest growing population of seniors in Canada with almost 17% being age 65 or older; this is expected to double in the next 25 years.[13] Many seniors develop complex health conditions as they age and many require multiple medications. Seniors are at a greater risk for adverse drug reactions and are five times more likely to be hospitalized as a result.[14]

Pharmacists have a professional responsibility to improve drug therapy outcomes for their patients and to improve the health care system. Pharmacist-led drug therapy management improves clinical outcomes for patients, contributes to health care cost savings, and receives high satisfaction ratings from patients.[15] Pharmacist prescribing optimizes the pharmacist's role in medication management and could improve continuity of care by decreasing the number of steps a patient must take to obtain the optimal medication regimen for their condition.[16]

[6] World Health Organization. Adherence to long-term therapies: Evidence for action. [Internet]. World Health Organization; 2003. Available from: http://whqlibdoc.who.int/publications/2003/9241545992.pdf

[7] De Vera MA, Bhole V, Burns LC, Lacaille D. Impact of statin adherence on cardiovascular disease and mortality outcomes: a systematic review. Br J Clin Pharmacol. 2014 Oct;78(4):684–98.

[8] Law MR, Ma T, Fisher J, Sketris IS. Independent pharmacist prescribing in Canada. Can Pharm J (Ott). 2012 Jan;145(1):17-23.

[9] Health Council of Canada. 2014. Where You Live Matters: Canadian Views on Health Care Quality.

[10] Ministry of Health of British Columbia. 2015. Primary and Community Care in BC: A Strategic Policy Framework.

[11] Ministry of Health of British Columbia. 2015. Rural Health Services in BC: A Policy Framework to Provide a System.

[12] Samoy, LJ, Zed PJ, Wilbur K, Balen RM, Abu- Laban RB, Roberts M. Drug-related hospitalizations in a tertiary care internal medicine service of a Canadian hospital: A prospective study. Pharmacotherapy 2006:26(11):1578-86.

[13] Ministry of Health of British Columbia. 2014. 2014/15 - 2016/7 Service Plan.

[14] Canadian Institute for Health Information. 2014. Adverse drug reaction- related hospitalizations among seniors 2006 to 2011.

[15] Ramalho de Oliveira D, Brummel AR, Miller DB. Medication therapy management: 10 years of experience in a large integrated health care system. *J Manag Care Pharm.* 2010;16(3):185-95.

[16] Pearson, Glen et al. An Information Paper on Pharmacist Prescribing Within a Health Care Facility. The Canadian Journal of Hospital Pharmacy, [S.l.], v. 55, n. 1, May 2009.

Pharmacists' role in medication management *(includes the initiation of drug therapy):

- assess patients and their medication-related needs and identify actual or potential drug therapy problems
- formulate and implement care plans to prevent and/or resolve drug therapy problems
- recommend, adapt or initiate drug therapy where appropriate
- monitor, evaluate and document patients' response to therapy
- collaborate and communicate with other health care providers, in partnership with patients[17]

Pharmacists monitor the effects of drug therapy and make dosing and drug selection recommendations. What results without the authority to prescribe is often a redundant and time-consuming process, where pharmacists make recommendations to other health care professionals who are asked to approve them. This causes delays and inefficiencies that are not in the interest of patient care or safety, especially in cases of adverse effects or lack of therapeutic response, and does not improve the overall quality of therapeutic decision-making. Further, it requires patients to visit multiple healthcare practitioners and constrains the time that prescribers (e.g., physicians and nurse practitioners, etc.) have to provide other care within their scopes of practice. Prescribing authority provides pharmacists with an important tool to contribute to the optimization of medication use and improve patient health outcomes.

Lack of continuity and prescribing errors at transitions of care from community to hospital and hospital to community are major causes of morbidity, readmission, inefficiency, and patient dissatisfaction with care.[18] [19] [20] [21] This has become a major priority of health authorities and is a focus of accreditation standards for hospitals.[22] Pharmacists in hospital and the community have a critical role in reconciling and optimizing drug therapy through these transitions. Prescribing is a key to doing this effectively and pharmacist prescribing would contribute greatly to achieving the goal of seamless care delivery.

---

* Medication management is defined as patient-centred care to optimize safe, effective and appropriate drug therapy. Care is provided through collaboration with patients and their health care teams. This definition was collaboratively defined by the Canadian Pharmacists Association, Canadian Society of Hospital Pharmacists, Association of Faculties of Pharmacy of Canada and Institute for Safe Medication Practices Canada.

[17] Blueprint for Pharmacy Steering Committee. Medication Management Definition. Ottawa (ON): Canadian Pharmacists Association; 2012

[18] Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med 2003;138:161–7

[19] Kwan JL, Kwan JL, Lo L, Lo L, Sampson M, Sampson M, et al. Medication Reconciliation During Transitions of Care as a Patient Safety Strategy. Ann Intern Med 2013;158:397–403

[20] Rennke S, Nguyen OK, Shoeb MH, Magan Y, Wachter RM, Ranji SR. Hospital-initiated transitional care interventions as a patient safety strategy: a systematic review. Ann Intern Med 2013;158:433–40

[21] Hesselink G, Schoonhoven L, Barach P, Spijker A, Gademan P, Kalkman C, et al. Improving patient handovers from hospital to primary care: a systematic review. Ann Intern Med 2013;158:417–28

[22] American College of Clinical Pharmacy, Hume AL, Kirwin J, Bieber HL, Couchenour RL, Hall DL, et al. Improving care transitions: current practice and future opportunities for pharmacists. Pharmacotherapy 2012;32:e326–37
https://accreditation.ca/medication-management-standards

British Columbians want better, faster access to health care and have specifically identified pharmacists and nurses as key professionals best qualified to assist in alleviating physicians' workload.[23] British Columbians believe an expanded scope of practice will allow health care providers to provide a level of care more reflective of their qualifications, while increasing the efficiency and accessibility of British Columbian's health care network.[24] The MoH has responded with expanded scope of practice, including prescribing rights for some health care providers (excluding pharmacists) to initiate prescriptions. Pharmacists are limited to adaptations of prescriptions from authorized prescribers.

As the most accessible health care providers and the first point of contact with the health system for most patients,[25] pharmacists can provide efficient care, and offer care when other providers are unavailable or unable to see patients in a timely manner. This expanded scope of practice for pharmacists could ease some of the pressure on access to primary care for British Columbians, and ensure quality continuity of care as patients move from hospital to community pharmacy care.

Pharmacists have the knowledge and skills to initiate, monitor and adjust drug therapy. These skills have been standard competencies in pharmacy degree programs for several years.[26] Pharmacists are well positioned for expanded prescribing rights to help patients, other health care professionals, and the health care system achieve more effective and efficient drug therapy outcomes. Several studies have shown improved patient outcomes with pharmacist prescribing.[27] [28] [29] [30] [31] [32] [33] [34]

3.2 Other prescribers in BC

Through the *Prescribed Health Care Professions Regulation*, prescribing authority has been extended over recent years to a number of BC health professionals including optometrists, naturopaths, midwives, and nurse practitioners (see Appendix 2). The objective of the Certified Pharmacist Prescriber Initiative is pharmacist authority for timely prescribing (initiating, modifying, and discontinuing therapies) as a

[23] Geoffrey Appleton, MB. The consensus? There is no consensus.. BCMJ, Vol. 50, No. 1, January, February, 2008, page(s) 10 — President's Comment.
[24] Ministry of Health of British Columbia. 2007. Input on the Conversation on Health.
[25] Available at: http://www.pharmacists.ca/index.cfm/news-events/news/pharmacists-improve-health-care-access-in-ontario/
[26] The Association of Faculties of Pharmacy of Canada (AFPC) "Educational Outcomes for First Professional Degree Programs in Pharmacy (Entry-to-Practice Pharmacy Programs) in Canada" [http://www.afpc.info/node/39]
[27] Al Hamarneh YN, Charrois T, Lewanczuk R, et al. Pharmacist intervention for glycaemic control in the community (the RxING study). *BMJ Open* 2013;3:e003154.
[28] McAlister FA, Majumdar SR, Padwal RS, et al. Case management for blood pressure and lipid level control after minor stroke: PREVENTION randomized controlled trial. *CMAJ* 2014;186:577-84
[29] Cochrane for Clinicians (2013). Appropriate use of polypharmacy for older patients. *Am Fam Physician*. 2013 Apr1;87(7):483-484.
[30] Tsuyuki R, Houle S, Charrois T, et al. A randomized trial of the effect of pharmacist prescribing on improving blood pressure in the community: the Alberta clinical trial in optimizing hypertension (RxACTION). *Can Pharm J (Ott)* 2014;147:S18.
[31] Rosenthal M, Tsuyuki R. A community-based approach to dyslipidemia management: pharmacist prescribing to achieve cholesterol targets (RxACT Study). *Can Pharm J (Ott)* 2014;147(4):S20
[32] Al Hamarneh Y, Sauriol L, Tsuyuki R. Economic analysis of the RxING study. *Can Pharm J (Ott)* 2014;147:S47
[33] Dole EJ, Murawski MM, Adolphe AB, et al. Provision of Pain Management by a Pharmacist with Prescribing Authority. AM J Health- Syst Pharm. 2007; 64: 85- 89.
[34] Finley PR, Rens HR, Pont JT, et al. Impact of a Collaborative Pharmacy Practice Model on the Treatment of Depression in Primary Care. Am J Health- Syst Pharm. 2002; 59(16): 1518- 1526.

component of drug therapy management to improve patient outcomes, enhance patient safety, care and access in multidisciplinary environments.

3.3 Current scope of pharmacist practice in BC

Since 2009, the pharmacist scope of practice has included continuing and adapting prescriptions written by authorized prescribers, as well as administering injections. For several years, pharmacists have been assessing patients and prescribing Schedule II and III drugs[35]. Since 1999, pharmacists have the authority to prescribe an emergency supply of prescription medications. The BC Ministry of Health's *Pharmacists Regulation*, states that pharmacists may prescribe Schedule IV drugs[36] for emergency contraception (ethinyl estradiol, norgestrol, progestin).

3.4 Position of the Canadian Pharmacists Association (CPhA)

In 2011, the CPhA released the *Position Statement on Pharmacist Prescribing*.[37] The Statement emphasizes the need for a patient-centred approach, collaboration with other health care providers, and communication and documentation. The document notes that, "*The pharmacist, by having the authority to initiate, continue, and modify prescriptions, can improve the safety and effectiveness of drug therapy. In addition, as the most accessible health care professional, pharmacists will be able to improve access to appropriate medication therapy for patients*."

3.5 Scope of pharmacist practice nationally and internationally

Pharmacists have gained different levels of prescribing rights in other Canadian jurisdictions as well as several international jurisdictions, e.g., the UK, parts of the USA, and New Zealand (see Appendix 3). The CPhA reported that, as of September 2015, initiating prescriptions is possible in all Canadian provinces except BC (see Appendix 3). Pharmacist prescribing rights have been established with the goals to improve access to primary care, improve timely access to medications, make better use of pharmacist knowledge and skills, increase drug-therapy monitoring, reduce costs (fewer visits to the emergency department), improve continuity of care and improve patient outcomes.[38] [39]

---

[35] Schedule II drugs may be sold by a pharmacist on a nonprescription basis and which must be retained within the Professional Service Area of the pharmacy where there is no public access and no opportunity for patient self-selection.
Schedule III drugs may be sold by a pharmacist to any person from the self-selection Professional Products Area of a licensed pharmacy. Examples include miconazole for vaginal use and tetracaine for topical use on mucous membranes. A description of the *Drug Schedules Regulation* is available at: http://library.bcpharmacists.org/D-Legislation_Standards/D-4_Drug_Distribution/5012-Drug_Schedules_Regulation.pdf

[36] Schedule IV drugs are those prescribed by a pharmacist and include "drugs which may be prescribed by a pharmacist in accordance with guidelines approved by the Board" (from the *Drug Schedules Regulation* available at: http://library.bcpharmacists.org/D-Legislation_Standards/D-4_Drug_Distribution/5012-Drug_Schedules_Regulation.pdf)

[37] Available at: http://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/PPPharmacistPrescribing.pdf

[38] Department of Health. Improving Patients' Access to Medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England. London: Department of Health; 2006.

[39] MacLeod-Glover, N. (2011), An explanatory policy analysis of legislative change permitting pharmacists in Alberta, Canada, to prescribe. International Journal of Pharmacy Practice, 19: 70–78. doi: 10.1111/j.2042-7174.2010.00074.x

4.0 Position of the College of Pharmacists of BC

The College is the regulatory body for the pharmacy profession in BC. The College protects public health by registering and regulating pharmacists and pharmacy technicians and the places where they practice. The College is responsible for making sure every pharmacist and pharmacy technician in BC is fully qualified and able to provide the public with competent care.

The Certified Pharmacist Prescriber Initiative is a priority of the College Board in response to the need for improved patient safety through effective drug therapy management (includes initiation of drug therapy). The College's position is that the Certified Pharmacist Prescriber Initiative will:

- make better use of pharmacist expertise with medication use to improve patient safety and drug therapy outcomes
- increase patient choice and access to primary care services
- reduce delays in treatment and access to medications
- improve support to patients, physicians, and other members of the health care team
- foster collaborative multidisciplinary environments
- align with primary health care reform

To ensure competency, 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.

Expanding the authority for pharmacist prescribing to initiate schedule I drugs is intended to make better use of pharmacist expertise with medication use in response to primary health care reform, multidisciplinary collaborative environments, more effective utilization of health human resources, and the need to improve patient safety and drug therapy management.

5.0 Alignment with BC Government Policy

BC's health system is challenged by demands for access, timeliness, quality, and sustainability. The Ministry of Health (MoH) has described the province's current health service design and delivery system as neither optimal in meeting the needs of several key patient populations nor sustainable over the next 10 to 15 years. Two of the three priority areas the MoH is focusing on are:[40]

- improving the effectiveness of primary, community, medical specialist, and diagnostic and pharmacy services for patients with moderate-to-high complex chronic conditions, patients with cancer, and patients with moderate-to-severe mental illness and substance use, to significantly reduce demand on emergency departments, in-patient bed utilization, and residential care
- establishing a coherent and sustainable approach to delivering rural health services

As part of its efforts to reform the health system, the MoH is aiming to enhance drug therapy management through multidisciplinary teams, citing evidence[41] that multidisciplinary teamwork and interventions that address polypharmacy decrease inappropriate prescribing and medication-related problems in patients. As a result, a key recommendation of the Ministry's *"Primary and Community Care in BC: A Strategic Policy Framework"*[42] is building multidisciplinary teams – including pharmacists – for people with complex needs. Pharmacists can play a key role in stopping, reducing, or slowly withdrawing medications that are inappropriate, unsafe or ineffective.[43]

The Certified Pharmacist Prescriber Initiative also aligns with the MoH document: "*Enabling Effective, Quality Population and Patient-Centred Care: A Provincial Strategy for Health Human Resources*". To help drive health system changes, a health human resource strategy will also be developed that will analyze issues such as optimizing scopes of practice, role enhancement, and role enlargement.[44] The initiative addresses current health system concerns and proposes an innovative solution used in other jurisdictions that will work synergistically with recommendations in the Ministry's cross-sector policy discussion papers.

The introduction of Certified Pharmacist Prescribers will improve patient choice and access to health care services, reduce delays in treatment, and provide timely access to medications. All of these are synergistic with the MoH's objectives for enhancing the effectiveness and efficiency of the health care system.

[40] Ministry of Health of British Columbia. 2015. Delivering a patient-centred, high performing and sustainable health system in BC: a call to build consensus and take action.

[41] Cochrane for Clinicians (2013). Appropriate use of polypharmacy for older patients. *Am Fam Physician*. 2013 Apr1;87(7):483-484.

[42] Ministry of Health of British Columbia. 2015. Primary and Community Care in BC: A Strategic Policy Framework.

[43] Kwan D, Farrell B. Polypharmacy. Canadian Healthcare Network – Pharmacy Practice. April 1, 2013.

[44] Ministry of Health of British Columbia. 2015. Enabling Effective, Quality Population and Patient-Centred Care: A Provincial Strategy for Health Human Resources.

6.0 Benefits of the Certified Pharmacist Prescriber Initiative for BC's Health Care System

The Certified Pharmacist Prescriber Initiative will help address current demands for enhanced access, timeliness, and quality of health care services by:

- increasing patient access to health care services while alleviating pressure on other parts of the health care system by allowing more time for other prescribers, such as physicians and nurse practitioners, to focus on other medical issues
- improving access to drug therapy for patients by optimizing the use of the expert drug knowledge of Certified Pharmacist Prescribers
- reducing delays in initiating and changing therapy to optimize drug therapy
- improving patient health outcomes[27 28 29 30 31 32 33 34]
- increasing the capacity of highly qualified health care professionals to meet the demands for appropriate prescription drug utilization by an aging population and the rising burden of chronic disease
- preventing delays in discharge for patients in hospital beds cleared for discharge but waiting for an authorized prescriber to write or sign the orders
- reducing the number of practitioners a patient must visit to be assessed and, if necessary, access drug therapy
- improving continuity of care and patient flow by reducing unnecessary interruptions and providing seamless care, for example, when transitioning between settings (e.g., between inpatient and community care)
- supporting greater collaboration among health care professionals
- creating opportunities to enhance patient safety and reduce adverse drug events and hospital admissions with drug therapy management which includes identifying, preventing, and resolving drug therapy problems

7.0 Details of the Certified Pharmacist Prescriber Initiative

7.1 Proposed eligibility criteria

A full pharmacist registered with the College would be qualified to apply as a Certified Pharmacist Prescriber after meeting the following criteria: be in good standing as a full pharmacist with the College, and successfully complete an educational program and assessment. The educational program will include testing on therapeutics, patient assessment, and the ordering and interpreting of laboratory tests. The College's multidisciplinary Drug Administration Committee will be leading the development of the educational program and assessment.

7.2 Proposed renewal requirements

Renewal requirements for a Certified Pharmacist Prescriber includes proof of additional 15 units of continuing education in the area of prescribing, and an annual self-declaration.

7.3 Proposed standards, limits, and conditions

***Standards**:*

1. Pharmacists prescribe Schedule I, II, or III drugs only within the scope of their education, training and competence.
2. Pharmacists must have the patient or patient's representative informed consent before undertaking prescribing.
3. Pharmacists must review the patient's PharmaNet profile prior to prescribing.
4. Pharmacists must conduct a patient assessment that includes:
    - developing and/or updating a best possible medication history
    - other relevant health information
5. Pharmacists must conduct a patient assessment that may include, as appropriate:
    - physical Assessment
    - mental health assessment
    - laboratory values
    - diagnostic information
6. Pharmacists must refer the patient to another prescriber as appropriate.
7. A pharmacist may prescribe a drug based on the pharmacist's own assessment.
8. A pharmacist may prescribe a drug based on validation of another regulated healthcare professional's assessment of the patient, as per standard 4 and standard 5.
    - The prescribing pharmacist is ultimately responsible for how they use the assessment information, regardless of who conducted the assessment

9. A pharmacist must only prescribe where there is a genuine clinical need for treatment, and should only prescribe medication to meet identified needs of patients and never for convenience, or because patients demand the medication.
10. A pharmacist engages in evidence-informed prescribing and considers best practice guidelines and other relevant guidelines and resources when prescribing for patients, including when recommending complementary or alternative health therapies.
11. A pharmacist is solely accountable for their prescribing decision.
12. If an adverse drug reaction as defined by Health Canada is identified the pharmacist must notify the patient's practitioner, make an appropriate entry on the PharmaNet record, and report the reaction to the Canada Vigilance Program regional office.
13. After prescribing, pharmacists must:
    - inform patients of the need for follow-up care to monitor whether any changes to the prescription are required
    - monitor patients for any adverse events, emerging risks, or complications
    - stop drug therapy, following appropriate protocol, if it is not effective, or the risks outweigh the benefits
14. Completes prescriptions accurately and completely, that includes all information required for a prescription, in accordance with Schedule F, Part 1, Section 6(2).
15. Notify and provide relevant information to the patient's primary care provider and other health professionals, as appropriate.
16. The pharmacist must document in the patient's record:
    - informed consent
        - the patient and/or the patient representative (name:_____) was provided sufficient information about the proposed course of treatment, including any known serious or common side effects or adverse reactions, and voluntarily provided their informed consent
    - patient assessment
    - prescribing decision and the rationale
    - patient understood the instructions provided
    - monitoring and follow-up plan
    - patient's primary health care provider and other relevant health professionals, as appropriate were notified and provided with relevant information

17. Pharmacists should collaborate by communicating respectfully, effectively and in a timely way about a patient with the patient's primary health care professionals, and other health care providers as appropriate.
18. Pharmacists should take reasonable steps to engage a patient's primary health care professional and other health care professionals as appropriate in discussions aimed at determining mutual goals of therapy for a patient and mutual sharing of relevant patient information.
19. A pharmacist who transfers care to another pharmacist or other health care provider within the same or different pharmacy, hospital, or other healthcare facility must ensure the accepting health care provider has the necessary information to assume care.

***Limits**:*

1. A Certified Pharmacist Prescriber is not authorized to prescribe controlled drug substances which are regulated federally by the *Controlled Drugs and Substances Act* and its regulations.
2. A Certified Pharmacist Prescriber must not prescribe a drug unless the intended use is:
    - an indication covered by Health Canada
    - considered a best practice or accepted clinical practice in peer-reviewed clinical literature
    - part of an approved research protocol
3. A Certified Pharmacist Prescriber that prescribes a medication for a patient must not dispense that medication, unless:
    - the patient has been advised that he or she may choose to have the prescription dispensed by another pharmacist or pharmacy
    - no other pharmacist is available on site
    - the patient's informed consent to dispense the drug has been obtained
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.

***Conditions**:*

1. A full pharmacist must apply to the College of Pharmacists of BC to be a Certified Pharmacist Prescriber to prescribe Schedule I, II or III drugs.
2. A full pharmacist must not prescribe Schedule I, II or III drugs prior to receiving confirmation from the College of Pharmacists of BC of their Certified Pharmacist Prescriber authority to prescribe Schedule I, II or III drugs.
3. Must have a private consultation room to conduct patient assessment.

8.0 Maintaining Patient Safety with Certified Pharmacist Prescribers

The College's role is to protect the public by ensuring that patients receive safe and effective pharmacy care. The following potential implementation challenges have been identified about maintaining patient safety with the introduction of the Certified Pharmacist Prescriber Initiative and were considered in the development of the draft framework. Stakeholder engagement will also help inform the best possible regulatory framework for the Certified Pharmacist Prescriber Initiative.

8.1 Considerations for standards, limits and conditions

Proposed Certified Pharmacist Prescriber standards, limits and conditions are included in the framework to ensure patient safety maintained:

- standards for transfer of care to avoid fragmentation of care
- standards for collaborative practice in an environment of multiple prescribers (considerations are facilitation of communication, mutual goals of therapy that are acceptable to patients, sharing of health information, establishing the expectations of each regulated health professional when working with a mutual patient)
- limits to ensure that the same pharmacist does not prescribe and dispense, unless:
    - the patient has been advised that he or she may choose to have the prescription dispensed by another pharmacist or pharmacy, and
    - no other pharmacist is available on site, and
    - the patient's informed consent to dispense the drug has been obtained

8.2 Managing the potential perverse incentive to prescribe and dispense

Robust standards are required to mitigate the potential for financial interests affecting advice or treatment of the patient. Considerations for addressing this incentive include:

- that any indication that a decision is based on benefit to the pharmacist or pharmacy, rather than the patient, will be considered professional misconduct
- that a pharmacy owner cannot prescribe drugs pursuant to the *BC Pharmacy Operations and Drug Scheduling Act (PODSA*), section 5(1) and therefore pharmacy owners are not eligible to apply for Certified Pharmacist Prescriber
- the College's Code of Ethics and Conflict of Interest Standards includes clear guidance for BC pharmacists (http://www.bcpharmacists.org/acts-and-bylaws) regarding patient choice, informed consent and conflict of interest clauses
- collaborative practice standards for prescribing are provided to keep physicians and other health care providers informed

- implementing monitoring activities such as: (a) monitoring pharmacist prescribing; (b) identifying pharmacist owner prescribing and dispensing; (c) identifying prescribing of narcotic and controlled drugs; (d) checking documentation for patient consent; (e) targeting drugs for chronic conditions or that require laboratory monitoring; (f) targeting duplicate prescribing; and (g) running PharmaNet exception reports to identify pharmacists prescribing and dispensing for the same prescription at the same pharmacy and at multiple pharmacies with the same owner

8.3 Ordering and accessing laboratory tests

The College has identified the value of a Certified Pharmacist Prescriber having the authority and ability to order and interpret laboratory tests to prescribe for relevant drug therapies. This element falls outside the scope of the Certified Pharmacist Prescriber Initiative, as it is not within the College's jurisdiction.

9.0 Stakeholder Engagement

The College will begin early stakeholder engagement in Spring 2016. Stakeholder groups include other health professionals in BC who have prescribing authority, pharmacy groups, and patient groups. Stakeholder engagement will help inform the final framework, which will be developed with direction from the Task Group, and presented to the Board for approval.

10.0 Next Steps

The stakeholder engagement results will inform the final framework which will be included in the College's submission to the Ministry of Health. The report on stakeholder engagement will be shared with the Board in June 2016. The final Certified Pharmacist Prescriber Framework will be submitted to the Board in September 2016 for approval.

Appendices	
1	Certified Pharmacist Prescriber Case Scenarios
2	Other Prescribers in BC – Prescribing Parameters
3	Pharmacists' Prescribing Authorities Nationally and Internationally
4	CPhA "*Pharmacists' Expanded Scope of Practice in Canada, January 2016*"

Appendix 1: Pharmacist Prescribing Case Illustrations

These cases are based on actual patients encountered in practice and illustrate actions taken by pharmacists.

They are written in the standard form of health care professionals communicating with each other.

Like all health care professionals, pharmacists must gather information about their patients' condition and/or concerns, synthesize this information to draw conclusions about the potential etiologies of problems, and perform interventions to resolve the problems and thereby improve their patients' health. Many terms are used for these fundamental components of health care provision. In the cases below, the following are the terms used and their definitions:

"Assessments by pharmacist" – Describes patient assessments performed by the pharmacist, including those based on interview, physical assessment, and laboratory test interpretation. Such assessments take many forms and are influenced and guided by the patient's presentation and the information available and the clinical acumen and professional judgment of the pharmacist.

"Synthesis" – a description of the conclusions reached by the pharmacist based on the Assessments performed. These conclusions may prompt actions in order to address and resolve the patient's issue(s).

"Actions" - distinct from the "Assessments" (which are also types of actions), these are the interventions the pharmacist performs in order to address the patients' problems and improve their health.

Cases 1 – 6 are prescribing pharmacists' approach to managing self-limiting conditions.
Acknowledgement: University of Saskatchewan Guidelines for Minor Ailment Prescribing (http://medsask.usask.ca/professional/guidelines)

Cases 7-17 are prescribing pharmacists' approach to managing chronic conditions and a few examples of other scenarios.

Selected Medical Abbreviations used in the Cases:

A+O: alert and oriented

A1C: hemoglobin A1C

ACR: albumin to creatinine ratio

AECOPD: acute exacerbation of COPD

AF: atrial fibrillation

ASCVD: atherosclerotic cardiovascular disease

BP: blood pressure

CAD: coronary artery disease

CC: chief complaint

CBC: complete blood count

CHADS2/ CHA2DS2-VASc: the two dominant atrial fibrillation stroke risk estimation clinical prediction rules

CKD: chronic kidney disease

COPD: chronic obstructive pulmonary disease

CVD: cardiovascular disease

eGFR: estimated glomerular filtration rate

EMR: electronic medical record

FBG: fasting blood glucose

FRS: Framingham risk score

GERD: gastroesophageal reflux disease

HCTZ: hydrochlorothiazide

HF: heart failure

HPI: history of present illness

HTN: hypertension

Hx: history

JVP: jugular venous pressure

LAA: left atrial appendage

LVEF / EF: left ventricular ejection fraction / ejection fraction

MedicationHx: medication history

MMSE: mini mental status exam

MPL: medical problem list

NFA: no fixed address

NKA: no known allergies

NOAC/DOAC: new oral anticoagulant / direct oral anticoagulant

NRT: nicotine replacement therapy

O/E: on examination

OAC: oral anticoagulant

PFT: pulmonary function test (spirometry)

POC: point-of-care

PMH: past medical history

PVD: peripheral vascular disease

QOL: quality of life

SOBOE: shortness of breath on exertion

SocialHx: social history

S&Sx: signs and symptoms

STEMI: ST-elevation myocardial infarction

T2DM: type 2 diabetes mellitus

Td booster: tetanus diphtheria booster

UBT: urea breath test

CASE 1: Acne

ID	A 15-year-old male presents to you in today in your community pharmacy, accompanied by his mother	**SOCIALHx**	Unremarkable
CC	They are seeking your recommendation on therapy for his "acne"	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• Topical benzoyl peroxide 2.5% for acne x 6 months. • NKA • Immunizations up to date
HPI	Acne first appeared about 1 year ago and he has been managing it with hygiene, "diet", and benzoyl peroxide products. It has progressed and he is eager to do something more effective	**O/E**	• Comedones (open and closed), papules, pustules on cheeks, forehead, nose, chin, neck • No cysts, no nodules • No other locations affected
PMH	None	**MPL**	Acne

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (including PharmaNet) (BPMH)
- Assess regimen and routine with current benzoyl peroxide
- Assess based on patient interview willingness to use topical medications, potential for adherence, and affordability

SYNTHESIS

- Mild-moderate acne vulgaris based on physical assessment
- Intensification of treatment and education warranted

ACTION

- Prescribe benzoyl peroxide 10% topical and educate (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost, administration instructions)
    - apply to the entire affected area, not "spot treatment"
- Educate and co-create treatment goal. e.g., within 8 weeks, lesion count decreased by 10-25%, comedones have decreased or less are developing, inflammatory lesions have mostly resolved
- Advise that therapy can continue indefinitely until after puberty, when acne usually resolves spontaneously

○ symptoms may worsen initially for the first 2 to 4 weeks ○ may take up to 3 months for maximum improvement of symptoms ○ if skin irritation is bothersome, use every other day ○ consult pharmacist or GP if skin irritation becomes severe	• Advise to use water-based moisturizing cream for skin dryness • Educate re: other therapeutic options if current strategy unsatisfactory [topical retinoids (tretinoin, adapalene, tazarotene), topical antibiotics (erythromycin, clindamycin), combinations] • Generate documentation and convey to primary care provider

MONITORING PLAN

- Reassess patient in 8 weeks in person

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Patient receives immediate assessment, education, therapy, support, and follow-up plan
- Physician visit avoided

CASE 2: Allergic Rhinitis

ID	27-year-old female presents to your community pharmacy today seeking a "better antihistamine" for her symptoms	**SOCIALHx**	Unremarkable
CC	Itchy eyes, rhinorrhea, and nasal congestion. Symptoms onset 3 weeks ago	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• loratidine 10mg once daily seasonally • NKA • Immunizations up to date
HPI	Similar syndrome annually at this time of year. Usually lasts ~8weeks and self-managed with H1 antagonists, but she suspects something more can be done	**O/E**	As above
PMH	None	**MPL**	Allergic rhinitis

ASSESSMENTS BY PHARMACIST

- Assess based on patient interview willingness to take, potential for adherence, affordability of additional medication, including intranasal therapy
- Assess loratidine adherence. Adherence is good

SYNTHESIS

- S&Sx consistent with allergic rhinitis

ACTION

- Prescribe beclomethasone 50ug/dose aqueous nasal spray, 1 spray in each nostril once daily
- Advise her to hold her loratidine starting in 2 days
- educate (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost, administration instructions and patient demonstration)
- Advise that if after a week there is no improvement or insufficient improvement, come back (options would include increasing the dose/frequency, adding loratidine to the regimen)
- Advise her to try discontinuing at the time when her symptoms usually abate
- Generate documentation and convey to primary care provider

MONITORING PLAN

- Reassess patient in 2 weeks via phone or in person

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Patient receives immediate assessment, education, therapy, support, and follow-up plan
- Physician visit avoided

CASE 3 : Atopic Dermatitis

ID	55-year-old female presents to your community pharmacy	**SOCIALHx**	Unremarkable
CC	Itchy rash on her hands and is seeking treatment	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• levothyroxine 75 mcg once daily x 3 years
HPI	Started 5 days ago. She has been using a moisturizing cream for the "dryness", but it hasn't helped much	**O/E**	• skin on backs of hands dry, cracking, erythematous, itchy, signs of excoriation d/t scratching • appears well otherwise
PMH	Hypothyroidism x 3 years	**MPL**	• rash, suspected atopic dermatitis

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- No exposure to photosensitizing drugs, suspicious plants, detergents, or other toxins, not suspicious for adverse drug reaction
- Based on patient interview, the rash is confined to the hands. No other body parts affected
- Patient reports having TSH measured 1 months ago and it was "normal"
- Assess based on patient interview willingness to use topical medication, potential for adherence, affordability

SYNTHESIS

- Appears to be atopic dermatitis warranting initial therapy
- No pustules, no plaques, appearance not consistent with bacterial infection

ACTION

- Educate about atopic dermatitis (chronic, recurring condition, manageable, not curable)
- Educate about potential allergen triggers (soaps, grass/leaves, detergents, alcohol based products, shampoos, astringents)
- Prescribe triamcinolone acetonide 0.1% cream, applied to affected area twice daily
- ~2 days after symptoms have resolved, use hydrocortisone 0.5% twice daily for 5-7 days before discontinuing, and educate re: rationale (rebound prevention)
- Advise to continue to use moisturizing lotion as needed 2-3 times/day indefinitely

- Educate (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost, administration instructions)
- Expect resolution in 1-2 weeks, and continue for ~2 days after resolution

- Advise to perform this treatment plan whenever the symptoms recur, which is likely
- Advise to consult with you or GP if the symptoms do not resolve after 2 weeks of triamcinolone therapy.
- Generate documentation and convey to primary care provider

MONITORING PLAN

- Reassess patient in 1 week via phone or in-person

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Patient receives immediate assessment, education, therapy, support, and follow-up plan
- Physician visit avoided

CASE 4: Cold Sore

ID	23-year-old male university student presents to your community pharmacy	**SOCIALHx**	Unremarkable
CC	Cold sore. He is aware that viruses cause them, and is seeking "antibiotics"	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• No medications • NKA • Immunizations up to date
HPI	Onset 2 days ago	**O/E**	• Vesicular lesion on border of upper lip
PMH	None, other than one previous cold sore 1 year ago	**MPL**	• Presumed cold sore

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- Lesion is visually consistent with herpetic cold sore
- No fever, so systemic symptoms, feels otherwise well
- Interview reveals that there were 2-3 days of tingling and burning before the lesion erupted
- Assess based on patient interview willingness to take medication, potential for adherence, affordability

SYNTHESIS

- S&Sx consistent with cold sore
- second episode, so recurrence is likely
- lesion present, so antiviral therapy unlikely to be effective

ACTION

- Educate re: causes (HSV), triggers (stress, sun exposure, systemic infections) transmission (via saliva), and prognosis (lesions normally crust over and heal without scarring in 7-10 days, and often recur)
- Educate re: non-pharmacologic treatment
  - keep the area clean using mild soap and water
  - avoid touching the lesion to prevent spread of HSV
- Recommend Zilactin® if pain and itching are an issue, and educate re: administration instructions (esp, hand washing)
- Advise that next time he feels the prodrome (tingling burning), consult with pharmacist or GP immediately (ie, within 1-2 hours) so that antiviral therapy (e.g. valacyclovir 2g bid x 2 doses) can be prescribed. Advise that you can provide a prescription for this now so he can initiate promptly in the future, if he wishes.

○ wash hands before & after applying products and after touching the affected area ○ avoid kissing and oral sex until lesion is gone	• Generate documentation and convey to primary care provider

MONITORING PLAN

- Reassess patient in 1 week via phone or in-person

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Patient receives immediate assessment, education, therapy, support, and follow-up plan
- Physician visit avoided

CASE 5: Aphthous Ulcers

ID	48-year-old male presents to your community pharmacy	**SOCIALHx**	Unremarkable
CC	"Canker sores" in the mouth that "keep happening and aren't going away"	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• No medications. • NKA • Immunizations up to date
HPI	Current ulcers present for ~1 week. No identifiable precipitants.	**O/E**	• 4 white ~3mm diameter sores in upper and lower oral mucosa
PMH	None, other than "canker sores" every few months. They typically persist for 1-3 weeks.	**MPL**	• presumed aphthous ulcers

ASSESSMENTS BY PHARMACIST

- Assess based on patient interview willingness to use topical medication, potential for adherence, affordability

SYNTHESIS

- S&Sx consistent with aphthous ulcers, no obvious precipitants or complicating factors (e.g., immunocompromised, adverse drug reactions), topical triamcinolone appropriate

ACTION

- Educate re: assessment, identity of the lesions, common causes
- Prescribe triamcinolone 0.1% oral paste (Oracort®) for 7 days
- Educate (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost, administration instructions [small dab of about ~0.5cm over the sore at bedtime until a smooth, slippery, thin film develops. Use only enough to coat the area with a thin film. Do not rub in as the film may break]). Reapply 2 or 3 times a day after meals, depending on the severity of symptoms. Stop using when lesions resolve.
- Advise to use acetaminophen or ibuprofen for pain PRN
- Educate re: avoiding possible precipitants (e.g., spicy foods, acidic drinks, oral injury from toothbrush, mouthguard)
- Generate documentation and convey to primary care provider.

MONITORING PLAN

- Reassess patient in 1 week via phone or in-person.
- May continue therapy x 1 more week if partial resolution

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Patient receives immediate assessment, education, therapy, support, and follow-up plan
- Physician visit avoided

CASE 6: Oral Thrush

ID	72-year-old female presents to your community pharmacy	**SOCIALHx**	Unremarkable. Stopped smoking 3 years ago.
CC	Fuzzy feeling and white spots in mouth	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• amlodipine 10mg once daily x 2 years • atorvastatin 20mg once daily x 2 years • Advair (salmeterol / fluticasone) 2 puffs bid x 1 month • Ipratropium 2 puffs qid prn
HPI	First noticed about 3 days ago	**O/E**	• White lesions visible on oral mucosa and tongue, non-painful • No respiratory distress, no cough, no sputum production • Otherwise unremarkable
PMH	• COPD • Hyperlipidemia • HTN	**MPL**	• Possible bacterial candidiasis (oral thrush)

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- Assess MDI technique, including all steps patient follows before and after using (i.e., including whether she rinses her mouth)
- Assess based on patient interview willingness to use topical medication, potential for adherence, affordability

SYNTHESIS

- Immunocompetent
- Lesions and Hx most consistent with oral thrush
- Oral thrush likely caused by recent initiation of fluticasone

ACTION

- Educate re: assessment and cause
- Prescribe nystatin oral suspension 100,000 U/mL QID x 1 week (swish, retain in mouth for as long as possible (up to a few minutes), swallow) and educate (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost, administration instructions and patient demonstration)
- Advise that lesions should improve within 48 hours, and call me if they have not improved within 4 days
- Educate re: proper use of Advair to avoid thrush (rinse mouth with water after each dose)
- Generate documentation and convey to primary care provider

MONITORING PLAN

- Reassess patient in 1 week via phone or in-person
- May continue nystatin x another 7 days if partial resolution

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Patient receives immediate assessment, education, therapy, support, and follow-up plan
- Physician visit avoided

CASE 7: Shingles

ID	Its 8PM. A 67-year-old male presents to your community pharmacy asking for antibiotic cream for his rash.	**SOCIALHx**	• Ex-smoker (quit 15 years ago) • Reports 5 alcoholic drinks weekly
CC	Itching red rash bugging me "right where my shirt is… it's rubbing."	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• HCTZ 12.5mg po daily • Ramipril 5mg po daily • Tylenol #3 1-2 tabs q4-6h prn for knee pain (uses approximately 30 tabs every 3 months) • Diclofenac 10% gel apply to knees 2-3 times a day prn • Tylenol arthritis 1300mg am and pm • NKA • Vaccinations: Yearly influenza vaccine, Pneumococcal pneumonia vaccine
HPI	First noticed this 48h ago	**O/E**	• Typical vesicular erythematous rash affecting single dermatome around the L side of waist
PMH	• chickenpox as a child • osteoarthritis x 5 years • hypertension x 10 years	**MPL**	• Suspected shingles episode

ASSESSMENTS BY PHARMACIST

- Rule out cellulitis, psoriasis, eczema, fungal infection based on observation, patient afebrile
- Rule out hypersensitivity based on patient interview re: cleansing products, detergents, other allergens (e.g., plant exposure, pet exposure)
- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- Rule out immunosuppression based on Hx and BPMH
- Confirm with patient no varicella vaccination, no prior shingles episodes
- Assess based on patient interview re: renal function, liver disease

- Describe antiviral therapeutic alternatives (acyclovir, valacyclovir, famciclovir), including efficacy, regimens, cost
- Assess based on patient interview willingness to take, potential for adherence, affordability

SYNTHESIS

- Shingles episode, within window of potential efficacy of antiviral therapy (48-5d)

ACTION

- Pharmacist prescribes valacyclovir 1000mg PO tid x 7d
- Educates patient re: goals of therapy, potential adverse effects, risk of PHN & its features, contingency if not resolving, importance of vaccination 1 year hence
- Generate documentation and convey to primary care provider

MONITORING PLAN

- Reassess patient in 1 week via phone or in-person

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- ED/Urgent care/ Primary care / walk-in clinic visit averted
- Timely initiation of therapy resulting in reduced risk of postherpetic neuralgia, and its significant chronic pain consequences
- Patient receives care immediately, no referrals, no waiting

CASE 8: Diabetes and CVD

ID	65-year-old male presents to the primary care clinic today for their intake consultation with pharmacist (initial patient assessment prior to seeing physician). He has a meet-and-greet appointment scheduled with his new GP scheduled for 2 months from now.	**SOCIALHx**	• Lives alone • Retired • Occasional EtOH • Non-adherent to diabetic diet • No regular exercise
CC	None	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• metformin 1000 mg PO bid x 15 yr • glyburide 10 mg PO bid x 10 yr • ramipril 2.5 mg PO daily x 1 month • acetaminophen 500-1000 mg PO daily PRN • sitagliptin 100 mg PO daily x 1 month (stopped himself 3 months ago due to high cost and no self-observed improvement to fasting glucose levels) •
HPI	N/A	**O/E**	• Appears well, A+O
PMH	• T2DM (diagnosed 15 yr ago) • HTN (diagnosed 15 yr ago) • Ex-smoker (quit 15 y ago) • CKD (diagnosed 3 yr ago)	**MPL**	• T2DM with inadequate glycemic control • HTN • High CV risk (primary prevention) • Diabetic nephropathy

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (BPMH) including PharmaNet
- Laboratory values accessed via my e-health
- Glycemic control assessment
    - Asymptomatic
    - A1c 9.6% (1 month ago), FBG (ac breakfast) 10-16 mmol/L

- CV risk assessment
  - Lipids: TC 5.5 mmol/L, HDL-C 1.0 mmol/L, LDL-C 3.8 mmol/L
  - BP 169/92 mmHg, HR 66 bpm and regular
  - Asymptomatic
  - No family Hx of premature CVD
  - Framingham Risk Score >20%
- CKD assessment
  - Asymptomatic
  - SCr 185 µmol/L, CrCl 50 mL/min, ACR 3 mg/mmol
- Ask patient re: most recent eye exam
- Perform diabetic foot exam
- Assess vaccination Hx (influenza, pneumococcal)
- Height 170 cm, weight 100 kg, BMI 34.6 kg/m^2
- Assess based on patient interview willingness to take medication, potential for adherence, affordability of medication

SYNTHESIS

- Pre-contemplative re: lifestyle changes
- Glycemic control not at target
- BP not at target
- Inadequate CV risk reduction therapy

ACTION

- Prescribe atorvastatin 10 mg PO daily and educate (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost)
- Increase ramipril to 5 mg PO daily and educate
- Secure special authority for linagliptin 5mg PO daily (covered by PharmaCare) and educate
- Prescribe 1 additional serving of fruit/vegetable per day and educate
- Document all above patient assessments, actions, rationale, monitoring plan in EMR

MONITORING PLAN

- Follow-up via phone in 2-4 weeks
- A1C, SCr and ACR in 2 months

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Timely initiation of therapy
- Increased efficiency (time, cost) of care by pharmacist performing initial consultation, which streamlines eventual physician assessment

CASE 9: Smoking Cessation

ID	65-year-old male presents to community pharmacist because they've heard that smoking cessation therapies are now covered in BC, and they are frustrated at their inability to quit smoking.	**SOCIALHx**	• Lives alone. Recently retired. • Alcohol: occasional 1-2 beer on the weekend but not routinely
CC	None	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• Allergy status: NKA • Vaccinations: influenza, Td booster up to date • HCTZ 12.5mg po daily • ramipril 10mg po daily • atorvastatin 20mg po daily • monitors BP at home: 125-130/80-85
HPI	N/A	**O/E**	• Appears well
PMH	• Smoking: 50 year pack history • HTN diagnosed 10 years ago • no ASCVD	**MPL**	• HTN-currently controlled • High CV risk – primary prevention

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- Provide detailed smoking cessation interview and education: review of pathophysiology of nicotine dependence, lifestyle and pharmacotherapy options and importance of preparation to quit
    - Has decreased from 2 ppd within the last year but struggling to smoke less than 1 ppd
    - Tried cold turkey several times but never got past a few days then relapsed
    - Varenicline didn't help
    - Hx of rash with NRT patch (trialed both Nicoderm and Habitrol)
    - NRT gum "didn't work" (using it appropriately but smoking 2 ppd at the time)
    - Drinking 4-6 cups of regular coffee/day currently
    - Struggles to identify smoking triggers during consultation
    - Fagerstrom: 7/10
    - Motivation 8/10 Confidence 5/10
- Review COPD pathophysiology, PFTs for monitoring and diagnosis, signs and symptoms and potential management
- Psychiatric and seizure history ruled out via patient interview.

- Review HTN lifestyle management strategies
    - Plant based approach to diet, no added salt
    - Exercise: walks, bikes 30-60 minutes 5 days/week and plays floor hockey once a week
- Assessments and labs based on interview, patient assessment, and patient's myEhealthBC report provided by patient:
    - A&O x 3
    - SCr: 80, LDL:2.0 Tchol: 5.0 HDL: 1.6, FBG: 5.6, PFTs: FEV1: .80 FEV1/Ratio: .75, FRS > 20%, BMI 26

SYNTHESIS

- No medication adherence concerns currently
- Would benefit from smoking cessation in view of increased risk for COPD and FRS
- Motivated to quit smoking but not confident he can do it
- Current LDL to target on statin for primary prevention
- Would benefit from gradual decrease in caffeine intake in preparation for stop date in view of potential for increased serum levels with smoking cessation
- BP to target with current pharmacotherapy and lifestyle strategies.
- Would benefit from Pneumovax- confirmed no vaccination to date

ACTION

- Give Pneumovax
- Advise patient to review quitnow.ca
- Provide & educate re: Score Card: for tracking of cigarettes and trigger identification
- Prescribe Nicorettte inhaler or spray and educate (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost)
- Educate re: working to decrease caffeine intake by 1-2 cups/day as tolerated
- Schedule follow-up appointment next week to review trigger management
- Generate documentation and convey to primary care provider

MONITORING PLAN

- Use scorecard for 1 week
- Follow-up appointment in 1 week
- Prescribe Zyban 150mg po x 3 days then 150mg po bid for start after follow up appointment next week

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Patient received care immediately, no referrals, no waiting

CASE 10: Optimizing BP

ID	40-year-old male presents at the pharmacy at 8pm on a Friday to pick up his refills for anti-hypertensives. Reports concern that home BP reading have been gradually increasing and wondering if current meds are working.	**SOCIALHx**	• Lives with his wife. Desk job with more work stress recently. • Occasional alcohol. • No regular exercise. Eats out 5-6 times a week. Admits that he has been gaining weight – up 10 lbs in the last 6 months.

CC	Home BP readings consistently > 140/90 recently	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• NKA
			• Vaccinations: influenza, Td booster up to date
			• Medication:
			  ○ HCTZ 12.5mg po daily (on for the last 5 years)
			  ○ ramipril 5mg po daily (on for the last 4 year)
			  ○ acetaminophen 500mg 2 po prn (takes for occasional headaches – max 2 doses/day)

HPI	Gradually increasing numbers over the last 6 months. Sees GP annually for BP review/refills. BPs at the time of last GP visit 6 months ago were consistently < 140/90.	**O/E**	• Appears well. Here with home BP readings diary from the last 4 weeks: 140-155/88-95
PMH	• Ex-smoker: Quit ~5 years ago • HTN diagnosed 5 years ago	**MPL**	• Uncontrolled HTN

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
  - No medication adherence concerns or barriers
  - No OTC NSAID use
- Home BP monitoring routine is twice weekly
- Consider secondary causes of HTN
  - Sleep apnea ruled out by patient interview
  - Hyperaldosteronism unlikely based on serum K
  - Hyper/hypothyroidism improbable in 40 year old male, no S&Sx based on interview, and much more probable explanation for worsening BP control (inactivity, weight gain, stress, inattentive diet)"
  - HPI does not indicate secondary causes as likely, and alternative hypothesis for worsening BP control is available
- Glycemic Control (via myEhealthBC and patient interview)
  - Last FBG outside normal range
  - Family Hx of diabetes: mother and older brother
  - Recent increasing stress and weight increases risk for insulin resistance
  - No symptoms of hyperglycemia but reports more carb craving
- CV risk assessment:
  - No symptoms of concern
- CKD assessment:
  - No concerns noted with last screening
- Lifestyle Management for HTN:
  - Diet: Eating red meat 3-4 times/week and struggles to eat fruits and veggies consistently. Some juice or pop 3-4 days/week as well. Salt: adding "a bit" and restaurant food is high
  - Exercise: "none" except for an occasional 20-30 minute walk on weekends
  - Stress management: No tools for managing this

O/E:

Labs provided per eHealth profile 6 months ago:
FBG: 5.8
LDL: 3.2 T Chol 5.0 HDL 1.2
Lytes normal (notably, Na/K)
SCr 85

BMI: 28
FRS < 10%
BP: 150/90 P 70

SYNTHESIS

- BP not at target
- Increasing risk for prediabetes and uncontrolled HTN in view of increasing weight
- Struggling with lifestyle management of HTN
- Primary prevention for CV disease and current risk remains low

ACTION

- Prescribe amlodipine 2.5mg po daily and educate patient re: goals of therapy, potential adverse effects (adding additional BP therapies is superior to maximizing doses of existing BP drugs)
- Daily BP monitoring at variable times of the day, keep BP diary
- Confirm Lifestyle Action Plan, including:
    1) 1 additional fruit/vegetable serving/day
    2) no added salt
    3) week day walking: park 5 blocks away from work and walk.
- Generate documentation and convey to primary care provider

MONITORING PLAN

- Reassess patient in 2 weeks via phone or in person

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- ED/Urgent care/walk-in clinic visit averted
- Timely initiation of therapy
- patient received care immediately, no referrals, no waiting

CASE 11: Polypharmacy

ID	92-year-old female is being assessed in residential care for regularly-scheduled 6-month medication review	**SOCIALHx**	• Widow • Lives alone • Retired • 2 children and 4 grandchildren—all live nearby • No EtOH
CC	None	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• alendronate 70 mg PO q week on Sundays x 2 yr • furosemide 40 mg PO daily x 3 months • KCl 8 mEq PO bid x 3 months • warfarin 5 mg PO daily • rabeprazole 20 mg PO daily x 3 months • metoprolol 25 mg PO bid • citalopram 20 mg PO daily • brinzolamide/timolol eye drops 1 drop ou daily • acetaminophen ER 650-1300 mg PO up to tid PRN pain
HPI	N/A	**O/E**	• Appears well, A+O
PMH	• Atrial Fibrillation (CHADS2 = 2) • Osteoarthritis (knee, hip) • Hypertension • Osteoporosis (diagnosed 2 yr ago) • Depression/anxiety • CKD • Glaucoma • Community acquired pneumonia requiring hospitalization (3 months ago)	**MPL**	(polypharmacy)

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (BPMH) including PharmaNet
  - Furosemide and KCl were prescribed on discharge from hospital 3 months ago (admitting diagnosis: community-acquired pneumonia). Had never taken either medication in the past
  - Does not know why she takes rabeprazole. No Hx of peptic ulcer disease, GERD or GI bleeding
  - Has never taken calcium or vitamin D
- Emergency Department assessment and discharge summary reviewed from 3 mos prior
  - Furosemide and KCl prescribed on admission for possible heart failure
  - Rabeprazole was prescribed for stress ulcer prophylaxis while in hospital
- Laboratory values from last week accessed from facility chart
  - SCr 55 µmol/L, CrCl 49 mL/min, Na 138 mmol/L, K 4.0 mmol/L, INR 2.3
- Functional assessment:
  - Ambulates with walker
- Heart failure assessment:
  - Denies SOBOE or at rest, orthopnea or PND
  - Able to ambulate around home normally
  - Denies peripheral edema
  - Recent echocardiogram: normal LV size and function, LVEF 55%, normal valves
- Assess vaccination Hx (influenza, pneumococcal)
- Height 158 cm, weight 54 kg, BMI 21.6 kg/m^2
- O/E: BP 135/80 mmHg, HR 50 bpm and irregularly irregular, no postural change in BP or HR, JVP <2 cm ASA, normal breath sounds bilaterally, no peripheral edema
- Denies palpitations, occasional presyncope

SYNTHESIS

- Questionable indication for furosemide and KCl, initiated during ED visit, sx later attributed to CAP, not heart failure. No diagnosis of HF made despite echo.
- No identifiable valid indication for rabeprazole
- Resting bradycardia—may not require current dose of beta-blocker
- No calcium and vitamin D for osteoporosis

ACTION

- Decrease furosemide to 20 mg PO daily
- Decrease KCl to 8 mEq PO daily
- Decrease metoprolol to 12.5 mg PO bid
- Discontinue rabeprazole
- Prescribe calcium 500 mg PO elemental PO bid and vitamin D 1000 units PO daily
- Educate for each of the above (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost)
- Document in facility health record and convey to primary care provider

MONITORING PLAN

- Follow-up via home visit in 1 week
- Monitor for worsening signs or symptoms of heart failure
- Monitor for palpitations/assess resting HR, BP
- Monitor for any symptoms of GERD

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Reduce polypharmacy
- Potentially avoid adverse effects associated with unnecessary therapy (e.g., hypovolemia leading to fall, C. difficile infection secondary to chronic PPI)
- Optimize osteoporosis therapy to prevent vertebral/non-vertebral fracture and associated hospitalization +/- mortality

CASE 12 : Medication Reconciliation on Admission

ID	35-year-old female admitted overnight to general surgery unit at a community hospital for cholecystectomy for recurrent cholecystitis. She is assessed by the clinical pharmacist in the morning.	**SOCIALHx**	• Single • Lives alone • Unemployed • No children or family support • Denies EtOH or illicit drugs • Smoker 1 ppd x 22 yr
CC	Right upper quadrant abdominal pain, nausea, abdominal tenderness	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• aripiprazole 15 mg PO daily in AM • divalproex 500 mg PO bid • sertraline 100 mg PO daily at HS
HPI	Patient was admitted for cholecystitis 6 months ago. She received supportive care and was discharged home. She did not have any recurrent symptoms until last night, and promptly presented to the Emergency Department. General surgery was consulted and laparoscopic cholecystectomy is planned for later today. The general surgery resident completed the admission orders, but did not perform any medication reconciliation, no orders currently written re: prior-to-admission medications.	**O/E**	• Appears in distress with abdominal pain and nausea • A+O x 3, able to converse appropriately
PMH	• Schizophrenia (x 8 yr) • Depression/anxiety • Obesity	**MPL**	• Cholecystitis • Schizophrenia • Depression/anxiety • Nicotine dependence

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (BPMH) including PharmaNet
  - Patient receives q1 weekly blister packs
  - Contact community pharmacy to review medication administration times
    - Knowledgeable about her medications—she is very concerned about worsening symptoms if she does not receive her medications
  - Carries accurate home medication list
  - Reports very good adherence (only 1 missed dose in past 3 months)
  - All medications deemed to be appropriate to continue while in hospital and not contraindicated by surgery.
- Perform assessment of nicotine dependence
  - 22-pack yr Hx
  - Never tried to quit in the past
  - No interest in quitting long-term, but willing to accept nicotine replacement therapy (NRT) while in hospital
  - Has never used NRT or pharmacotherapy
  - Starting to experience symptoms of withdrawal (restlessness, agitation, tachycardia)

SYNTHESIS

- High-risk for exacerbation of psychiatric medications due to lack of medication reconciliation—all members of the general surgery team are currently in the operating room (and unavailable)
- Indication for NRT to prevent/treat withdrawal symptoms

ACTION

- Prescribe medications as per home regimen including aripiprazole, divalproex and sertraline
- Order nicotine patch 21 mg applied daily
- Explain actions patient

MONITORING PLAN

- Pharmacist to follow-up daily while in hospital
- Assess for psychiatric symptoms
- Assess for nicotine withdrawal symptoms

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Prevents adverse event due to lack of indicated psychiatric medications
- Prevent medication withdrawal symptoms (e.g., SSRI)
- Positive patient experience due to lack of interruption of chronic therapy, and minimization of discomfort form mandatory temporary smoking interruption
  Surgical team not interrupted

CASE 13: Medication Reconciliation on Discharge from Hospital

ID	72-year-old male recently discharged to a shelter as he was no-fixed-address prior. Admitted 3 weeks ago due ischemic right arm and bilateral leg ischemia. Identified by primary care clinic pharmacist for med review due to discharge 3 days go from hospital. Patient not previously known to the clinic.	**SOCIALHx**	• etOH abuse • Smoker 1ppd • Was NFA now living in shelter • Receives pension
CC	He is out of meds, lost discharge prescription	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• NKA • Patient did not have any meds with him Med list per discharge summary: ○ warfarin 7mg OD ○ bisoprolol 5mg OD ○ ASA 81mg OD ○ furosemide 40mg OD ○ ramipril 2.5mg OD ○ spironolactone 12.5mg OD
HPI	None	**O/E**	• Reviewed labs from chart prior to discharge • WBC 6.9, Hgb 123, Hct 0.38, HCV 110, Plts 460, INR 2.2, Na 136, K 4.5, SrCr 104, eGFR 61 • Vague historian unable to describe what happened in hospital or where his discharge prescription went
PMH ***(from hospital d/c summary and CareConnect)***	• CAD with STEMI in 2011 and bare metal stent x 1 • CHF with EF 27% • PVD • Left atrial appendage and left ventricular apex thrombus found while hospitalized	**MPL**	• CHF with reduced EF – not on treatment • Identified thrombus – not on anticoagulation • CAD – not on appropriate secondary prevention

ASSESSMENTS BY PHARMACIST

- BPMH based on discharge note, PharmaNet and client. Nothing on PharmaNet
- Assess vitals: BP 130/70, HR 66, weight 63.5kg
- Patient currently not on any medications or OTCs
- Lab values from CareConnect
- CHF assessment/CAD/Secondary prevention
- Denies orthopnea, SOBOE, sleeps with 2 pillows, can walk 2 blocks until leg pain makes him stop
- Denies pre/syncope
- Denies angina
- LV/LAA thrombus
- Denies numbness or unusual weakness to arms/legs, visual changes, difficulty speaking or vertigo
- Ascertain pts PharmaCare coverage status (Plan I, able/willing to pay deductible)
- Ascertained that his shelter provides Medication Management and Outreach workers to help him store and administer his medications. Outreach workers can walk with him to the lab for INR and other labwork

SYNTHESIS

- CHF assessment: Bblocker, ACEi, diuretics should be restarted
- CAD/secondary prevention: ACEi, ASA should be restarted; Statin should be initiated
- LV/LAA thrombus risk of sequelae (embolic stroke, peripheral embolism) as not anticoagulated
- With the supports provided by his shelter, it may be feasible to prescribe these indicated therapies

ACTION

- Restart/initiate medications from hospital discharge Rx
    - ramipril 2.5mg OD
    - furosemide 40mg OD
    - spironolactone 12.5mg OD
    - bisoprolol 5mg OD
    - ASA 81mg OD
    - warfarin 7mg daily.
- Prescribe atorvastatin 10 mg once daily.
- Plan to titrate ACEi, B-blocker to target doses (10mg, 10mg, respectively).
- Adjust furosemide to symptoms.
- Educate for all of the above re: rationale, administration/titration, goals of therapy, common adverse effects & their management, cost
- Additional education
    - Anticoagulation: importance of compliance, and risks of bleed and embolic risks
    - CHF: fluid management, salt restrictions
    - Medication education regarding each med and monitoring parameters.
- Liaise with shelter to communicate therapeutic plan, schedule follow-up, coordinate outreach and medication management services.

MONITORING PLAN

- Reassess patient in 2 weeks in person at shelter
- Bloodwork: SrCr/eGFR, lytes, INR at 7 days.
- Need to be re referred at 3 mos for possible echocardiogram to determine duration of warfarin

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Prevention of serious adverse effects /hospitalization from any of his conditions. He could have deteriorated quickly (CHF/fluids, embolic event etc)
- Timely access to care especially for marginalized patients
- Was able to work with his social supports to coordinate supportive services

CASE 14 : COPD

ID	60-year-old male coming to see primary care clinic pharmacist for general medication review.	**SOCIALHx**	• Smoking – decreased to 13 cigs/day • Family Hx – father – emphysema, mother smokes, sister recently dx with non hodgkins lymphopa
CC	None	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• NKA • warfarin titrated to INR 2-3 • OTCs including senna, CaCarbonate • Never had flu/pneumo vaccine
HPI	N/A	**O/E**	• No visible distress, well groomed, good eye contact • Height 178, weight 90.2kg, RR 16, oximetry resting SpO2 95%, HR 78 • Cough, productive of grey sputum
PMH	• Hx of recurrent unprovoked PEs/DVTs, prothrombin gene mutation– indefinite anticoagulation • COPD diagnosed 6 months ago via spirometry. No AECOPD since diagnosis. • GI – polypectomy • Remote history of suicidal ideation in the 80s	**MPL**	• History of COPD - untreated

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- Review Spirometry results (patient has spirometry report): FEV1/FVC ratio 0.55.
- History of symptoms: SOBOE, mild cough, worse at night, moderate grey sputum to clear during the night and AM
- Infrequent colds

- INR therapeutic – continue same dose
- Assess based on patient interview willingness to take medication, potential for adherence, affordability of medication

SYNTHESIS

- Patient would benefit from initiation of chronic COPD therapy
- Guideline-recommended therapy for his level of severity is LABA+ICS
- Willingness / ability to use MDIs, cost, coverage status make starting with ICS, LABA, or both debatable
- Smoking cessation is an important priority

ACTION

- Initiate salbutamol 2 puffs QID PRN and ipratropium 2 puffs QID
- Education about
  - rationale, goals of therapy
  - optimal MDI use
  - monitoring (may need LABA and/or ICS if regular bronchodilator use)
  - smoking cessation
  - vaccines
- Initiate patient self-management through COPD Action Plan
- Reassess smoking cessation plan
- Generate documentation and convey to primary care provider

MONITORING PLAN

- Reassess patient in 1 month via phone or in person
- Reinforce COPD education and warning signs on each visit
- Reassess smoking cessation plan on each visit

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Timely initiation of treatment
  - Reduce risk of AECOPD
  - Improved quality of life

CASE 15: H.pylori

ID	A 45-year-old female presents to the community pharmacy with a prescription for H.pylori eradication treatment. You notice on her prescription profile that prescriptions for the same indication were filled 4 months ago. Today's prescription is for: • omeprazole 20mg bid • clarithromycin 500mg bid • amoxicillin 1gm bid (all x 14 days)	SOCIALHx	• Non-smoker • Drinks alcohol 2-3 standard drinks/week although has been abstaining recently due to dyspeptic symptoms
CC	Patient continues to be troubled by dyspeptic symptoms (heartburn, general abdominal discomfort, some nausea and bloating)	MEDICATIONHx/ ALLERGIES / IMMUNIZATIONS	• Levothyroxine 88mcg po once daily • Ibuprofen 200-400mg bid prn for menstrual cramps or lower back pain (estimates use at 3-4 days per month, max 800mg/24 hours) • Tums prn for dyspeptic symptoms (estimates use at 5 tablets weekly), minimal improvement seen with use • NKA • Has been avoiding dairy products as it was suggested she may have an intolerance. This hasn't resulted in any appreciable change in symptoms. Immunizations • Completed Twinrix (Hepatitis A/B) 2010 • Tyhpoid po vaccine 2010 • Tetanus, diphtheria, pertussis 2010 • MMR booster 2014

HPI	Patient states that symptoms have been bothering her on most days for several months. Her appetite has been diminished somewhat and she has lost about 2kg. She says a referral to a gastroenterologist is pending but may take 6 months or more until she can be seen. She went to a new GP today as she was frustrated that her symptoms haven't resolved with the treatment prescribed by her regular GP 4 months ago.	**O/E**	• Appears well although expressing frustration at ongoing symptoms • Weight 63kg (states she is normally around 65kg)

PMH	• Hypothyroid x 5 years
	• Multiparous (children are 16 and 12)
	• Treated for H.pylori 4 months ago with sequential therapy
	  ○ rabeprazole 20mg twice daily x 10 days
	  ○ amoxicillin 1gm bid days 1-5
	  ○ clarithromycin 500mg bid days 5-10
	  ○ metronidazole 500mg bid days 5-10
		MPL	• Risk of inadequate H.pylori eradication therapy – prescription not appropriate given suspected prior eradication therapy failure

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
  - Patient states that she was compliant with the treatment given 4 months ago but that it did not result in an appreciable improvement in symptoms
- Patient reports a second urea breath test performed last week was positive for H.pylori

- Patient denies any signs of bleeding; reports that, per GP, abdominal exam was normal Patient has third party insurance and is not worried about cost. Is confident that she can adhere to a complicated medication regimen for 2 weeks as she really hopes to resolve her symptoms
- Patient is able to access myeHealthBC which shows a normal CBC and UBT positive for H.pylori

SYNTHESIS

The new prescription for H.pylori eradication is not likely to be effective. This combination is no longer recommended due to potential macrolide resistance and increased failure rates.

ACTION

- Provide patient with a prescription for:
  - bismuth subsalicylate 2 tabs po qid
  - metronidazole 500mg po tid
  - tetracycline 500mg po qid
  - omeprazole 20mg bid, all for 14 days
- Generate documentation and convey to primary care provider, in this case the most recent GP that she saw
- Educate patient on importance of a follow up urea breath test 4 weeks after completion of treatment to confirm H.pylori eradication, per Canadian guidelines for this context
- Assist patient in creating a medication schedule for new regimen, advise on how to prevent and manage potential side effects

MONITORING PLAN

- Reassess patient within 1 week via phone or in-person.
- Patient to obtain a requisition for a follow up urea breath test in 6 weeks
- Encourage patient to remain with one GP for the best continuity of care

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Reduce the risk of treatment failure by optimizing treatment for H.pylori infection
- Patient does not have to return to the GP for an additional visit

CASE 16: AF Stroke Prevention

ID	66-year-old female presents to your primary care clinic today, prompted by a cardiologist who recently diagnosed her with recent-onset atrial fibrillation. The cardiologist told her to talk to her primary care provider about starting anticoagulation.	**SOCIALHx**	Unremarkable
CC	Asymptomatic, no specific complaints. She presents the report from the cardiologist which documents atrial fibrillation and advises her primary care provider to "start anticoagulation".	**MEDICATIONHx/ ALLERGIES / IMMUNIZATIONS**	• amlodipine 10 mg daily x 3 years for HTN • bisoprolol 10mg daily x 2 weeks for rate control since ED visit. • NKA • Immunization status unknown
HPI	Last seen in your clinic 6 months ago for routine check-up. Developed palpitations and dizziness 1 week ago and went to ED. Assessed there by a cardiologist who prompted today's visit.	**O/E**	• HR 70, irregularly irregular • Otherwise unremarkable
PMH	• HTN x 3 years. • Hysterectomy 10 years ago for uterine fibroids	**MPL**	• plan to initiate AF stroke prevention therapy

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- CHADS2/ CHA2DS2-VASc re: AF stroke risk. CHADS2=1 (3.6% annual stroke risk); CHA2DS2-VASc=3 (4.3% annual stroke risk). Candidate for OAC therapy.
- HAS-BLED score re: OAC major bleeding risk. Score ~0 (HTN, but controlled) (2-3% annual risk of major bleeding on any OAC).
- Assess based on patient interview willingness to take, potential for adherence, affordability

SYNTHESIS

- Patient remains in AF. Ventricular rate is controlled.
- Patient is willing to take SPAF therapy. Prefers OAC to aspirin. Wants to take a NOAC/DOAC, but is concerned about the cost, has no private coverage, understands PharmaCare won't cover unless warfarin unsuccessful.

ACTION

- Educate patient re: AF, stroke risk, therapeutic options, implications of OAC therapy vs. aspirin vs. no therapy. Bleeding risks, INR testing, cost, diet/etOH, drug interactions, # of daily doses.
- Guide patient through choice of therapy based on preferences using a decision aid (e.g., sparctool.com, afib.ca)
- Based on this, prescribe warfarin 10mg daily. Use dosing nomogram, schedule INR testing, followup phone calls to titrate to INR 2-3.
- Do warfarin teaching and provide written and online counselling resources
- Discuss self-monitoring and self-adjusting via POC testing at a pharmacy or at home, and advise that we can assess this once stabilized on warfarin
- Generate documentation and convey to community pharmacist and cardiologist

MONITORING PLAN

- As above

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- More efficient management of drug therapy than by GP
- Pharmacist in clinic more accessible than physician

CASE 17: HF diuretic optimization

ID	73-year-old male presents to your community pharmacy today.	**SOCIALHx**	• Lives independently with partner • Quit smoking 7 years ago
CC	He mentions that he has been feeling dizzy when transitioning from lying or sitting to standing and "almost fainted" this morning when doing so.	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• ramipril 10mg daily x ~5 years • bisoprolol 10mg daily x ~7 years • furosemide 60mg daily x 2 weeks. Formerly 40mg daily x 1 year. • ASA 81 mg daily x 7 years • atorvastatin 10 mg daily x 7 years • NKA
HPI	His furosemide dose was increased from 40mg qAM to 60mg qAM 2 weeks ago by his cardiologist in response to his having had several episodes of pedal edema and reduced exercise tolerance over the past year that prevented him from completing his daily exercise goals. Patient associates his dizziness with the furosemide dose change, but is worried because it takes many months to get an appointment with his cardiologist for an assessment/resolution, and usually >1 week to see his GP.	**O/E**	• A+O x 3 based on conversation • Appears bright, ambulating independently • Physical assessment deferred
PMH	• Heart failure (systolic, EF 30%, NYHA class II/III) x 5 years. Last echocardiogram 1 year ago. • CAD (MI 7 years ago). No angina since.	**MPL**	• Heart failure, possible hypovolemia, fall risk

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- Interview re: HF symptoms. No edema x 2 weeks. Exercise tolerance improved over the week since increasing furosemide, but has declined in the past few days to similar levels as when he had edema. No respiratory sx in the past year aside from SOB on exertion.
- Interview re: dietary changes recently, particularly changes in salt or water intake. Patient was reminded by cardiologist to "watch his salt" and has been more adherent to a <3 g/d regimen than previously. No change to water intake lately.
- Informally assess his cognition (he is known to you to be cognitively intact and sharp – MMSE?)
- Inquire about whether he weighs himself regularly (he does not, but he says he "normally weighs 175 lbs" based on ~weekly weights and has a scale at home).
- Patient confirms that he feels well and is able to do his physio-guided HF exercise routine when his weight is ~175 lbs. Weigh him now (170 lbs).
- Do vitals, including sitting→standing BP & HR (with supports in case of dizziness). [sitting: 135/85 HR 80; standing: 115/85 HR 115; dizzy] – positive test for hypovolemia.
- Obtain most recent serum electrolytes (from patient via myEhealth BC or GP office). (1 month ago Na 133, Cl 100, K 4.1, SCr 145)

SYNTHESIS

- Patient is receiving excessive daily furosemide for systolic HF, resulting in progressive hypovolemia, now symptomatic
- Hypothesis is that furosemide 40 mg daily combined with new adherence to <3g/d Na intake was the etiology
- Patient is cognitively intact and potentially able to self-titrate diuretic based on daily weight
- Patient's safety is at risk, intervention is pharmacotherapeutic, and can be quickly resolved

ACTION

- Educate patient about your assessment, and explain your hypothesis about its etiology. (excessive diuresis, possibly compounded by increased adherence to low-Na intake).
- Inquire about patients' interest/willingness to self-titrate furosemide based on weight. (He is interested in learning more about this).
- Advise him to weigh himself each morning after getting up (slowly) and first morning void.
- Advise him to hold his furosemide dose tomorrow AM, and the next morning, expecting his weight to increase to 175 lbs.
- Advise him to continue adhering to low-Na diet and maintaining his current water intake.
- Make a diary/table for him with his goal weight (175 lbs) and instructions re: furosemide dose: regular daily dose is 40mg qAM. If AM weight is 174-176, take furosemide 40mg that AM. If AM weight *increases* by >2 lbs vs. previous day, take an extra 20mg of furosemide (ie, 60mg) that morning and every day until weight is in target range. If AM weight *decreases* by >2 lbs vs. previous day, hold furosemide that morning and every day until weight is in target range. If >3d of holding or taking 60mg/d, call pharmacist to reassess.
- Advise him to make an appointment with his cardiologist, and that you will convey today's events and plan to cardiologist and GP in writing.

- Generate documentation and convey to primary care provider and his cardiologist.
- Additional pharmacotherapeutic optimization: add eplerenone or spironolactone per CCS HF Guidelines. Defer until stabilized re: fluid status.

- Make a plan to supply patient with the diary sheets (by pharmacist, by printing themselves, etc.)

MONITORING PLAN

- Call patient in 2 days to assess progress/understanding
- Advise patient to bring in their diuretic diary in 1 week to assess progress/understanding and offer to provide the same education to his partner so she can support him

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- ED/UCC visit for fall/injury avoided
- patient's lifestyle and exercise regime maintained/restored
- patient empowered to self-monitor and titrate therapy within appropriate parameters and with support/supervision
- long-term instability / reduced QOL due to long lead-times for specialist visits avoided

Appendix 2: Other prescribers in BC – Prescribing parameters

	Naturopaths	Midwives	Nurse Practitioners	Optometrists
Training	Prescribing Certification requirements: Registrants must successfully complete the Prescribing Upgrade Course offered by the Boucher Institute of Naturopathic Medicine (BINM) including an online course and oral exam.	4-year undergraduate degree. Clinical experience requires 40 births attended as a primary midwife.	Master's degree program. No additional training; however, created new competencies and updated OSCE's. Three streams of practice are used to register NPs: family, adult and pediatric	No training requirements if they graduated after 2000. *Optometrists certified in Ocular Therapeutics to treat and manage ocular disease as per Bylaws Schedule:* Successfully completed a 20-hour therapeutic pharmaceutical agent updating course given at any time after January 1, 2004 and has also successfully completed one of the following: (a) a 100-hour course in ocular therapeutics; (b) the Treatment and Management of Ocular Disease section of the National Board of Examiners in Optometry; or (c) the ocular therapeutics section of the national qualifying examination.
Schedule of Drugs	Schedule I, II and III.	Schedule I, IA, II and III.	Schedule I, IA (controlled prescriptions), II.	Schedule I, II and III.
List of Drugs	List of excluded drugs (e.g., antibiotics with narrow therapeutic index and antipsychotics.	Inclusive list of drugs.	List of drugs: Schedule I, IA, II. NP prescribes in area registered to practice (family, adult, pediatric)	Limited list of drugs: Glaucoma agents, topical treatment of eye disease.
Standards	Usual and customary standards for prescribing	Standards provide indications, routes of administration and upper dosage limits where appropriate.	Usual and customary standards for prescribing.	Co-manage with ophthalmologist for glaucoma. Inform patients they have a choice to be managed by an optometrist or ophthalmologist for glaucoma. Must refer to an ophthalmologist if condition does not improve or worsens.

Appendix 2: Other prescribers in BC (continued)

	Naturopaths	Midwives	Nurse Practitioners	Optometrists
Limits	Cannot prescribe drugs for a number of categories.	Limited to pregnancy, lactation and labour.	Limits and conditions by drug category. A drug category with the notation "No Exceptions" means that NPs may prescribe all drugs in that category. A drug category with the letters C (continuation prescribing only) and/or O (cannot prescribe) mean there are restrictions on NP prescribing.	No glaucoma drugs for patients age < 30.
Conditions	Can request special authority medications	Conditions around prescribing some drugs in collaboration with a medical practitioner, e.g., controlled drugs for labour.	Restrictions on prescribing – see above.	Cannot prescribe if glaucoma is advanced.
Narcotics	Under the federal *Controlled Drug Substances Act and Regulations*, no authority to prescribe narcotics and controlled drugs, including benzodiazepines.	Yes	Yes	No

Appendix 3: Pharmacists' Prescribing Authorities Nationally and Internationally

Table 1: Pharmacists Initiating Prescriptions in Canadian Provinces (from the CPhA, 2015)

Province	Can Initiate Prescription Drug Therapy	Can Order and Interpret Laboratory Tests
BC	x	x
AB	✓	✓
SK	✓	Pending legislation, regulation, or policy for implementation
MB	✓	✓ (authority limited to ordering lab tests)
ON	For smoking/tobacco cessation	x
QC	For smoking/tobacco cessation For minor ailments	✓
NB	✓	Pending legislation, regulation, or policy for implementation
PE	For smoking/tobacco cessation For minor ailments	Pending legislation, regulation, or policy for implementation
NS	✓	✓
NL	For smoking/tobacco cessation For minor ailments	x

Table 2: Pharmacists Initiating Prescriptions Internationally

Country	Can Initiate Prescription Drug Therapy	Can Order and Interpret Laboratory Tests
NZ	✓	✓
UK	✓	✓
USA	✓	✓ >75% of the States and federal government (armed forces and Veterans Affairs)

Appendix 4: Pharmacists' expanded scope of practice in Canada, January 2016

Available at: http://www.pharmacists.ca/index.cfm/pharmacy-in-canada/scope-of-practice-canada/

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

College of Pharmacists of British Columbia

Certified Pharmacist Prescriber Stakeholder Engagement Process

The College Board supports expanding the scope of practice of BC pharmacists to allow for pharmacist prescribing, with qualified pharmacists known as a Certified Pharmacist Prescriber. The Board has directed the College to undertake stakeholder engagement on a Draft Certified Pharmacist Prescriber Framework (draft framework).

Purpose of Engagement

The College is looking for feedback on the draft framework and will listen to and acknowledge suggestions and concerns. The level of engagement is assessed as "Consult" on the **(IAP2 Spectrum) Engagement Spectrum** and as "Partnering with Patients" on the **Continuum of Patient Engagement** spectrum.

The stakeholder engagement on the draft framework is intended to:

- build awareness and indications of support from pharmacy professionals, other prescribing health care providers and patients for the new prescribing authority;
- gather input from pharmacists on how prescribing could work in their practice;
- gather input from pharmacists and other prescribing healthcare providers on the possible issues and risks and identity possible solutions; and,
- gather input from patients on their interest and concerns about pharmacist prescribing authority.

A report summarizing the stakeholder engagement will be developed by College staff and used by the Certified Pharmacist Prescriber Task Group (Task Group) to inform the final framework. The stakeholder engagement report will be shared with the Board in June 2016 and the final Certified Pharmacist Prescriber Framework will be shared with the Board in September for approval.

Engaging Leadership

The College will involve both Board members and the Certified Pharmacist Prescriber Task Group throughout the engagement process drawing on their expertise, leadership and support for this initiative.

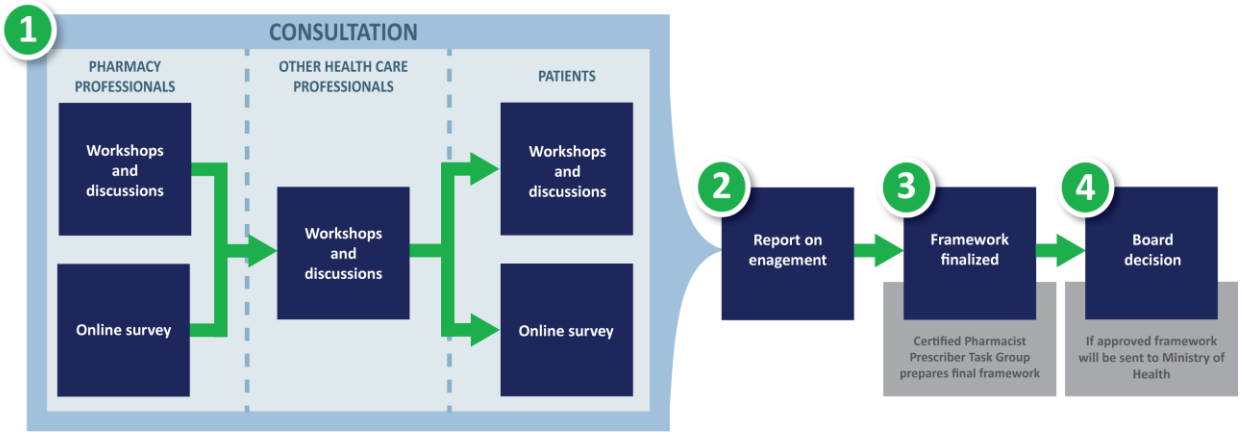
Certified Pharmacist Prescriber Stakeholder Engagement Process

Framing the Discussion

The Certified Pharmacists Prescriber Framework is the focal point for framing the engagement. The College will also prepare additional materials to describe the engagement process and provide additional context for pharmacy professionals, other health care providers and patients for each phase of the engagement to guide participants in providing valuable feedback to the College.

While most communication surrounding workshops and discussions will be conducted in person, the College will use a variety of communication methods to encourage input through online surveys. In particular the College will use web articles, slide decks, infographics and social media to help frame the discussion, build understanding of new authority proposed in the draft framework, and build awareness of the opportunity to contribute to the discussion. The College will also look at where it can feature the consultation at conferences or events.

Certified Pharmacist Prescriber Engagement Process



The College will clearly communicate how the results of the stakeholder engagement will be used to inform the final framework – this level of transparency in the engagement process ensures participants understand the level of impact their input will have in decisions and how their input will be used.

Certified Pharmacist Prescriber
Stakeholder Engagement Process

There will be a phased approach for stakeholder engagement that includes multiple stakeholder groups.

CONSULTATION PHASE 1 - PHARMACY PROFESSIONALS	
February - April 2016	• Both executive and practicing pharmacy professionals will be engaged through workshops and roundtables. • The College's Hospital, Community and Residential Care Advisory Committees will be asked to provide input. • All registrants with the College will be invited to contribute to the consultation through an online survey. • A town hall will also be considered.
CONSULTATION PHASE 2 - OTHER (PRESCRIBING) HEALTH CARE PROFESSIONALS	
April 2016	• Other health care prescribers will be engaged through workshops and roundtables. This includes Physicians, Nurse Practitioners and Naturopathic Physicians. • Executive management and those who work closely with pharmacists in their practice will be invited to provide input.
CONSULTATION PHASE 3 - Patients (and Patient Groups)	
April - May 2016	• Patients will be invited to contribute to the consultation through an online survey. • Patient groups will be engaged through a workshop.

Stakeholder Engagement Report

College staff will gather all stakeholder input and prepare a report that summarizes the input provided. This report will be shared with the Task Group to inform the final Certified Pharmacist Prescriber Framework. The report will also be shared with the Board and will be made public through the College's website.

The stakeholder engagement report will include:

- purpose of engagement
- scale of engagement
- summary of what we heard
- conclusion
- next steps

POINT-OF-CARE HIV TESTING: COMMUNITY PHARMACY PILOT

REKA GUSTAFSON, Vancouver Coastal Health

BOB RAI, Medicine Shoppe Pharmacy

Thanks to: Sophie Bannar-Martin, Chris Buchner, Nancy Chow, Afshan Nathoo, Jillian Pringle, Marla Steinberg

February 18, 2015

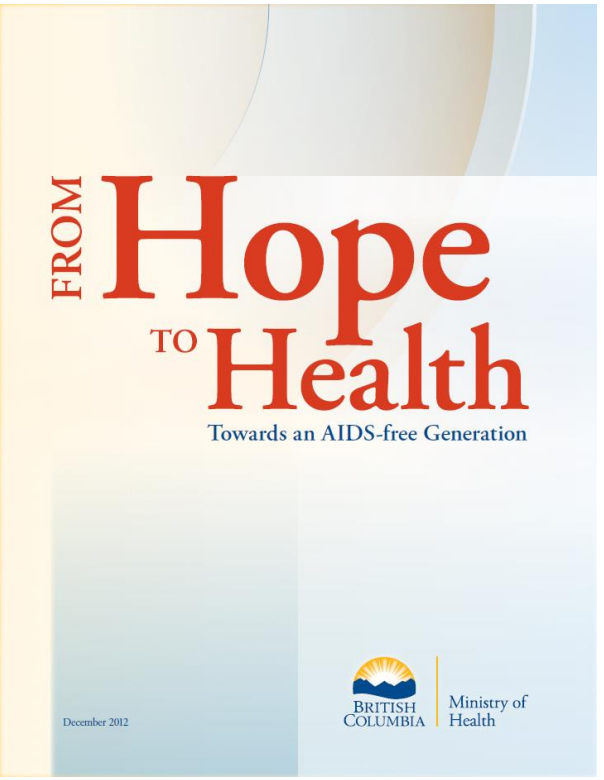
PUBLIC-PRIVATE PARTNERSHIP

Partners

- Medicine Shoppe Pharmacies
  - Vancouver: Medicine Shoppe at 6180 Fraser Street; Medicine Shoppe at 2030 Kingsway (Owner Bob Rai)
  - Victoria: Medicine Shoppe 1964 Fort Street (Owner Dejan Trinajstic)
  - Nanaimo: Medicine Shoppe 1150 Terminal Park Avenue (Owner Elijah Semaluulu)
- Vancouver Coastal Health
  - Chris Buchner, Regional Director Prevention
  - Reka Gustafson, Medical Health Officer and Director Communicable Disease Control
  - Afshan Nathoo, Regional Clinical Practice Lead, HIV
  - Nancy Chow, HIV Educator
- Island Health
  - Dee Hoyano, Medical Health Officer
  - Sophie Bannar-Martin, STOP HIV Project Coordinator
- BC Ministry of Health
  - Ciro Panessa, Director Blood Borne Pathogens
- Partnering Medical Clinics

RATIONALE

- In the context of the Provincial Hope to Health Framework which provides strategic direction to Health Authorities in the progress towards an AIDS free generation.
- G3: Diagnose those living with HIV as early as possible in the course of their infection
- M1: By 2016, rates of HIV testing in each health service delivery area will be at or above 3,500 per 1000,000 people, and each HSDA will have increased HIV testing by at least 50%.
- M2: By 2016, the proportion of people diagnosed early in the course of their infection will meet or exceed 50% in each health authority.
- Evidence shows that the majority of people newly diagnosed with HIV have had many missed opportunities in health care for earlier diagnosis.
- Part of an overall approach: combination of routine offer in healthcare settings AND targeted testing for key populations
- Offering testing in a non-traditional setting may increase access to testing to a subset of the population and help reduce the stigma associated with HIV testing.



PILOT OVERVIEW

- Pilot took place over 12 months or when target # of tests/site reached (600 tests/site).
- Rapid HIV POC testing was offered free-of-charge to pharmacy customers.
- VCH provided training and support to clinical pathway/documentation development, including data collection, reporting, quality assurance and referrals pathways for clients requiring confirmatory testing and/or support.
- Island Health funded the initiative (including payment of pharmacist time -$15/test and cost of evaluation) and provided technical and operational support to the Vancouver Island sites.
- Pilot pharmacies was responsible for the development, printing, distribution and costs related to promotional materials.
- HIV Testing kits provided by BC Centre for Disease Control provincial program.

LAUNCH

- Vancouver sites launched July 2014.
- Nanaimo site launched August 2014 and Victoria site in September 2014.
- Media release received great coverage, both online and print:

  •Globe and Mail, National Post, The Province, The Vancouver Sun, Omni TV, Yahoo Canada, CBC Montreal, CBC TV English, CBC TV French, CTV News Vancouver, CTV News across Canada (at all stations across Canada), PG Citizen, Northern View (Prince Rupert), CHNL Kamloops, Vancity Buzz, City TV Winnipeg, Daily Nanaimo News, Burns Lake District Gazette, Creston Valley Advance, Goldstream News Gazette, Montreal Gazette, Maple Ridge News, Williams Lake Tribune, Cowichan News Leader, Tri City News, Burnaby News Leader, Cloverdale Reporter, Houston Today

TRAINING AND LINKAGE TO CARE

- Pharmacists received extensive training in HIV 101, HIV pre and post test counseling, use of rapid tests (including proficiency testing), quality assurance, documentation, and pathways for linkage to care. Training also included data collection, reporting and documentation standards.
- All clients receiving positive POC will be immediately referred to the partnering medical clinic for confirmatory blood-work and any additional counseling.
- Other referrals may include public health HIV nurses, outreach teams, and AIDS Service Organizations.
- All confirmed positive tests are reported to public health. Public health nurses will link with physicians to provide clients counseling support upon diagnosis, linkage to treatment and support services and partner notification services.

MONITORING AND EVALUATION

- Pilot evaluation included:
  - Testing volumes
  - Yield
  - Population tested: Client demographics (age, gender, ethnicity), first HIV test
  - Pharmacists’ experiences
  - Client satisfaction
- A final report contained recommendations for consideration by provincial policy makers was produced

EVALUATION QUESTIONS ADDRESSED

1. How feasible was it for the community pharmacies to offer point of care HIV testing (including marketing efforts)?

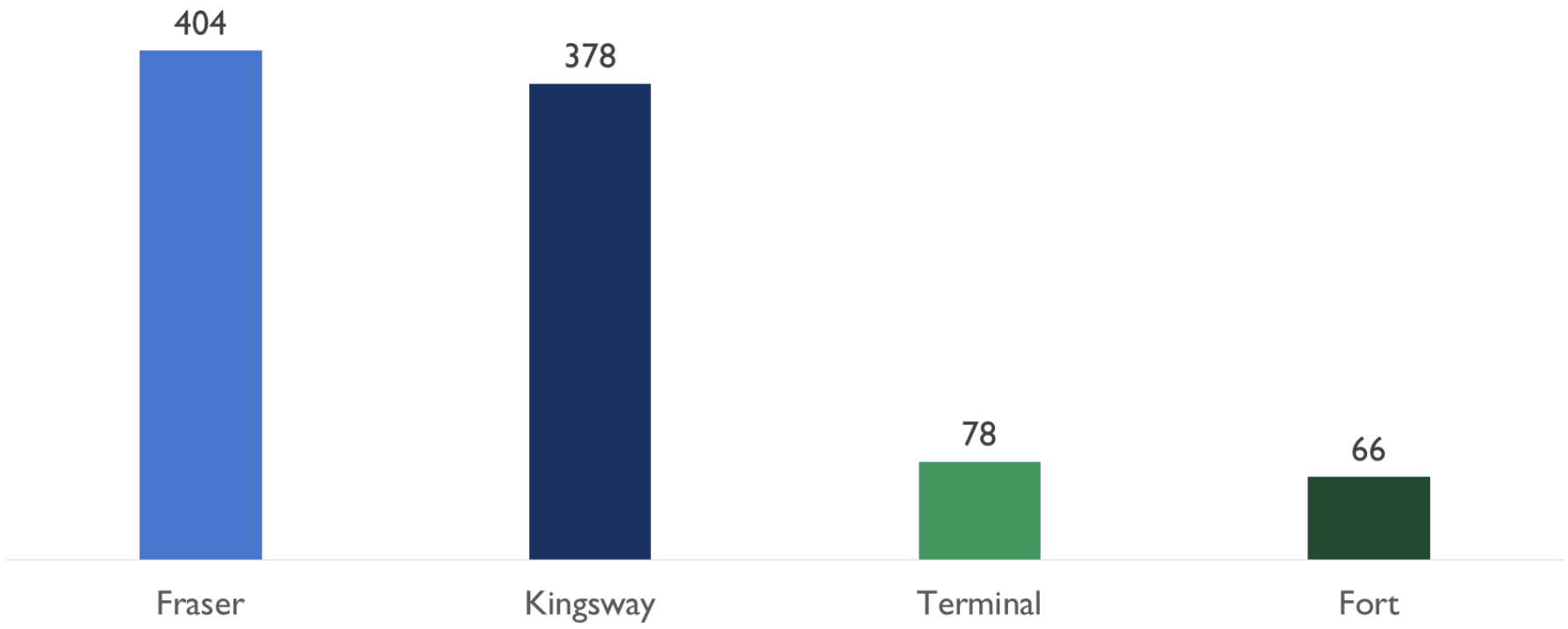
2. To what extent is point of care HIV testing acceptable to clients?

3. How do the point of care clients compare to clients tested through other services (% of first time testers, gender, ethnicity, and positivity yield)?

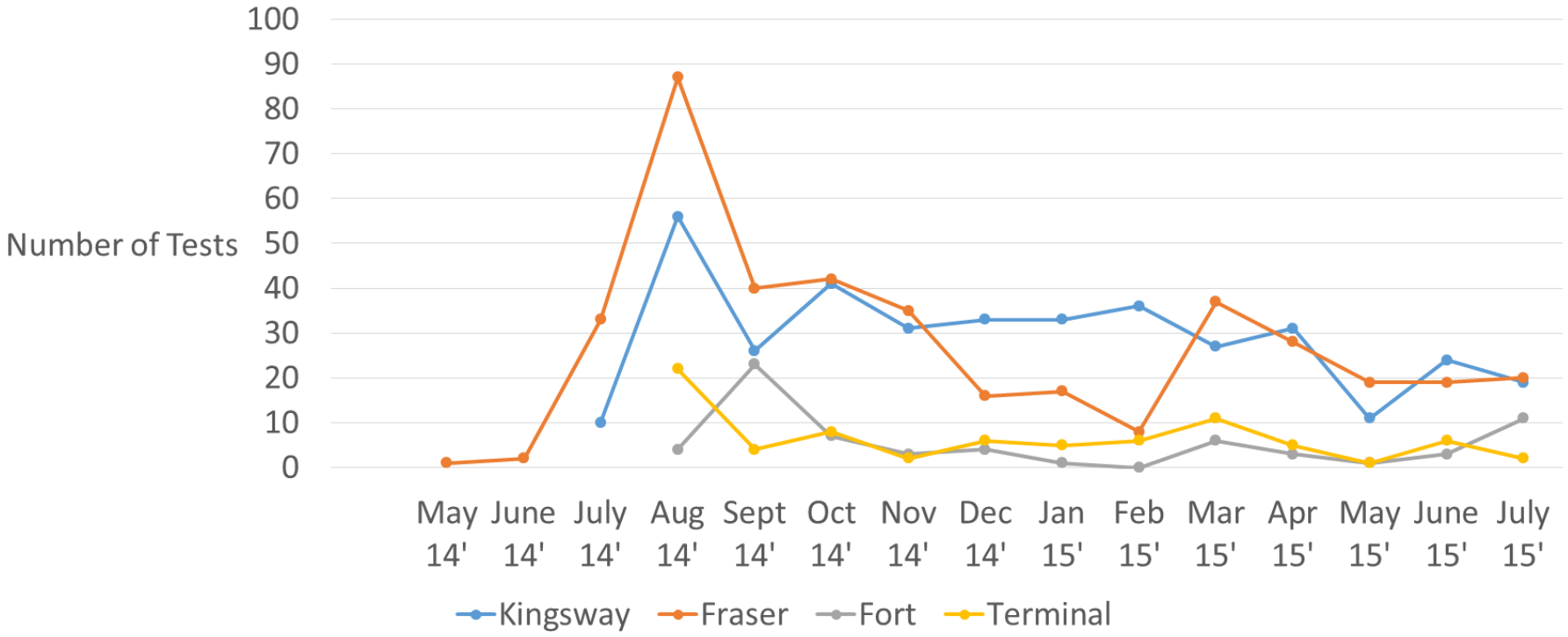
METHODOLOGY

MAIN FINDINGS

926 POC TESTS WERE CONDUCTED OVER THE PILOT PERIOD



TESTING VOLUMES SPIKED AFTER INITIAL PROMOTION WITH VARIABILITY IN TESTING VOLUMES OVER TIME IN VANCOUVER SITES AND OVERALL SMALL DECLINE ACROSS PILOT PERIOD



CLIENT DEMOGRAPHICS

Pharmacy POC Testing Pilot Vancouver Sites - Kingsway & Fraser May 6, 2014 to July 31, 2015			
	#	%	%
Total # of tests	782		
Female	221	221/782	28%
Male	558	558/782	72%
Transgendered	0	0/782	0%
First test for client	483	483/782	62%
Ethnicity			
Aboriginal	23	23/782	3%
Asian	406	406/782	52%
Caucasian	230	230/782	29%
South Asian	90	90/782	12%
Other	31	31/782	4%

Pharmacy POC Testing Pilot Combined - Fort and Terminal August 1, 2014 to July 31, 2015			
	#	%	%
Total # of tests	144		
Female	50	50/144	35%
Male	94	95/144	65%
Transgendered	0	0/144	0%
First test for client	49	49/144	34%
Ethnicity			
Aboriginal	2	1/144	1%
Asian	2	1/144	1%
Caucasian	129	129/144	90%
South Asian	0	0/144	0%
Other	11	11/144	7%

POC TESTING WAS VERY FEASIBLE FOR PHARMACISTS TO IMPLEMENT

- On average, pharmacists rated ease of implementation as 8.2 on a scale of 1 to 10 with 1 representing very difficult and 10 representing very easy
- Training was rated as good
- Only one pharmacy had to create private space for testing and pre and post testing discussions
  - They were going to do that anyway to implement other programs

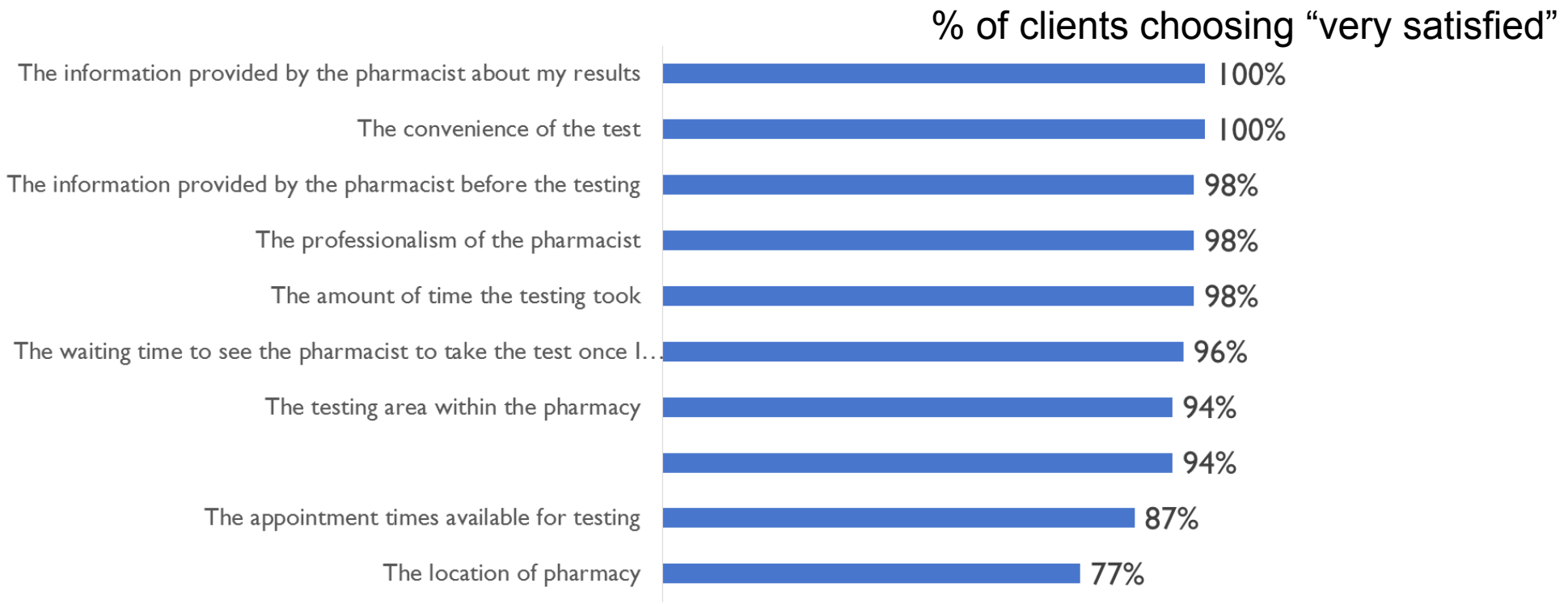
CHALLENGES

- Learning curve of adjusting to new practice
- Making clients comfortable
- Lack of anonymity (clients were asked to provide two pieces of identification: name and date of birth)
- Slow down in uptake

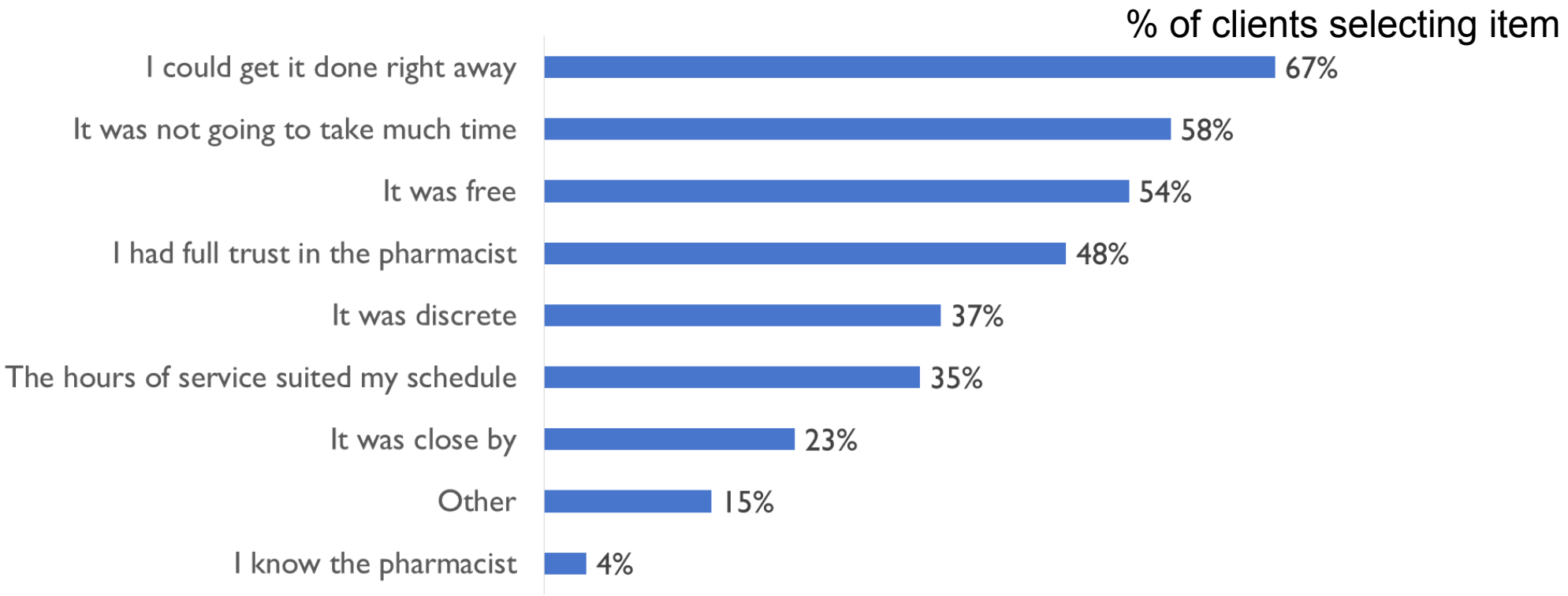
BENEFITS

- Opportunity to provide expanded therapeutic service:
  - *“I just found that level of trust was very rewarding for us.”*
  - *“Well it added definitely an interesting component to it. I had a few amazing interactions I have to say.”*
  - *“We feel that we are doing a noble job. We are caring beyond prescription and I feel very proud that I am a part of it.”*
- Increased awareness of HIV
- Rewarding

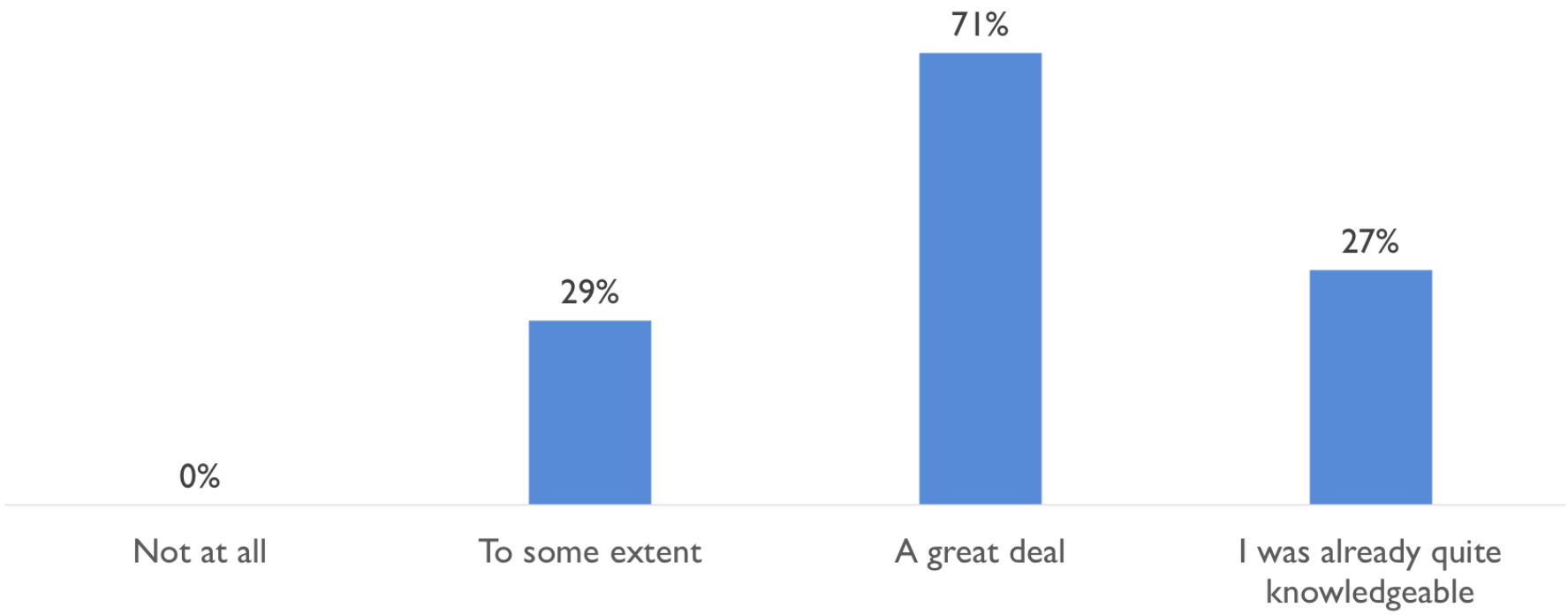
CLIENT SATISFACTION



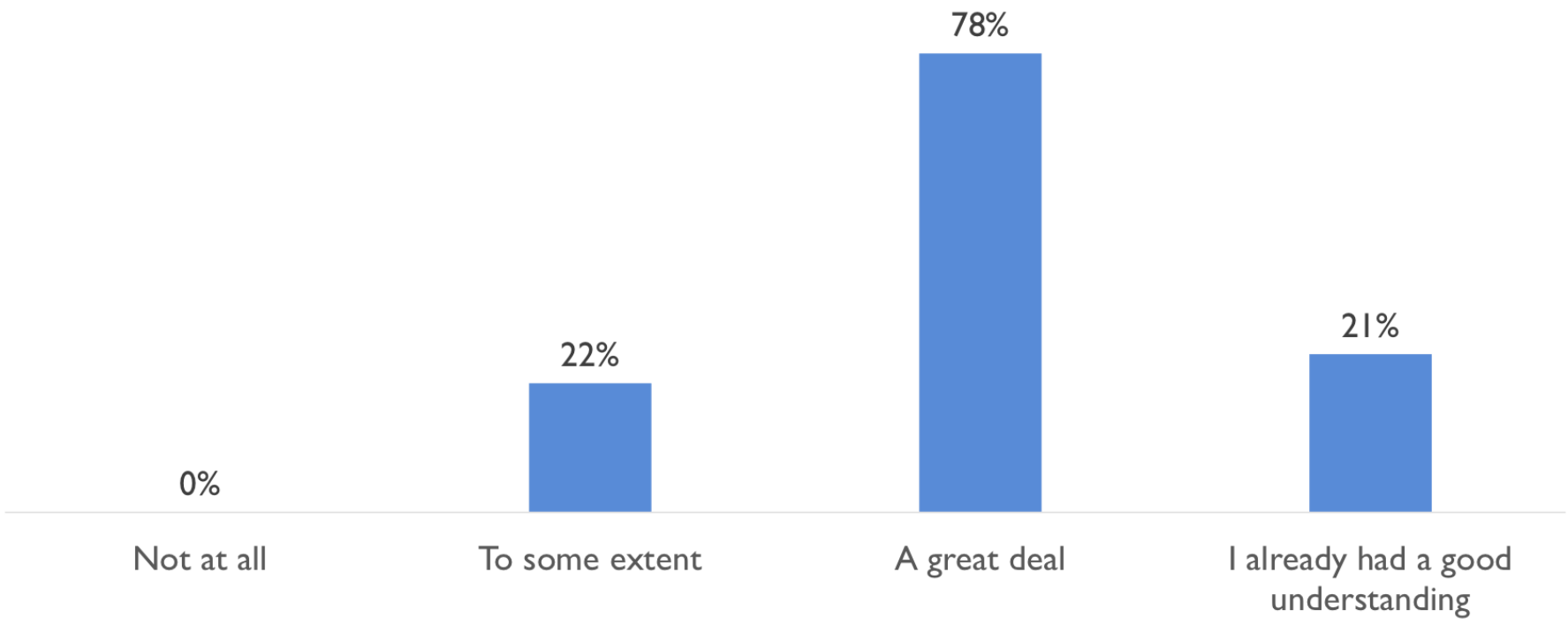
DRIVERS FOR ACCESSING POC TESTING AT PHARMACY



CLIENT FEEDBACK SURVEY FOUND THAT POC TESTING INCREASED KNOWLEDGE OF HIV PREVENTION



CLIENT FEEDBACK SURVEY FOUND THAT POC TESTING INCREASED UNDERSTANDING OF THE IMPORTANCE OF TESTING



COSTS FOR POC TESTING

- $15 per pharmacist per test conducted
- $16.65 for testing kits
- $4,800 for pharmacists marketing and renovation costs
- In-kind contributions by VCH, Island Health and other partners for:
  - Training of pharmacists
  - Project management
  - Communication support
  - Data support
  - Testing kits
- In total, $46,000 was spent on the pilot which was funded by Island Health
  - External evaluation
  - Testing kits
  - Pharmacist compensation

LIMITATIONS OF FINDINGS

- Generalizability of client survey results
  - Not able to determine if client feedback respondents are representative of all Vancouver POC testers
- No client feedback data from Vancouver Island
- Not able to compare POC clients to clients obtaining HIV tests at other venues
- No Preliminary Positive results during pilot period to assess pharmacist/client follow-up and experience

CASE STUDY – PRELIMINARY POSITIVE

- The first preliminary positive result occurred at a Vancouver pharmacy site (Fraser)
- Occurred after pilot period in December 2015
- Testing performed by pharmacy technician (trained by the pharmacist)
- No contact information obtained (no phone number or PHN)
- False name was provided by client
- Client was brought to the neighbouring clinic, heard there was a 45 minute wait
- Physician was a new physician not yet trained in follow-up of POC testing
- As a result, patient left without being seen
- Ultimately, the client left without confirmatory bloodwork being done

WHAT WE LEARNED

- POC testing at pharmacy sites resulted in nearly 1000 HIV tests
- A large proportion of patients tested at these sites were first time testers
- With appropriate training, pharmacists were comfortable delivering this service
- Value of offering this service needs further evaluation and will depend on a variety of factors, including
  - Diagnostic yield
  - Staff turnover
  - Availability of follow-up and linkage to care

DISCUSSION

Personalized Medication in Our Communities

Presentation to College of Pharmacists of BC

February 19, 2016

British Columbia Pharmacy Association

Presented by

Allison Nourse, President

BC Pharmacy Association

British Columbia Pharmacy Association

Genomics for Precision Drug Therapy in the Community Pharmacy

- Genome BC, UBC and BCPhA launched project October 2014
- Project set out to prove community pharmacy could be conduit to making pharmacogenomics available to all Canadians
- Uses whole exome sequencing – complete decoding of all the genes, NOT selected variants
- Largest community-based pharmacogenomics project in Canada

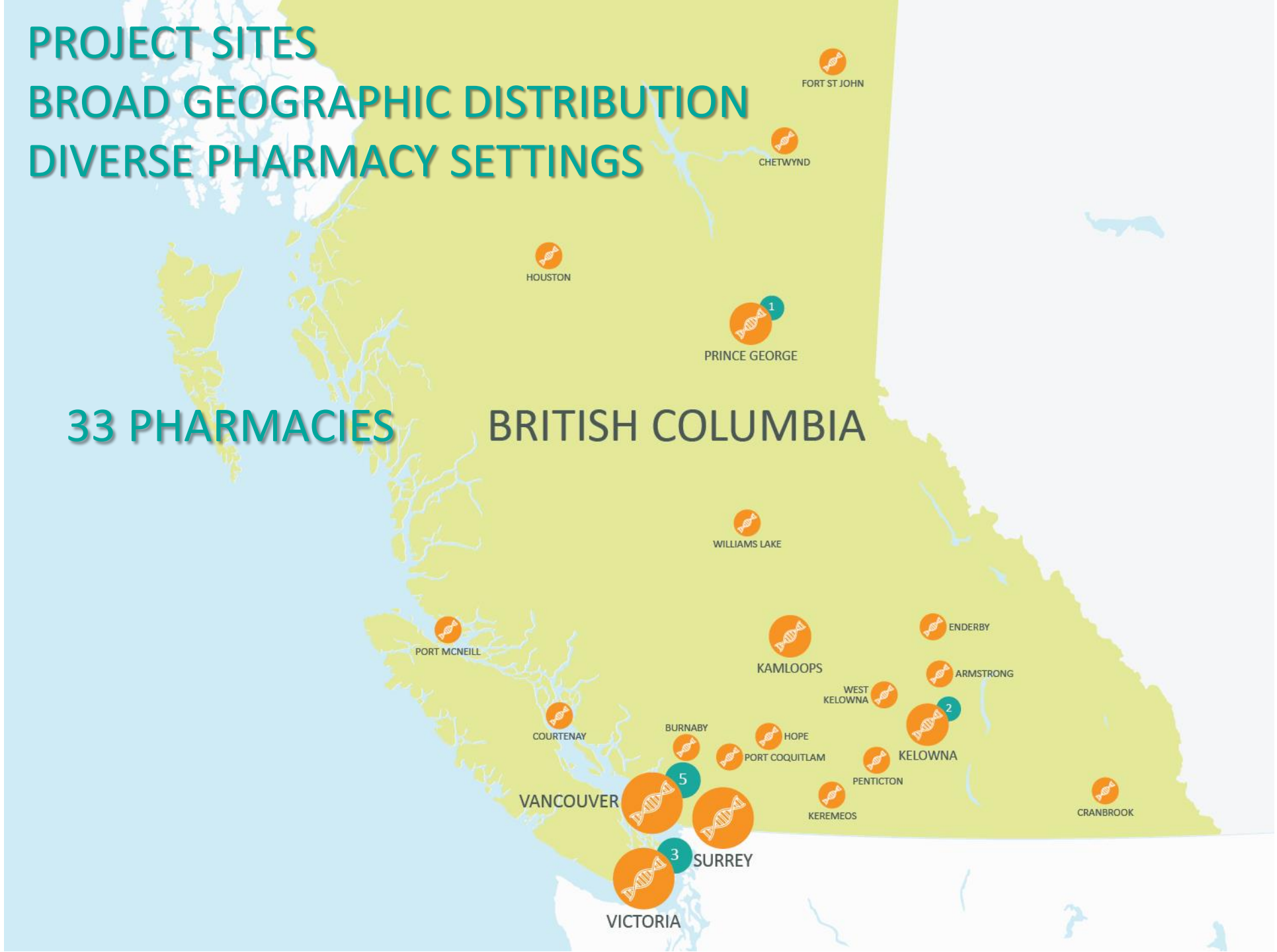
Genomics for Precision Drug Therapy in the Community Pharmacy

- De-mystifying the process through patient point-of-care education
- Warfarin was the test drug
- Project is designed to test implementation protocols not the science
- Same consistent, quality patient experience in both urban and rural pharmacies

Genomics for Precision Drug Therapy in the Community Pharmacy

- 33 pharmacies, with 39 pharmacists trained
- 200+ patients
- Final sample collected in pharmacy late Nov. 2015
- Sequencing complete at UBC last month
- Researchers will do retrospective analysis

PROJECT SITES
BROAD GEOGRAPHIC DISTRIBUTION
DIVERSE PHARMACY SETTINGS



PHARMACIST TRAINING PROCESS

Privacy & Consent

- Face-to-face, off-site (not pharmacy)
- 60-90 minutes
- Regulations, legislation, rationale for study design

Logistics & Operations

- Face-to-face, on-site
- 20-30 minutes
- Sample collection, packaging, shipping & documentation

Quality Assurance

- Phone call 20-30 minutes
- Role play through consent process
- Feedback provided on terminology, phrasing & content

Pharmacist Training Process Rigorous and Standardized

PATIENT CONSENT PROCESS

Identification

- Passive
- ID'd during normal patient care interaction

Education

- 30-45 minutes
- Checklist ensures truly informed consent
- Video shows concepts visually

Deliberation

- 1 day
- Patient takes home consent form to reflect & generate questions

Enrollment

- 20-30 minutes
- Pharmacist answers any questions
- Patient consents
- Info & saliva collected

Rigorous and Uniform Regardless of Location, Pharmacy or Client

Stakeholder Engagement

- Ernst & Young engaged to consult with key industry stakeholders
- 27 interviews completed
- Core stakeholders, professional & regulatory bodies, insurance companies, pharmacy retailers, pharmaceutical companies & industry associations, laboratories, innovation sector, government agencies & physicians

Stakeholder Engagement – What we heard

- Strong support for making better use of pharmacists' skills
- Opportunity to improve quality of care through better drug management
- Physicians say this is feasible and work underway on communication protocols

What we found out

- Implementation at community pharmacy level is possible
- No patient declined to participate (200+)
- Physician buy-in is possible
- Laid the groundwork for broader trial

Next steps

- Researchers analyzing data
- Media outreach for public awareness
- Planning for Phase 2

Thank you

www.bcpharmacy.ca

British Columbia
Pharmacy Association

CLINICAL COMMUNITY PHARMACISTS

OPTIMIZING PHARMACEUTICAL CARE FOR POST-TRANSPLANT AND CHRONIC KIDNEY DISEASE PATIENTS

BENEFITS OF THE COMMUNITY PHARMACY INTEGRATION PROJECTS IN BC

FEBRUARY 2016

AGENDA

1. Objectives
2. Info about the BC Transplant and BC Renal Community Pharmacy Integration Projects
    a. Background
    b. Pilot Projects
    c. Pharmacist's Role
    d. Achieved Outcomes
3. Current challenge with the program
4. Next Steps

A MEDICATION REVIEW SUCCESS STORY

- **Medication reviews are a valuable pharmacist service that can:**
  - Improve patient adherence to prescribed therapies by providing education on medications and building patient buy-in for compliance
  - Identify and minimize medication-related problems, such as drug interactions and adverse drug reactions
  - Provide medication expertise to the health care team and patients
  - Allow the other health care team members to focus on their area of professional expertise
- **We are presenting a positive example of how community pharmacists throughout British Columbia are improving patient care by successfully integrating onto multidisciplinary care teams supported by medication reviews**

COMMUNITY PHARMACIES SUPPORT TRANSPLANT AND RENAL PATIENTS

- **Both BC Transplant and BC Renal contract community pharmacies to provide pharmacy services in all BC Health Authorities**

Penticton Pilot

- Initial pilot to integrate community pharmacists into post-transplant & chronic kidney disease clinics
- Addressed gaps in hospital staff & funding
- Leveraged medication review funding model

Expansion

- Success leads to expansion to:
  - Outpatient CKD clinics in Kamloops, Trail, and Kelowna
  - Post-transplant clinics in Kelowna & Surrey

Further Expansion

- More post-transplant clinics in Nanaimo and Kamloops waiting to implement

- **BC Transplant, BC Renal, The Health Authorities and the Clinic Teams all believe that the benefits of integrating the community pharmacy partners into these out-patient clinics has a positive impact on patients by providing medication expertise and continuity of care between the community and the clinics**

COMMUNITY PHARMACISTS ARE AN ESSENTIAL PART OF PATIENT CARE

The Challenge

- Post-transplant and chronic kidney disease (CKD) patients typically receive multiple medications to prevent and treat chronic conditions and serious complications

The Pharmacist's Role

- Improve patient adherence to medications
- Interpret lab data and evaluate medications
- Reduce potentially serious drug interactions & adverse drug reactions
- Provide medication expertise to patients and the other allied healthcare professionals

The Impact

- Pharmacists have been recognized as an essential part of the multidisciplinary health care team
- Improved patient care and enhanced their continuity of care in the community

THE BC TRANSPLANT COMMUNITY PHARMACY INTEGRATION PROJECT

<u>GOAL</u>: Standardize the current model to ensure the long-term, sustainable integration of community pharmacy partners into BC Transplant's post-transplant out-patient clinics

- The concept of integrating community pharmacists into post-transplant clinics as part of the patient care team is supported by the transplant community and by all the members of the BCT Drug Strategy Advisory Committee and the Medical Leadership Committee
- Information from the pilot is currently being used to develop a case for a sustainable provincial model in 2016 to formalize community pharmacy integration into the BCT provincial post-transplant clinics to:

Standardize the integration process

Define the clinical roles and responsibilities of community pharmacists

Create a sustainable and fair funding formula

ROLE OF THE COMMUNITY PHARMACIST

- **Community Pharmacist:**
  - Attends all post-transplant clinics (up to 4 days/week) to perform **medication reviews**
  - Meet with each post-transplant clinic patient before seeing the nurse and the Nephrologist to complete the BPMH and identify and solve medication management issues (drug-related problems).
  - Provide medication expertise and education to patients and other health care team members
  - Provide patients with a current list of all medications and their indications
- **Transplant Clinic Staff:** **Provides orientation to the clinic, health records, and an office space to perform the work**
- **Hospital Transplant Specialist Pharmacist:** **Collaborates with the community pharmacist by providing an overview of transplant pharmacotherapy in addition to ongoing consultation as needed**

SNAPSHOT OF MEDICATION REVIEWS DONE AT FOUR PILOT PROJECTS

- Community pharmacists integrated into multidisciplinary teams completed over 700 medication reviews during the pilot projects
- These clinics continue to operate and support thousands of patients throughout the province

	Fraser Health Transplant Clinic Sept. 2015	Kelowna Transplant Clinic Dec 23, 2014	Kamloops CKD Clinic Feb 10, 2013	Penticton CKD Clinic April 15, 2012
Medication Reviews Completed	251	118	187	165
Qualifying Full Medication Reviews	90 (36%)	100 (85%)	148 (79%)	141 (86%)
Qualifying Follow-up Medication Reviews	59 (24%)	13 (11%)	24 (13%)	17 (10%)

COMMUNITY PHARMACISTS UNCOVERED A NUMBER OF POTENTIAL DRUG ISSUES

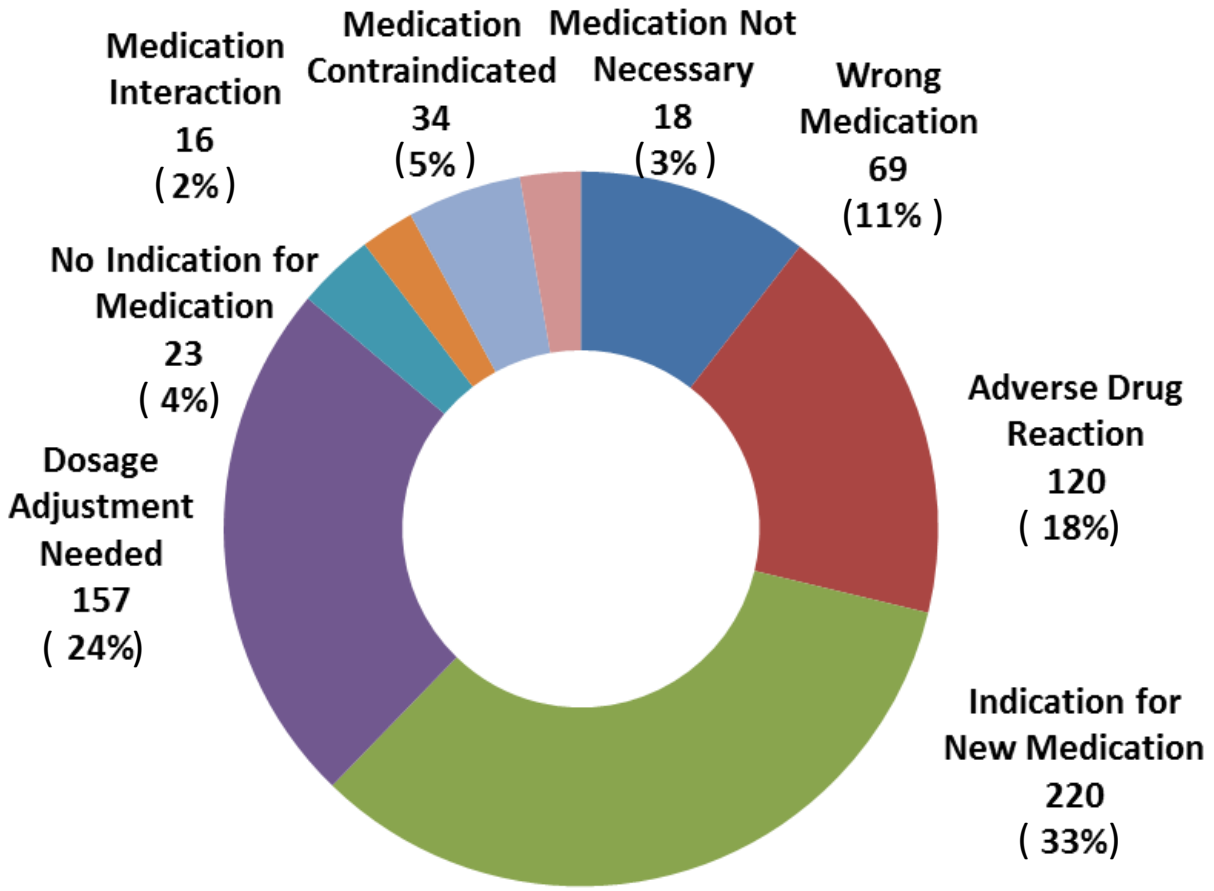
Appendix 16

	Fraser Health Transplant Clinic Sept. 2015	Kelowna Transplant Clinic Dec 23, 2014	Kamloops CKD Clinic Feb 10, 2013	Penticton CKD Clinic April 15, 2012
Total Number of Patients Seen	251 (100%) All Patients Seen	118 (n/a) Not All Patients Seen	187/334 (56%) Not All Patients Seen	165 (100%) All Patients Seen
Average Number of Medications per Patient	10.7	12.2	12.4	12.5
Total Number of Discrepancies	**409**	**690**	**320**	**659**
Total Number of Drug-related Problems	**257**	**228**	**74**	**105**
Total Number of Adherence Issues	**86**	**10**	**7**	**55**

- A Discrepancy is any mismatch between the patient's official BC Transplant/BC Renal medication record and what they are actually taking
- A Drug-related Problem (DRP) is a clinically significant issue arising from what the patient is taking

UNCOVERED DRPS COULD HAVE HAD SERIOUS PATIENT CONSEQUENCES

Breakdown of 664 Drug-related Problems Experienced Across All Pilots (2012-2016)



PHYSICIANS SUPPORT COMMUNITY PHARMACISTS' RECOMMENDATIONS

	Fraser Health Transplant Clinic Sept. 2015	Kelowna Transplant Clinic Dec 23, 2014	Kamloops CKD Clinic Feb 10, 2013	Penticton CKD Clinic April 15, 2012
Total Number of Pharmacist Recommendations	96	38	150	178
Total Number of Accepted Recommendations by Physician	**71 (74%)**	**23 (61%)**	**104 (69%)**	**125 (70%)**

PATIENTS ARE APPRECIATIVE OF THE MEDICATION REVIEWS THEY RECEIVE

	Fraser Health Transplant Clinic Sept. 2015	Kelowna Transplant Clinic Dec 23, 2014	Kamloops CKD Clinic Feb 10, 2013	Penticton CKD clinic April 15, 2012
Total # of Patients Surveyed	15	21	19	18
# of Patients who reported a positive experience	13 (87%)	20 (95%)	N/R	15 (83%)
# of Patients who reported improved medication knowledge	3 (20%%)	15 (71%)	8 (42%)	7 (39%)
# of Patients who reported changing their medication behavior	N/R	10 (43%)	10 (53%)	10 (56%)
# of Patients who reported they wanted Pharmacists in clinic permanently	N/R	19 (90%)	18 (95%)	N/R

A POTENTIAL RISK

- Although BC PharmaCare reimburses pharmacists for medication reviews and it has been used to develop this concept from the beginning, more and more post-transplant patients are not eligible.

- However, medication review funding is still critical to the success of this model and we are concerned that the BC PharmaCare medication review funding model will be changed in the future without notice or consultation

GOALS

- **Increase awareness of these pilot projects, as well as the great work and patient impact these community pharmacists have been providing across the province with the support of the medication review program**

- **Ask BC PharmaCare to consult with BC Transplant and BC Renal before any future changes to the Medication Review Program.**

Q&A

THANK YOU!

18. Methadone Maintenance Treatment Update

Suzanne Solven
Deputy Registrar

George Budd
Senior Investigator

Historical Background and Context

Year	Accomplishment
2007	MMT guidelines published for the first time
2008	Strategic Plan goal alignment
2009	HPA Bylaw implemented “patient choice”
2010	MMT undercover operations for the first time
2011	PPP-66 and Policy Guide published Mandatory training sessions (x26)
2012	Interprofessional clinical education sessions (x15) Patient Liaison Group established
2013	Updated PPP-66 published Mandatory training sessions (x23) Overall 3863 pharmacists and 389 technicians “trained”
2014	Undercover results: 9 pharmacies, 31 regs. and 2 owners College results provide evidence for Ministry to act

MMT Action Plan Overview

College of Pharmacists of British Columbia

Focused Inspections

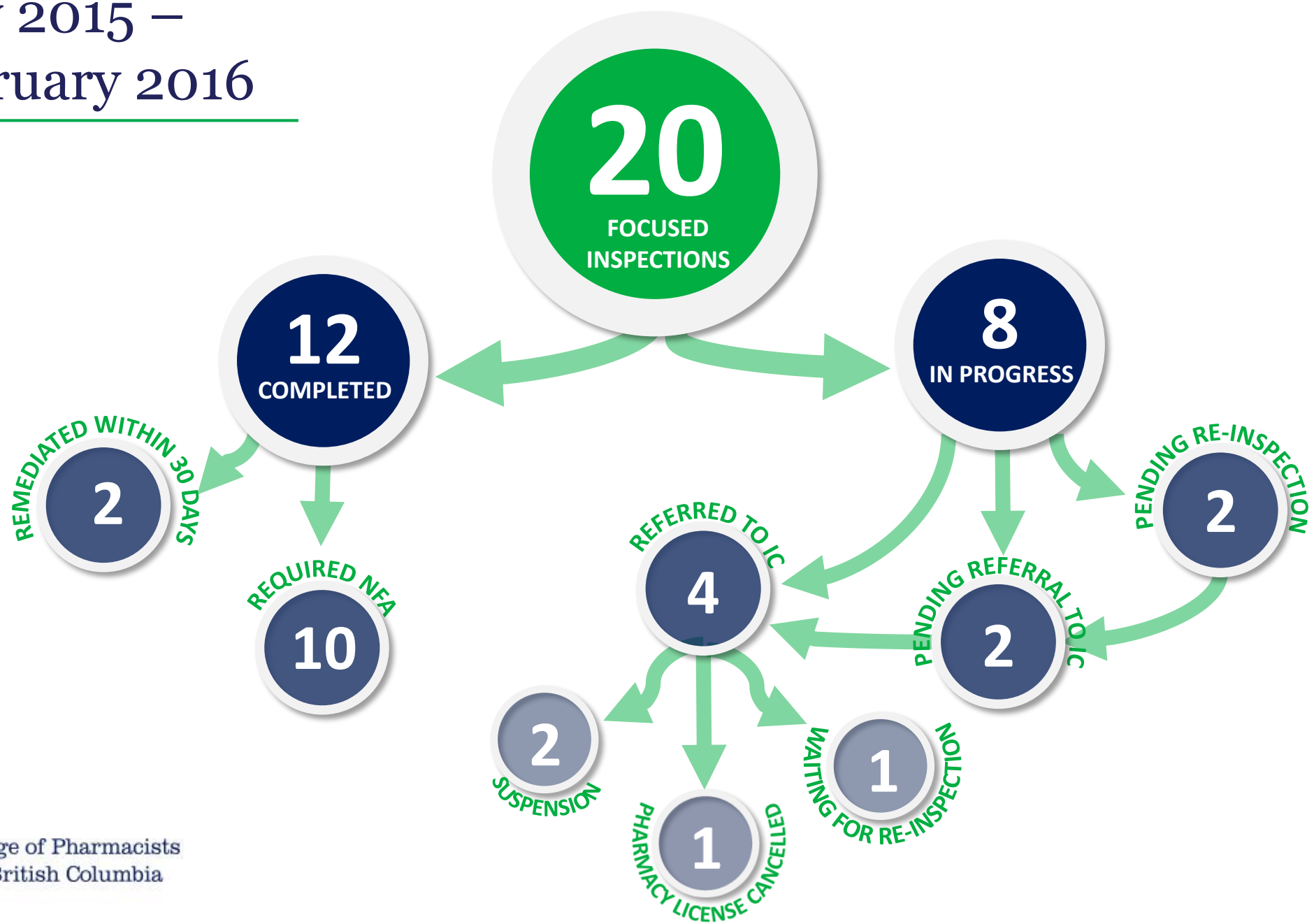
Prioritized based on:

- Premises which are not appropriate for the practice of pharmacy
- Denied or terminated PharmaCare enrollment
- Top 20 MMT dispensing pharmacies

Other factors:

- Tips/complaints
- Immediate public safety risk

May 2015 – February 2016



College of Pharmacists of British Columbia

College of Pharmacists of British Columbia

College of Pharmacists
of British Columbia

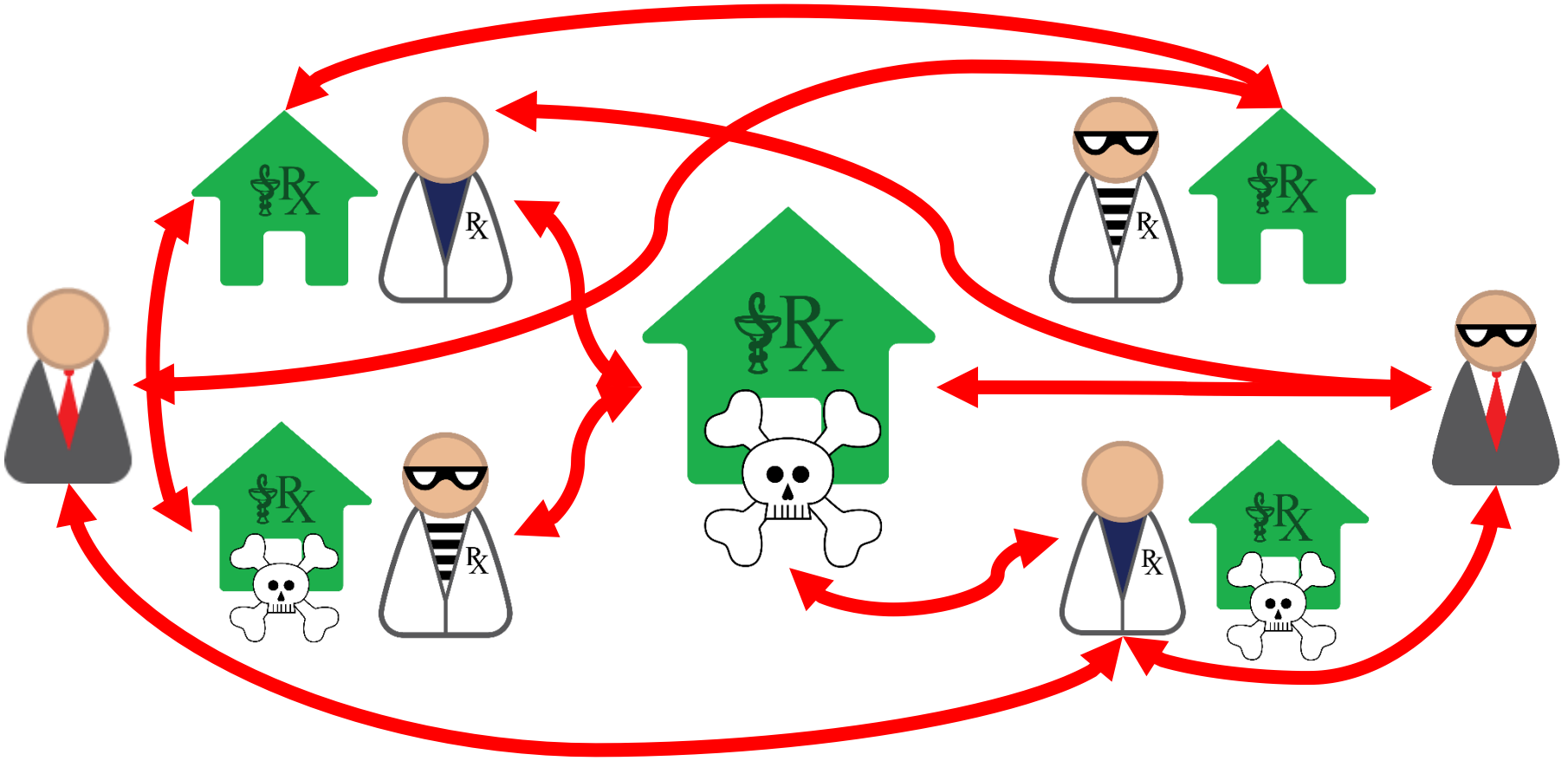
College of Pharmacists
of British Columbia

Taking Action: “Straightforward” Case

Obvious, immediate risk to public safety

- Native Pharmacy
- Downtown Pharmacy

Taking Action: Complex Case



Taking Action: Obstacles

- Unknown pharmacy owners (PODSA)
- Pharmacy owner/director changes
- Ownership of multiple pharmacies
- Previous undercover investigations
- Criminal Activity – liaise with law enforcement
  – lose jurisdiction

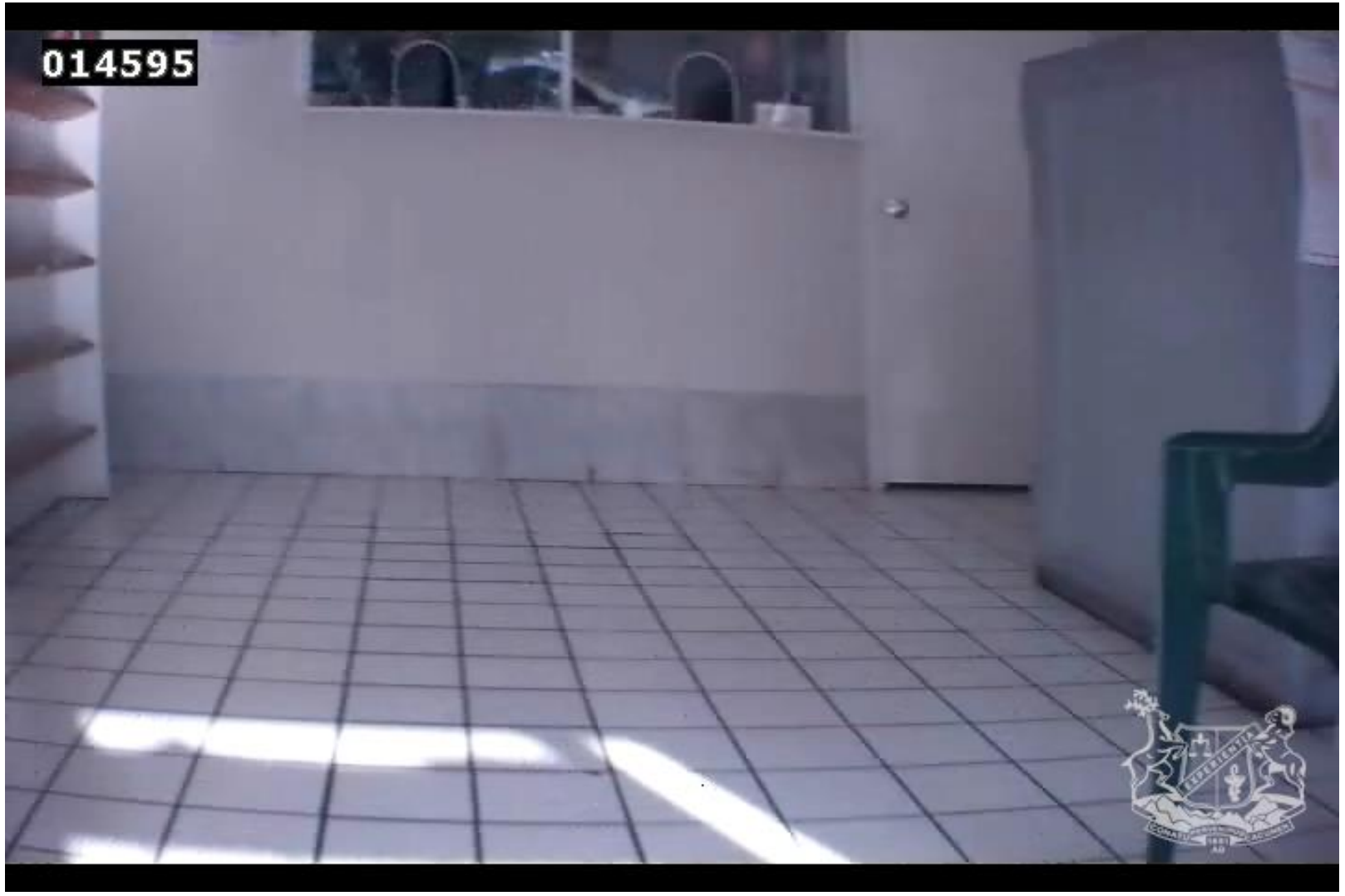
Undercover Investigations

May 2015 – February 2016

In the interest of confidentiality & security, the College will not be reporting on the progress of undercover investigations.

Undercover Investigations

Undercover Investigations

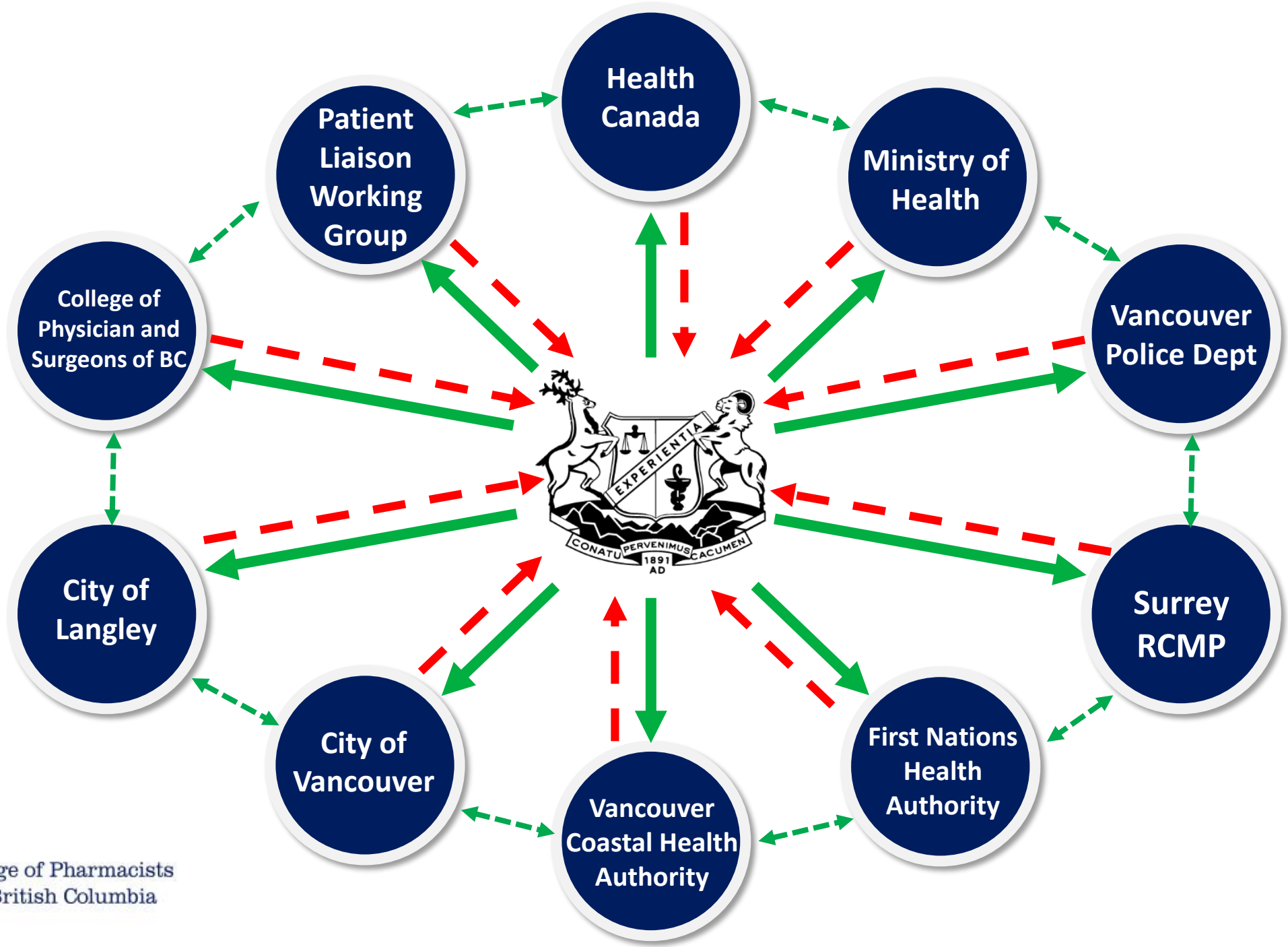


Stakeholder Relations

May 2015 – February 2016

Based on:

- Keeping stakeholders informed and involved
- Supporting transparency and accountability
- Co-ordinating organizational resources
- Pre-empting unintended consequences



College of Pharmacists of British Columbia

Legislation Review

May 2015 – February 2016

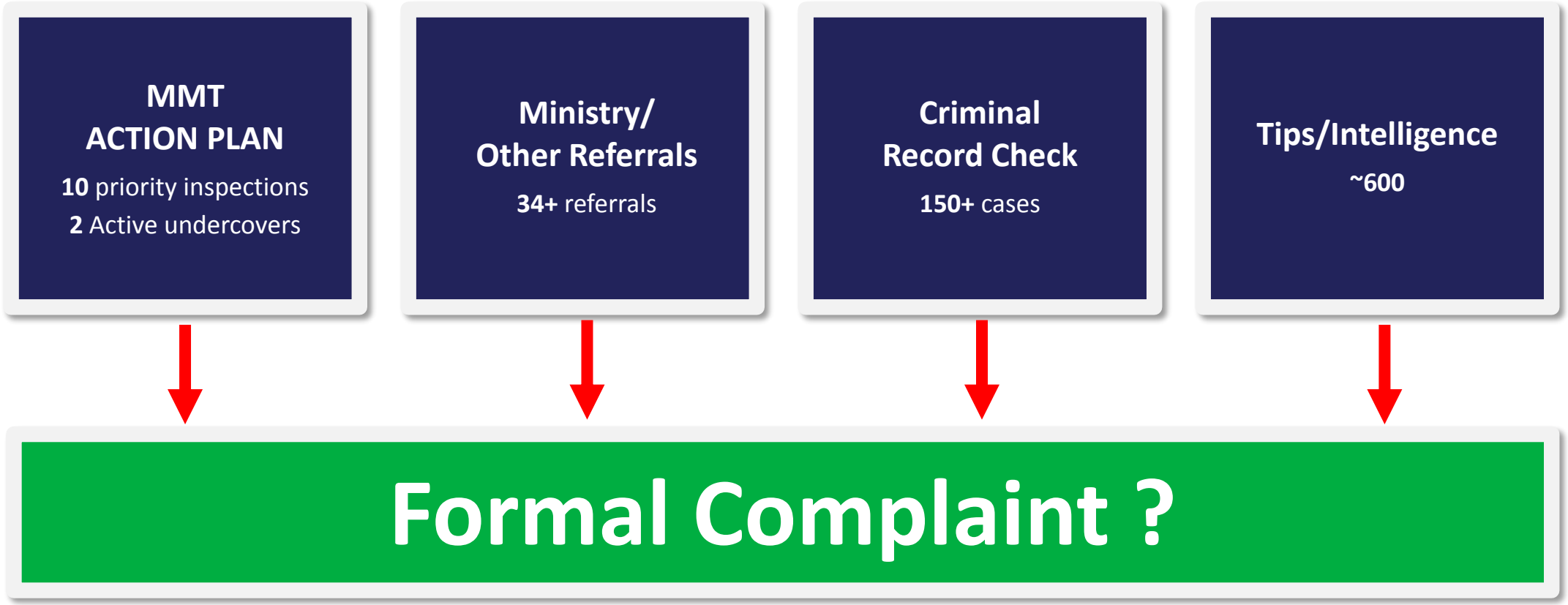
- Strengthen pharmacy licensure requirements for MMT dispensing, and
- Strengthen pharmacist and pharmacy technician registration requirements for dispensing of MMT.
- Changes to be informed by results of inspections
- Prioritized on larger Legislation Plan
  (to be presented at November Board meeting)

Complaints Resolution 2015

715 Points of Contact	80 Investigations	100 Formal Complaints	142 Registrants Involved	1 Discipline Hearing

Stats as of December 31, 2015

Complaints Resolution 2016



College of Pharmacists of British Columbia

On our Radar

Prioritization of tips/information related to:

- “repeat” offenders
- robberies and B&Es
- incomplete/unauthorized medication reviews
- inappropriate PharmaNet access

Informing the Public