



**ONTARIO COLLEGE OF PHARMACISTS**

**COUNCIL MEETING AGENDA**

**MONDAY, JUNE 12, 2017– 9:00 A.M.**

**COUNCIL CHAMBERS, 483 HURON STREET, TORONTO**

- 1. Noting Members Present**
- 2. Declaration of Conflict**
- 3. Approval of Agenda**
- 4. President's Opening Remarks**
  - 4.1 Briefing Note - President's Report to June 2017 Council ..... Appendix 1
  - 4.2 Briefing Note – March 2017 Council Meeting Evaluation ..... Appendix 2
- 5. Approval of Minutes of Previous Meeting**
  - 5.1 Minutes of March 2017 Council Meeting ..... Appendix 3
- 6. Notice of Motions Intended to be Introduced**
- 7. Motions, Notice of Which Had Previously Been Given**
- 8. Inquiries**
- 9. Matters Arising from Previous Meetings**
  - 9.1 Briefing Note – Medication Safety CQI – Framework and Implementation Plan  
..... Appendix 4
- 10. For Decision**

None

**11. For Information**

- 11.1 Briefing Note - President - Governance – Non-Council Committee Members . Appendix 5
- 11.2 Briefing Note - Registrar’s Report to Council ..... Appendix 6
  - Strategic Priorities Progress Update
  - Ministry/Government Activities
  - Legislative Initiatives
  - Federal/Provincial Initiatives
  - Inter-Professional Relationships
  - Other Stakeholder Meetings
  - Miscellaneous Items

**12. Other Matters**

- 12.1 Cannabis Discussion – Preamble .....Appendix 7
- 12.2 Presentation by Ms. Susan James, Director, Competence  
Re: Scope of Practice Strategy
- 12.3 Presentation by Ms. Sandra Winkelbauer, Manager, Continuing Competency  
Re: Strategic Plan Update
- 12.4 Appointment of Elections Committee
  - Discussion on Second Term Election for Executive Committee positions

**13. Unfinished Business**

**14. Motion of Adjournment**

*As a courtesy to other Council Members, you are requested to please turn off your cell phones/pagers/blackberries and other hand-held devices that may cause disruption during the Council Meeting. There are breaks scheduled throughout the day in order to allow members the opportunity to retrieve and respond to messages.*

***Please note:** The College is a scent free environment. Scented products such as hairsprays, perfume, and scented deodorants may trigger reactions such as respiratory distress and headaches. In consideration of others, people attending the College are asked to limit or refrain from using scented products. Your co-operation is appreciated.*

*Thank you.*



**COUNCIL BRIEFING NOTE**  
**MEETING DATE: JUNE 2017**

<b>FOR DECISION</b>	<b>FOR INFORMATION</b>	<b>X</b>
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**INITIATED BY:** Régis Vaillancourt, President

**TOPIC:** President’s Report to June 2017 Council

**ISSUE:** As set out in the Governance Manual, the President is required to submit a report of activities at each Council meeting.

**BACKGROUND:** I respectfully submit a report on my activities since the March 2017 Council Meeting. In addition to regular meetings and phone calls with the Registrar, and the Vice President, listed below are the meetings, conferences or presentations I attended on behalf of the College during the reporting period. Where applicable, meetings have been categorized into general topics or groups.

**Other Stakeholder Meetings:**

April 25<sup>th</sup> Health Canada Meeting re: The Role of Pharmacists in Cannabis Regulations and the Opioid Crisis

**College Meetings:**

March 29<sup>th</sup> Executive Committee Conference call re NAPRA Cannabis Position Statement  
 April 10<sup>th</sup> Executive Committee Conference call re NAPRA Cannabis Position Statement  
 April 11<sup>th</sup> ICRC Mid-Year Meeting  
 April 18<sup>th</sup> Discipline Committee Spring Meeting  
 May 8<sup>th</sup> Governance Review Meeting  
 May 9<sup>th</sup> Discipline Hearing  
 May 10<sup>th</sup> Elections Committee Conference call  
 May 15<sup>th</sup> AGRE Governance Roundtable  
 May 16<sup>th</sup> New Council Member Orientation – C. Henderson – Conference call  
 May 23<sup>rd</sup> Opioid Task Force Meeting  
 May 25<sup>th</sup> Executive Committee Meeting

This reporting period saw increased activity in the realm of Governance. For example, over the past several Council meetings, we have discussed and addressed governance issues that have come up at the National Association of Pharmacy Regulatory Authorities (NAPRA) and the Advisory Group for Regulatory Excellence (AGRE) tables.

As a reminder, the [Governance Manual](#) states:

*Effective governance involves each entity within an organization being accountable for their activities, reporting on what they have done and receiving comments on their performance. Evaluation should result in feedback to the person or entity. Areas of strength should be recognized. Areas for enhancement should be identified and the person and entity should be encouraged to improve*

*their performance. In rare cases, action should be taken to ensure that the person or entity complies with the organization's expectations.*

*As a Council member, your role is to actively participate in Council meetings and other Council activities (e.g., serving on its Committees) to help Council fulfill its mandate. Your duty of diligence fosters preparation and attendance at all Council meetings, participation in Council debates (including constructively expressing differing opinions), voting on all matters unless there is a conflict of interest or a compelling reason for abstaining, completing agreed upon activities between meetings, and serving on College Committees with equal attentiveness.*

As you are aware, attendance at Council and Committee meetings is noted and a summary report of attendance record of Council members is provided to Council annually (in September) so that Council can hold itself accountable on this measure of performance. Our Governance Manual also states that in addition, each year, individual Council members will go through an evaluative process. With your agreement, I am proposing that at the end of each Council year, Council members participate in an assessment (see Appendix 7 of the [Governance Manual](#)) that will allow us to understand and recognize what is working well and identify areas for improvement. Therefore, in late July, every Council member will be asked to complete a questionnaire and to forward to the Council and Executive Liaison (Ms. Rajdev) who will collate the results into a document for review by the incoming President.



**COUNCIL BRIEFING NOTE**  
**MEETING DATE: JUNE 2017**

<b>FOR DECISION</b>	<b>FOR INFORMATION</b>	<b>X</b>
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**INITIATED BY:** Régis Vaillancourt, President

**TOPIC:** March 2017 Council Evaluation Report to June 2017 Council

**ISSUE:** As set out in the Governance Manual, after each Council meeting, Council performs an evaluation of the effectiveness of the meeting and provides suggestions for improvement.

**BACKGROUND:** At the March 2017 Council meeting, we provided Council members with the opportunity to provide their feedback. 15 Council members responded to the survey. A summary of the input is being provided to Council for information.

**1. Governance philosophy Council and staff work collaboratively, each in distinct roles, to carry out self-regulation of the pharmacy profession in the interest of the public and in the context of our mission statement and legislated mandate. How would you evaluate the meeting overall?**

Answer Options	Always	Frequently	Often	Occasionally	Never	Response Count
1. In accordance with the governance philosophy, topics were related to the interest of the public and the purpose of OCP	15	0	0	0	0	15
2. Members were well prepared to participate effectively in discussion and decision making	10	5	0	0	0	15
3. In accordance with the governance philosophy, Council worked interdependently with staff	13	1	0	1	0	15
4. There was effective use of time	13	2	0	0	0	15
5. There was an appropriate level of discussion of issues	12	3	0	0	0	15
6. The discussion was focused, clear, concise, and on topic	11	3	1	0	0	15

**2. Did the meeting further the public interest?**

YES = 15 = 100%

NO = 0 = 0%

**3. Identify the issue for which you felt the discussion and decision-making process worked best, and why.**

- Good discussion on all issues.
- Good fulsome discussion surrounding our response to the proposed amendments to the RHPA (Bill 87). I also enjoyed both the presentation and ensuing discussion with the Deputy Minister Bob Bell. It was enlightening to see how the government proposes to restructure the provision of care in Ontario in the not too distant future. Additionally I have to commend the Finance and Audit group for a great presentation and discussion of the budget and annual results. The addition of the slides to augment the discussion was a great idea and did make it easier to follow along and stay focused on the discussion instead of on trying to find the corresponding report in your package.

- Introduction to the items, discussion with council and then voting.
- A member would be surfing the internet not paying attention and then he was allowed to waste Council's time with questions that were not relevant.
- The issue on mandatory revocation of license for serious offenses like fraud and drug trafficking. I thought the robust discussion brought out perspectives that may typically be sublimated when people judge such offenses as meritorious of license revocation or a simple black and white matter. The person who initiated the discussion and who brought to bear his own experience made the rest of us more sensitive of the implications of mandatory revocation to the professional member. Bottom-line: Carefully weigh the issue and not simply surrender to public optics.
- Loved the slides for the budget discussion -- very helpful.
- Bill 87.
- Worked best when Roberts Rules were adhered to. 1st time, 2nd time, speaking lists.
- All discussion at the meeting ran smoothly in my opinion.
- Both the medication safety and the discussion on Bill 87 and proposed RHPA amendments were good, allowed for debate and points of view to be brought forward.
- The report from the Registrar concerning public member appointments-a fulsome and concise discussion.
- The discussion on the addition of non-government appointed members to specific committees was good and the issue of mandatory revocation of licenses under certain conditions was also enlightening.

**4. Identify the issue(s) for which you have felt the discussion and decision-making process was not effective, and why. Note any areas where the distinction between governance and operations was unclear.**

- Although it was good to have some discussion surrounding the College staff's progress on the Strategic Plan, there wasn't much more discussed than what was on the slides so it felt like we were just rereading the package together. I would suggest it be limited to highlighting the key initiatives that might need further clarification than what was included in the package.
- It is difficult when the staff do not abide by the will of the Council.
- I did not feel that any issues raised were not properly debated and discussed.
- On some points the chair seem to have his mind made up and didn't seem to appreciate some opinions
- Can't think of any at the moment. Being my first time to attend the Council meeting, I was impressed at the level of participation by everybody.
- N/A
- None
- N/A
- Some confusion around Roberts Rules of the motions around the revocation through discipline.

**5. Using the Code of Conduct and Procedures for Council and Committee Members as your guide, in general, how satisfied are you with Council members' ability to demonstrate the principles of accountability, respect, integrity and openness?**

Answer Choices	Responses
Completely Satisfied	11
Mostly Satisfied	3
Neither Satisfied Nor Dissatisfied	1
Mostly Dissatisfied	0
Completely Dissatisfied	0
<b>Total Responses</b>	<b>15</b>

**6. Suggestions for improvement and General Comments (name of respondent - optional)**

- I felt the Registrars' report could have been broken up into a few different reports to Council instead of it being one huge report (97 pages). Some of it (like the Risk Analysis) could have been simply an FYI and other parts would have warranted more discussion. Although it is great that Council members are so cordial with each other, there seemed to be a great deal of personal comments or 'joking around' the Council table. These comments may have been more productively made outside of the actual meeting rather than around the table itself.
- No phone or computer use unless it relates to the discussion on hand. You shouldn't be pricing vehicles
- Following the sequencing of materials uploaded in the computer presented some challenge for me. Probably it was a matter of getting use to it (in my previous College, materials for discussion were in printed or hard copies that were sequentially followed). But a great meeting, all in all!! :)
- None
- Excellent opportunity to hear from and speak with Dr. Bell; would be better in the future to ensure the questions and discussion afterwards focused on council related business and activities. This could be done by setting expectations with everyone prior to the presentation.

Respectfully submitted,

Régis Vaillancourt, President



**Ontario College  
of Pharmacists**

Putting patients first since 1871

**MINUTES OF MEETING**

**OF COUNCIL**

**MARCH 20, 2017**

Draft



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**MONDAY, MARCH 20, 2017 – 9:00 A.M.**

**COUNCIL CHAMBERS, ONTARIO COLLEGE OF PHARMACISTS**

**Elected Members**

District H Dr. Régis Vaillancourt, Ottawa  
District H Ms. Christine Donaldson, Windsor  
District K Dr. Esmail Merani, Carleton Place  
District K Ms. Tracey Phillips, Westport  
District L Mr. Billy Cheung, Markham  
District L Mr. James Morrison, Burlington  
District L Dr. Sony Poulouse, Hamilton  
District M Mr. Fayez Kosa, Toronto  
District M Mr. Don Organ, Toronto  
District M Ms. Laura Weyland, Toronto  
District N Mr. Gerry Cook, London  
District N Mr. Chris Leung, Windsor  
District N Dr. Karen Riley, Sarnia  
District P Mr. Jon MacDonald, Sault Ste. Marie  
District P Mr. Douglas Stewart, Sudbury  
District T VACANT  
District TH Mr. Goran Petrovic, Kitchener

Dr. Heather Boon, Dean, Leslie Dan Faculty of Pharmacy, University of Toronto  
Dr. David Edwards, Hallman Director, School of Pharmacy, University of Waterloo

**Members Appointed by the Lieutenant-Governor-in-Council**

Ms. Kathleen Al-Zand, Ottawa  
Ms. Linda Bracken, Marmora  
Ms. Carol-Ann Cushnie, Toronto  
Mr. Naj Hassam, North York  
Mr. Javaid Khan, Markham  
Mr. James MacLaggan, Bowmanville  
Ms. Elnora Magboo, Brampton  
Ms. Sylvia Moustacalis, Toronto  
Ms. Joan A Pajunen, Kilworthy  
Mr. Shahid Rashdi, Mississauga  
Ms. Joy Sommerfreund, London - **Regrets**  
Mr. Ravil Veli, North Bay  
Mr. Wes Vickers, LaSalle

## **Staff present**

Ms. Connie Campbell, Director, Finance and Administration  
Ms. Susan James, Director, Competence  
Ms. Nancy Lum-Wilson, CEO and Registrar  
Ms. Ushma Rajdev, Council and Executive Liaison  
Ms. Anne Resnick, Deputy Registrar/Director, Conduct

## **Invited Guests**

Dr. Robert Bell, Deputy Minister, Ministry of Health and Long-Term Care

### **1. Noting Members Present**

Member attendance was noted.

### **2. Declaration of Conflict**

There were no conflicts declared.

### **3. Approval of Agenda**

**It was moved and seconded that the Agenda be approved. CARRIED.**

### **4. President's Opening Remarks**

President Vaillancourt welcomed Council members to the meeting, noting that there have been several changes at the Council table since the meeting in December. He introduced Mr. Najmudin (Naj) Hassam, Public Member from North York to Council. Mr. Hassam was appointed to College Council in October 2016 but was unable to attend the December Council meeting. Mr. Hassam was invited to briefly introduce himself to Council.

Council next noted that Ms. Elnora Magboo, Public Member from Brampton was appointed to College Council on January 11, 2017 for a period of 3 years. An orientation was held on January 26. Also on January 11, Mr. John Laframboise tendered his resignation and Ms. Magboo was appointed to serve on the Committees on which Mr. Laframboise was serving, namely the Accreditation, Drug Preparation Premises, Inquiries, Complaints and Reports (ICRC) and Quality Assurance Committees. Ms. Magboo was invited to briefly introduce herself to Council.

President Vaillancourt next advised that on March 1, Ms. Joan A Pajunen, Public Member from Kilworthy, was appointed to College Council. He advised that her orientation was held earlier that morning and that she has been appointed to the ICRC and Discipline Committees of the College. Ms. Pajunen was invited to briefly introduce herself to Council.

The President went on to advise that Ms. Filo, Elected Member from District T, had tendered her resignation on December 2, 2016 and that a by-election will be held over the summer to fill that seat.

He then reminded Council members that as noted on the Agenda, Dr. Robert Bell, Deputy Minister of Health and Long-Term Care will be addressing Council later in the day and that the Agenda would be adjusted as needed to accommodate this presentation.

#### **4.1 Briefing Note - President's Report to March 2017 Council**

The President referred to his report which summarized his activities since the previous Council meeting. These included attending various committee meetings at the College and various phone calls and meetings with the Registrar and the Vice President.

The Briefing Note was received by Council for information.

#### **4.2 Briefing Note – December 2016 Council Meeting Evaluation**

Referring to the December 2016 Council Meeting Evaluation, President Vaillancourt noted that suggestions from the survey were considered and that the key achievements under the Strategic Plan from the past quarter would be projected on the screen to help guide discussion.

The Briefing Note was received by Council for information.

### **5. Approval of Minutes of Previous Meeting**

#### **5.1 Minutes of December 2016 Council Meeting**

**It was moved and seconded that the Minutes of the December 2016 Council Meeting be approved. CARRIED.**

### **6. Notice of Motions Intended to be Introduced**

There were none.

### **7. Motions, Notice of Which Had Previously Been Given**

There were none.

### **8. Inquiries**

There were none.

## 9. Matters Arising from Previous Meetings

There were none.

## 10. For Decision

### 10.1 Briefing Note – Finance and Audit Committee

Dr. Merani, member of the Finance and Audit Committee, was invited to present the Briefing Note to Council. **A motion to receive the Briefing Note from the Finance and Audit Committee was moved and seconded. CARRIED.**

Dr. Merani thanked management for their hard work in the preparation of the financial statements, as well as for the internal controls which have resulted in a clean audit with no issues to report. In response to a question from the floor, Dr. Merani confirmed that it is customary for the Committee to have an in-camera meeting with the auditors and that no issues were identified or reported during this in-camera session.

Ms. Campbell was invited to present the financial overview to Council. She highlighted the areas that came in above or below budget both on the revenue and expense side of the income statement, noting that there was an excess of revenue of \$1.2 million over expenses. She noted that much of this surplus was predicted and reported to Council at mid year when the 2017 budget was prepared – e.g. there was an expected revenue shortfall in hospital pharmacy accreditation fees, which gave rise to a concerted effort to manage our expenses. . She pointed out other variances on the revenue side such as low technician enrollment. Under the expenses side, Council noted that spending on district meetings had been deferred until the new Registrar had been hired and discontinuation of Quality Assurance Practice Reviews meant there was underspending in those areas. On the administration/personnel side, delayed hiring as well as unanticipated departures resulted in underspending. Referring to the variance under legal costs, Ms. Campbell explained that since the ministry is currently focused on the issue of sexual abuse, the rewrite of the registration and quality assurance regulation was delayed pending confirmation that our policy approach is aligned with government's direction.

Together with Mr. Khan (Chair of Finance and Audit Committee) and Dr. Merani, Ms. Campbell responded to questions from the floor and provided clarification on the various line items. She then introduced Ms. Liana Bell, Partner at Clarke Henning, LLP to present the audited statements to Council.

Following discussion, **it was moved and seconded that Council approve the Audited Financial Statements and Summary Statements for the operations of the Ontario College of Pharmacists for 2016 as prepared by management and audited by Clarke Henning LLP, Chartered Accountants.**

Council members voted in favour of the motion. There were no negative votes or abstentions. The motion **CARRIED.**

## 10.2 Briefing Note – Medication Safety Task Force

**A motion to receive the Briefing Note from the Medication Safety Task Force was moved and seconded. CARRIED.**

Ms. Donaldson, Chair of the Task Force, presented the Briefing Note from the Medication Safety Task Force to Council. Council was reminded that at its meeting in December 2016, the issue of medication incident reporting was addressed and that there had been unanimous support for requiring members to report medication errors to an external body. Ms. Donaldson provided a comprehensive report of the steps undertaken since that meeting, specifically the establishment of a Task Force tasked with the development of a model for error reporting.

In order to obtain broad and informed input, the Task Force members comprised a public Council member, a patient representative, a pharmacy technician, a hospital pharmacist and two pharmacists from varying community practice.

Medication incident reporting models from other jurisdictions (Nova Scotia, New Brunswick and Saskatchewan) together with information provided by ISMP (Institute for Safe Medication Practice) were studied. Following review of the information, the Task Force determined that an effective approach would be for the College to implement a mandatory standardized continuous quality assurance (CQA) program that would apply to all pharmacies to support ongoing continuous quality improvement that will achieve four key elements: Report (anonymous, specified, independent third party); Document (include plans and outcomes); Analyze (for causal factors in order to take appropriate steps to minimize recurrence); and Share Learning (through open dialogue).

Ms. Donaldson added that all jurisdictions consulted had stated that mandatory standardized CQA programs have resulted in numerous benefits such as reduction in blame and fear in discussing medication errors, more open discussions about near misses to prevent similar incidents from reaching a patient, increased practitioner accountability, clearer practice expectations, increase in shared learnings and increased awareness of safety issues. Furthermore, medication error reporting provides the data required to support a systemic review of errors in individual pharmacies as well as an aggregate review of national trends.

Comments and questions from Council members in discussing this Briefing Note fell into several themes: support for the requirement for mandatory reporting, questions on how other jurisdictions (both within and outside Canada) and other professions manage and deal with challenges of error reporting (including buy-in from corporate entities); and questions on the more technical aspects on the collection, communication and use of such information, while keeping in mind the transparency philosophy. Council noted that while the specific details for this reporting model had not yet been determined, the Task Force has recommended that the proposed CQA program be posted for thirty days of public consultation on the College's website beginning March 31. Following the close of the consultation period, the College will analyze the feedback to inform the development of a final recommendation that will be reported to Council for their June 2017 meeting.

Hearing no further discussion on the matter, **a motion was moved and seconded that Council approve the recommendation of the Task Force to support public consultation on the proposed model for a Continuous Quality Assurance Program in Pharmacies in**

**order to determine potential barriers to full implementation as well as factors to support successful rollout.** Council members voted in favour of the motion. There were no negative votes or abstentions. The motion **CARRIED**.

President Vaillancourt advised Council that the agenda item regarding the Briefing Note on Bill 87 (Proposed Amendments to *The Regulated Health Professions Act*), which was next on the agenda, would be discussed after Council had heard the presentation from Dr. Bell.

## **11. For Information**

### **11.1 Briefing Note – Registrar’s Report to March 2017 Council**

President Vaillancourt asked the Registrar, Ms. Lum-Wilson, to address Council. Ms. Lum-Wilson highlighted the salient points from her report and responded to questions posed by Council.

Referring to the Strategic Priorities document and the key accomplishments for the last quarter, Ms. Lum-Wilson provided Council with information on the noteworthy activities that were completed or have been ongoing since the December 2016 meeting.

Regarding Bill 84, *Medical Assistance in Dying Stature Law Amendment Act, 2016*, Council noted that on June 17, 2016, Federal Legislation, Bill C-14 received Royal Assent, legalizing medical assistance in dying. In response to the many gaps the legislation left to individual provinces to negotiate, the Ontario Government introduced Bill 84 in December 2016. The College, in close collaboration with other health colleges, developed a guidance document specifically to help pharmacy professionals navigate the interpretation of the federal legislation and to support them as this issue continues to evolve.

Next, the Registrar advised that the Ministry’s Health Workforce Planning and Regulatory Affairs Division presented to the Federation of Health Regulatory Colleges of Ontario (FHRCO) their new Model for the Evaluation of Scopes of Practice in Ontario (MESPO). The framework uses a patient and system-centered approach that considers alignment with Ministry priorities, patient need, system need and value. With respect to the issue of prescribing for Common Ailments, Ms. Lum-Wilson advised that the Ministry has indicated that further due diligence is needed before the Ministry will consider further discussion on this initiative. In response to questions from the floor regarding specific components for MESPO, Ms. Lum-Wilson advised that as this is a new initiative, she anticipates more information from the Ministry in the future.

Council was reminded that in November 2016, Federal Health Minister Jane Philpott and Ontario Health Minister Eric Hoskins convened a two-day summit to address the ongoing opioid crisis in Canada. The meeting included other provincial health ministers, addiction experts and affected families. Ontario’s commitment was to implement a comprehensive Opioid Strategy that focuses on enhancing data collection, modernizing prescribing and dispensing practices, and connecting patients with high quality addiction treatment services.



Ms. Lum-Wilson reported that she is currently serving as a co-lead with the Registrar of Nova Scotia College of Pharmacists to assist with a national (National Association of Pharmacy Regulatory Authorities) opioid strategy.

President Vaillancourt commented that over the last few months, there has been a lot of activity and information on the opioid crisis and that the profession is well-positioned to do more to better serve and protect the public. He added that given the importance of this issue, the matter was discussed by the Executive Committee who recommended the creation of an Opioid Task Force to support the development of a College Opioid Strategy that aligns with provincial and national strategies. The College's Strategy would address short, medium and long term initiatives and will report to Council through the Executive Committee. Comments from the floor suggested members were in support of the creation of such a task force and strategy. Hearing no negative comments regarding this initiative, President Vaillancourt advised that together with staff, he will proceed with the establishment of the task force and requested that Council members interested in serving with him on this task force connect with him.

Referring to the federal/provincial initiatives in her briefing note, Ms. Lum-Wilson advised that in anticipation of legislation affecting the regulation of cannabis, the College engaged Dr. Jake Thiessen to assist the College to develop an understanding of the appropriate regulatory role to support practice and operational standards related to cannabis use. Ms. Lum-Wilson confirmed that Dr. Thiessen's report would be made available to Council to inform the approach that the College should take.

Referring next to the issue of Governance, Ms. Lum-Wilson drew Council's attention to the documents attached to her briefing note which address Bill 87 (*Protecting Patients Act, 2016*), and the proposed changes to the *Regulated Health Professions Act (RHPA)*. The Registrar noted that, in anticipation that Bill 87 will make significant changes to the RHPA, and building on previous work of the College of Nurses of Ontario (CNO), the Advisory Group for Regulatory Excellence (AGRE) recognized an opportunity to proactively influence system change and engaged Blais Consulting to develop a "Governance Discussion Paper" on best practices in governance to potentially begin a higher level conversation on governance. The paper and other attachments were received for information by Council.

Ms. Lum-Wilson next advised that since the Financial Statements were approved by Council earlier in the day, the Annual Report, which includes these Financial Statements, will shortly be posted to the College's website.

## **11.2 Briefing Note – CEO and Registrar re Pharmacy Technicians Strategy**

Ms. Lum-Wilson advised Council that at its meeting in November 2016, the Executive Committee explored the issue of increasing Pharmacy Technician members on Council to more closely reflect the representation of membership. Discussion during that meeting led the Committee to recommend the development of an engagement strategy that will build on existing efforts to achieve integration of pharmacy technicians within practice in order to help maximize the clinical role of pharmacists as medication therapy experts. In addition to the implementation of core College programs such as quality assurance that will impact the integration of pharmacy technicians in practice, the College will engage educators, pharmacy owners, corporations and other stakeholders with aligned objectives to support the strategy.



Successful implementation of the strategy will create an environment that better enables the profession to practice to scope.

Council members expressed their support for the development of such a strategy and following discussion, it was noted that the strategy will be brought forward at the June Council meeting, with further progress reporting through the regular College quarterly reports.

## **12. Other Matters**

### **12.1 Presentation by. Dr. Robert Bell, Deputy Minister of Health and Long-Term Care**

At the Chair's request, Registrar Lum-Wilson introduced Dr. Bell and invited him to address Council. Dr. Bell spoke about the modernization of governance of regulated health professionals in light of the *Patients First Action Plan for Health Care* and the health system transformation initiatives underway in Ontario. He spoke about the government's commitment to evolve the health system into one that puts the needs of patients at its centre, the successes to date and the work yet to be done to improve the patient experience in part by making the system more transparent and accountable. He also commented on the need for a single integrated system, rather than the creation of parallel practice systems and funding mechanisms.

Comments and questions from Council members included but were not limited to: access to health care spending, the status of electronic prescriptions, pharmacists' scope of practice to include common ailments, the impact of Bill 87, and governance models in other professions.

## **10. For Decision (continued)**

### **10.3 Briefing Note – Executive Committee**

**A motion to receive the Briefing Note from the Executive Committee was moved and seconded. CARRIED.**

Registrar Lum-Wilson presented a comprehensive synopsis of expected changes to the *Regulated Health Professions Act*. Council heard that Bill 87, the *Protecting Patients Act*, passed First Reading on December 8, 2016 in the Ontario Legislature. The Bill reinforces the government's emphasis on patient safety and is a response to the Sexual Abuse Task Force Report set up by the Minister of Health and Long-Term Care.

Ms. Lum-Wilson provided some high-level observations on the proposed changes that, among other initiatives which aim to increase transparency of information, will: specify how complaints or reports of sexual abuse must be dealt with; consider the qualification, selection, appointment and terms of office of committee members as well as the composition of College committees and panels; expand the functions of the Patient Relations Committees;, and provide funding for therapy and counselling in cases of sexual abuse. If passed, Bill 87 will give the Minister of Health and Long-Term Care the power to make regulations respecting each of these areas.

Ms. Lum-Wilson highlighted particular areas on which this College will want to provide input. These include the sections which deal with: (1) committee and panel structures (the suggestion

is that in recognition of the difficulty in recruiting public members, the College collaborate with the ministry to develop a process that does not result in unintended consequences); (2) sexual abuse (the College will seek flexibility in the types of expenses that qualify, eligibility for funding, patient choice and will recommend a criteria-based approach to the definition of “Patient” which should be broad enough to take into account the variety of ways that pharmacy professionals and patients/public interact); (3) mandatory revocation (the College will suggest expansion of criteria to include egregious proprietary misconduct such as fraud or drug offences in addition to sexual misconduct); and (4) alternate dispute resolutions and withdrawal of complaints (the College will request consultation on established timeframes to minimize barriers to reaching an agreement).

**A motion was moved and seconded that Council approve the Next Steps as proposed in the Briefing Note.** President Vaillancourt opened the floor for discussion. Referring to the section in the Briefing Note regarding changes that would allow Non-Council Public Members to serve on the ICRC and Discipline Committees, several Council members acknowledged that while the intent to ensure that matters before these committees should be addressed in a timely, efficient and effective manner was laudable, these members were against this proposal. They recalled the discussion and decision made at an earlier Council meeting (June 2016) where Council had debated the matter at length and a decision was made to not proceed with the appointment of non-Council public members to serve on Committees at this time but to continue to urge the government to appoint the maximum number of public members.

Following discussion, **an amendment to the recommendation was proposed: it was moved and seconded that Council approve the Next Steps proposed in the Briefing Note with the following amendment that Council request the Ministry of Health and Long-Term Care to appoint public members to serve only on ICRC and Discipline Committees.** There were no members in favour of the motion. The motion was defeated.

Council then considered a subsequent motion: **moved and seconded that the component regarding the appointment of non-Council public members be removed from the Briefing Note.** Council members voted in favour of the motion. There was one abstention and there were no negative votes. The motion **CARRIED.**

Referring to the section regarding Mandatory Revocation and the recommendation in the Briefing Note that the changes be supported by the College (which would permit the College to take measures to protect the public in the face of egregious proprietary misconduct, such as fraud or drug offences, in addition to sexual misconduct) there was discussion on the concept of Mandatory Revocation itself. Concern was expressed that its application in circumstances of egregious professional or proprietary misconduct could potentially lead to more fully contested hearings and could impact the College’s ability to enter into agreements that could achieve the same public protection mandate.

Accordingly, **a motion was moved and seconded that the section regarding Mandatory Revocation be removed from the Briefing Note.** The Chair invited further comments from the floor. There were questions as to what other acts would be considered so egregious as to warrant mandatory revocation. It was further noted that the inclusion of this particular section in our feedback to the Ministry will result in the College being able to participate in conversations to shape the inclusion criteria for mandatory revocation. Council further noted that the regulations under this Act would include the details that were part of today's discussion. Hearing no further comments or questions, the President asked for a vote on the motion. All members voted against the motion. There were no abstentions. The motion was defeated.

**It was moved and seconded that Council approve the Next Steps, as amended, and proposed in the Briefing Note.** Council members voted unanimously in favour of the motion. There were no negative votes or abstentions. **CARRIED.**

## **12. Other Matters (continued)**

### **12.2 Presentation by Ms. Perlman, Manager, Community Practice**

The Registrar's reporting activity also includes regular program updates/presentations from the program managers and accordingly, Ms. Tina Perlman, Manager, Community Practice was invited to present to Council.

#### **Motion respecting Future Council Meeting Dates**

President Vaillancourt next announced that in order to support planning for various College and program activities, the following dates/schedule was being proposed to Council for approval:

#### **2018**

Monday March 26 and Tuesday March 27, 2018

Monday June 11, 2018

Monday September 17 and Tuesday September 18, 2018

Monday December 10, 2018

**A motion to approve the dates was moved and seconded. CARRIED.**

## **13. Unfinished Business**

There was no unfinished business.

#### **Motion respecting Circulation of Minutes**

**A motion to approve the circulation of the draft minutes of this Council Meeting to Council members was moved and seconded. CARRIED.**

President Vaillancourt reminded Council members to provide an evaluation of today's meeting, adding that the feedback will serve to ensure efficiency and enhance Council members' participation at these meetings.

#### **14. Motion of Adjournment**

**It was moved and seconded that the Council meeting be adjourned at 3:00 p.m. and to reconvene on Monday, June 12, 2017, or at the call of the President. CARRIED.**

**Ushma Rajdev  
Council and Executive Liaison**

**Régis Vaillancourt  
President**

**DRAFT**

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## COUNCIL BRIEFING NOTE MEETING DATE: JUNE 2017

**FOR DECISION**

**X**

**FOR INFORMATION**

**INITIATED BY:** Executive Committee

**TOPIC:** Continuous Quality Improvement (CQI) for Medication Safety

**ISSUE:** Approval of a standardized Continuous Quality Assurance (CQA) Program (the Program) for pharmacies, including the collection of medication incident data.

### **BACKGROUND:**

- In March 2017 the Task Force on Medication Safety proposed to Council a framework for the development of a standardized continuous quality assurance program that will apply to all pharmacies and include mandatory incident reporting to a third party.
- Council unanimously agreed that such a Program will:
  - Enable sharing of lessons learned from medication incidents through reporting, resulting in ongoing process improvements to minimize errors and maximize health outcomes, thereby improving patient safety;
  - Require shared accountability between pharmacies, for the systems they design and how they respond to staff behaviour, and pharmacy professionals, for the quality of their choices and for reporting their errors;
  - Emphasize learning and accountability through developing a culture where individuals are comfortable bringing forward medication incidents without a fear of punitive outcomes; and
  - Ensure a consistent approach within the profession respecting continuous quality improvement processes and outcomes achieved.
- The required components of an effective standardized Program include the following four key elements:
  - *Report* – enable reporting to a specified independent third party
  - *Document* – document details of medication incidents, CQI plans and outcomes
  - *Analyze* – analyze errors for causal factors in order to take appropriate steps to minimize recurrence
  - *Share Learnings* – communicate learnings through open dialogue
- Council endorsed the Program proposed by the Task Force and directed the College to move forward with consultation for a period of 30 days, which began March 31, 2017.

## ANALYSIS:

- The [consultation](#) received 89 responses (77 from pharmacy professionals, 4 from the public and 8 from organizations) (Appendix A).
- The College also held face to face meetings with the Ontario Pharmacists Association, Neighbourhood Pharmacy Association of Canada, the Canadian Society of Hospital Pharmacists, Health Quality Ontario, the Ontario Hospital Association and the College of Physicians and Surgeons.
- The consultation was framed by presenting five specific questions to guide feedback and best ensure successful adoption by pharmacists (Appendix A).

**Based on analysis of the feedback (Appendix A), the following conclusions were drawn. As a result, no revisions to the proposed Program are suggested:**

- There was no opposition to the development of a mandatory standardized program.
- All of the consultation comments received were related to implementation details.

### Continuous Quality Assurance Programs in Pharmacies

The required components of an effective standardized quality assurance program for pharmacies addresses both medication errors that reach the patient as well as near misses that are intercepted prior to dispensing, and must achieve all of the following four elements:

#### Report

- Enable and require *anonymous* reporting of all medication incidents by pharmacy professionals to a specified independent, objective third-party organization for population of an aggregate incident database to identify issues and trends to support patient safety improvement.

#### Document

- Require pharmacy professionals to document appropriate details of medication incidents and near misses in a timely manner to support the accurateness of information reported.
- Document CQI plans and outcomes of staff communications and quality improvements implemented.

#### Analyze

- Necessitate that when a medication incident occurs pharmacy professionals analyze the error in a timely manner for causal factors and commit to taking appropriate steps to minimize the likelihood of recurrence of the incident.
- Require completion of a medication safety self-assessment (MSSA) within the first year of implementation of the Standard, then at least every 2-3 years. The Designated Manager may determine an MSSA is required more frequently if a significant change occurs in the pharmacy.
- Analyze individual and aggregate data to inform the development of quality improvement initiatives.

#### Share Learning

- Require prompt communication of appropriate details of a medication incident to all pharmacy staff, including causal factors of the error and actions taken to reduce the likelihood of recurrence.
- Ensure the scheduling of regular CQI communication with pharmacy staff to educate pharmacy team members on medication safety, encourage open dialogue on medication incidents, complete an MSSA, and develop and monitor quality improvement plans.
- Support the development and monitoring of CQI plans, outcomes of CQI communications and quality improvements implemented.



## **Implementation**

- The Program will be formally integrated into College operations in a similar manner as other standards and requirements in that the College will support pharmacy professionals with tools and resources while changes to workflow processes and culture are adopted.
- Implementation will occur over two phases, with the initial phase to include pharmacies that are representative of practice across Ontario and the second phase to build upon learnings identified in phase one.
- Given that hospitals already have a strong medication safety foundation and are at a more advanced stage than community sites, the College intends to initially focus on implementation in community pharmacies. Implementation in hospital settings will be addressed once implementation in community is complete.

### **Implementation in Community Pharmacy (Appendix B)**

- The first phase will start in fall 2017 and occur over a six month period. By December 2017 approximately 100 pharmacies will be participating in the Program and reporting medication incidents. This phase will provide an opportunity to assess the program requirements.
- The second phase will start in spring 2018 and occur over a four to six month period. This phase would expand on phase one by recruiting additional pharmacies and incorporating the changes and best practices identified by pharmacies during the first phase.
- The intent and goal is to complete full implementation of the Program in all community pharmacies by December 2018, subject to the development and readiness of technology required to support the mandatory reporting and data analysis.
- Practice advisors will undergo comprehensive training to support pharmacies and pharmacy professionals through mentoring and educating as this program is transitioned into an expectation of practice.
- Assessment criteria for pharmacies will be reviewed to ensure that Program requirements are appropriately incorporated.

### **Implementation in Hospital Pharmacy**

- The College will continue collaborating with hospital stakeholders, Health Quality Ontario and other health care professionals during phase one and two. This will inform analysis of how current hospital quality and reporting systems can be strengthened and aligned with community systems to gain the benefit of more fulsome data.

### **NEXT STEPS:**

- The College will finalize a comprehensive implementation and monitoring plan that will incorporate consultation feedback.
- While the Program will be cost neutral once implemented, we may need to expend resources to source and manage the specifications, vendor sourcing/selection and agreement.



- The College will proceed with the development of a robust communication plan to support successful implementation and will communicate additional details to stakeholders as implementation progresses.
- The College will continue to work with stakeholders to identify opportunities for seamless integration of medication incident reporting with current and anticipated systems at the local, provincial and national level.

**DECISION FOR COUNCIL:**

- **Recommend that Council approve the Continuous Quality Assurance Program to allow the work to focus on implementation.**

## Appendix A: Consultation Themes

**General themes identified from comments under each of the following five consultation questions:**

### **1. Do you see the program benefitting practice in your own pharmacy?**

#### Support for a standardized program

- There was no opposition to the development of a mandatory standardized program; respondents did identify the need for clarification regarding details of the reporting system and integration into current workflow.
- Respondents agreed that anonymous reporting is important to fostering a reporting culture and that shared learnings will improve patient safety.
- There was consensus that a program would ensure consistency in continuous quality improvement (CQI) processes.
- To support CQI, pharmacy professionals and pharmacies require information on medication incident trends, benchmarking and summaries of incident key learning.

#### Current causes of errors identified that a standardized program may address or help prevent

- Workflow and staffing levels.
- Illegible prescriptions in the absence of universal e-prescribing.

### **2. What would support successful implementation?**

#### Seamless reporting system technology

- A user friendly data entry process and reporting tool would require an integrated and seamless reporting system that can interface with existing medication reporting systems and workflow across all practice settings.
- To ensure consistency the reporting system should include standard fields and classifications for medication incident reporting submissions that align with existing definitions and include the ability to enter contributing factors.

#### Culture change

- To enable culture shift, designated managers and owners need to foster a safety and CQI culture and encourage open discussion of incidents to support learning and system improvements from one of “blame and shame”.
- The program should focus on systematic versus individual sources of errors.

#### Systems approach to reporting and CQI

- Reporting should include incidents that are the result of practices outside of pharmacy (e.g. prescription errors) and those by pharmacy professionals.
- Consideration of a multidisciplinary reporting model and shared learnings between various healthcare professionals at a local, provincial and national level.

### **3. How could the College help with the implementation?**

#### Clearly outlining expectations with respect to reporting

- Develop a clear definition of ‘medication incident’, including reporting requirements and accountabilities.
- Include reporting of “near miss” incidents.
- Focus on CQI processes and not just incident reporting.

#### Clarify role of the college regarding reporting of medication incidents

- Reporting should be distinct from College processes and not be used punitively against pharmacy professionals; incident data should go to a third party.
- Multiple stakeholders questioned how the College will assess and enforce adherence to a standardized program.

### **4. What are you are already doing in your pharmacy around continuing quality assurance?**

#### Community

- Some pharmacies and pharmacy corporations have internal or corporate reporting systems in place for specifically defined medication incidents.
- Research has established that Ontario community pharmacies do not currently seem to have a standardized CQI approach or program in place<sup>1</sup>.

#### Hospitals

- Hospitals presently have varying levels of CQI and reporting systems in place, as such stakeholders requested clarity regarding hospital accountability for implementation of the standardized program proposed by the College.
- Near misses and non-critical incidents are reported through internal reporting systems.
- *Public Hospitals Act* Regulation 965 outlines specific requirements for hospitals regarding the review and disclosure of critical incidents.
- Hospitals are required to report critical incidents relating to IV/fluids to the Canadian Institute for Health Information’s (CIHI) National System for Incident Reporting (NSIR).
- Reporting is multi- disciplinary (i.e. multiple professions accountable for reporting).
- Aggregate critical incident data is reported to hospital board quality committee at least twice annually, as well as operational quality and patient safety committees.
- Incident data is considered when developing the hospital’s Quality Improvement Plan.
- Accreditation Canada outlines requirements related to patient safety incident disclosure and management process in the governance and leadership standards, as well as a specific Required Organizational Practices (ROP).

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<sup>1</sup> ISMP Canada. Continuous Quality Improvement (CQI): An Essential Constituent of Patient/Medication Safety. Pharmacy Connection Ontario College of Pharmacists Winter 2017. Retrieved on May 4, 2017 from [http://www.ocpinfo.com/library/pharmacy-connection/download/OCP\\_PharmacyConnection\\_Winter2017.pdf](http://www.ocpinfo.com/library/pharmacy-connection/download/OCP_PharmacyConnection_Winter2017.pdf)

- Health Quality Ontario (HQP) is developing a patient safety learning system that will enable hospitals to report and share recommendations and learnings from medication incident reviews.

#### Non-traditional pharmacy settings

- The College should consider reporting for pharmacists in clinical roles in non-traditional settings (e.g. Family Health Teams, home care, chemotherapy clinics and outpatient clinics).

#### **5. Is it reasonable to implement the Program in two phases?**

#### Support for phased implementation

- Feedback supported phased implementation across a variety of settings that are representative of practice sites in Ontario.

## Appendix B: Implementation Timeline

Project Activities	2017												2018											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Environmental Scan	█	█	█																					
Consultation				█																				
Vendor Selection					█	█	█																	
Council						█																		
Volunteer Recruitment							█	█																
Training and Orientation							█	█	█															
<b>Phase 1 Implementation</b>																								
Data Analysis and Evaluation																		█	█					
Make Adjustments for Phase 2																		█	█					
<b>Phase 2 Implementation</b>																								
Data Analysis and Evaluation																								
Project Close Out																								
<b>Full Implementation</b>																								



## EXECUTIVE COMMITTEE BRIEFING NOTE

MEETING DATE: JUNE 2017

FOR DECISION

FOR INFORMATION

X

**INITIATED BY:** President Vaillancourt

**TOPIC:** Governance

**ISSUE:** Competency-based Application Process for Non-Council Committee Members

### BACKGROUND:

- College Committees require the appointment of pharmacists and pharmacy technicians who are not elected members of Council to serve on various statutory or standing committees. In addition, pharmacists and pharmacy technicians with particular experience or expertise are occasionally required to serve on various special committees, working groups or task forces.
- To be eligible for appointment as a non-council committee member (NCCM), among other requirements, practitioners must be a member in good standing and must not have a conflict of interest regarding the committee they wish to join.
- Until now, the process by which NCCMs were appointed to various committees relied solely on the [eligibility criteria](#) set out in the bylaws. Members who wished to be considered for appointment as an NCCM were invited to submit a letter of interest including their resume and any other relevant information that would support their application for appointment to a particular Committee.
- At the March Council meeting, Deputy Minister Bob Bell shared his views with Council on the modernization of the governance of regulated health professionals. Council also discussed Bill 87 (*Protecting Patients Act, 2016*), which includes amendments that are specifically relevant to governance and are anticipated to have a high impact on Colleges. Bill 87 completed clause by clause review and amendments which were reported back to the House on May 18 and on May 30, it received Royal Assent.
- Led by the work of the College of Nurses of Ontario, the Advisory Group for Regulatory Excellence (AGRE) group, comprised of the 6 largest health regulatory colleges, brought forward a discussion paper on best practice in governance that was shared with Council at the March meeting. The perspectives brought forward in the paper are rooted in evidence and best practice in regulatory governance in Ontario, Canada and around the world.
- While discussion on governance leadership amongst the health regulatory colleges is ongoing, one of the key best practices that has received significant interest amongst the colleges is that the selection of members serving on Council and Committees be based on competency (i.e. knowledge, skills and attitude).

### ANALYSIS:

- While this type of competency screening cannot currently be applied to the election process, the appointment of members to Committees will benefit from a robust application process that will further serve to ensure that a Committee has the needed diversity of perspectives and skills. It will also allow for consideration of specific needs at a given time and identification of the competencies and backgrounds needed to meet those needs.

- All NCCMs will be appointed in the same way which will serve to build mutual respect as each member has met the same expectations and gone through the same process.
- Reappointments to all positions will be based on meeting role expectations as evidenced by evaluation and peer feedback.
- Risks, if any, associated with impact to the number of interested candidates, challenges to screening process etc., will be assessed as we gain experience.

#### **PROCESS:**

- The attached Application Guide and Form will be available on the College website for all potential NCCMs.
- Upon submission of the Application Form, the member will receive an email acknowledging receipt of his/her application.
- The Applicant will be screened initially for eligibility and core competencies (see Application Form) by Human Resource staff at the College in a manner similar to that used for screening employment applications after which, it will be reviewed by the Elections Committee to determine suitability of appointment to Committees.
- If selected as a potential candidate for a committee position, the Elections Committee will provide the application to the Nominating Committee and the Committee Chairs at the Council meeting in September who will decide upon the NCCM appointment.

## NON-COUNCIL COMMITTEE MEMBER – APPLICATION GUIDE

Committees require the appointment of pharmacists and pharmacy technicians who are not elected members of Council to serve on various statutory or standing committees. In addition, pharmacists and pharmacy technicians with particular experience or expertise are occasionally required to serve on various special committees, working groups or task forces.

At the beginning of each Council year (September Council), the statutory and standing committees of the College are established. The Chairs of the Committees are elected on the first day of the Council meeting after which, the remaining committee members are appointed. Page 2 of this guide provides more information on each committee.

To be eligible for appointment as a non-council committee member (NCCM), practitioners must meet the requirements as set out under the [By-laws](#) (Article 7.6). These requirements are also set out in the [Application Form](#).

In order to ensure that the College has high quality individuals who understand the role and mandate of the College, all NCCMs are asked to review this Guide prior to completing the Application Form. Having suitable and skilled committee members can also help avoid reputational harm to the College and to the individual.

### THE ROLE OF A NON-COUNCIL COMMITTEE MEMBER

It is important to note that you have a fiduciary duty of undivided loyalty and good faith to the mandate of the College, which is to regulate the pharmacy sector in the **public interest**.

Your fiduciary duties also include:

- Being **Diligent** – i.e. being prepared for meetings, reviewing materials, arriving on time and participating in discussion
- Being **Respectful** – i.e. respecting the process and fellow committee members, paying attention (e.g., no mobile devices during the meetings), genuine listening and consideration and not making up your mind before arriving to the meeting
- Being **Ethical** – i.e. using College resources appropriately, being accurate on the facts (e.g., reading the materials on a particular matter)
- Being aware of **Conflicts of Interest** (e.g. financial, adjudicative, organizational)
- Ensuring **Confidentiality** is maintained. This applies to all information obtained in the course of duties for the OCP, unless an exception applies. This is especially important when discussing complaints since you will often be dealing with unsubstantiated allegations and maintaining confidentiality will prevent tainting of processes, facilitate exploration of all options and avoid misinterpretation

To help you further understand the role of an NCCM, please review the College Objects (Appendix 4 of the [Governance Manual](#)), [By-laws](#), [Code of Ethics](#) and [Code of Conduct](#) for Council and Committee members.



### COMMITTEE DESCRIPTION AND MEETING FREQUENCY

The table below provides a brief description of the duties of the Committees, the minimum number of NCCM positions required to be filled and the approximate number of days required for meetings.

Staff will solicit the availability of members well in advance of booking meetings, and will confirm meeting times with participants. For most meetings, material will be made available online and prior to the meeting to allow time for review.

Committee	Frequency of meetings and number of NCCMs required
<b>Accreditation</b> - <i>considers matters relating to the operation of community and hospital pharmacies in Ontario and also reviews issues relating to pharmacy assessments conducted by the College where the pharmacy has failed to comply with the requirements.</i>	6 times a year 2 NCCMs
<b>Drug Preparation Premises (DPP)</b> - <i>considers all matters relating to the operation of DPPs in Ontario (DPP members also sit on the Accreditation Committee).</i>	1-2 times a year (meetings tend to be coordinated with Accreditation Committee meetings) 2 NCCMs
<b>Discipline</b> - <i>hears allegations of professional or proprietary misconduct.</i>	Approximately 25 hearings a year are heard by panels* of the Discipline Committee; plus 2 meetings a year of the full Committee 5 NCCMs
<b>Fitness to Practise</b> – <i>considers incapacity matters referred by the Inquiries, Complaints and Reports Committee.</i>	1-2 times a year 1 NCCM
<b>Inquiries, Complaints and Reports (ICRC)</b> – <i>oversees all investigations into a practitioner’s conduct, competence and capacity. Also oversees all complaint investigations, Registrar’s investigations and health inquiries.</i>	4 panel* meetings a month; plus 2 meetings a year of the full Committee 7 NCCMs
<b>Patient Relations</b> – <i>advises Council regarding the patient relations program which enhances relations between practitioners and patients. It also deals with preventing and handling matters related to sexual abuse of patients by practitioners.</i>	1-3 times a year 1 NCCM
<b>Quality Assurance</b> – <i>develops and maintains the Quality Assurance program which supports continued competence and encourages continuing professional development of practitioners.</i>	4 times a year 3 NCCMs
<b>Registration</b> - <i>provides guidance to Council on matters concerning registration, examinations and in-service training required prior to registration.</i>	Monthly panel* meetings; plus 3-4 meetings a year of the full Committee 1 NCCM

\* Note that the Discipline, ICRC and Registration Committees all operate using panels comprised by interchanging committee members. **Note also that for the Discipline Committee, contested hearings may require multiple-day attendance i.e. between 3-5 days at a time.**

### **TERM, EFFECTIVE DATE AND ORIENTATION**

NCCMs serve a **one-year term** which starts at the beginning of each Council year i.e. at the September Council Meeting. An Orientation will be conducted by the Chair of the Committee to which you are appointed.

### **REMUNERATION AND EXPENSES**

The College recognizes that although the NCCMs' time is volunteered and is therefore unpaid, members choosing to serve on a Committee should not be out of pocket for costs incurred. NCCMs will therefore be paid an expense allowance of \$300 for each day when out of the community in which they reside or \$165 for each day when in the community in which they reside when on College business. As well, reasonable expenses for travel will be reimbursed. For more details, refer to the [By-laws](#) (Article 6).

### **WHO MAY APPLY FOR THE POSITION OF A NON-COUNCIL COMMITTEE MEMBER?**

You are eligible for appointment to a Committee if, on the date of the appointment:

- you hold a valid Certificate of Registration as a pharmacist or as a pharmacy technician
- you either practise or reside in Ontario
- you are not in default of payment of any fees prescribed in the By-laws
- you are not the subject of any disciplinary or incapacity proceeding
- your Certificate of Registration has not been revoked or suspended in the six years preceding the date of the appointment
- your Certificate of Registration is not subject to a term, condition or limitation other than one prescribed by regulation
- you have not been disqualified from serving on Council or a committee within the six years immediately preceding the appointment
- you do not have a conflict of interest in respect of the Committee to which you are to be appointed
- you are not the Owner or Designated Manager of a pharmacy that, within the six years immediately preceding the appointment, has undergone a re-inspection, as a result of deficiencies noted in an initial inspection, for a third time or more after the initial inspection; and
- you are not an employee, officer or director of a Professional Advocacy Association or, if you are such an employee, officer or director of a Professional Advocacy Association, you give an undertaking to resign from such position upon being appointed

### **WHO TO CALL IF YOU HAVE QUESTIONS**

You may contact Ms. Ushma Rajdev, Council and Executive Liaison in the Registrar's Office by email at [council@ocpinfo.com](mailto:council@ocpinfo.com)

### **HOW TO APPLY**

Fill in this [Application Form](#), ensure that all sections have been completed, and submit your application form **by July 31, 2017** to [council@ocpinfo.com](mailto:council@ocpinfo.com).

## NON COUNCIL COMMITTEE MEMBER (NCCM) – APPLICATION FORM

Complete all sections of this form paying particular attention to the Core Competencies section from pages 2 to 4. Your responses will allow the College to assess on which Committee your experience and expertise will be of utmost value and benefit.

### 1. YOUR GENERAL INFORMATION

<b>First and Last Name</b>	
<b>OCP Number</b>	
<b>Phone Numbers</b>	
<b>Email Address</b>	

### 2. ELIGIBILITY REQUIREMENTS FOR AN NCCM

	<b>Yes</b>	<b>No</b>
<i>(answer all questions)</i>		
Do you hold a valid Certificate of Registration as a pharmacist or pharmacy technician?	<input type="checkbox"/>	<input type="checkbox"/>
Do you either practice or reside in Ontario?	<input type="checkbox"/>	<input type="checkbox"/>
Are you in default of payment of any fees prescribed in the by-laws?	<input type="checkbox"/>	<input type="checkbox"/>
Are you the subject of any disciplinary or incapacity proceeding	<input type="checkbox"/>	<input type="checkbox"/>
Has your Certificate of Registration been revoked or suspended in the six years preceding the date of the appointment?	<input type="checkbox"/>	<input type="checkbox"/>
Is your Certificate of Registration subject to a term, condition or limitation other than one prescribed by regulation?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been disqualified from serving on Council or a committee within the last six years?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a conflict of interest in respect to the Committee to which you are to be appointed?	<input type="checkbox"/>	<input type="checkbox"/>
Are you the owner or designated manager of a pharmacy that, within the last six years, has undergone a re-inspection, as a result of deficiencies noted in an initial inspection, for a third time or more after the initial inspection?	<input type="checkbox"/>	<input type="checkbox"/>
Are you an employee or an elected or appointed member of the governing body of any local, regional, provincial or national professional association of pharmacists or pharmacy technicians?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, do you give an undertaking to resign from such position upon being appointed?	<input type="checkbox"/>	<input type="checkbox"/>

.../2

### 3. CORE COMPETENCIES

**Competence** is the ability of an individual to perform a task properly. A competency is a set of defined behaviours that provide a structured guide enabling the identification, evaluation and development of the behaviours in an individual.

Defined below are statements and questions in which you are asked to describe how you demonstrate these competencies that will allow you to serve as an effective NCCM.

#### STRATEGIC LEADERSHIP

**Definition:** Strategic leadership involves approaching initiatives from a strategic perspective, championing new initiatives and working towards their achievement to deliver quality services to the public and the protection of the public interest. It is expressed by inspiring, motivating and leading others, linking long-range vision and concepts to daily work, and articulating a simple understanding to a sophisticated awareness of the impact of internal and external factors on strategies and choices. It also includes adapting strategies when change is required and taking action to ensure adequate support and resources.

*Explain how you have demonstrated this skill/attribute in your current employment/professional or community involvement*

#### IMPACT/INFLUENCE

**Definition:** Impact / influence is the ability to influence, persuade or convince others to adopt a specific course of action impacting plans, processes, practices and people. It involves influencing others by leading by positive example, setting high standards and charting a clear and steady course. It also involves the use of effective strategies, persuasive techniques and facilitation skills to achieve desired results in sometimes high-impact, high-risk and complex situations.

*Give an example that illustrates your experience and ability to influence others*

.../3

PARTNERSHIP/RELATIONSHIP BUILDING

**Definition:** Partnership / relationship building is working cooperatively with all partners / alliances / stakeholders to solve common issues, meet mutual goals and build synergies. It includes leveraging existing relationships and partnerships, building a more effective network of existing contacts, or developing and solidifying new partnerships. It also involves awareness that change is more effectively made together, and that a mutual interests-based relationship that operates on trust forms the foundation for success in delivering results.

*Provide an example(s) where you have been able to satisfy multiple and diverse stakeholders and requirements and why you were successful*

INTEGRITY/ETHICS/VALUES

**Definition:** Integrity / ethics / values is the willingness to hold oneself and others accountable for acting in ways, both privately and publicly, that are consistent with stated values, principles and professional standards (ability to separate business and self-interest and putting the patient first).

*Provide an example(s) of where you have taken action based on values even when cost or risk is at stake*

PROFESSIONAL AWARENESS

**Definition:** Professional awareness is the depth and breadth of the knowledge, skill and experience particular to the position. It involves knowledge of laws, practices, processes, professional skills, stakeholders and the culture specific to the regulatory environment.

*In your own words, describe your understanding of your role in society as a health professional*

GOVERNANCE

**Definition:** Governance is the knowledge and skills required to effectively govern the affairs of an organization, in keeping with the organization's legal framework and mandate. It also involves acting to achieve public service values such as transparency, efficiency and effectiveness and the accountability and governance requirements of the College.

*Describe what this statement means to you*

4. SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Electronic signature or name will be acceptable)

#### WHO TO CALL IF YOU STILL HAVE QUESTIONS

You may contact Ms. Ushma Rajdev, Council and Executive Liaison in the Registrar's Office by email at [council@ocpinfo.com](mailto:council@ocpinfo.com)

Once all the sections have been completed, submit your application form **by July 31, 2017** to [council@ocpinfo.com](mailto:council@ocpinfo.com).

#### UPON SUBMISSION:

1. You will receive an email acknowledging receipt of your application.
2. Your application will be reviewed by the Elections Committee to determine suitability.
3. You will be contacted by staff and a teleconference interview will be arranged at a mutually convenient time with a member of the Elections Committee to discuss your application.
4. If you are selected as a potential candidate for a committee position, the Elections Committee will provide your application to the Nominating Committee and the Committee Chairs at the Council meeting in September who will decide upon the NCCM appointments.
5. If you are selected to serve on a committee, you will be contacted by staff after the September Council Meeting.

***Thank you for your interest!***



## COUNCIL BRIEFING NOTE MEETING DATE: JUNE 2017

<b>FOR DECISION</b>	<b>FOR INFORMATION</b>	<b>X</b>
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**INITIATED BY:** Nancy Lum-Wilson, CEO and Registrar

**TOPIC:** Report to June 2017 Council

**ISSUE:** As set out in the Governance Manual, Council holds the Registrar accountable for the operational performance of the organization. As well, the Registrar is responsible for reviewing the effectiveness of the College in achieving its public interest mandate and the implementation of the Council's strategic plan and directional policies. As such, the Registrar is expected to report on these activities at every Council meeting.

**BACKGROUND:** I respectfully submit a report on the activities that have taken place since the March 2017 Council Meeting. In addition to various internal meetings with staff and regular meetings and phone calls with the President and the Vice President, summarized below are some of the meetings I attended and matters that I dealt with on behalf of the College during the reporting period.

### **Strategic Priorities Progress Update**

A key part of the Registrar's performance is to regularly provide an update to Council on the College's Operational Plan. The program activities and intended outcomes support the priorities outlined in the Strategic Framework developed by Council in March 2015. Attached for Council's information is an update of progress made on the various strategic directions since the March 2017 Council meeting. It is appropriate at this time that Council review the priorities, outcomes and planned activities and affirm our ongoing commitment to them as they will be the foundation upon which the 2018 Operations budget will be developed over the summer for Council's consideration in September.

### **Ministry/Government Activities**

During this reporting period, I have continued to build relationships with officials from the various branches of the Ministry and with the Minister's Office to inform about the College's strategic priorities and plans. More recently, staff from the hospital team and I met with officials from the Health Capital Division of the Ministry to explore opportunities to collaboratively manage the capital impact of OCP oversight of hospital pharmacies. I also met with staff from the Health System Quality and Funding area to obtain feedback on the impact of College oversight of hospital pharmacies and to explore opportunities for quality indicators in pharmacy.

Together with key College staff, I met with Ministry staff from the Health Analytics and Ontario Public Drug Programs branches to discuss opportunities for collaboration on data about pharmacies and pharmacy professionals that will enhance the College's ability to analyze practice data to inform policy development and establish appropriate pharmacy indicators to identify trends and evaluate the impact of practice initiatives. Further meetings with the appropriate staff from the College and Ministry have since been established to move this initiative forward.



As well, I have engaged with Health Quality Ontario (HQO) to explore opportunities to work together on several endeavours including consideration of synergies between the work of HQO and the College in establishing a Quality Improvement approach to pharmacy across the province; reporting opportunities based on pharmacies for opioid and overall medication incidents; development of quality indicators for pharmacy and input into the development of the Opioid quality standards. HQO Leads for these initiatives have been introduced to College staff in order to initiate work in each of these areas.

### **Ontario's Budget**

Supported by the province's higher-than-expected economic growth, the government tabled a balanced budget this year. On April 27<sup>th</sup>, the Finance Minister released the 2017 Ontario Budget which includes significant investments in health care and education. It introduced free prescription drug coverage for everyone aged 24 and under and made important investments to reduce wait times and improve access to care. The 2017 Ontario budget referenced the opioid crisis and the Ontario Naloxone Program for Pharmacies (ONPP). It stated that as of March 31, 2017, over 28,000 naloxone kits have been distributed by over 1,000 participating pharmacies, 40 public health units and community-based organizations that provide needle exchange and hepatitis C programs. Additionally, the government is exploring opportunities to make the new nasal spray kits available through pharmacies. Section A "Strengthening Health Care" from the Budget is attached for Council's information.

### **Legislative Initiatives**

#### **Bill 87, *Protecting Patients Act 2016***

This new legislation was introduced by the Ontario government to further protect patients by strengthening and reinforcing Ontario's zero tolerance policy on sexual abuse of patients by any regulated health professional. The Bill includes, among others, a schedule to amend the *Regulated Health Professions Act, 1991* (RHPA).

Following discussion at the March 2017 Council meeting, we provided a letter of support for this Bill to Minister Hoskins which reflected Council discussion and included suggested amendments to the RHPA to further enhance public protection. A copy of this letter is attached for Council's information.

The Bill passed second reading on April 4, 2017 and was referred to the Standing Committee on the Legislative Assembly. Public hearings were held on April 12, April 26, May 3 and May 10. I provided an oral presentation to the Standing Committee on May 3 which reflected our letter of support. On May 17, Bill 87 underwent clause by clause review and on May 30<sup>th</sup>, Bill 87 received Royal Assent.

The College was successful in capitalizing on the opportunity with Bill 87, which required opening of the DPRA to make changes where the Act references sections in the RHPA, to obtain additional DPRA changes to enable implementation of the proposed registration and quality assurance regulations and allow interim suspension of certificates of accreditation where imminent risk of patient harm is identified. This latter provision will mirror the process followed by ICRC for interim orders relating to members.

We anticipate that extensive consultations with the Ministry will be held following the passing of Bill 87 that will focus on the development of regulations that will provide the College with the tools to address ongoing public protection issues through our own bylaws and policies. An important aspect of the work still to be done relates to the ongoing consideration of the Sexual

Abuse Task Force Recommendations. Attached is a letter from Denise Cole regarding the role of Deanna Williams in the implementation of these recommendations.

### **Bill 84, *Medical Assistance in Dying Statute Law Amendment Act, 2017***

On May 9, the Ontario government passed legislation that will support the implementation of medical assistance in dying in the province by providing more protection and greater clarity for patients, their families, health care providers and health care institutions. The Bill complements the federal government's medical assistance in dying (MAiD) legislation (Bill C-14) enacted in June 2016, and addresses issues that fall within provincial jurisdiction. It amends several Ontario statutes to provide clarity and legal protections for care providers, including institutions and clinicians, and patients navigating MAiD. The legislation also establishes a new role for the coroner in overseeing MAiD.

In particular, the Bill:

- Ensures that having a medically-assisted death will not affect a right or benefit that would otherwise exist under a contract or statute (i.e., life insurance);
- Provides immunity to physicians, nurse practitioners and persons assisting them, as well as care provider institutions, from civil actions or proceedings for damages, when lawfully providing MAiD;
- Requires the Minister of Health and Long-Term Care to establish a Care Co-ordination Service to assist patients and caregivers in accessing additional information and services for MAiD and other end-of-life options;
- Protects identifying information about clinicians and health care facilities that provide MAiD from disclosure pursuant to access to information requests;
- Requires that the coroner be notified of all MAiD deaths, and allows the coroner to determine whether to investigate the death; and
- Clarifies the application of the *Vital Statistics Act* consistent with the *Coroners Act* amendments.

The Bill was referred to the Standing Committee on Finance and Economic Affairs and on March 30, I appeared before the Standing Committee to speak in support of the legislation. Many stakeholders presenting to the Committee strongly objected to the government's decision to not address the issue of conscientious objections within the legislation. In response, MPP Jeff Yurek put forth Bill 129, a Private Member's Bill, to address this issue. The Bill was voted down in the House on May 18. The government continues to work with the health regulatory colleges which have already put measures into place requiring those professions to refer their patients to a health care provider who is agreeable to provide the service. The Care Co-ordination Service, a referral service for MAiD, is expected to be in place by May 31<sup>st</sup> and will include pharmacists.

The College has developed a [guidance document](#) to assist pharmacy professionals to comply with legal obligations and professional expectations with respect to MAiD. This guidance was last updated on June 27, 2016 to reflect federal amendments to the Criminal Code of Canada, which were passed on June 17 2016, to include circumstances to which medical assistance in dying is permitted.

Given the recent passage of Bill 84 and the experience the province now has in providing MAiD, the College will be reviewing and updating this guidance material to identify how we can provide further clarity and support to pharmacy professionals. The College has also met with the Ontario Pharmacists Association to discuss the results of a survey conducted in June 2016 on Pharmacists' Perceptions on Medical Assistance in Dying. The survey results will be considered when updating guidance material.

Attached is a copy of the news release as well as a link to the *Medical Assistance in Dying*

*Statute Law Amendment Act, 2017:*

[http://www.ontla.on.ca/web/bills/bills\\_detail.do?locale=en&BillID=4460&detailPage=bills\\_detail\\_the\\_bill](http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=4460&detailPage=bills_detail_the_bill)

### ***Pharmacy Act – Professional Misconduct and Conflict of Interest Regulation***

Amendments to the Professional Misconduct regulation, originally approved by Council in 2013, (which addressed the addition of a new class of registrants, the expanded scope of practice, and the expectation that members will exercise professional judgement in choosing to deliver services and/or referring patients to another health professional as needed) were updated on February 1, 2017. O. Reg. 681/93 (Professional Misconduct) under the *Pharmacy Act, 1991* has been revoked and replaced with O. Reg. 130/17 (Professional Misconduct and Conflict of Interest) under the *Pharmacy Act, 1991*. The Regulation came into force on May 5, 2017.

## **Federal/Provincial Initiatives**

### **Opioid Crisis**

As previously reported, in November 2016, Federal Health Minister Jane Philpott and Ontario Health Minister Eric Hoskins convened a two-day summit to address the ongoing opioid crisis in Canada. Since then, there has been considerable activity nationally and provincially, by regulators and advocacy groups alike. Noted below are some significant measures that have been undertaken.

#### Ontario

Ontario's commitment at the November 2016 meeting was to implement a comprehensive Opioid Strategy that focuses on enhancing data collection, modernizing prescribing and dispensing practices, and connecting patients with high quality addiction treatment services. A core component of the Strategy is to modernize prescribing and dispensing practices to align with evidence-based guidelines and standards. The update of the Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain were released May 8, 2017. Attached is a letter from Minister Hoskins, requesting our support in knowledge transfer and implementation of these guidelines.

On April 20, 2017, the Ontario Drug Policy Research Network published a [report](#) that provides startling statistics of opioid-related deaths. The report suggests a multipronged approach is required that includes altering doctors' prescribing patterns to prevent people becoming addicted to the drugs, while helping those who are already dependent on the painkillers to pare down their medicinal use without driving them toward more dangerous forms of illicit opioids. It also recommends other public health measures such as increasing addiction treatment programs, establishing safe-injection sites, and providing widespread access to naloxone.

As well, the College's newly-established Opioid Task Force will be meeting over the summer to develop an Opioid Strategy that aligns with provincial and national strategies. It is anticipated that more information on the College's strategy will be brought to Council at its meeting in September.

#### National

As reported at the last Council meeting, together with Bev Zwicker, Registrar of the Nova Scotia College of Pharmacists, I am serving as a co-lead to assist with a national (National Association of Pharmacy Regulatory Authorities) opioid strategy. At the April 2017 meeting, NAPRA's Board approved a strategy that will encompass the following commitments:

1. Development of a communication that articulates the NAPRA action plan to address the Opioid Crisis from a regulatory perspective;
2. Development of “Guidance” or “Advice” to the professional that will form the basis for CQI assessments
3. Development of a plan for educating that will consider both entry to practice requirements as well as continuing professional development and licensing for both pharmacists and pharmacy technicians
4. Development of a plan for monitoring and enforcement

Similarly, the Canadian Pharmacists Association had also made a commitment at the November 2016 summit and have organized an Opioid Invitation-Only Summit to discuss a pharmacy sector response to the crisis. NAPRA’s message at this event will be that a national regulatory response is being developed, which will be specific to patient and public protection and separate from that being developed by the Associations.

#### Health Canada - Exempted Codeine

Also at the November Summit, Health Canada made a commitment to review the current scheduling of low-dose codeine with a view to up-regulating to address the opioid crisis. During the April CPRC meetings, Health Canada informed the Registrars that while the rationale for exempting low-dose codeine is not clear and dates back to a World Health Organization agreement in the 1960’s, persons with Lived Experience (PWLEs) have indicated that a Harm Reduction approach would require that exempted codeine remain in the current schedule to prevent users from seeking more dangerous street drugs. PWLEs cited the restrictions on oxycodone resulting in increased use of street drugs and resultant deaths.

Health Canada has therefore made the decision that it will continue to collect data from other jurisdictions to assess the impact of up-regulation before taking any action. They have also indicated that there may be appetite from Health Canada to submit an application to NDSAC (National Drug Scheduling Advisory Committee) to change exempted codeine to Schedule I.

#### Opioid Labeling requirements

In June 2016, the Minister of Health announced a 5-Point Action Plan on Opioid Misuse to address Canada’s growing opioid crisis. One of the overarching priorities under this Plan is to better inform Canadians about the risks of opioids. To ensure that patients receive consistent, easy to understand information about the risks of opioids, Health Canada is developing a regulatory proposal to require a warning sticker and patient handout be provided with all prescription opioids at time of dispensing.

Existing drug labelling regulations do not explicitly require warning stickers and patient handouts to be dispensed with prescription drugs. To date in Canada, the selection and provision of stickers or handouts with prescription drugs has been at the discretion of individual pharmacists. While there are a few exceptions, the requirement for and content of stickers and handouts has remained largely unregulated at the provincial level (and has never before been mandated federally).

It is anticipated that once developed, the proposed regulations will be gazetted and stakeholders will have 75 days within which to provide feedback. As expectations of the

proposed regulations are clarified, the College will assess the legal and practical implications and the expectations for enforceability and accountability.

## **Cannabis**

On April 13, the federal government introduced its legislation to legalize cannabis by July 2018. As was recommended by the Taskforce on Legalization, there is currently no change to access to cannabis for medical purposes - it will continue to follow the Access to Cannabis for Medical Purposes Regulations (ACMPR).

Together with President Vaillancourt, I met with Health Canada (HC) officials to discuss the Role of Pharmacists in Cannabis Regulations and the Opioid Crisis. We communicated Ontario's position that pharmacists should be involved in a clinical role with cannabis for medical purposes regardless of how the provinces choose to distribute. The need for child-proof containers, prohibiting any advertising, assurance from HC of product quality, and plain packaging were also discussed.

We further communicated the need to have a way of tracking use and studying the long-term impact. HC is studying impact only from a public health perspective, e.g. accidents and impaired driving, and are starting to collect baseline data.

HC is proposing to control licensing of production facilities, including assurance of quality and safe products with provinces controlling the distribution of cannabis. HC has taken a Harm Reduction approach that will require that cannabis is accessible and comparable in price to the illegal system, but they will assure a quality product.

We were further informed that \$9.6 Million has been allocated to the Cannabis legalization strategy, with \$6.6 million of that being allocated to front line education. While pharmacists had not been initially identified to receive education, further to this meeting, HC will now include pharmacists in the group of front-line health professionals to receive education.

In the meantime, the Council of Pharmacy Registrars of Canada (CPRC) held a one-day face-to-face strategy session on Cannabis on March 30, 2017, in Toronto.

At the April 17 NAPRA meeting, there was agreement at the table that NAPRA will release an initial statement (see page two of NAPRA representative, Mark Scanlon's memorandum) in response to the federal government's announcement around the areas where there was clear consensus (see NAPRA statement attached). All provincial Councils are asked to provide feedback on the Statement which will then be finalized by NAPRA at their November meeting.

## **Inter-Professional Relationships**

### **Federation of Health Regulatory Colleges of Ontario (FHRCO) Update**

The Federation of Health Regulatory College of Ontario (FHRCO) maintains a strategic focus on regulatory matters while promoting effective communication and cooperation among its members. The Board met on May 4 and discussed matters of mutual concern among the member colleges, held elections for the positions on the Executive Committee, appointed members to various committees and discussed several matters including Bill 87.

The Communications Committee brought forward a public engagement project for discussion. The regulatory colleges have been asked to review the plan and provide input to FHRCO for consideration. No timelines for approval were provided.

## **AGRE - Governance**

Since its formation in 2012, the Advisory Group for Regulatory Excellence (AGRE) has had considerable success in collaborating together to develop the AGRE Transparency Principles, engaging with the provincial government regarding these principles and having them adopted in bylaw by the AGRE regulators.

On May 15<sup>th</sup>, the Group organized a Governance Roundtable where participants engaged in discussion on governance issues. Attending from the College were President Vaillancourt, Ms. Weyland and Ms. Moustacalis from the Executive Committee, as well as myself and the senior management of the College (Ms. Resnick and Ms. Campbell).

While no concrete recommendations stemmed from the session, there was agreement that the AGRE Colleges will focus their efforts on developing a model governance framework that will demonstrate commitment to addressing skepticism of the current regulator model. Details of the framework will be shared with council as a framework is constructed, similar to the manner in which the transparency framework evolved.

## **Citizens Advisory Group**

A number of interested colleges met on April 7, 2017 to discuss forming a partnership to support a Citizens Advisory Group (CAG). The College of Physiotherapists of Ontario created such a group in 2015 to increase opportunities to engage patients in the regulatory process. Contribution has included work on the FHRCO patient website. The broad purpose of the CAG is to provide feedback representative of Ontario health care users on colleges' activities and initiatives. The contribution of the CAG is distinct from that of the public members of Council in that the CAG is used as a broad public sounding board to provide qualitative insight which will help Council in their decision-making. The proposal before colleges is a partnership that will share management of and access to the CAG, including shared costs for colleges that participate in any given meeting (in the past about \$14,000 per meeting). Administrative costs will be shared by all.

## **Other Stakeholder Meetings**

### **National Association of Pharmacy Regulatory Authorities (NAPRA) Update**

#### **Governance Update**

The NAPRA Board met April 26 and 27, 2017 in Ottawa and topics for discussion, among others, included cannabis (previously reported), governance review, and an update from the audit committee. A memorandum from Mr. Mark Scanlon, OCP representative, is attached for Council's information.

NAPRA established an Ad-hoc Committee on Governance Implementation (the Ad-hoc CGI) in November 2016 and has been providing regular reports on its work. At this Board meeting, the Ad-hoc CGI asked the Board to discuss and consider the following:

1. Addressing how NAPRA will measure the success of and report on the new model
2. Basic principles to guide decision-making on financial resourcing
3. Overview of anticipated by-law and policy changes

There was agreement that the Ad-hoc CGI will be working over the summer on the various sections of the by-law and board policy amendments that will be required by the November 2017 timeline. In the meantime, there was consensus that the current Executive Committee will remain in place until November 2017 when the new structure comes into force.

NAPRA's Financial Statements were approved by the Board at a meeting on March 31 and at the Board meeting, there was support that going forward, a meeting be schedule to allow for Board approval of draft Audited statements in advance of the Annual General Meeting.

The Council of Pharmacy Registrars of Canada (CPRC) has continued informal discussions on issues of mutual concern to foster communication and collaboration on pan-Canadian trends.

### Sterile Compounding

Another issue discussed at the NAPRA table was sterile compounding capacity. The discussion revealed that most provinces do not have the necessary expertise to inspect sterile compounding facilities but would like to implement a consistent approach across the country. Ontario's expertise (hospital inspection tool and assessors) has been cited as a possible resource. Related to this issue, the College very recently hosted an intensive 3 day training program for our practice advisors, offered by CriticalPoint, which is a company that also trains inspectors for the National Association of Boards of Pharmacy in the United States. In order to support consistency across the country OCP invited other provincial regulators to participate, and had representatives from 5 other provinces and 4 organizations involved in assessing and/or educating pharmacy professionals.

### **Ontario Pharmacists Association (OPA)**

On April 10, 2017, the OPA announced the appointment of Mr. Andrew Gall as CEO effective May 1, 2017. Gall was previously the Vice President, Finance and Administration at Health Shared Services Ontario (formerly the Ontario Association of Community Care Access Centres). I met with Mr. Gall on May 9 and discussed his objectives of helping the Association achieve the aggressive goals set out in its most recent strategic plan, including further expanding pharmacists' scope of practice to better meet the needs of Ontarians. On August 31, 2017, the Executive Committee and senior staff at the College, as well as selected Board members and staff at the OPA will again meet to discuss issues of mutual concern.

### **Miscellaneous Items**

#### **Canada Health Infoway**

Canada Health Infoway (Infoway) is working with Health Canada, the provinces and territories, and industry stakeholders to create, operate and maintain a financially self-sustaining, multi-jurisdiction e-prescribing service, known as PrescribeIT™. Canada Health Infoway is supporting a single service that can be scaled for use across the country, enabling prescribers to electronically transmit a prescription to a patient's pharmacy of choice. On May 11, 2017, Infoway announced that it selected TELUS Health as the successful bidder for the technical solution provider for PrescribeIT™.

#### **Beyond Use Date**

Attached for Council's information is a Guideline that outlines the College's expectations when a practitioner or organization chooses to extend the Beyond Use Date (BUD) for sterile preparations. As reported in March, the Compounding Standards Working Group met regularly over the last 3 months in order to create the guidance document which is principle based and identifies the necessary considerations when determining whether or not to extend the BUD.

This guideline is one of the tools the College is providing to pharmacies to support the implementation of the new Standards for Pharmacy Compounding of Sterile Preparations (Hazardous and Non-hazardous). The working group notes that this guidance is preliminary and will be updated as technology and practice evolve.

### **Live-tweeting Council meetings**

We are pleased to report that as part of our commitment to transparency and in keeping with our practice of Council meetings that are open to the public, the College will begin live-tweeting decisions during Council meetings effective June 12<sup>th</sup>. Live-tweeting Council meetings is becoming a common practice among regulators. Adopting this practice will further position our College as a leader in using social media as part of a broader integrated communications strategy for pharmacy professionals and the public.

### **Program Updates/Presentations**

This reporting activity also includes regular program updates/presentations from the program managers. At this June Council meeting, I will invite Sandra Winkelbauer, Manager of Continuing Competency, to present her program update to Council.



# Strategic Priority #1

Key to Impact of Strategic Initiatives: PF = Patients First, EC = Effective Communication, CQI = Continuous Quality Improvement

Strategic Priority #1: CORE PROGRAMS – FULFILLMENT OF MANDATE									
Processes meet or exceed societal expectations. (Members, Premises)									
Values	Outcomes & Key Performance Indicators	Estimated Degree of Attainment	Activity	Timeline	Estimated Degree of Completion	Strategic Initiatives Focus			Additional Resource Required
						PF	EC	CQI	
Transparency Accountability Excellence	1.1 Fair and objective assessment framework.	70%	Refine assessment tools and activities. <u>Premises:</u> Current authority and others i.e. long-term care, family health teams. <u>Members:</u> Pharmacists - at entry, in practice, (site based and standardized). Pharm techs – as above.	Ongoing Ongoing 1 – 3 years 1 – 3 years	90%  Phcst 75% Tech 10%	High	Med	High	Transparency expansion • Inspection Outcomes
	1.2 A decision-making framework that is consistently applied across the organization.	65%	Utilize risk tools for use at adjudicative committees. Develop informed and objective decision-makers – training/legal support. Define and mine data to support decisions. Develop or acquire analytic and technical expertise.	1 year  Immediate  Ongoing Immediate	90%  75%  25% 40%	Low	Low	High	Policy and analytics support. Governance Refresh in light of Bill 87. Public input.
	1.3 A defined Professional Development Framework that incorporates coaching, remediation and monitoring.	45%	Raise awareness of Standards of Practice and Code of Ethics. Develop and refine tools and resources that apply to all members. Develop specific tools and resources that apply to identified applicants/members/ Premises. Develop model for coaching and remediation/monitoring.	1 – 2 years  1 – 3 years  2 – 3 years  2 – 3 years	75%  30%  50%	Med	High	Med	Development/training programs to bring professionals up to scope.

# Strategic Priority #2

Key to Impact of Strategic Initiatives: PF = Patients First, EC = Effective Communication, CQI = Continuous Quality Improvement

Strategic Priority #2: OPTIMIZE PRACTICE WITHIN SCOPE									
Patients receive quality health care services from pharmacy professionals.									
Values	Outcomes & Key Performance Indicators	Estimated Degree of attainment	Activity	Timeline	Estimated Degree of Completion	Strategic Initiatives Focus			Additional Resource Required
						PF	EC	CQI	
Transparency Accountability Excellence	2.1 Pharmacists consistently practising to established expectations including Standards of Practice and Code of Ethics.	50%	Develop and communicate Code of Ethics. Provide guidance and education on expectations of Standards of Practice and Code of Ethics. Provide guidance and education on specialty standards e.g. sterile compounding. Use OCP assessments and professional development to remediate/coach.	1 year 2 - 3 years 1 – 2 years Ongoing	90% 60% 50% 35%	Med	High	Med	Cannabis?
	2.2 Pharmacy Technicians consistently practising to established expectations including Standards of Practice and Code of Ethics.	25%	Develop and communicate Code of Ethics. Provide guidance and education on expectations of Standards of Practice and Code of Ethics. Provide guidance and education on specialty standards e.g. sterile compounding. Use OCP assessments and professional development to remediate/coach.	1 year 2 - 3 years 1 - 2 years Ongoing	90% 15% 10% 0%	Med	High	Med	Increase data collection. Scope of Practice Strategy.
	2.3 Pharmacies meeting Standards of Operation and consistently providing an environment to support pharmacy professionals practising to established expectations including the Standards of Practice and Code of Ethics.	25%	Educate and reinforce to the “controllers of the pharmacies” their obligations. Develop and communicate Standards of Operation.	Immediate 1 - 2 years	5% 60%	Med	Med	Med	Public engagement on posting of inspection results.
	2.4 The pharmacy profession integrates technology and innovative approaches to improve the quality and safety of patient care.	50%	Raise awareness of PPMS (pharmacy practice management systems) with members, stakeholders, government. Participate and influence e-Health initiatives. OCP assessments and adjudications encourage and support innovation in practice.	Immediate Ongoing Ongoing	50% 50% 50%	Low	High	Med	Medication Safety – Error Reporting • External support to define requirement.

# Strategic Priority #3

Key to Impact of Strategic Initiatives: PF = Patients First, EC = Effective Communication, CQI = Continuous Quality Improvement

Strategic Priority #3: INTER & INTRA PROFESSIONAL COLLABORATION									
High performing health professional teams in place to achieve coordinated patient-centered care.									
Values	Outcomes & Key Performance Indicators	Estimated Degree of Attainment	Activity	Timeline	Estimated Degree of Completion	Strategic Initiatives Focus			Additional Resource Required
						PF	EC	CQI	
Transparency Accountability Excellence	3.1 Pharmacy Team: Pharmacy services are organized to empower pharmacists and pharmacy technicians to practice to their full scope. Pharmacists and pharmacy technicians maximize their respective roles.	10%	Gather data to determine the degree to which pharmacies are meeting expectations and understand the barriers. Educate members through videos, sharing best practices. OCP to encourage and support experimental models that integrate technicians in practice.	1 - 2 years  Ongoing  Immediate	25%  5%  5%	Med	High	High	Execute Scope of Practice Strategy. Scope of Practice work for both pharmacists and technicians
	3.2 Health Care Team: Pharmacists and pharmacy technicians exercise their responsibility within the patient's professional team.	10%	Develop and provide guidance to members on how they can educate and collaborate with other health care professions. Develop guidance on expectations at transitions of care. Gather information from patients on their understanding of the pharmacy services role in health care team.	1 - 3 years  1 - 3 years  1 - 3 years	40% 5%  0%	High	High	Med	Analytics to align with health outcomes. Research on transitions of care. Funding for research on Patient Perspective.



## **Strategic Priorities 2015 - 2018**

**Progress Update – June 2017**

### **Mission**

**The Ontario College of Pharmacists regulates pharmacy to ensure that the public receives quality services and care.**

### **Vision**

**Lead the advancement of pharmacy to optimize health and wellness through patient-centred care.**

### **Values**

**Transparency – Accountability - Excellence**

Strategic Priority #1: CORE PROGRAMS – FULFILLMENT OF MANDATE - Processes meet or exceed societal expectations. (Members, Premises)						
Values – Transparency, Accountability, Excellence						
Outcomes/KPI	Activity	Strategic Initiatives Focus			Last Quarter Accomplishments (Dec 2016 – Feb 2017)	Noteworthy Accomplishments this Quarter (March – May 2017)
		PF	EC	CQI		
Fair and objective assessment framework.	Refine assessment tools and activities. <u>Premises:</u> Current authority and others i.e. long-term care, family health teams. <u>Members:</u> Pharmacists - at entry, in practice, (site based and standardized). Pharm techs – as above.	High	Med	High	<ul style="list-style-type: none"> <li>• PACE successfully launched for student registrants January 18, 2017</li> <li>• Assessment rubric for Pharmacy Technician Standardized Assessment Tool ready for validation.</li> <li>• Behavioral based interview tool for the QA practice assessments calibrated and ready for piloting.</li> <li>• QA coaches fully trained and initiated coaching with members</li> <li>• 55% of practice assessments now scheduled (on target for 95% by end of 2017).</li> <li>• Data from first breakfast meeting, demonstrates the strategy is very effective.                             <ul style="list-style-type: none"> <li>• 100% made practice adjustments based on meeting attendance alone</li> <li>• 70% used the assessment criteria to conduct a Self Assessment</li> <li>• 70% made improvements prior to assessment.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Data collection matrix and survey instruments for PACE Phase I evaluation finalized</li> <li>• Backlog of QA coaching sessions have been addressed and QA coaching sessions now occurring within 6-8 weeks of identification.</li> <li>• QA assessment tool finalized and cut score session with subject matter experts completed</li> <li>• Post Pharmacy assessment feedback survey implemented March 1, 2017 and Post Pharmacist assessment feedback survey implemented April 1, 2017. Response rate of 38% as of mid-May.</li> <li>• Sterile compounding training for hospital and community practice advisors completed</li> <li>• BUD guidance document developed to support implementation of Sterile Compounding</li> </ul>

Strategic Priority #1: CORE PROGRAMS – FULFILLMENT OF MANDATE - Processes meet or exceed societal expectations. (Members, Premises)						
Values – Transparency, Accountability, Excellence						
Outcomes/KPI	Activity	Strategic Initiatives Focus			Last Quarter Accomplishments (Dec 2016 – Feb 2017)	Noteworthy Accomplishments this Quarter (March - May 2017)
		PF	EC	CQI		
A decision-making framework that is consistently applied across the organization.	Utilize risk tools for use at adjudicative committees. Develop informed and objective decision-makers – training/legal support. Define and mine data to support decisions. Develop or acquire analytic and technical expertise.	Low	Low	High	<ul style="list-style-type: none"> <li>Annual statistics compiled for program evaluation and annual report.</li> <li>Upgraded Records Management System to enable Outlook integration; enables implementation of the zone approach to email management.</li> </ul>	<ul style="list-style-type: none"> <li>HPDB data submission completed and the process streamlined.</li> </ul>
A defined Professional Development Framework that incorporates coaching, remediation and monitoring.	Raise awareness of Standards of Practice and Code of Ethics. Develop and refine tools and resources that apply to all members. Develop specific tools and resources that apply to identified applicants/members/premises. Develop model for coaching and remediation/monitoring.	Med	High	Med	<ul style="list-style-type: none"> <li>Professional Development and Remediation technology for resource catalogue finalized.</li> </ul>	<ul style="list-style-type: none"> <li>None.</li> </ul>

**Strategic Priority #2: OPTIMIZE PRACTICE WITHIN SCOPE – Patients receive quality health care services from pharmacy professionals.**

**Values – Transparency, Accountability, Excellence**

Outcomes/KPI	Activity	Strategic Initiatives Focus			Last Quarter Accomplishments (Dec 2016 – Feb 2017)	Noteworthy Accomplishments this Quarter (March - May 2017)
		PF	EC	CQI		
Pharmacists consistently practicing to established expectations including Standards of Practice and Code of Ethics.	Develop and communicate Code of Ethics. Provide guidance and education on expectations of Standards of Practice and Code of Ethics. Provide guidance and education on specialty standards e.g. sterile compounding. Use OCP assessments and professional development to remediate/coach.	Med	High	Med	<ul style="list-style-type: none"> <li>Baseline data collected for 95% of 2016 target for pharmacist assessments by 31/12/2016.</li> <li>Project Charter for Practice Based assessments for Hospital Pharmacists completed.</li> <li>Completed last 3 Code of Ethics learning modules.</li> <li>Implemented the Code of Ethics declaration for 2017 membership renewal.</li> </ul>	<ul style="list-style-type: none"> <li>Conducted 1182 member assessments as of May 12, 2017 (38% of 2017 target of 3150). Feedback survey results indicate that 92% changed or intended to change aspects of their practice as a result of the assessment learnings.</li> <li>Decision-making tool to support application of the Code of Ethics published in Pharmacy Connection.</li> </ul>
Pharmacy Technicians consistently practicing to established expectations including Standards of Practice and Code of Ethics.	Develop and communicate Code of Ethics. Provide guidance and education on expectations of Standards of Practice and Code of Ethics. Provide guidance and education on specialty standards e.g. sterile compounding. Use OCP assessments and professional development to remediate/coach.	Med	High	Med	<ul style="list-style-type: none"> <li>Underway – see Strategic Priority #1.</li> </ul>	<ul style="list-style-type: none"> <li>Initiated first of several presentations to hospital pharmacy technicians regarding professional responsibility.</li> </ul>

Strategic Priority #2: OPTIMIZE PRACTICE WITHIN SCOPE – Patients receive quality health care services from pharmacy professionals.						
Values – Transparency, Accountability, Excellence						
Outcomes/KPI	Activity	Strategic Initiatives Focus			Last Quarter Accomplishments (Dec 2016 – Feb 2017)	Noteworthy Accomplishments this Quarter (March – May 2017)
		PF	EC	CQI		
Pharmacies meeting Standards of Operation and consistently providing an environment to support pharmacy professionals practising to established expectations including the Standards of Practice and Code of Ethics.	Educate and reinforce to the “controllers of the pharmacies” their obligations. Develop and communicate Standards of Operation.	Med	Med	Med	<ul style="list-style-type: none"> <li>Achieved 95% of 2016 target to assess 2500 community pharmacies.</li> </ul>	<ul style="list-style-type: none"> <li>As of May 12, 2017, 982 pharmacy assessments completed (44% of 2017 target of 2250).</li> <li>Post Assessment Feedback Survey reflects that 96% indicated that they had a better understanding of some key operational processes.</li> <li>Gap analysis document developed and posted on website to facilitate practice change to meet NAPRA Sterile Compounding standards by Jan 2019.</li> </ul>
The pharmacy profession integrates technology and innovative approaches to improve the quality and safety of patient care.	Raise awareness of PPMS (pharmacy practice management systems) with members, stakeholders, government. Participate and influence e-Health initiatives. OCP assessments and adjudications encourage and support innovation in practice.	Low	High	Med	<ul style="list-style-type: none"> <li>None.</li> </ul>	<ul style="list-style-type: none"> <li>None.</li> </ul>



Key to Impact of Strategic Initiatives: PF = Patients First, EC = Effective Communication, CQI = Continuous Quality Improvement

Strategic Priority #3: INTER & INTRA PROFESSIONAL COLLABORATION - High performing health professional teams in place to achieve coordinated patient-centered care.						
Values – Transparency, Accountability, Excellence						
Outcomes/KPI	Activity	Strategic Initiatives Focus			Last Quarter Accomplishments (Dec 2016 – Feb 2017)	Noteworthy Accomplishments this Quarter (March – May 2017)
		PF	EC	CQI		
Pharmacy Team: Pharmacy services are organized to empower pharmacists and pharmacy technicians to practice to their full scope. Pharmacists and pharmacy technicians maximize their respective roles.	Gather data to determine the degree to which pharmacies are meeting expectations and understand the barriers. Educate members through videos, sharing best practices. OCP to encourage and support experimental models that integrate technicians in practice.	Med	High	High	<ul style="list-style-type: none"> <li>Mined pharmacy assessment data to determine baseline of pharmacies reporting integration of pharmacy technicians (currently about 25%).</li> <li>Initiated a study within U of T Practice Optimization project to identify factors that support pharmacy technicians practicing to their full scope.</li> </ul>	<ul style="list-style-type: none"> <li>Scope of Practice Strategy developed to set out intention on engagement of registrants to practice to scope through interprofessional collaboration.</li> </ul>
Health Care Team: Pharmacists and pharmacy technicians exercise their responsibility within the patient's professional team.	Develop and provide guidance to members on how they can educate and collaborate with other health care professions. Develop guidance on expectations at transitions of care. Gather information from patients on their understanding of the pharmacy services role in health care team.	High	High	Med	<ul style="list-style-type: none"> <li>Developed and posted joint guideline with CPSO on Mifegymiso.</li> </ul>	<ul style="list-style-type: none"> <li>None.</li> </ul>

## Section A: Strengthening Health Care

### Introduction

Along with world-class public education, universal access to public health care is part of the social fabric of Ontario that gives everyone a chance to succeed. Ontarians rely on high-quality, publicly funded health care to be there when and where they need it, now and in the future.

Today in Ontario, 94 per cent of Ontarians have access to a family doctor or nurse practitioner. According to the Canadian Institute for Health Information, Ontario is leading the way among all provinces and territories in the country on wait times for hip and knee surgeries, and for computerized tomography (CT) and magnetic resonance imaging (MRI) procedures. Ontario's cancer care system is among the best in the world.

The government is investing an additional \$7 billion in health care over the next three years, compared to the *2016 Budget Plan*, to reduce wait times, improve access to care and enhance the patient experience. With these new investments, growth in health care spending will now average 3.3 per cent over the medium term.

Ontario will launch a new drug benefit program, OHIP+: Children and Youth Pharmacare, in 2018 to expand access to prescription medicines for all children and youth, regardless of family income. Ontario's children and youth need medications to treat most acute conditions, common chronic conditions, childhood cancers and other diseases. See Chapter II: *Helping You and Your Family* for more details.

## Summary of New Investments

### Increasing Access

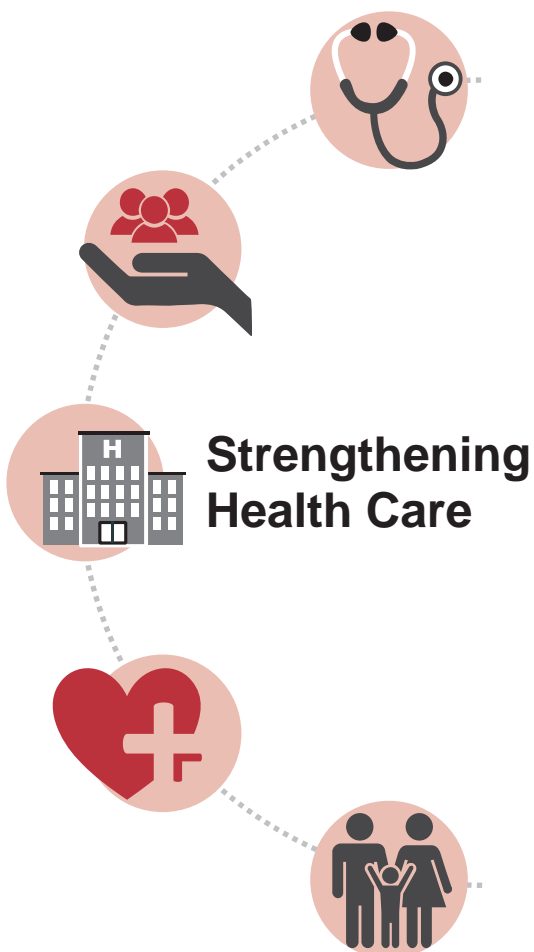
- **Building New Hospitals** — an additional \$9 billion over 10 years to support the construction of new major hospital projects across the province. These transformational investments will provide Ontarians with faster access to care and support the delivery of high-quality services.
- **Increasing Operating Funding for All Public Hospitals** — an investment of \$518 million will provide a three-per-cent increase to the hospital sector. This investment will support vital hospital services, keep wait times low, and maintain access to elective surgeries.
- **Enhancing Interprofessional Primary Care Teams** — \$15-million investment to enhance Ontarians' access to primary care and a suite of OHIP-funded non-physician specialized health services.
- **Modernizing and Enhancing Cancer Screening** — enabling early identification and treatment based on the latest evidence.

### Reducing Wait Times

- **Reducing the Time to See a Specialized Care Provider** through an additional investment of \$245 million over three years in enhanced referral pathways for treatment of back pain and other bone and joint conditions, including using new digital tools like eReferrals, and the expansion of a central intake system for each Local Health Integration Network (LHIN).
- **Reducing Wait Times for Key Services** through an additional investment of \$890 million over three years by funding more procedures such as foot, knee, hip and cataract surgeries, and other priority procedures.
- **Expanding Home and Community Care** through an additional investment of \$85 million over three years to enhance programs such as home nursing, personal support and physiotherapy as well as respite care services. Home and community care programs provide valuable services to Ontarians, including 23,000 home care visits per day.
- **Faster Access to Mental Health Services** through an additional investment of \$74 million over three years to provide faster access to mental health services, including new supportive housing units and structured psychotherapy.

## Enhancing the Patient Experience

- **Launching Ontario’s Dementia Strategy** with more than \$100 million over three years, improving and better coordinating services for Ontarians living with dementia, and their caregivers.
- **Expanding the Northern Health Travel Program** through a \$10-million enhancement that helps northern patients with costs associated with receiving care outside their communities.
- **Helping People Live Well in Their Homes** by investing \$18 million in new funding for community programs, such as Meals on Wheels and transportation support.
- **Improving Maternal Care**, such as funding breast pumps for mothers of premature babies, enhanced newborn screening and more midwifery services.



### What We’ve Been Doing since 2013

- Adding almost 1,700 additional doctors and over 8,400 more nurses to provide Ontario families with quality care
- Improving access to home and community care and increasing wages for personal support workers
- Enabling more seniors to qualify for lower out-of-pocket drug costs and offering free shingles vaccines to those aged 65–70
- Providing approximately \$4 billion in capital grants to expand, renew and modernize hospitals
- Approximately 39 major hospital projects have been completed or are under construction
- Enabling more than 365,000 children and youth from low-income families to be eligible for free dental services
- Helping more than 7,200 families each year by covering the cost of one cycle of in vitro fertilization
- Expanding mental health supports for more than 50,000 children and youth by hiring more front-line staff in schools, communities and courts

## Increasing Access

### Building More Health Infrastructure

Investments in health infrastructure support the creation of a sustainable, high-quality health care system that will meet the needs of future generations. Over the next 10 years, the Province plans to provide more than \$20 billion in capital grants to hospitals. This includes a new commitment of approximately \$9 billion to support the construction of new major hospital projects across the province. These transformational investments will support timely access to the right care, in the right place, at the right time.

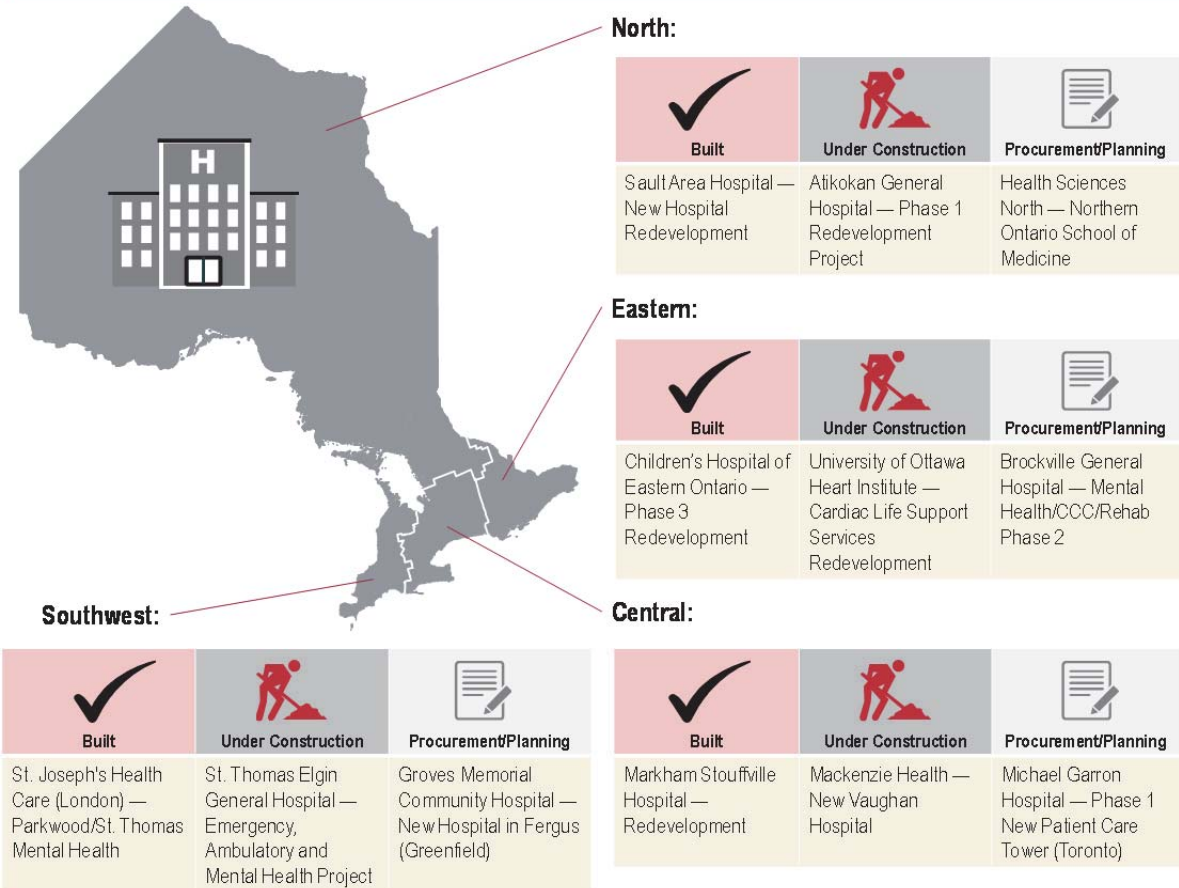
The Province is committing to several new priority major hospital projects that will address growing demand for health care services and facility condition deficiencies, and support new and innovative models of care. Continued investment in health infrastructure will ensure that the health system remains sustainable into the future.

**TABLE 4.1 Newly Approved Major Hospital Projects**

Southwest	Niagara Health System — New South Niagara Hospital Capital Project	The project will include construction of a new hospital in support of service transformation in the Niagara Region.
	Windsor Regional Health Centre — New Greenfield Hospital Project	The project will include construction of a new hospital in support of service transformation in the Windsor Region.
Central	Hamilton Health Sciences — Hamilton Redevelopment Project	The project will address Hamilton Health Science's high-growth needs and update aging infrastructure to meet current hospital standards.
	Trillium Health Partners — Broader Redevelopment Project	The project includes investment in the Mississauga Hospital and Queensway Health Centre to add new spaces to address capacity issues, as well as renovate existing space.
North	Weeneebayko Area Health Authority — Replacement Hospital Project	Ontario is committing to the provincial share of the project costs for a new hospital to serve the health care needs of the population along the James Bay coast. Ontario will work with the federal government to advance planning for this project.

The Province has demonstrated its commitment to securing the future of Ontario's health care system by providing several hospitals with planning grants since 2013. Through detailed upfront planning work, the Province is taking a responsible approach to addressing the emerging needs of the health care system. Planning grants ensure that proposals meet the needs of local communities across Ontario.

## CHART 4.1 Hospital Projects Completed and Underway



## Hospital Projects



Source: Ministry of Health and Long-Term Care.





Mackenzie Vaughan Hospital will be Vaughan’s first hospital, serving more than 500,000 people.



Providence Care Hospital’s new state-of-the-art facility in Kingston.



St. Joseph’s Health Care’s London and St. Thomas facilities were completed in 2014.



Atikokan General Hospital’s renovated space will provide integrated acute and long-term care for the community.



A rendering of CAMH’s future Complex Care and Recovery Building (part of Phase 1C).

Ontario is also committing to a new \$2.5-million planning grant for the Centre for Addiction and Mental Health (CAMH), Canada’s largest mental health and addiction teaching hospital. The grant will help the hospital move forward with the Phase 1D redevelopment project focused on complex mental illness forensic services, the final project in CAMH’s redevelopment.

The Province has expanded eligibility and streamlined the approval process for community infrastructure funding to shift care from hospital to community settings. Ontario is providing funding to renew and expand the facilities of organizations such as Community Health Centres, Public Health Units and Family Health Teams. Investments in community health care infrastructure support the co-location and integration of multiple health and social services under one roof. See Chapter II: *Helping You and Your Family* for more details on community hubs.

Expanding eligibility for community infrastructure funding will also allow for needed investments to increase the number of hospice beds across the province. Funding will support facilities to deliver on the Province’s Palliative and End-of-Life Care Strategy and ensure Ontarians have access to high-quality health services at the end of life’s journey.

## **Increasing Operating Funding for All Public Hospitals**

Ontario hospitals have demonstrated leadership in their efforts to help transform the province’s health system. In response to the growing demand for highly specialized and complex services and the need to expand access in growing communities across the province, in 2017–18 the Province will provide an additional \$518 million, a three-per-cent increase to the sector. This investment will ensure all hospitals receive, at minimum, a two-per-cent increase for vital hospital services, to expand access to complex clinical services, keep wait times low, maintain access to elective surgery and ensure that important health service programs are maintained.



Ontario has reduced hospital wait times to some of the shortest in the country.



## Investing in Primary Care

Primary health care is the entry point to the health care system for most Ontarians. Primary care is generally understood as the first level of care Ontarians turn to, including the services of family physicians, nurse practitioners, nurses, pharmacists and others. These care providers play an important role in improving the health and well-being of Ontarians and helping them access other health and social services, such as specialized care and broader community supports. The experience that Ontarians have in the health care system is largely influenced by the type of access, care and coordination they receive through their primary care provider or team.



Improving access to primary care by recruiting nurse practitioners, social workers and registered dietitians.

Ontario has made considerable improvements in primary care. Currently, 94 per cent of Ontarians report having access to a regular primary care provider — 1.7 million more people than in 2003. New models of primary care have been introduced or expanded, including Aboriginal Health Access Centres, Community Health Centres, Family Health Teams and Nurse Practitioner-Led Clinics. Advances have also been made in quality improvement, programs to help people stay healthy, and care coordination for complex patients.

Access to high-quality primary care, including prevention and early management of health problems, a focus on the patient as a whole person, and ensuring appropriate use of specialized care, can be expected to lead to improved population health, health equity and lower costs of care.

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### More Health Care Professionals

Ontario has experienced a significant increase in its health workforce. Since 2013, some notable examples of net increases\* include:

- 98 midwives (16.0%).
- 1,680 physicians (6.2%).
- 8,439 nurses (6.4%), including 601 nurse practitioners (29.2%).

\* Physician data current to 2015 calendar year. Nurse and midwife statistics current to 2016.

### ***Enhancing Interprofessional Primary Care Teams***

Since 2003, the government has created 184 Family Health Teams and 25 Nurse Practitioner-Led Clinics, and has expanded and supported 75 Community Health Centres and 10 Aboriginal Health Access Centres.

These interprofessional primary care organizations deliver comprehensive primary care services and programs through a team of health care professionals, including physicians, nurse practitioners, registered nurses, physician assistants, dietitians, pharmacists, mental health workers, social workers, psychologists, physiotherapists, chiropractors and other professionals. Programs are designed and delivered around the holistic needs of patients, ranging from programs to help people manage their chronic diseases, to services that help with life challenges that negatively impact health.

Collectively, these 294 primary care organizations are delivering team-based, OHIP-funded comprehensive care to more than 4 million Ontarians.

The Province's investments in these models of team-based care have helped to improve access to primary care for communities that need it most, resulting in health care improvement in communities across the province. In 2017, Ontario will invest an additional \$15 million in team-based primary care to create new or expand existing interprofessional care teams so that all 76 sub-regions across the province have a team.

To further support and improve these important services, the government is continuing its commitment by investing an additional \$145 million over the next three years to effectively recruit and retain nurses, nurse practitioners, dietitians, social workers, pharmacists, reception staff and other care providers who provide valuable services alongside family doctors on these teams. This is in addition to the \$85 million in investments in interprofessional teams announced in the *2016 Budget*.

### ***Expanding Registered Nurses' Scope of Practice***

To further reduce wait times for key health services, Ontario has also expanded scopes of practice for some health professionals. Most recently, the government has taken steps toward expanding the scope of practice of registered nurses so they can independently prescribe some medications to patients. This initiative would give patients more choice in primary care and improve timely access to care and patient experience, particularly in rural and northern communities. Starting in 2017, Ontario will further improve access by expanding or enhancing the scopes of practice for additional health care providers.

## Increasing Equitable Access to Health Care through Ontario's First Nations Health Action Plan

Investing in the health and wellness of Indigenous communities is one of many steps on Ontario's journey of healing and reconciliation with Indigenous peoples. See also Chapter V: *Working with Our Partners* for more information on Ontario's *Commitment to Reconciliation with Indigenous Peoples*.

As highlighted in Ontario's First Nations Health Action Plan (OFNHAP), Ontario is investing nearly \$222 million over three years, followed by sustained funding of \$104.5 million annually, to address health inequities and improve access to culturally appropriate health services over the long term. While focused on northern First Nations, where there are significant gaps in health services, the OFNHAP also includes investments in Indigenous health care across Ontario in home and community care, primary care, and diabetes prevention and management, both on- and off-reserve.



The First Nations Health Action Plan focuses on primary and hospital care, public health and crisis support.

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### Providing Health Care for Ontario's Indigenous Peoples

Both federal and provincial governments provide health care services for Indigenous peoples in Ontario. All eligible residents of Ontario, including Indigenous people, are entitled to receive insured health services anywhere in the province. As well, some provincially funded health care services focus on specific needs of Indigenous people, both on- and off-reserve, especially in remote and northern communities. These include:

- 10 Aboriginal Health Access Centres and five Indigenous-governed Family Health Teams across the province, which provide traditional healing; culturally sensitive primary and chronic care; and mental health, addictions and social support services.
- Investing up to \$30 million for the development and operation of up to 10 expanded culturally appropriate interprofessional primary care teams.
- Physician services for 30,000 people in 28 First Nation communities in the Sioux Lookout region.
- Aboriginal midwifery services (described later in this section).
- Four on-reserve long-term care homes.
- Air and land ambulance services and first response teams for First Nation communities.

## **Advancing Timely Cancer Care and Stem Cell Transplants**

Stem cell transplants can be an essential component of treatment for people with lymphoma, leukemia, myeloma and other blood disorders. While the Province provides funding for Ontario residents for treatment outside of Canada, the government is building capacity within Ontario to treat complex cancers so that more Ontarians can receive the care they need closer to home.

Last year, Ontario announced investments of \$130 million over three years for cancer care services. Over the past year, the Province has also announced investments in infrastructure to improve access to highly specialized stem cell transplant programs at University Health Network, Hamilton Health Sciences Centre, The Ottawa Hospital and Sunnybrook Health Sciences Centre.

In 2017, the government will focus on continuing to build capacity to provide stem cell transplant treatment for complex blood cancers within the province by investing an additional \$32 million. This means that up to 150 more Ontarians will receive life-saving stem cell transplants. As additional capacity is developed, fewer patients will require transplants in the United States.

### ***Modernizing and Enhancing Cancer Screening***

Ontario continues to modernize and enhance cancer screening programs to enable early identification and treatment based on the latest evidence. Working with Cancer Care Ontario, the Province will modernize two primary cancer screening tests and develop a new screening program for those at high risk of developing lung cancer. These tests, based on the latest technology, include modernizing colorectal cancer screening from the existing fecal occult blood test (FOBT) to the fecal immunochemical test (FIT), and the primary screening test for cervical cancer from the existing Papanicolaou (Pap) test to the human papillomavirus (HPV) test for women aged 30 to 69. In addition, the Province will launch a lung cancer screening project for people at high risk at three pilot sites: The Ottawa Hospital, Health Sciences North and Lakeridge Health.

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### **Expanding Access to Safe Abortion**

In 2017, Ontario will expand access to health care options for women by publicly funding the new abortion pill Mifegymiso (combination mifepristone/misoprostol).

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## Improving Pain Management

One in five Canadians experiences chronic pain. With new investments, Ontarians will have better access to support and guidance in managing chronic pain through interprofessional Chronic Pain Management Clinics and other services. Additionally, health professionals will have better access to tools and resources that will improve the treatment of chronic pain.

In 2017, the government committed \$17 million under this strategy, including funding for five pediatric hospitals, 11 academic hospitals and one hospital-affiliated community clinic to enhance or develop chronic pain programs. In 2018, an additional program is planned for Health Sciences North, to serve Sudbury and the surrounding area. The programs focus on prescribing principles and treatments that prioritize patient safety, decrease reliance on opioids in pain management, and increase patients' ability to manage pain and improve their quality of life.

## Acting on Ontario's Opioid Strategy

Individuals, families and communities across Ontario have been affected by opioid addiction and overdose.

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### Preventing Opioid Overdose

One of the key components of Ontario's Opioid Strategy is the prevention of overdose deaths. Increasing access to naloxone, an anti-overdose medication, is part of the strategy's commitment to reducing the harm associated with opioid use and misuse.

On June 6, 2016, naloxone kits were made available free of charge, over-the-counter, and without prescription at pharmacies through the Ontario Naloxone Program for Pharmacies (ONPP). Ontario is expanding access to naloxone by providing it in over 200 cities across the province. As of March 31, 2017, over 28,000 naloxone kits have been distributed by over 1,000 participating pharmacies, and at 40 public health units and community-based organizations that provide needle exchange and hepatitis C programs. In addition, new easier-to-use nasal spray kits are available through participating public health units and are being rolled out for at-risk inmates when they are released from provincial correctional facilities. The government is exploring other opportunities to make the nasal spray available for Ontarians, which may include access through pharmacies.

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To ensure that patients with opioid addiction are receiving care that allows them to balance addiction treatment and recovery with the rest of their lives, since 2016, Ontarians have had greater access to buprenorphine/naloxone (brand name Suboxone) as a first-line treatment for opioid substitution therapy.

Supervised injection services (SIS) are one part of the broader strategy that responds to growing public health concerns related to injection drug use. Community-supported and community-run SIS permit people to inject their own personally acquired drugs in controlled health care settings. As part of a larger strategy for comprehensive harm reduction, with supports for people struggling with addiction, SIS will save lives.

The government plans to fund three locations for SIS in Toronto and one in Ottawa, pending their required exemption from federal legislation, and will set up a provincial review panel to consider future applications for SIS on a case-by-case basis.

## **Preventing Fetal Alcohol Spectrum Disorder (FASD) and Supporting Those Affected by FASD**

Ontario is investing \$26 million over four years to expand support for children, youth and families affected by FASD. To increase awareness of the disorder and how it can be prevented, Ontario is supporting six initiatives that will:

- Create one-stop access to information/training resources;
- Provide funding for 56 FASD workers to support approximately 2,500 Ontarians with FASD;
- Support parent support networks;
- Increase access to FASD initiatives developed by Indigenous partners;
- Establish a consultation group to provide advice and feedback to inform implementation planning and prioritization of efforts; and
- Create a research fund and invest in knowledge mobilization.

These initiatives will help reduce the prevalence of the disorder, increase coordination of services, improve the quality of life for those with FASD, and enhance support for families and caregivers.

## Reducing Wait Times

According to the Canadian Institute for Health Information, Ontario is leading the way among all provinces and territories in the country on wait times for hip and knee surgeries, as well as MRI and CT scans.<sup>1</sup>

Over the next three years, the Province will invest \$1.3 billion in additional funding to reduce wait times, including \$890 million for key surgical and other priority procedures; \$245 million to improve specialist access, including new digital solutions to streamline consults and eReferrals; \$85 million in new home and community care services; and \$74 million to provide more timely mental health services.

### **Thousands of Patients See Benefits through Shorter Wait Times**

Over 230,000 patients have seen benefits — including shorter waits for needed surgeries, shorter hospital stays and fewer readmissions — linked to the growing use of evidence-based best practices, called Quality-Based Procedures (QBPs). QBPs have been used almost 300,000 times for 24 common conditions, including stroke, congestive heart failure, cataracts, hip fractures, and in hip and knee replacements.

QBPs promote efficient, consistent, high-quality patient care and improve patient outcomes. Providers are compensated based on an established price.

In 2017, Ontario will increase targeted QBP funding by over two per cent to address growing patient demand and reduce wait times for about 4,000 more patients. Increased funding for QBPs is projected to treat over 330 more patients with stroke, 2,800 with incremental hip or knee replacements (up eight per cent over the previous year), about 2,100 more with cataracts and over 500 more with congestive heart failure this year.

## Improving Critical Procedures and Wait Times

Since 2003, the Province has made significant investments to help reduce wait times for Ontario patients, including more than three million additional specialized priority procedures, such as hip and knee replacements, cancer radiation therapy and cataract surgeries. These investments have resulted in more than 322 million days of wait time saved for patients since 2005.

In the coming year, to help more patients access the care they need within target times, the Province is focusing investments on high-priority procedures where access is challenging or demand is increasing. These will include more than 28,000 additional MRIs, about 2,100 more cataract surgeries, as well as over 2,800 more hip or knee replacement surgeries.

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<sup>1</sup> Canadian Institute for Health Information, “Wait Times for Priority Procedures in Canada” (2017).  
[https://www.cihi.ca/sites/default/files/document/wait-times-report-2017\\_en.pdf](https://www.cihi.ca/sites/default/files/document/wait-times-report-2017_en.pdf)

This year, as part of increased funding for hospitals, Ontario will provide \$114 million to increase the number of critical services available in hospitals and help constrain wait times for treatment, including new cardiovascular procedures, expanded care for people with rare diseases, and organ transplants.

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### **Appropriate Care, When and Where It's Needed**

A key indicator of whether Ontarians are receiving care when and where they need it is alternative levels of care (ALC) utilization (the proportion of patients who no longer require hospital care but remain in hospital awaiting an available bed or appropriate services elsewhere – whether at home or in the community). Over 15 per cent of hospital beds are currently occupied by patients who are eligible for care in other settings, and who, if they could receive their care elsewhere, would open up hospital beds for others who need them.

In 2017, \$24 million in funding will be invested in new innovative models to ensure patients are receiving care in the most appropriate care settings possible – at home or in the community. These new care models will offer patients and care providers more choices and put patients first.

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## **Streamlining Access and Reducing Wait Times for Specialized Care**

The government will continue to reduce wait times for health services so that patients can access specialized care as soon as possible. Ontario is making additional investments to help improve access to specialized care providers, including \$20 million to improve timely, appropriate and transparent referral pathways to care, with improved electronic tools linking primary and specialized care providers and interprofessional team services. In addition, the government is investing \$15 million to increase the availability of insured optometry services.

### ***Innovating for Timely Specialized Care***

To streamline access to specialized care for patients being assessed for hip or knee replacement surgery, some regions are using a central intake and assessment centre. Patients who need a surgical consultation are referred to a surgeon based on their choice or the shortest surgical waitlist; those whose conditions do not require surgery receive non-surgical treatment recommendations. This program will be expanded across the province.



Ontario will expand programs like Inter-professional Spine Assessment and Education Clinics (ISAECs). ISAECs assess patients' need for treatment and work with primary and specialized care providers like chiropractors, physiotherapists and surgeons. They leverage the expertise and full scope of practice of health professionals, giving patients faster access to the care they need and reducing their risks, such as opioid addiction through pain management while awaiting treatment. In 2017, \$10 million in new funding will go towards this expansion.

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### **eConsult**

Many Ontarians already enjoy the benefits of eConsult, a web-based service in which patients have access to advice from specialists. On average, patients receive a response within three business days, and 40 per cent of eConsult cases remove the need for patients to be referred to a specialist for an in-person appointment.

Building on the successful Champlain LHIN BASE eConsult Service, the ministry plans to expand the eConsult service province-wide in 2017–18.

### **eReferral**

Working with the eHealth Centre of Excellence, physicians in Waterloo-Wellington can now use an online eReferral system to connect their patients to specialists and other health care services in their community.

In 2017–18, the ministry will explore ways to help make this innovative eReferral system available to patients across the province, starting with its expansion to at least five more LHIN areas.

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## Expanding Home and Community Care

Since 2013, the government has grown its investment in home and community care by about \$250 million per year, in addition to the government's ongoing funding of more than \$5 billion. This investment has provided more Ontarians with greater access to nursing care, personal support and caregiver support, and has been foundational to helping more people live independently at home, where they want to be. The funding has provided more services and more hours of care for patients. In 2016, 94 per cent of home care clients received home nursing services within five days of their health care provider's authorization.<sup>2</sup> Part of the home and community care funding also improved stability in the workforce and enhanced wages for personal support workers.

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### Personal Support Worker Registry

Personal support workers are at the front lines of care and provide services and supports to the most vulnerable citizens. The government will establish a mandatory registry for personal support workers so that Ontarians have peace of mind knowing that the people delivering essential care have the necessary training to care for them and their loved ones, helping them feel safe and supported. The registry will provide transparent information on details such as education and training, and adherence to a code of conduct.

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A continued investment of \$250 million in 2017–18 for community and personal support services will help meet increased demand and support faster and more equitable access to services across the province. The funding will continue to support more hours of care for complex patients, much-needed respite for caregivers, and the delivery of key improvements in mental health and addiction services. It will also help provide health care for Indigenous peoples, and support implementation of a strategy to help those affected by dementia, including their caregivers. See Chapter II: *Helping You and Your Family* for further details.

Starting in the fall of 2017, Ontario will also support more education and training programs to support caregivers. The Province is committed to the development of a caregiver toolkit, which will be available online and in paper format as a resource for these valuable care partners.

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<sup>2</sup> Health Quality Ontario website, <http://www.hqontario.ca/System-Performance/Home-Care-Performance>

Better system integration, assistance with navigation of services, increased caregiver respite and more caregiver education and training programs were all key recommendations of the “Bringing Care Home” report. The government is responding to these recommendations and the needs of caregivers by creating an organization focused on coordinating supports and information resources.

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**Ontario Caregiver Tax Credit**

To make life a little easier for caregivers so they can focus on helping loved ones, the Province proposes to simplify and improve access to tax relief by replacing the caregiver and infirm dependant tax credits with a new Ontario Caregiver Tax Credit (OCTC). For further details, see Chapter VII: *A Fair and Sustainable Tax System*.

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### **Care Teams Integrate Bundled Patient Care from Hospital to Home**

Patients are benefiting from having the support of the same interdisciplinary health care team both when being treated in hospital and later, when recovering at home. This bundled care approach supports smoother patient transitions in several cities in the province, including London, Hamilton, Brampton, Mississauga and Toronto.

Patients are seeing improved initial results:

- At four bundled-care sites, emergency department visits after release from hospital dropped by over 25 per cent.
- At two sites, patients' hospital stays were 50 per cent shorter than before.
- At three sites, hospital readmission rates declined by half.

When patients get the coordinated care they need, their health care experience is better and they benefit from better outcomes.



Helping more patients transition out of hospital and into their homes with the same health care team.

## **Faster Access to Mental Health and Addiction Services**

Mental illness results in more person-years lost to death than cancer, and requires the same determined focus on driving improvements to treatment and access to supports and services. Mental health must be seen as just as important as physical health, and prioritized equally. The Government of Ontario believes there is no health without mental health.

Phase 1 of *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (from 2011 to 2014) focused on services and supports for children and youth. Building on those, Phase 2 of the Strategy also includes adults, youth in transition and people with addictions, and is meant to ensure that every person in Ontario can access consistent, appropriate services, no matter where they live, so that Ontarians living with mental illness or addiction can recover and participate more fully in community life.

Ontario already provides more than \$3.7 billion in ongoing funding for mental health and addictions services, including those for children and youth. In February 2017, the Province announced an additional investment of \$140 million over three years to advance the expansion of important evidence-based mental health and addictions initiatives.

As outlined in *Open Minds, Healthy Minds*, the Province will create mental health and addictions services based on recommendations from Ontario's Mental Health and Addictions Leadership Advisory Council. The Council consists of representatives from diverse sectors, including experts and people with lived experience of mental illness and addictions.

Additionally, in recognition of the need to address mental health and addictions across sectors, the government is establishing a special committee of cabinet to drive system change.

Expanding effective mental health and addictions services will enable people living with mental illness or addiction to have earlier access to services in their community. This will help improve access to early identification before crises arise. Investing more in community services is expected to reduce the frequency and length of patients' stays in psychiatric facilities or hospitals, and to support people in the community.

### **Increased Access to Structured Psychotherapy**

The government is investing close to \$73 million over three years to provide greater access to publicly funded structured psychotherapy for thousands of Ontarians living with conditions like anxiety and depression. Ontario is the first province in Canada to commit to a publicly funded psychotherapy program. Structured psychotherapy helps people learn strategies to improve their mental health and their quality of life. More Ontarians will now have access to this evidence-based therapy, either online or in-person, through individual or group sessions. Meanwhile, the government will work with Health Quality Ontario and other stakeholders to develop quality standards for a provincial structured psychotherapy program.

Ontario is also exploring opportunities to better integrate patient care for major depression disorder, by improving referrals to the most appropriate health care providers and expanding tools linking primary care providers to psychiatrists. This will allow more patients to benefit from well coordinated, team-based care.

### **Providing More Supportive Housing**

Ontario is investing more than \$45 million over three years to provide up to 1,150 additional supportive housing units for those with serious mental illness or addictions who are homeless or at risk of becoming homeless. These housing units would provide residents with support services and secure, affordable, stable places to live. With these new investments, by 2019, the government will have funded a total of almost 17,000 units of supportive housing for people living with mental illness or addictions, and other vulnerable people.

## **Bringing Together Youth Services in One-Stop Hubs**

Integrated youth service hubs offer an innovative approach to the early identification of, and intervention in, mental health and addiction issues among youth and young adults to help prevent more serious conditions from developing later in life. Working in new ways with community partners, the government is developing and evaluating a network of up to nine hubs where young people aged 12 to 25 can find walk-in, one-stop access to mental health and addictions services, as well as other health, social and employment supports in a youth-oriented environment.

## **Enhancing Patient Experience**

### **Supporting Seniors in Their Communities**

Ontario is undertaking a number of important initiatives in 2017 to support the health of seniors and their families, outlined in further detail in Chapter II: *Helping You and Your Family*.

The government is launching a new Dementia Strategy that will provide more than \$100 million over three years to expand access to the most appropriate care and supports province-wide for patients and their caregivers.

The Province is also providing \$8 million over the next three years to support 40 new community centres. These centres — 263 in all — provide transportation services, social and recreational programs, and other supports to help seniors stay active and independent in their communities.

### **Enhancing Long-Term Care**

Long-term care homes provide residential care and support to some of Ontario's most vulnerable citizens. Ontario is making investments in long-term care to improve services, such as \$58 million for resident care. For additional information on long-term care homes, see Chapter II: *Helping You and Your Family*.

### **Ensuring the Best Quality of Care for Patients**

The *Excellent Care for All Act* (ECFAA) underlines the importance of quality in the health care system by defining quality for the health care sector, reinforcing the shared responsibility for quality of care, and ensuring health care organizations make information on their quality of care publicly available. Health Quality Ontario (HQO), established through ECFAA, helps improve the care delivered in Ontario by promoting health care that is supported by the best available scientific evidence. In 2017–18, HQO will be releasing quality standards in a number of clinical areas, establishing important elements of high-quality care for patients in the health system.

Every year, Health Quality Ontario publishes *Measuring Up* — a comprehensive report outlining details on the health experience of patients in Ontario so they can better understand how the system is performing.

Through its Ontario Health Technology Advisory Committee (OHTAC), HQO also makes recommendations to government regarding funding based on the best available evidence for health care services and medical devices. This advice guides important decisions on what new, innovative services and technologies should be invested in. For example, HQO advice has supported investments in 2017–18 in innovative technologies for cardiovascular care, such as Stroke Endovascular Treatment (EVT). Since 2011, OHTAC has provided the government with over 70 recommendations.

## **Making Northern Health Travel More Affordable**

The government is increasing the amount of assistance available to help patients in northern Ontario who must travel long distances to access specialized medical services.

The Northern Health Travel Grant Program helps cover medically related travel costs that residents of northern Ontario incur in order to access OHIP-insured health care services through a medical specialist or designated health care facility, unavailable locally within a radius of 100 kilometres.

Over the last three years, the program has helped over 600,000 northern Ontarians access specialized medical services or health facility-based procedures.

The investment of \$10 million will provide additional funding for northern Ontarians through an enhanced accommodation allowance. It will cover more than one night's accommodation for people who are required to stay away from home for more than one night when travelling from the north for an OHIP-insured service. This investment will ensure that the cost of travelling for northern Ontarians to receive the care they need doesn't impede their ability to access needed health care services not available close to their home.

## **Improving Care for Mothers, Babies and Children**

In 2017, Ontario will be investing in new and existing programs to improve maternal and child health. This includes a new infant hearing screen as part of the Newborn Screening Ontario program. This new screen will identify approximately 100 babies per year who are affected by hearing loss, and will allow for earlier intervention and improved outcomes. Ontario is also investing in the creation of a provincial prenatal screening program that will enhance access to standardized and high-quality prenatal screening across the province.

A new integrated health network for children, the Kids Health Alliance at Sick Kids Hospital will be introduced in Ontario and will improve the care children receive in emergency departments in hospitals across the province. This network will also achieve a more coordinated, consistent and high-quality system of health care for children and their families.

Additionally, improved supports for premature babies and their families are being made through investment in Ontario’s Human Donor Milk Bank, as well as a new program to improve access to breast pumps for mothers of premature babies.

The Province continues to invest in and support families who have experienced pregnancy or infant loss by expanding support services and improving the collection of data to support the commitments under the *Pregnancy and Infant Loss Awareness, Research and Care Act, 2015*.

Midwifery services provide low-risk birthing options to improve the quality of care and value for Ontarians. In 2017, the government will continue to support more choice and high-quality care for expectant families by continuing to grow Ontario’s midwifery sector by up to 90 new midwives. This continued growth will increase access to safe and family-centred pregnancy and newborn care for Ontario’s families across the province.

About 250 new midwives are expected to enter the profession over the next three years. Families with low-risk births will have increased choices for quality care, reducing the need for more costly hospital or specialized care.

As part of Ontario’s enhanced midwifery services program, two new Indigenous midwives will be hired at the Dilico Family Health Team Clinic in Fort William First Nation. These midwives will provide culturally appropriate child and maternity care for up to 30 Indigenous women and their children in the Robinson Superior Treaty area (the districts of Thunder Bay and Algoma) over the next three years.

The government is investing to establish a further five Indigenous midwifery programs across the province: K’Tigaaning Midwives, Powassan; Kenhte:ke Midwives, Tyendinaga Mohawk Territory; Onkwehon:we Midwives, Akwesasne; Shkagamik-Kwe Health Centre, Sudbury; and Southwest Ontario Aboriginal Health Access Centre, London. Ontario is also offering development grants to Indigenous organizations across the province to explore how midwifery services could be established in their communities.

## **Integrating Local Health Care Services**

Since 2006, Local Health Integration Networks (LHINs) have guided funding and planning for hospitals, home and community care, mental health services and long-term care. In the *2016 Budget*, following extensive public consultations as part of the “Patients First: Action Plan for Health Care,” the Province proposed to better integrate health care, particularly primary, home and community care, and to foster a closer collaboration with public health, to help ensure seamless, consistent, high-quality health care for Ontarians.

In 2017, Ontario will take the next steps to enhance the model by expanding the authority of LHINs to assume responsibility for the planning of primary care and the delivery of home and community care.



Beginning in 2017, LHINs will also start working through smaller sub-regions to ensure that individual communities' health needs are better identified and addressed. These sub-regions ensure a better, more local lens for planning and performance improvement in Ontario's diverse communities.

In alignment with the *Patients First Act, 2016*, Ontario is supporting patient engagement. The Minister of Health and Long-Term Care will establish a provincial Patient and Family Advisory Council to advise on strengthening patient engagement and key health policy priorities that impact patient care and experience, to ensure the needs and concerns of patients and caregivers are heard and understood. Each of Ontario's 14 LHINs will also establish a regional Patient and Family Advisory Committee to improve communication between patients, families and the LHINs, support improved patient care experiences, and foster patient involvement in care delivery.

## Easy Access to Health Services

Similar to businesses, international organizations and other governments, Ontario recognizes the importance and value of information and communication technologies to inform and advance patient care. The investments made to-date have laid the foundation for the digital health system in place today, and have appropriately focused on health care organizations and clinicians. It is time to do more. As Ontarians are finding new ways of using technology to make their daily lives easier and more convenient, Ontario must do the same for patients — from accessing health records online to accessing home care support for a loved one without leaving home, or using telemedicine technology.

In 2017, Ontario will release a 10-point action plan for Digital Health in Ontario, investing \$15 million focused on opening up new ways for patients and families to access health information and services digitally. These actions will strengthen the quality, effectiveness and accountability of the care delivered, and stimulate innovation and growth for the economy through investments in digital health that will reduce wait times, improve access to care, and improve the patient experience.

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### Providing Easy-to-Access Health Information

In 2017, the government will launch Ontario.ca/Health — a user-focused, mobile-friendly trusted source for information about health services in Ontario. Ontario.ca/Health will be designed to help people make informed choices about their health and effectively navigate the province's health care system. The site will be designed and organized around patient needs, based on their experience and feedback.

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## Protecting Health Care for Tomorrow

More Ontarians want to play an active role in protecting and improving their personal health and wellness, and the government can help by providing more information about smoking, and empowering Ontarians to make healthier choices.

### Encouraging a Smoke-Free Ontario

Smoking prevalence has decreased in Ontario, from 19.4 per cent in 2011 to 17.4 per cent in 2014, yet two million people still smoke. To support more Ontarians in quitting tobacco use and to address the current landscape of emerging products, the government will modernize the Smoke-Free Ontario Strategy in 2017.

The government will continue to support its strong commitment to create a smoke-free Ontario. By providing free nicotine replacement products and by investing in new smoking cessation programs across the province, Ontarians will have the support they need to quit smoking and stay healthy.

The government will also continue to build on the strategy's progress by increasing tobacco tax rates by \$10 per carton of cigarettes over the next three years, beginning with an immediate \$2 per carton increase, effective 12:01 a.m., Friday, April 28, 2017. Tobacco taxes are a proven method of supporting smoking cessation and prevention efforts, and these increases will help drive Ontario towards the lowest smoking rates in Canada.



Helping more smokers quit is part of the Smoke-Free Ontario Strategy.

### Helping Ontarians Make Healthy Choices – So They Stay Healthy Longer

- To give people the information they need to make healthier food choices, as of 2017, the *Healthy Menu Choices Act* requires food outlets with 20 or more Ontario locations to post calorie information.
- Ontario provides screening of about 140,000 newborn babies for 29 diseases that are all treatable, including metabolic, endocrine and sickle cell diseases, and cystic fibrosis. In 2003, newborns were screened for only two diseases.
- To protect Ontarians against preventable – and sometimes serious – diseases, like measles, mumps, tetanus, whooping cough and chicken pox, 23 routine vaccinations are now offered free of charge for babies, children and adults. In 2003, just 15 such vaccines were publicly funded.
- Ontario's Healthy Kids Strategy encourages kids, families and communities to support healthy behaviours and healthy weights before birth and in the early years.
- The Province's Healthy Kids Community Challenge, offered in 45 communities across Ontario, including six Indigenous communities, enhances the well-being of Ontario's children by promoting nutritious eating, physical activity and healthy behaviours.
- The Province will be providing \$5 million over five years to the Canadian Men's Health Foundation to lead initiatives that will promote and improve men's health across the province, using an outcome-based strategy to achieve patient-centric behavioural change.



The Healthy Kids Community Challenge helps create communities where it's easy for children to lead healthier lives.

## Health Innovation

With the creation of the Office of the Chief Health Innovation Strategist, the government is driving the adoption and diffusion of new health technologies and processes to improve patient outcomes, add value to Ontario's health care system and create jobs. This is part of the government's efforts to grow small and medium-sized enterprises in Ontario while transforming the health care system.

Through the \$20-million Health Technologies Fund, Ontario is improving patient care with cutting-edge health technology by providing grants for 15 new projects that will improve people's care at home and in their communities. The Ontario government will be providing grants to additional projects in the coming year. The fund supports the development of Ontario-based health technologies that improve care for people, bring value to the health care system, and create jobs.



### **Budget Talks: Accessing Digitized Health Data**

This pilot was one of the top three ideas selected by the public for funding through the Budget Talks platform.

Through this initiative, the Province will develop a proof-of-concept digital registration and public authentication service that will allow parents and/or guardians to securely and easily access their child's "Yellow Card" immunization records electronically, using their banking credentials. This digital process may be expanded to test a Patients' First Access Channel where patients can find their health data (e.g., lab records, current medications, hospital visits), regardless of where the digital record actually resides.

The idea will receive a one-time investment of \$1 million in 2017-18, and progress updates will be provided throughout the year at [Ontario.ca/budgettalks](http://Ontario.ca/budgettalks).

### **Spotlight on Innovative Technology**

**BresoDx** — A simple-to-use, cordless diagnostic device for obstructive sleep apnea. It provides a more patient-centred option for sleep testing because it is suitable for use at home instead of a sleep laboratory. Left untreated, sleep apnea can lead to serious health complications, including increased risk of hypertension, stroke and heart failure. Funded by the Ministry of Health and Long-Term Care, the MaRS EXCITE program demonstrated the benefits of BresoDx, the first technology to complete the EXCITE program.

## **Health System Research Fund**

The need for scientific evidence to solve complex health sector challenges is greater now than ever before. Ontario will continue to invest in the Health System Research Fund (HSRF) including two new awards in 2017: the Program Awards and the Targeted Call for Nursing Research. By fostering collaboration between the researchers and knowledge users, this Fund is contributing to strategic health system priorities and delivering on the Patients First Action Plan.

March 24, 2017

Hon. Dr. Eric Hoskins, Minister  
Ministry of Health and Long-Term Care  
Hepburn Block, 10<sup>th</sup> Flr  
80 Grosvenor St  
Toronto ON M7Z 2C4

**TRANSMITTED BY FAX AND EMAIL**

Dear Minister Hoskins:

**Re: Response of the Ontario College of Pharmacists to Bill 87**

The College welcomes the opportunity to provide input to the proposed amendments to the *Regulated Health Professions Act (RHPA)* found in Schedule 4 of Bill 87, the *Protecting Patients Act, 2016*.

Introduction

The Ontario College of Pharmacists is the registering and regulating body for the profession of pharmacy in Ontario. The College's mandate is to serve and protect the public and hold Ontario's pharmacists and pharmacy technicians accountable to the established legislation, standards of practice, code of ethics, and policies and guidelines relevant to pharmacy practice. The College is also the accrediting and oversight body for the operation of pharmacies.

The College strongly supports the objectives of Bill 87 to strengthen the sexual abuse and transparency provisions of the RHPA. We have reviewed the measures contained in the proposed legislation with our health regulatory colleagues, achieving consensus on many of the items as detailed in the February 27, 2017 submission of the Federation of Health Regulatory Colleges of Ontario. This includes a number of drafting issues, which we ask be given close scrutiny.

In conjunction with other health regulators, the College has been taking steps over the past several years to increase transparency and provide patients with the information they need to make decisions about their care and treatment. To that end, the College has exceeded the requirements of the current legislation and enhanced the information posted on the Public Register, including posting criminal charges, findings of guilt, and custody or release conditions, enhancements that are

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proposed in Bill 87. The College supports maintaining the by-law authority that permits Council to add categories of information to the existing list of what is posted on the register

The College believes that timely and concerted collaboration with Ministry staff throughout the drafting process will improve the efficiency and effectiveness of the regulation making process, leading to an optimal framework to support the identification, investigation and prosecution of sexual abuse.

Recently, the College worked collaboratively with Ministry staff to draft an outcome-based regulation in support of the *Drug and Pharmacies Regulation Act*. As a result, the College has more flexibility to act in the public interest through the development of policies and guidelines to support patient protection outcomes. This approach permits the College to address issues that affect public protection much more quickly than a regulatory process.

In reviewing the legislation, the College has identified areas where an outcome-based high-level approach would provide regulators with the ability to act quickly and efficiently in achieving the goals of the legislation. It is in this spirit of support that the College offers the feedback provided below.

**1. Committee and Panel Structures:**

Without more information, it is difficult to evaluate what changes will be proposed; however, an outcome-based approach could be used to articulate the qualifications required by potential members. We note that any measures that would rebalance committee and panel structures by adding additional public members would also need to address the appointment process, potentially by working closely with regulators to establish criteria.

In the event of enhanced public participation on committees and panels, the College proposes that the appointment of public members be directed to the Inquiries, Complaints and Reports and Discipline Committees. There will also need to be resources and a robust training and education process established to prepare public members to participate in the process.

The College proposes that the Ministry consult specifically on the addition of functions for the Patient Relations Committee, including seeking and incorporating feedback from existing committee members.

**2. Funding for Sexual Abuse:**

The College supports the proposal to provide earlier funding to individuals who may have been sexually abused and to expand the types of expenses for which funding is made available. This will permit an individual to choose to use the funds in whatever way best supports them, whether it is counselling, transportation or child support.

The College also recommends flexibility in determining which individuals are eligible for funding. There may be situations where patients may wish for their name to be withheld from mandatory reports, but would qualify for support.

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Finally, as drafted, it appears that the ability to provide funding to patients through alternative criteria as established by this College through Part X of O Reg 202/94, will be removed. If this is the case, it would be a disservice to those individuals who are currently eligible for funding through this mechanism.

**3. *Mandatory Revocation:***

The College fully supports this penalty for conduct relating to sexual abuse. More discussion is required to determine how it would be applied in additional circumstances of egregious professional or proprietary misconduct. The College requests an opportunity to participate in further dialogue on this issue.

**4. *The Definition of 'Patient' for Sexual Abuse Purposes:***

This is an area requiring latitude among health regulators in order to establish a definition in keeping with the scope of practice, type of contact between members and patients, and consideration of the appropriate length of time that a person will be deemed to be a 'patient' for sexual abuse purposes.

A recent jurisdictional review of pharmacy regulators failed to identify a clear definition of 'patient' for this health profession. Some regulators use the term 'client' to describe the recipient of services, given the variety of practice settings and contexts in which pharmacy professionals are employed. Other jurisdictions define patient according to whether a member provides a service within the scope of practice, which does not entirely reflect the types of potential contact between a pharmacy professional and an individual. In a community pharmacy, it may well be best to define 'patient' according to access to personal health information and an ongoing professional relationship.

While it is laudable to envision a time-limit when a person will no longer be considered a patient, as this is a clear measure easily understood by all, in some circumstances more than a year may elapse from the last to the next clinical contact between a patient and a provider. However, an individual may continue to regard him or herself as a patient of that provider and would be troubled by contact that falls outside the expected interaction.

The College suggests a criteria based approach to this issue and requests further engagement to assist in the development of a definition that will minimize or avoid unintended consequences.

**5. *Alternate Dispute Resolutions and Withdrawals of Complaints***

The College supports the provision of authority to the Registrar to approve Alternate Dispute Resolutions (ADR) and withdrawals of complaints by complainants when in the public interest. In participating in the ADR process, members may develop insight into the impact of their conduct on the patient, as well as the potential to view behaviour from the patient's perspective.

The College recommends further study to determine the impact of setting a time limit to achieve a good resolution, as this may reduce the ability to reach an agreement in the public interest where the parties are negotiating in good faith. Alternatively, in some cases, the College would benefit from an earlier resumption of an investigation into a complaint if ADR is likely to fail through a lack of good faith or the withdrawal of one party from the process.

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## **Additional Legislative Changes**

### **1. Early Interim Suspension**

The College supports this measure under the RHPA as it will lead to an early removal from practice of individuals who are unsafe and unethical. As Bill 87 is an omnibus piece of legislation, permitting changes to multiple statutes, the College recommends extending this measure to the *Drug and Pharmacies Regulation Act (DPRA)*.

The DPRA and its related regulations provide the framework for the College to regulate pharmacy practice sites in Ontario and to issue certificates of accreditation to community and hospital pharmacies. Within the context of the accreditation process, the College has the authority to apply terms, limits or conditions on a certificate of accreditation, or revoke a certificate where it is appropriate to do so. Patient safety and protection will be enhanced by permitting the Accreditation Committee to order an immediate interim suspension of a pharmacy's certificate of accreditation where it is in the public interest to do so.

The College notes that with the proposed provisions to the RHPA, an existing historical disconnect between the DPRA and the RHPA will increase, such that wording in some sections will no longer make sense. We are very concerned about the effect this will have on the activity of the Accreditation Committee, a statutory committee dealing with matters relating to the operation of pharmacies. The College requests an opportunity to discuss this issue further.

### **2. Discretionary Disclosure of Information to the Police**

At present the College can only provide information to police about a member. The College recommends that the confidentiality provisions in the legislation be amended to permit the College the discretion to provide information to the police about a non-member, when it is in the public interest to do so.

### Conclusion

The College looks forward to working with you as the Bill moves through the legislative process. In addition to offering our suggestions and support for continued discussion on measures to identify, investigate and prosecute sexual abuse, we recommend a joint review to determine how we can use this opportunity to strengthen our regulatory oversight of pharmacies. We are available to collaborate with you and to provide any further information that might be helpful.

Sincerely,



Régis Vaillancourt, OMM, CD, BPharm, PharmD, RPh  
President



Nancy Lum-Wilson, RPh, BScPhm, MBA  
CEO and Registrar

c.c. Dr. Bob Bell, Deputy Minister, Ministry of Health and Long-Term Care  
Ms. Denise Cole, Assistant Deputy Minister  
Ms. Allison Henry, Director, Health System Labour Relations and Regulatory Policy Branch  
Mr. Stephen Cheng, Manager (Acting), Regulatory Policy Unit

**Ministry of Health  
and Long-Term Care**

**Ministère de la Santé  
et des Soins de longue durée**

Health Workforce Planning and  
Regulatory Affairs Division

Division de la planification et de la réglementation  
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**MAY 19 2017**

HLTC2968IT-2017-110

Dear Registrars:

As you are aware, the ministry has engaged Deanna Williams to undertake work relating to the recommendations of the Sexual Abuse Task Force. I am writing to let you know that Ms. Williams has officially begun her work with the ministry and may be reaching out to you in the coming weeks and months to seek your opinions and perspectives as regulators.

Ms. Williams will be providing advice and expertise to the ministry on four key areas:

1. Best practices in Ontario and other jurisdictions in the intake of complaints, investigation and discipline of misconduct matters, including sexual abuse.
2. Best practices in Ontario and other jurisdictions with regards to patient supports and patient relations provided at the college level.
3. Best practices in Ontario and other jurisdictions in college governance and college committee membership.
4. Review and analysis of the Task Force recommendations to establish independent bodies responsible for the investigation and adjudication of sexual abuse matters.

While thematically similar to the proposed amendments to the *Regulated Health Professions Act, 1991* (RHPA) included in Bill 87, the *Protecting Patients Act, 2016*, I want to stress that Ms. Williams' work is entirely independent from that Bill. The ministry anticipates that most of the advice resulting from her work would be implemented via policy and programmatic changes as well as through regulation-making authorities. The ministry is not contemplating, at this time, further amendments to the RHPA beyond the provisions currently being debated as part of the legislative process around Bill 87.

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- 2 -

I trust that you will provide Ms. Williams with the same support you have demonstrated to the ministry to date. I look forward to continued partnership and collaboration as we move forward.

Sincerely,



Denise Cole  
Assistant Deputy Minister  
Health Workforce Planning and Regulatory Affairs Division

803 81 7347

Enclosure

- c: Presidents, Health Regulatory Colleges  
Dr. Robert Bell, Deputy Minister, Ministry of Health and Long-Term Care  
Derrick Araneda, Chief of Staff, Office of the Hon. Dr. Eric Hoskins  
Allison Henry, Director, Health System Labour Relations and Regulatory Policy Branch

**Ontario Passes Legislation on Medical Assistance in Dying**  
*Province Providing Clarity and Protection for Patients and Health Care Providers*  
May 9, 2017 12:16 P.M.

Ontario passed legislation today that will support the implementation of medical assistance in dying in the province by providing more protection and greater clarity for patients, their families, health care providers and health care institutions.

Federal legislation, which came into force in June 2016, sets out the parameters for how medical assistance in dying can be provided. Ontario's Medical Assistance in Dying Statute Law Amendment Act aligns with the federal legislation and will address areas that fall under provincial jurisdiction.

The Medical Assistance in Dying Statute Law Amendment Act will ensure:

- Benefits, such as insurance payments and workplace safety and insurance benefits, are not denied only because of a medically assisted death
- Physicians and nurse practitioners, those who assist them, and care provider institutions, are protected from civil liability when lawfully providing medical assistance in dying, except in cases of negligence
- Identifiable information about individuals and facilities that provide medical assistance in dying are protected from disclosure under access to information requests
- Effective ongoing reporting and monitoring by the Chief Coroner of Ontario for cases of medical assistance in dying.

The Ministry of Health and Long-Term Care will also be establishing a care coordination service to assist patients and caregivers in accessing additional information and services for medical assistance in dying and other end-of-life options.

Ontario has also worked with many health care partners to develop information, tools and training to support patients, caregivers and health care providers on medical assistance in dying-related matters.

## QUOTES

" It is critical that end-of-life care, including medical assistance in dying, is provided safely and compassionately. This legislation will help ensure that patients, health care providers and health care institutions have more clarity and effective legal protection when medical assistance in

dying takes place. "

- Dr. Eric Hoskins

Minister of Health and Long-Term Care

## QUICK FACTS

- Ontario's health regulatory colleges for physicians, nurses and pharmacists provide additional guidance to help their members provide appropriate medical assistance in dying.
- Ontario has established a Clinician Referral Service to support physicians and nurse practitioners in making effective referrals for patients seeking medical assistance in dying.
- Ontario's approach to medical assistance in dying has also been informed by public consultations, with thousands of Ontarians, health care providers and stakeholders sharing their views through in-person and online consultations.
- Ontario is investing \$155 million over three years to improve community-based palliative and end-of-life care.

## LEARN MORE

- [Details on medical assistance in dying](#)
- [Information for health care providers](#)
- [The Medical Assistance in Dying Statute Law Amendment Act](#)

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HLTC2972IT-2017-81

Dr. David Rouselle  
President  
College of Physicians and Surgeons of Ontario  
80 College Street  
Toronto ON M5G 2E2

Ms. Megan Sloan  
President  
College of Nurses of Ontario  
101 Davenport Road  
Toronto ON M5R 3P1

Mr. Regis Vaillancourt  
President  
Ontario College of Pharmacists  
483 Huron Street  
Toronto ON M5R 2R4

Dr. Ronald Yarascavitch  
President  
Royal College of Dental Surgeons of Ontario  
6 Crescent Road  
Toronto ON M4W 1T1

Dear Dr. Rouselle, Ms. Sloan, Mr. Vaillancourt, and Dr. Yarascavitch:

I am writing to you, as Presidents of colleges that regulate professions with opioid prescribing authority, to thank you for your ongoing efforts in the fight against opioid addiction and overdose, and to ask you and your members for your continued commitment.

Last Fall, we announced Ontario's first comprehensive Strategy to Prevent Opioid Addiction and Overdose, to improve access to pain management and also reduce the harms associated with both illicit opioid use and the inappropriate use of prescribed opioids. A core component of the Strategy is to modernize prescribing and dispensing practices to align with evidence-based guidelines and standards. This will not only improve patient outcomes such as reduced pain and improved function but also reduce the incidence of Opioid Use Disorder, overdose, or other adverse events related to these drugs.

As you are aware, the update of the *Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* was released May 8, 2017, which provides 10 recommendations on when to initiate, continue, taper, and discontinue opioids for chronic pain. Health Quality Ontario, together with patients, clinicians, researchers and other health sector partners, is also developing two quality standards on appropriate opioid prescribing for chronic and acute pain, as well as a quality standard on Opioid Use Disorder. These quality standards will be shared for public consultation in the Fall and released in March 2018.

I am asking for your support in ensuring that your members are aware of these guidelines and standards and that they are incorporated into their practices as appropriate.

I have asked ministry staff to work collaboratively with you and with our other sector partners in health care training and education to develop a comprehensive plan to ensure that all health care professionals receive the training and supports they need to appropriately prescribe or dispense opioids. Staff will be in contact with you shortly to discuss how we can work together to leverage existing resources and expertise to move this forward as quickly as possible.

I would like to thank you for your continued contributions to the healthcare system in Ontario and I look forward to collaborating on this important endeavour.

Yours sincerely,



Dr. Eric Hoskins  
Minister

- c: Dr. Rocco Gerace, Registrar, College of Physicians and Surgeons of Ontario  
Anne Coghlan, Executive Director and Chief Executive Officer, College of Nurses of Ontario  
Nancy Lum-Wilson, Registrar and Chief Executive Officer, Ontario College of Pharmacists of Ontario  
Irwin Fefergrad, Registrar, Royal College of Dental Surgeons of Ontario  
Dr. Robert Bell, Deputy Minister, MOHLTC  
Denise Cole, Assistant Deputy Minister, HWPRAD, MOHLTC  
Suzanne McGurn, Assistant Deputy Minister and Executive Officer, OPDP, MOHLTC  
Melissa Farrell, Assistant Deputy Minister, HSQFD, MOHLTC  
Lynn Guerriero, Assistant Deputy Minister, NAMD, MOHLTC  
Dr. David Williams, Chief Medical Officer of Health and Provincial Overdose Coordinator, MOHLTC  
Dr. Joshua Tepper, Chief Executive Officer, Health Quality Ontario.

**Date:** May 16, 2017  
**To:** Executive Committee  
**From:** Mark Scanlon, OCP Representative on NAPRA  
**Re:** NAPRA Meeting Update – April 2017

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The NAPRA Board of Directors April meetings in Ottawa, 2017, proceeded smoothly and quickly, culminating in a one day meeting instead of the two days which had been previously scheduled. Much of the material was presented “for information only”, and very little “decision-required” information was present.

However, two topics generated the lion’s share of the discussion.

### **Cannabis**

- NAPRA has developed a cannabis Position Statement (see attached). Registrars are taking the draft statement back to their respective Councils for input prior to finalizing.
- work is ongoing on this matter

### **Governance Review**

- the current goal is to transition into the new governance model at the November NAPRA meeting
- current concerns include questions about how NAPRA is going to measure success of the new model, decision-making principles, and anticipate guideline and by-law amendments
- risk evaluation and mitigation strategies are being evaluated
- next steps include an interim report, anticipated in August
- in order to help ensure a relatively smooth transition into the new governance model, a recommendation was made to have the current executive be re-elected to the same positions. Consequently, Anjli Acharya remains as President, Craig Connelly will remain as Past-President, and Linda Henchman will continue as Vice-President.

Respectfully submitted,

Mark F. Scanlon, R.Ph.  
OCP Representative on NAPRA



## EXTENDING THE BEYOND-USE DATE FOR STERILE PREPARATIONS

### GUIDELINE

**Approved:**

#### References

- National Association of Pharmacy Regulatory Authorities (NAPRA) *Standards for Pharmacy Compounding of Non-hazardous Sterile Preparations* and *Standards for Pharmacy Compounding of Hazardous Sterile Preparations*

**College Contact:** Pharmacy Practice

#### Introduction

The NAPRA *Standards for Pharmacy Compounding of Non-hazardous Sterile Preparations* and *Standards for Pharmacy Compounding of Hazardous Sterile Preparations* were approved by the College Council in September 2016 for adoption and implementation in Ontario pharmacies by January 1, 2019. The College is providing pharmacies with tools to support implementation of the standards. This guidance is preliminary and will be updated as technology and practice evolves.

In all circumstances, patient safety is the primary concern. Every compounded preparation must be prepared using aseptic technique. Risks to patients are reduced when the established beyond-use dates (BUD) dates are applied according to a verified process.

BUDs are based on the risk that a preparation may be contaminated. An organization choosing to extend the BUD of a sterile preparation is expected to be able to provide the following:

- Risk assessment;
- Rationale and process;
- Evidence to support the stability of the preparation in the final container and storage conditions;
- Batch specific evidence to demonstrate sterility; and
- Consultation and involvement of microbiology, and infection prevention and control.

Practitioners and/or organizations have a responsibility to ensure that any process used to prepare a sterile compounded preparation is verified and that there is no contamination of the preparation.

The following principles will assist practitioners to determine whether to extend the BUD of a compounded preparation.

#### PRINCIPLES:

1. The NAPRA standards are understood and met;
2. Patient safety guides decision-making;

3. A process of continuous quality improvement is applied to maintaining the environment, training staff and confirming competencies, and with respect to data gathering and analysis; and
4. The anticipated urgency for access to a preparation is considered.

## **PREAMBLE TO THE DISCUSSION – CANNABIS DISTRIBUTION THROUGH PHARMACIES**

Prior to discussion of the issue Council members are asked to reflect on the Conflict of Interest provisions in the Council Governance Manual. While declarations of conflict will be called for in advance of discussion, members are encouraged to discuss the matter with the Registrar in advance of the meeting.

### **Conflicts of interest:**

The College's Governance Manual states:

A conflict of Interest can be defined as a personal or financial interest that would reasonably be viewed in all of the circumstances as influencing a Council or Committee member's ability to make an impartial and objective decision. A conflict of interest can be actual or potential.

Council members should examine whether they might have an actual or potential conflict of interest in this matter. For example, a Council member who is affiliated with a retail pharmacy organization that is advocating for the distribution of cannabis through pharmacies may have a conflict of interest. Similarly, if the affiliated organization is planning to pursue licensure as a producer of cannabis a conflict may need to be declared.

Conflict of interest issues are always dependent on the details of the circumstances. For example, if the vast majority of the profession is in a similar position as a professional Council member, it is less likely that participating in the discussion is a conflict of interest. Alternatively, if only one or two Council members are affected by the conflict of interest concern, it is more likely that they should declare the concern and withdraw from the discussion. Similarly, a member of Council or their employer who is actively considering certain action that will be materially affected by the decision is more likely to have a conflict of interest.

Some questions that might assist a Council member in assessing whether the position or interests of their employer creates a conflict of interest are as follows:

1. Whether their employer is advocating on the issue;
2. How vigorous / extensive those advocacy activities are;
3. Whether the Council members have been or are likely to be involved in the discussions on the issue by their employer or their employer's advocacy activities;
4. Whether the Council member has is likely to obtain confidential information from their employer about the issue that is potentially relevant to the Council discussion;
5. The position of the Council member with their employer (i.e., the more senior and responsible the position, the more likely there may be a conflict of interest);
6. The financial impact of any Council decision on their employer;
7. Whether their employer is advocating for a special status for a portion of the profession (e.g., pharmacy chains only) or for the entire profession (i.e., the more exclusive the advocacy position the more obvious that it has a commercial advantage for them);
8. Whether the Council member has made either private or public statements on the issue and, if so, the degree of definiteness of those statements;
9. Whether their employer has spoken to the Council member on the issue with even a greater emphasis on this factor if the conversation was about how the College would deal with the issue; and

10. How closely the issue relates to the core public interest mandate of the College. This consideration can affect the perception in different ways. For example, if the issue goes to the very heart of the public interest mandate of the College (e.g., unsafe or unethical practices), the Council member needs to ensure there is no perception of dual loyalties. On the other hand, if the issue has minimal public protection implications, the perception of pursuing the issue at Council may be that it is being discussed primarily because of the commercial advantages the issue bestows.

In addition, Council members should consider any other circumstance that might be relevant to the perception that the Council member may give weight to their employer's position or interests in the issue.

While some of these questions may create an almost automatic conflict of interest (e.g., question 3 on whether the Council member is an active participant in their employer's advocacy activities on the issue), others may have a cumulative impact on the conflict of interest issue.

Where there is an apparent conflict of interest concern, a Council member should not turn a "blind eye" to it. For example, if a Council member suspects that the proposal may materially affect the position or interests of their employer, but does not make any inquiries as to the likely extent of the impact of the proposed changes, they do not benefit from this "willful ignorance".

Where there is a possible conflict of interest, Council members should pursue the following process:

1. **Discuss.** Consult with the President, College staff and, if they recommend, legal counsel if there is any possibility of a conflict. If all agree there is no possible conflict of interest, the process can end there. If all agree that there is a clear conflict of interest, declare it and withdraw from the discussion.
2. **Disclose.** If the matter is unclear, disclose the material facts to the Council for discussion. Depending on the circumstances, Council may suggest you withdraw from the discussion or may be confident there is no conflict of interest. Either way, your colleagues and the public will be aware of the circumstances. And there will be a record of the disclosure.
3. **Declare.** If at any point you or Council determines there is a conflict of interest, declare it, leave the room while the matter is being discussed, and do not try to otherwise influence the decision.