Ontario College of Pharmacists
Putting patients first since 1871

Agenda

ONTARIO COLLEGE OF PHARMACISTS

COUNCIL MEETING AGENDA

MONDAY, SEPTEMBER 18, 2017 – 9:00 A.M. – 3:00 P.M.

TUESDAY, SEPTEMBER 19, 2017 – 9:00 A.M. START

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 September 2017 Council ..... Appendix 1
4.2 Briefing Note - June 2017 Council Meeting Evaluation ..... Appendix 2

5. Annual Council Member Orientation and Committee Chair Training
9:15 a.m. to 11:30 a.m. - conducted by Mr. Richard Steinecke

6. Approval of Minutes of Previous Meeting
6.1 Minutes of June 2017 Council Meeting ..... Appendix 3

7. Notice of Motions Intended to be Introduced

8. Motions, Notice of Which Had Previously Been Given

9. Inquiries

10. Briefing Note - Registrar's Report on Election of Members to Council Appendix 4

11. Briefing Note - Elections Committee..... Appendix 5

12. Appointment of Tellers *(Electronic voting will be used)*

13. Election of President

14. Election of Vice President

15. Past President Award

16. Appointment of Nominating Committee

17. Election of Executive Committee Members

18. Election of Committee Chairs

19. Matters Arising from Previous Meetings

19.1 Briefing Note – Council – Cannabis for Medical Purposes ..... Appendix 6
19.2 Briefing Note – Opioid Task Force – Opioid Strategy .....Appendix 7

20. For Decision

20.1 Briefing Note – Finance and Audit Committee (2018 Proposed Budget) .....Appendix 8
20.2 Briefing Note – Finance and Audit Committee (Appointment of Auditor) .....Appendix 9
20.3 Briefing Note – Registration Committee (Regulation amendments) .....Appendix 10
20.4 Briefing Note – Quality Assurance Committee (Regulation amendments) Appendix 11

21. For Information

21.1 Briefing Note - Registrar's Report to Council .....Appendix 12
- Strategic Priorities Progress Update
- Ministry/Government Activities
- Legislative Initiatives
- Federal/Provincial Initiatives
- Inter-Professional Relationships
- Other Stakeholder Meetings
- Miscellaneous Items

21.2 Briefing Note – Statutory and Standing Committee Reports .....Appendix 13

22. Other Matters

22.1 Presentation by Dr. David Juurlink – Opioids
(Time: 2:00 p.m. – Monday, September 18)
22.2 Presentation by Ms. Lum-Wilson – *The Protecting Patients Act:* Status Update
22.3 Approval of Appointments to Statutory and Standing Committees

23. Unfinished Business

24. Registrar's Annual Performance Appraisal – *in camera*

25. 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.

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Ontario College of Pharmacists
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COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Régis Vaillancourt, President

TOPIC: President's Report to September 2017 Council

ISSUE: As set out in the Governance Manual, the President is required to submit a report of activities at each Council meeting. As well, annually, a summary report of attendance record of Council members at Council and Committee meetings is to be provided so that Council can hold itself accountable on this measure of performance. Furthermore, to strengthen the College's governance process, Council members are expected to participate in a year end assessment to evaluate how Council performs as a group as well as individually.

BACKGROUND: I respectfully submit a report on my activities since the June 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.

Attached to my report is a summary of Council member attendance at meetings and a summary of the Council and Council member evaluation, the results of which will assist us in understanding and recognizing what is working well and identifying areas for improvement as we strive to advance the College's mandate to serve and protect the public interest.

College Meetings:
June 13th - Teleconference – Opioid Task Force Meeting
June 28th – Discipline Committee Meeting
July 7th – Opioid Task Force Meeting
July 13th - Teleconference – Opioid Task Force Meeting
July 17th – Discipline Committee Meeting
July 25th - Teleconference – Opioid Task Force Meeting
August 15th – Finance and Audit Committee Meeting
August 31st - OCP/OPA Conjoint Meeting; Executive Committee Meeting, Elections Committee meeting

Other Stakeholder Meetings:
June 15,16th – OPA Conference, London

COUNCIL

Meeting Dates: **√ = attended** **X = not attended**	**Sept. 19 2016**	**Sept. 20 2016**	**Nov 24 2016**	**Dec 12 2016**	**Mar 20 2017**	**Jun 12 2017**
Chair: Régis Vaillancourt	√	√	√	√	√	√
Kathy Al-Zand	√	√	√	√	√	√
Linda Bracken	√	√	√	√	√	√
Heather Boon	√	√	x	√	√	x
Billy Cheung	√	√	√	√	√	√
Gerry Cook	√	x	√	x	√	x
Carol-Ann Cushnie	√	√	√	√	√	√
Christine Donaldson	√	√	√	√	√	√
David Edwards	√	√	√	√	√	√
Ronald Farrell[1]	√	√	√			
Michelle Filo[2]	√	√	x			
Christine Henderson[3]						√
Naj Hassam[4]			x	x	√	
Javaid Khan	√	√	√	√	√	√
Fayez Kosa	√	√	x	x	√	x
John Laframboise[5]	√	√	√	√		
Chris Leung	√	√	√	√	√	√
Jon MacDonald	√	√	√	x	√	√
James MacLaggan	√	√	√	x	√	x
Elnora Magboo[6]					√	x
Esmail Merani	√	√	√	√	√	√
James Morrison	√	√	√	√	√	√
Sylvia Moustacalis	√	√	√	√	√	√
Don Organ	√	√	√	√	√	√
Joan A Pajunen[7]					√	√
Goran Petrovic	√	√	√	√	√	√
Tracey Phillips	√	√	√	√	√	√
Sony Poulose	√	√	√	√	√	√
Shahid Rashdi	x	x	√	√	√	x
Karen Riley	√	√	x	√	√	√
Joy Sommerfreund	√	√	√	√	x	√
Doug Stewart	√	√	x	√	√	√
Ravil Veli	√	√	√	√	√	√
Wes Vickers	√	√	x	√	√	x
Laura Weyland	√	√	√	√	√	√

1. Mr. Farrell resigned December 2, 2016
2. Ms. Filo resigned January 2, 2017
3. Ms. Henderson was appointed April 26, 2017
4. Mr. Hassam was appointed October 5, 2016 and resigned May 17, 2017
5. Mr. Laframboise resigned January 11, 2017
6. Ms. Magboo was appointed January 11, 2017
7. Ms. Pajunen was appointed March 1, 2017

ACCREDITATION COMMITTEE

Meeting Dates: **✓ = attended** **X = not attended**	**Oct. 26 2016**	**Feb. 22 2017**	**May 3 2017**	**June 1 2017**	**June 27 2017**	**Aug. 2 2017**
Council Members						
Chair: Tracey Phillips	√	√	√	√	x	x
Billy Cheung	√	√	√	x	x	√
Michelle Filo[1]	√					
John Laframboise[2]	√					
Elnora Magboo[3]		√	√	√	√	√
James Morrison	√	√	x	√	√	√
Joy Sommerfreund	√	√	√	x	x	√
Non-Council Members						
Lavinia Adam	√	√	√	√	x	x
Tracy Wiersema	√	√	√	√	√	√

1) Ms. Filo resigned January 2, 2017
2) Mr. Laframboise resigned January 11, 2017
3) Ms. Magboo appointed to Accreditation Committee January 26, 2017

DRUG PREPARATION PREMISES

Meeting Dates: **√ = attended** **X = not attended**	**February 22 2017**
Council Members	
Chair: Tracey Phillips	√
Billy Cheung	√
Elnora Magboo	√
James Morrison	√
Joy Sommerfreund	√
Non-Council Members	
Lavinia Adam	√
Tracy Wiersema	√

Meeting Dates: **√ = attended** **X = not attended**	**Orientation** **Nov. 4, 2016**	**Discipline Training** **Nov 28, 2016**	**Spring Meeting** **April 18, 2017**	**Summer Meeting** **July 17, 2017**
Council Members				
Chair: Doug Stewart	√	√	√	√
Kathy Al-Zand	√	√	√	√
Linda Bracken	√	√	√	√
Heather Boon	X	X	√	√
Gerry Cook	X	√	X	X
Carol Cushnie [1]	√	√	X	√
Christine Donaldson	√	X	√	X
David Edwards	X	X	X	X
Najmudin Hassam[2]	√	√	√	
Christine Henderson[3]				√
Javaid Khan	√	X	√	√
Fayez Kosa	X	X	√	X
Christopher Leung	√	√	√	√
Jon MacDonald	√	X	√	X
James MacLaggan	√	X	√	X
Esmail Merani	X	X	X	X
Sylvia Moustacalis	√	√	√	√
Don Organ	√	X	√	√
Joan Pajunen [4]			√	√
Goran Petrovic	X	X	X	X
Sony Poulose	√	√	√	X
Karen Riley	√	√	√	√
Shahid Rashdi	√	X	X	√
Regis Vaillancourt	√	√	√	√
Ravil Veli	√	√	√	√
Wes Vickers	X	X	√	√
Non-Council Members				
Chris Aljawhiri	√	√	√	√
Jennifer Antunes	√	√	√	√
Ramy Banoub	√	√	√	√
Jocelyn Cane	√	X	X	X
Charles Chan	√	√	√	√
Fel dePadua	√	√	√	X
Dina Dichek	√	√	√	√
Debbie Fung	X	X	X	X
Jim Gay	√	√	√	√
Jillian Grocholsky	√	√	√	√
Sherif Guorgui [5]	√	X	√	
Andrew Hanna	√	X	√	√
Rachel Koehler	√	√	√	√
Andreea Lachuk	√	√	√	√
Jaime MacDonald	√	X	X	X
Cara Millson	X	√	X	√
Akhil Pandit Pautra	√	√	√	√
Chintan Patel	√	√	√	X
Kelly Pogue	X	X	X	X
Mark Scanlon	√	√	√	√
Jeannette Schindler	√	√	√	√
Connie Sellors	√	√	√	√
David Windross	X	√	√	√

1) Ms. Cushnie resigned July 29, 2017
2) Mr. Hassam resigned May 17, 2017
3) Ms. Henderson appointed to Discipline Committee May 16, 2017
4) Ms. Pajunen appointed to Discipline Committee March 20, 2017
5) Mr. Guorgui resigned June 14, 2017

EXECUTIVE COMMITTEE

Meeting Dates: **√ = attended** **X = not attended**	**Nov. 24 2016**	**Mar. 2 2017**	**May 25 2017**	**Aug. 31 2017**
Chair: Régis Vaillancourt	√	√	√	√
Kathy Al-Zand[1]		√	√	√
Christine Donaldson	√	√	√	√
Esmail Merani	√	√	√	√
Sylvia Moustacalis	√	√	√	√
Joy Sommerfreund	√	√	√	√
Laura Weyland	√	√	√	√

1) Ms. Al-Zand was appointed November 2016

FINANCE AND AUDIT COMMITTEE

Meeting Dates: **√ = attended** **X = not attended**	**January 5 2017**	**February 27 2017**	**August 15 2017**	**August 22 2017 (teleconf)**
Chair: Javaid Khan	√	x	√	√
Linda Bracken	x	√	√	√
Gerry Cook	√	x	√	√
Esmail Merani	√	√	√	√
Doug Stewart	√	√	√	√

FITNESS TO PRACTISE COMMITTEE

Meeting Dates: **√ = attended** **X = not attended**	**Orientation Nov. 25, 2016**
Council Members	
Chair: Kathy Al-Zand	√
Carol Cushnie [1]	√
James Morrison	√
Goran Petrovic	x
Non-Council Members	
Jocelyn Cane	√
Mark Scanlon	√

1) Ms. Cushnie resigned July 29, 2017

INQUIRIES, COMPLAINTS, AND REPORTS COMMITTEE

Meeting Dates: **√ = attended** **X = not attended**	**Orientation October 13, 2016**	**Mid Year April 11, 2017**
Council Members		
Chair: Laura Weyland	√	√
Kathy Al-Zand	X	√
Linda Bracken	√	√
Billy Cheung	√	√
Gerry Cook	X	√
Carol Cushnie[1]	X	√
Christine Donaldson	√	√
Ronald Farrell[2]	√	
Michelle Filo[3]	X	
Naj Hassam[4]		√
Christine Henderson[5]		
Javaid Khan	√	√
John Laframboise[6]	X	
Chris Leung	√	√
Jon MacDonald	X	X
James MacLaggan	X	X
Elnora Magboo[7]		√
James Morrison	√	√
Sylvia Moustacalis	X	√
Joan Pajunen[8]		√
Goran Petrovic	X	X
Sony Poulose	√	√
Shahid Rashdi	X	√
Joy Sommerfreund	X	X
Ravil Veli	√	√
Wes Vickers	X	X
Non-Council Members		
Elaine Akers	√	√
Kalyna Bezchlibnyk-Butler	X	X
Andrea Fernandes	X	X
Sherif Guorgui[9]	√	√
Frank Hack	√	√
Bonnie Hauser	X	√
Mary Joy	√	√
Elizabeth Kozyra	√	X
Curtis Latimer	√	√
Dean Miller	X	X
Akhil Pandit Pautra	√	X
Kelly Pogue	X	√
Saheed Rashid	X	X
Satinder Sanghera	X	X
Richard Sigesmund	√	X
Dan Stringer	√	√
Asif Tashfin	√	X
Tracy Wiersema	√	√
Debra Willcox	√	√

1) Ms. Cushnie resigned July 29, 2017
2) Mr. Farrell resigned December 2, 2016
3) Ms. Filo resigned January 2, 2017
4) Mr. Hassam appointed to ICRC October 5, 2016; resigned May 17, 2017
5) Ms. Henderson appointed to ICRC May 16, 2017
6) Mr. Laframboise resigned January 11, 2017
7) Ms. Magboo appointed to ICRC January 26, 2017
8) Ms. Pajunen appointed ICRC March 20, 2017
9) Mr. Guorgui resigned June 14, 2017

PATIENT RELATIONS COMMITTEE

Meeting Dates: √ = attended X = not attended	December 2 2016	May 11 2017	August 14 2017
Council Members			
Chair: Joy Sommerfreund	√	√	√
Linda Bracken	x	√	√
Sylvia Moustacalis	√	√	√
Goran Petrovic	√	√	x
Doug Stewart	√	√	√
Non-Council Members			
Fel DePadua	√	x	√

QUALITY ASSURANCE COMMITTEE

Meeting Dates: √ = attended X = not attended	Nov. 10 2016	Jan. 5 2017	March 30 2017	May 29 2017	July 18 2017
Council Members					
Chair: Jon MacDonald	√	√	√	√	√
Linda Bracken	x	x	√	√	√
Elnora Magboo[1]			√	√	√
Sylvia Moustacalis	√	√	√	√	√
Tracey Phillips	x	x	√	√	√
Sony Poulose	√	√	√	x	x
Non-Council Members					
Tina Boudreau	√	√	x	√	√
Mary Joy	√	√	√	√	√
Sarah Woodworth-Giroux	√	x	x	x	x

1) Ms. Magboo appointed to QA Committee January 26, 2017

REGISTRATION COMMITTEE

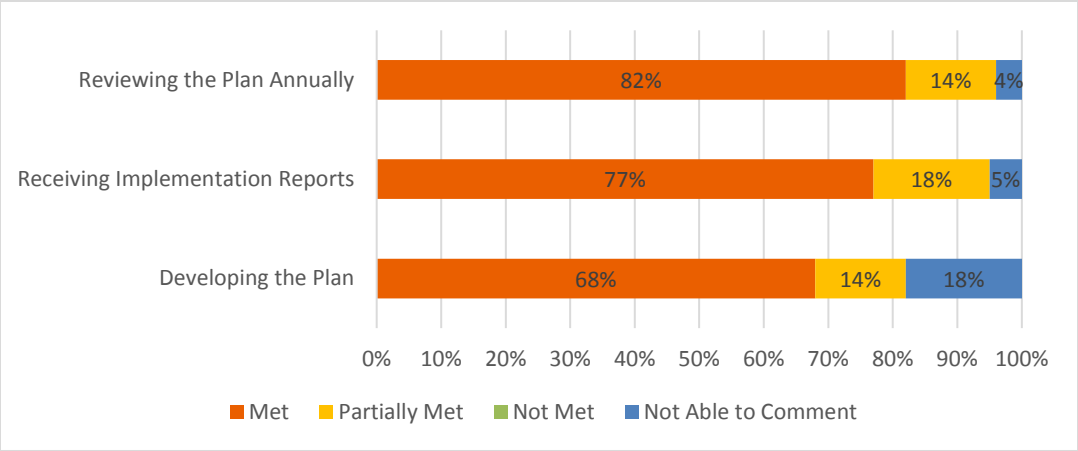
Meeting Dates: √ = attended X = not attended	Nov. 10 2016	Mar. 21 2017	Jul. 12 2017
Council Members			
Chair: Christine Donaldson	√	√	√
Billy Cheung[1]		√	√
Carol Cushnie[2]	√	√	√
Michelle Filo[3]	√		
Ravil Veli	√	x	x
Wes Vickers	x	√	√
Academic Appointments			
Heather Boon	√	x	√
Sharon Lee[4]	√	√	√
Non-Council Members			
Jillian Grocholsky	√	√	√
Deep Patel	√	√	√
Marie Pomainville[5]		√	√

1) Mr. Cheung appointed to Registration Committee January 20, 2017
2) Ms. Cushnie resigned July 29, 2017
3) Ms. Filo resigned January 2, 2017
4) Ms. Lee also a Non-Council Committee Member (NCCM)
5) Ms. Pomainville appointed to Registration Committee January 20, 2017

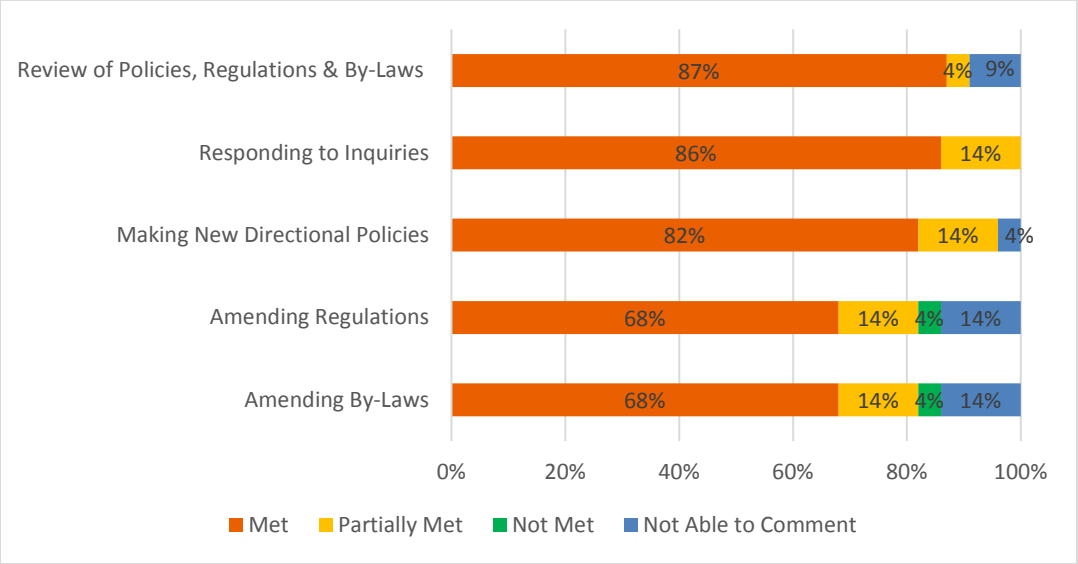
COUNCIL EVALUATION

LEADERSHIP — 22 RESPONSES

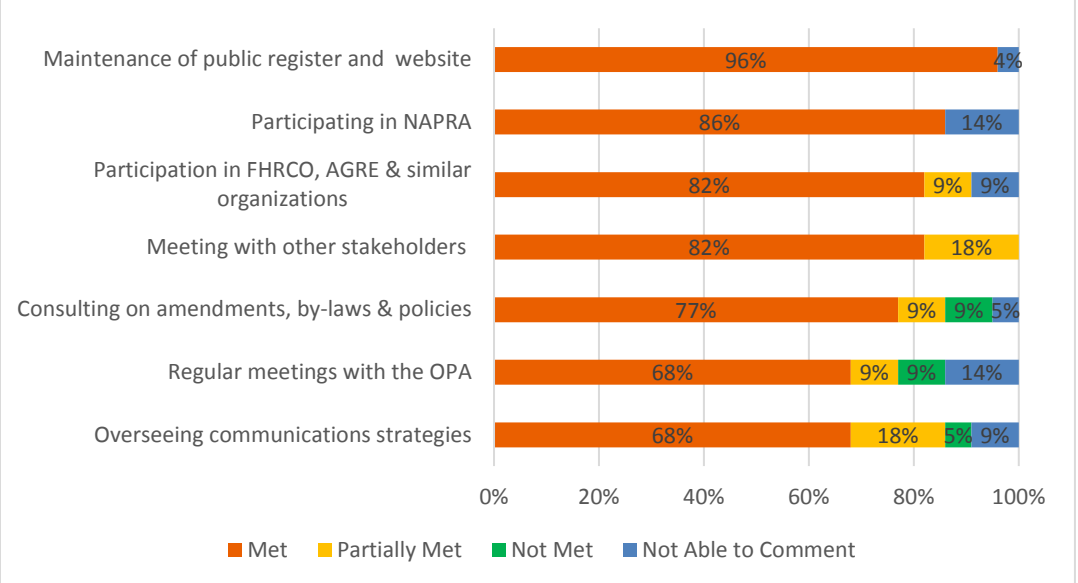
A – STRATEGIC PLANNING



B – MAKING DIRECTIONAL POLICIES AND DECISION

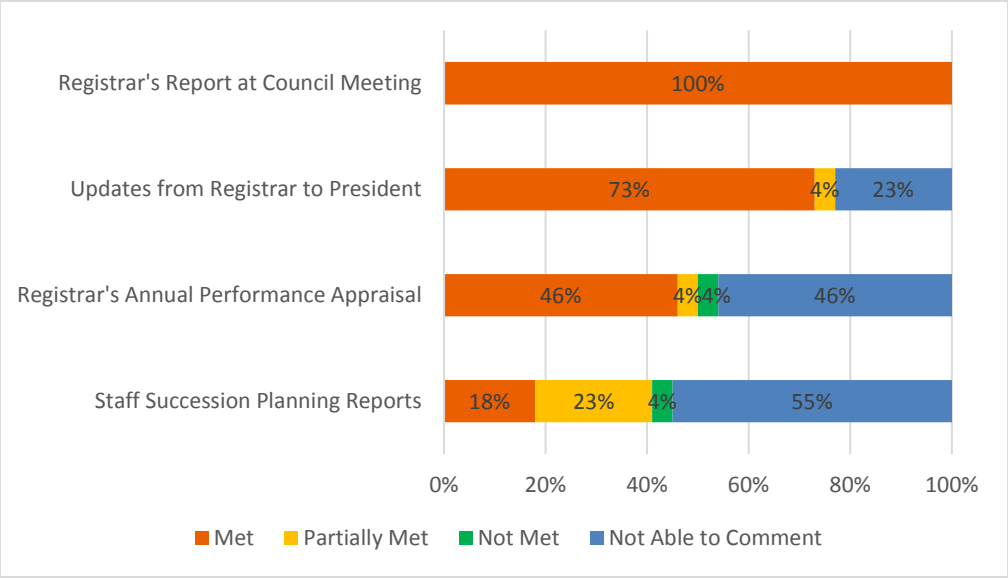


C – COMMUNICATIONS

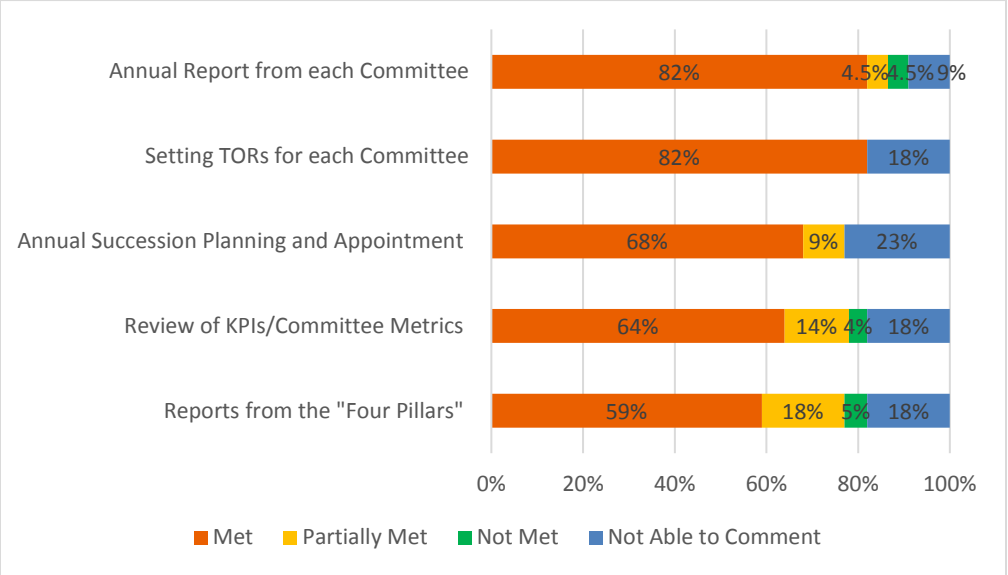


DIRECTION **22 RESPONSES**

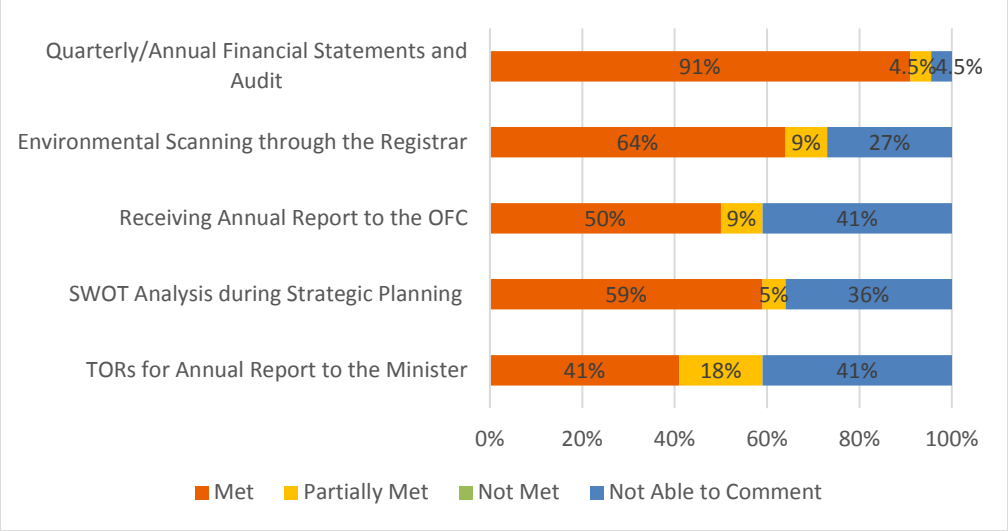
A – DIRECTING THE REGISTRAR



B – DIRECTING COMMITTEES



C – MONITORING COLLEGE PERFORMANCE



TOP THREE PRIORITIES REQUIRING ATTENTION — 10 RESPONSES

1	Council member attendance, member participation, more details provided to council (ex medical cannabis)
2	1). Transparency: We will need more transparency between all committees including the Executive Committee's workings and the Council. Council is the one who elects the Executive Committee. This will fill in the missing gap of communication between the council members. 2). Encouraging each member to come prepared with the agenda and encouraging them to voice their concerns, provide their recommendations, suggestions and input. 3). For formation of Task Force groups, more transparency should be exercised and Council Members should be canvassed to apply and included as per their experience and performance in the Council.
3	I believe Council functions very effectively especially as background info is provided to help guide discussions. Something for us to consider is our monitoring of the strategic plan in a meaningful way. Staff put time and energy into providing very detailed updates. I wonder if there is another simpler way info can be shared and/or highlighted for Council's information, input or questions.
4	Medication safety, public safety, pharmacist accountability
5	Role of Council in setting long-term strategic direction of College. Training of new Council members regarding their role.
6	Ensuring members are aware of issues before the meeting/continued structured meetings/having officers stand for more than one year.
7	Theoretically, I would say 1) committed participation by all members 2) OCP staff support; 3) respect. Again, I have had to pre-empt my reply as theoretically based since my experience with the Council has not yet matured to the level when I can speak from observation.
8	1. Review of strategic plan to align with NAPRA/MOHLTC 2. Focus on inclusion of more technicians within OCP structure 3. Implement a smaller, competency based Council
9	The Staff should not sit on same table of council as it is indeed affecting council members decisions', moreover, elections for chairs, president and vice president should be electronically or by third party to ensure transparency and fairness. OCP, is not a profit organization and should not be involved in investments .
10	In my opinion, Council functions effectively on the vast majority of issues that we deal with.

ADDITIONAL COMMENTS — 5 RESPONSES

1	none
2	The functioning of the council rests with the members who sit on the council, depending on their commitment, dedication, interest and enthusiasm which will determine how progressive the council is in strategic planning, carrying out the mandate and moving the 'mountain'.
3	Please note I have indicated that I am unable to comment in most of the questions since I am relatively new to the Council and have only attended one Council meeting to date which also explains why I have indicated "Met" in a few questions based from that meeting.
4	This year with change in Registrar, ongoing strat plan transitioned well and also new activities were accomplished
5	The Council needs to make decisions, leaving staff to do the decisions, then council approves on same day is little weird, Council meeting is nowadays 4 days per year, leaving all decisions to executive committee or Senior staff is not what the council meant for, most of the agenda is to inform !!

Ontario College of Pharmacists
Putting patients first since 1871

COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Régis Vaillancourt, President

TOPIC: June 2017 Council Evaluation Report to September 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 June 2017 Council meeting, we provided Council members with the opportunity to provide their feedback. 14 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	13	1	0	0	0	14
2. Members were well prepared to participate effectively in discussion and decision making	6	8	0	0	0	14
3. In accordance with the governance philosophy, Council worked interdependently with staff	10	4	0	0	0	14
4. There was effective use of time	6	6	2	0	0	14
5. There was an appropriate level of discussion of issues	9	5	0	0	0	14
6. The discussion was focused, clear, concise, and on topic	7	4	3	0	0	14

2. Did the meeting further the public interest?

YES = 14 = 100%
NO = 0 = 0%

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

- The discussion on the length of appointment of the President was very effective in reaching a consensus.
- There was not any ONE issue that worked best and I would like to comment on four issues that I found of equal relevance to the public interest. 1) Bill 84-MAiD: The College is updating guidance material to identify how we can provide clarity and support to pharmacists. 2) Opioid Crisis: OCP has established an Opioid Task Force to develop a strategy that aligns with Provincial and National (NAPRA) strategies. 3) Cannabis: OCP meeting with Health Canada to discuss the role of Pharmacists in Cannabis regulations and the Opioid crisis. 4) Sterile

Compounding: Recognition of OCP expertise in the inspection of sterile compounding facilities and its availability to be a possible resource to other provincial Regulatory Authorities.

- The issue of Conflict of Interest was well done, we should have had the same talk around the issue of Charter 54 stores.
- Solid, informative discussion on cannabis. Well chaired.
- I felt the issue regarding marijuana was done best as it led to much discussion. The method in allowing those to speak first time before taking a second round was much appreciated and allowed for frank and coherent discussion. Although there were many declared conflicts and many council members could not partake in the discussion, the debate among those that were left was good.
- n/a
- New process for non-council committee members - good suggestions were made for improvements.
- I felt the discussion and decision-making process throughout the meeting was very good.
- It was very helpful and proactive to have Richard Steineke available to review conflict of interest guidelines and to be available to discuss potential conflicts with council members. Good discussion on election term of President. Thanks Sylvia for bringing it forward to council.
- The discussion around Susan James' topic I felt there was significant discussion and progression.
- The COI process was very effective to ensure that there wasn't any perceived issues for the cannabis discussion.
- Presentation by Nancy was informative and very well done.
- Members are getting the chance to participate in the discussion.

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.

- None (5)
- I wouldn't say that the discussion on medical marijuana was not effective but it was negatively impacted by the large number of pharmacist members who left the room.
- Members need to understand what the motion is about and what is being discussed. If members go off topic please interject as presiding person(s) and keep members on track, in the interest of time and not going way off topic. Nobody likes wasted time.
- Discussion around Cannabis for medical use, there was information that could have clarified the discussion which was given to council only after many speakers.
- I did not notice any.
- n/a
- Discussion on cannabis was fulsome although at times we circled the main questions. Ultimately ended up with good decision for going forward.
- Around the medical cannabis question.
- It was unusual for public members to be able to hear the discussion that took place, while the council members who had a conflict where not allowed to be present. Perhaps another way to ensure no perceived issues, is that council members with a COI would be specifically identified in the room prior to the discussion, and even sit in a different area? Just a thought.
- Sometimes it's not clear during the discussion whether it's a governance issue or operational issues. It will be useful if the distinction make clear before start discussing any issue.

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	10
Mostly Satisfied	4
Neither Satisfied Nor Dissatisfied	0
Mostly Dissatisfied	0
Completely Dissatisfied	0
Total Responses	14

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

- Although I understand that this is a public meeting, the presence of a chain drug executive in the gallery had the potential to influence the ability of members who work for that organization to effectively represent the public interest - Dave Edwards
- Stay in control of the meeting, add n/a, other, don't know, to survey answer selections.
- It would be helpful for council to have all information concerning a subject prior to discussion. I sense some struggle between staff and council which may disappear over time.
- Good meeting. Good overall discussions.
- This is my last council meeting and I felt that we have come a long way since I started 9 years ago. I feel the level of discussion is more focused and better managed than from the time I started. I am glad that we are continuously improving on how we govern.
- None (2)
- No suggestions for improvement, very good meeting.

Respectfully submitted,

Régis Vaillancourt, President

Ontario College of Pharmacists

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MINUTES OF MEETING

OF COUNCIL

JUNE 12, 2017

Page

MONDAY, JUNE 12, 2017 – 9:05 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 Poulose, Hamilton
District M	Mr. Fayez Kosa, Toronto **- Regrets**
District M	Mr. Don Organ, Toronto
District M	Ms. Laura Weyland, Toronto
District N	Mr. Gerry Cook, London **- Regrets**
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 **- Regrets**
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
Ms. Christine Henderson, Toronto
Mr. Javaid Khan, Markham
Mr. James MacLaggan, Bowmanville **- Regrets**
Ms. Elnora Magboo, Brampton **- Regrets**
Ms. Sylvia Moustacalis, Toronto
Ms. Joan A Pajunen, Kilworthy
Mr. Shahid Rashdi, Mississauga **- Regrets**
Ms. Joy Sommerfreund, London
Mr. Ravil Veli, North Bay
Mr. Wes Vickers, LaSalle **- Regrets**

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 Guest

Mr. Richard Steinecke, Partner, Steinecke Maciura LeBlanc

1. Noting Members Present

Member attendance was noted.

2. Declaration of Conflict

President Vaillancourt advised Council that Mr. Steinecke, Partner, Steinecke Maciura LeBlanc has been invited to address Council on the conflict of interest provisions in the Governance Manual and that this will be dealt with under agenda item 12.1 which includes the preamble documents for the Cannabis discussion. He added that he assumed that Council members had reviewed and reflected on the material under that agenda item and that conflicts, if any, could be declared prior to the discussion on Cannabis. In the meantime however, he invited members to declare conflicts related to other items on the agenda.

There were no conflicts declared at this time.

3. Approval of Agenda

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

4. President's Opening Remarks

The President noted that there have been several changes at the Council table since the meeting in December. He introduced to Council Ms. Christine Henderson from Toronto. He announced that Ms. Henderson had been appointed to College Council on April 26, 2017 for 3 years. Her Orientation was held on May 16 and she has been appointed to the Discipline and ICRC Committees. Ms. Henderson was invited to briefly introduce herself to Council.

Council noted for information the reappointment of Mr. Rashdi (to May 2020), Ms. Moustacalis (to August 2020) and Mr. Khan (to June 2018) and Mr. Hassam's resignation effective May 17, 2017.

President Vaillancourt added that at the Executive Committee meeting in May, Ms. Moustacalis brought forward the issue of second term for President. Ms. Moustacalis will be invited to address Council later in the agenda.

He then went on to advise that elections will be held in Electoral Districts M, N, P and T this year and that at its meeting on May 25th, the Executive Committee had appointed Drs. Austin and Hindmarsh as scrutineers for these elections.

Noting that there were a few people for whom this Council meeting would be their last because they had decided not to run for re-election or their appointments to Council would be coming to an end, President Vaillancourt advised all outgoing members would be given an opportunity to address Council at the end of the meeting today, under "Unfinished Business".

4.1 Briefing Note - President's Report to June 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.

He added that in order to strengthen Council's governance process, commencing this year, Council members will participate in a year end assessment to evaluate how Council performs as a group, as well as individually. The results of the evaluation will assist Council in understanding and recognizing what is working well and identifying areas for improvement as it advances the College's mandate to serve and protect the public interest.

The Briefing Note was received by Council for information.

4.2 Briefing Note – March 2017 Council Meeting Evaluation

Referring to the March 2017 Council Meeting Evaluation, President Vaillancourt thanked Council members for providing feedback, adding that this was another way for Council to hold itself accountable. He encouraged members to continue to provide input but requested that where possible, for comments that address specific issues, members provide more details in order that they may be dealt with appropriately.

The Briefing Note was received by Council for information.

5. Approval of Minutes of Previous Meeting

5.1 Minutes of March 2017 Council Meeting

It was moved and seconded that the Minutes of the March 2017 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

9.1 Briefing Note – Executive Committee

The President invited Ms. Donaldson to present the Briefing Note to Council. **A motion to receive the Briefing Note from the Executive Committee was moved and seconded. CARRIED.**

Council received an update on the outcome of the public consultation on the CQA for Medication Safety Program. Ms. Donaldson advised that feedback through the consultation indicated broad support of the program from pharmacy professionals, stakeholders and members of the public.

She then briefly outlined for Council the proposed recommendations related to the implementation of this initiative. Council noted that implementation of the program will be in stages, beginning with approximately 100 community pharmacies this fall. Learnings will inform further roll out, eventually expanding to include all community pharmacies in the province by the end of 2018.

Council further noted that a comprehensive education and communication plan is being developed to support the successful roll out of the program and that more details will be forthcoming. Council expressed its unanimous support to move forward with the program and **a motion to approve the Briefing Note was moved and seconded.** Members voted unanimously in favour of the motion. There were no negative votes or abstentions. The motion **CARRIED.**

10. For Decision

There were no matters under this agenda item.

11. For Information

11.1 Briefing Note - President

President Vaillancourt advised Council that in addition to implementing a comprehensive evaluation of Council and Council members, another process he would like to implement is the way in which Non-Council Committee Members (NCCMs) are appointed.

The Protecting Patients Act includes amendments that will increase powers of the Minister to make regulations controlling all aspects of the structure of statutory committees. In anticipation of these changes, the Advisory Group for Regulatory Excellence (AGRE) recently held a Governance Roundtable to discuss governance issues. 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 should be based on competency (i.e. knowledge, skills and attitude).

Accordingly, President Vaillancourt announced that going forward, NCCM applications will be screened to assess competency before being considered for appointment. Council members spoke in favour of this initiative, agreeing that a robust application process will benefit the College and allow for appointment of the necessary diversity of perspectives and skills.

An application guide outlining the process and the application form will be available on the College website.

11.2 Briefing Note – Registrar's Report to June 2017 Council

President Vaillancourt asked the Registrar, Ms. Lum-Wilson, to address Council. Starting with the Strategic Priorities document, the Registrar presented to Council a status report on achievement of goals and outstanding objectives set out in the 2015-2018 Strategic Plan, what the focus will be for remainder of the year, how/where the priorities tied into the next planning cycle and what will be needed as capacity is built for the rest of this and next year.

She requested Council's affirmation for ongoing commitment to the priorities, outcomes and planned activities since they will be the foundation upon which the 2018 operations budget will be drafted over the summer for Council consideration in September. She added that the work at the College not only focussed on how the core programs were delivered, but also on how the College's work as a regulator was evolving to improve health outcomes of patients. In order to continue to advance Council priorities, she continued, there will be a greater focus on access and analysis of data to help measure our impact on public policy and health outcomes of patients.

Council noted that together with key College staff, Registrar Lum-Wilson 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 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.

Ms. Lum-Wilson also advised that during this reporting period, she continued to engage and collaborate with health system partners to address existing and emerging priorities and opportunities that will strengthen the College's role as a regulator. She added that to advance these activities, the right resources and capacity are necessary, requiring a realignment of the College's workforce and an investment in and capitalization of resources.

She reminded Council that their spring planning retreat will occur in March 2018, at which time the strategic direction for the College for the next three years will be established. Planning for this retreat will commence in December, she added.

With respect to *The Protecting Patients Act, 2017* (formerly known as Bill 87), 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, Council heard that the Bill received Royal Assent on May 30th. Council further noted that former College Registrar, Deanna Williams, has been engaged by the Ministry to undertake work relating to the recommendations of the Sexual Abuse Task Force. It is anticipated that extensive consultations will occur, leading to the development of regulations.

The Protecting Patients Act,2017 required the amendment of multiple statutes and Council was advised that the College asked and was successful in obtaining changes to the *Drug and Pharmacies Regulation Act, 1990* (DPRA). These changes will enable implementation of proposed registration and quality assurance regulations as well as permit the interim suspension of certificates of accreditation of pharmacies where imminent risk of patient harm has been identified. This latter provision will mirror the process now in place followed for interim orders relating to members.

Council was also updated on the passage of Bill 84 — Ontario's *Medical Assistance in Dying Statute Law Amendment Act (MAiD).* The Bill, which came into force on May 10, 2017, aligns with the federal MAiD legislation and addresses areas relevant to MAiD that fall under provincial jurisdiction. The legislation provides greater clarity and legal protection for healthcare providers (including institutions and clinicians) as well as patients navigating this care option. The legislation also establishes a new role for the coroner in overseeing medically assisted deaths. Council noted for information that a provincial Care Co-ordination Service, available to patients, caregivers or clinicians, including pharmacists was put in place on May 31st. Pharmacists who are unable or unwilling to dispense drugs for the purposes of MAiD can now contact the Care Co-ordination Service to enable referral. Council was reminded that the College developed a guidance document last year to assist pharmacy professionals to comply with legal obligations and professional expectations with respect to MAiD, including effective referral. 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 provide further clarity and support.

Registrar Lum-Wilson informed Council that 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) came into force on May 5, 2017.

Council also received a comprehensive update on the Opioid Crisis. Not only is the crisis being addressed at provincial and federal levels, regulators as well as professional advocacy groups are also discussing and dealing with this issue. In November 2016, Government of Ontario committed to implement a comprehensive Opioid Strategy focusing on enhancing data collection, modernizing prescribing and dispensing practices, and connecting patients with high quality addiction treatment services. A component of the Strategy is to modernize prescribing and dispensing practices to align with evidence-based guidelines and standards.

The College also established an Opioid Task Force. Led by President Vaillancourt, the aim of the Task Force is to develop an Opioid Strategy that aligns with provincial and national strategies. Registrar Lum-Wilson then gave an update on the National Association of Pharmacy Regulatory Authorities' (NAPRA) progress with respect to its opioid strategy. At the April 2017 meeting, NAPRA's Board committed to developing a plan encompassing communication, education, guidance and enforcement strategies, she added.

At this time, President Vaillancourt advised Council that in the interest of keeping to the schedule, the Registrar's Report to Council would continue after Mr. Steinecke's presentation and the Cannabis discussion (agenda item 12.1) had taken place.

12. Other Matters

12.1 Cannabis Discussion

Prior to discussion regarding distribution of cannabis through pharmacies, President Vaillancourt referred members of Council to the Preamble (appendix 6.6) which was created specifically to help Council Members better understand the issue and to provide clarity and direction to members on how to deal with Conflict of Interest. Acknowledging the fact that some pharmacy groups have advocated for distribution, he informed Council that it was deemed necessary that direction be provided to Council members before the actual discussion took place.

He then invited Mr. Steinecke to address Council regarding the College's Governance Manual which states that 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. Mr. Steinecke explained that a conflict of interest could be actual or potential and dependent on the details of the circumstances. To assist Council members in assessing whether the position or interests of their employer creates a conflict, he went through a series of questions to help members determine whether a conflict of interest existed.

A break was then declared which allowed members of Council to consult with the President, the Registrar and Mr. Steinecke to help them determine for themselves whether there were conflicts of interest that needed to be declared.

Following the break, and before proceeding with the first part of the discussion - NAPRA's position statement on the role of pharmacy practitioners with respect to cannabis for medical and non-medical purposes - the President asked whether any Council members had a conflict to declare in connection with this particular discussion. There were no conflicts declared at this time.

Registrar Lum-Wilson explained to Council that on April 13, 2017, the Government of Canada proposed the *Cannabis Act*, which would create a strict legal framework for controlling the production, distribution, sale and possession of cannabis across Canada. The proposed legislation focuses on cannabis for non-medical purposes – with the understanding that the current program for accessing cannabis for medical purposes would continue. Council heard that NAPRA's position is that: pharmacy practitioners must not be involved in the distribution of cannabis for non-medical purposes; distribution sites for non-medical cannabis must not be permitted to use terms which may lead the public to believe the distribution site is a pharmacy or that it has professional oversight from pharmacy practitioners; smoked cannabis products should be subject to the same provincial or territorial legislation as smoked tobacco products; advertising and marketing of cannabis be restricted; and, suppliers of cannabis be subjected to quality, packaging, labelling and shipping standards.

Discussion ensued following the introduction of this position statement and the Registrar responded to questions from the floor and provided clarification where needed. Council had no further feedback for NAPRA and endorsed the fundamental points contained in NAPRA's position statement including those aimed at preserving the integrity of the healthcare system through regulatory safeguards. Council noted that NAPRA anticipates finalizing this statement at its meeting later this fall.

The second part of the discussion was then introduced: Should the OCP Council take a position on where cannabis should be distributed in Ontario? And if yes, what information does Council need to make an informed decision?

At this time, the following members declared a conflict and left the Council Chambers: Mr. Cheung, Ms. Cushnie, Mr. Merani, Ms. Phillips, Mr. Poulose, Mr. Stewart, Mr. Veli and Ms. Weyland.

There was extensive discussion on this subject. Summarized below are some of the points of views expressed by the remaining Council members:

- The College should take a position on distribution, possibly in the form of a broad-based recommendation
- College's public protection mandate necessitates college involvement
- Pharmacists are well positioned to sell medicinal cannabis; dispensing should be in pharmacies as advice and product knowledge as it relates to other medicines that the patient is taking cannot be provided elsewhere
- Public should be protected and products should be safe
- Health professionals should be involved in the care of patients and individuals must have access to health care professionals

- Patients accessing medical marijuana more likely to prefer pharmacy access and access through health care professionals
- Unproven therapeutic value of medicinal cannabis; evidence can only be obtained through extensive research
- No Drug Identification Number (DIN) or a Natural Product Number (NPN) will be issued; not an approved therapeutic product
- Currently there is no prescription for the product – physicians provide patients with an authorization to self-medicate
- Currently no recommendations in place as to where cannabis for recreational use is to be distributed.
- Health Canada intends to maintain the current distribution system for cannabis for medicinal use until they are confident that infrastructure is in place for people to access the substance
- Irrespective of OCP position, pharmacists will have the choice to sell/dispense or not
- Thorough risk assessment and policy analysis would need to be conducted prior to making a decision on a position statement
- Key is to have pharmacists involved when patients need to access cannabis for medicinal use regardless of how they obtain the substance or where it is distributed
- There are a number of outstanding questions on whether different forms will come to market, and whether the same product can be used for both medicinal and recreational use; would and should there be different sets of regulatory standards for the same product?

President Vaillancourt summarized for Council the discussion that had taken place thus far, noting that there appeared to be a general consensus around the table that the College should make a statement on distribution of cannabis for medical use but that more information was needed in order for Council to make an informed decision on the nature of the statement. **A motion to this effect was moved and seconded. Council members voted unanimously in favour of the motion.** There were no negative votes or abstentions. **CARRIED.**

Accordingly more information will be gathered in order to inform further discussion at the next Council meeting in September. Such information to include: how other countries deal with this issue, formulations that cannot be smoked, position of other colleges (both pharmacy and other health professions), expectations of pharmacists if dispensing, labelling legislation, inspection processes for licensed producers, risk assessment, public perception and models for medical use.

Members conflicted from this discussion then returned to the Council Chambers.

11.2 Briefing Note – Registrar's Report to June 2017 Council (continued)

Registrar Lum-Wilson was invited to continue to address Council to highlight the remaining salient points from her report.

Council noted for information that since its formation in 2012, the Advisory Group for Regulatory Excellence (AGRE) has had considerable success in collaborating on various initiatives (e.g. transparency principles which were developed through engagement with the provincial government and later adopted by the AGRE regulators (not only were by-laws amended but the elements were embedded in the legislative amendments in the Protecting Patients Act). As advised earlier in the day, the group recently organized a Governance Roundtable where participants engaged in discussion on governance issues. 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 public protection. Similar to the manner in which the transparency framework evolved, details of the framework will be shared with Council prior to the adoption of any position.

Another collaborative initiative being undertaken is the formation of a Citizen's Advisory Group (CAG). Council heard that a number of colleges have expressed an interest in forming a partnership to support such a group that will provide feedback that is representative of Ontario health care users on colleges' activities and initiatives. The intent is that the CAG will be used as a broad public sounding board to provide qualitative insight and help Councils in their decision-making.

The Registrar next reported 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 during Council meetings.

12.2 Presentation by Ms. James, Director, Competence

Ms. James was invited to address Council and to present the Strategy that will support optimal pharmacy practice that results in improved patient care. As reported at the March Council meeting, the College commenced work on developing a strategy to address the underutilization and integration of pharmacy technicians, particularly in community practice.

Legislation enabling the regulation of pharmacy technicians was passed in 2010 and expansion of pharmacists' scope of practice was passed in 2012. While it was recognized that pharmacy technicians played an important role in enabling pharmacists to maximize their clinical role as medication therapy experts, it appeared that pharmacists had not achieved this objective despite the regulation of technicians and the additional scope. Ms. James went on to explain that it therefore became clear that a broader strategy was needed to include initiatives that would optimize the scope of practice of both professions, with the end result of improved patient health outcomes.

Council noted for information that research indicated that use of technicians enabled increased opportunities for clinical care by pharmacists. Data also indicated that less than a quarter of the community pharmacies utilized technicians and pharmacies were not fully optimizing the current scope of practice. While there was indication that there were several opportunities for growth, the barriers to progress appeared to indicate that in order to achieve success, focus was needed on professional engagement (identity/confidence, competency, intra professional relationships); practice models (definition of best practice, transfer of knowledge and creation of community of practice); and data collection (demonstration of impact on practice and patient outcomes and business models).

Accordingly, the following elements are included in the Strategy:

1. Creation of an Advisory Committee (to inform, support, align and identify partnerships with stakeholders);

2. Definition of best practice models (and the value proposition) and creation of a community of best practice to help facilitate growth;

3. Identification of barriers and facilitators impacting utilization of pharmacy technicians to optimize pharmacist scope;

4. Establishment of an education and training agenda for entry and continuing education to enhance professional engagement for both professions; and

5. Development of quality indicators to measure the impact of collaborative practice models on clinical pharmacy services and patient outcomes.

Comments from the floor indicated a strong support for the strategy with several suggestions and comments including but not limited to: the need for buy-in from chains; creation of a second class of pharmacy registrants for those who do not want to move from the perceived dispensing-only role; more pharmacy technician representation on Council; study of current working environment; expansion of scope to include ordering of lab tests by pharmacists; and more public education.

Council noted that regular progress updates will be provided to Council as the Strategy is implemented.

12.3 Presentation by Ms. Winkelbauer, Manager, Continuing Competency

The Registrar's reporting activity also includes regular program updates/presentations from the program managers and accordingly, Ms. Winkelbauer, Manager, Continuing Competency, was invited to present to Council.

12.4 Appointment of Elections Committee

President Vaillancourt advised Council members that the Vice President, Ms. Donaldson, and Ms. Al-Zand, Public Member had indicated their willingness to serve with him on the Elections Committee and accordingly**, a motion to approve the appointment of the Elections Committee was moved and seconded. CARRIED.**

Discussion on Second Term Election for Executive Committee positions

President Vaillancourt passed the Chair to Dr. Merani, Past President, for this portion of the meeting.

Council noted for information that at its meeting in May, the Executive Committee discussed the issue of a second term for the President, which was brought to the Committee's attention by Ms. Moustacalis.

Council members were reminded that per the by-laws, all members of the Executive Committee are elected by Council annually, including both public and professional members; that a second-term for the President or any other elected role on committees has always been permissible and does not require a by-law change and that the Vice President does not automatically assume the role of the President – rather he/she must be elected to that role.

Ms. Moustacalis was invited to address Council. She informed Council that her intention was to bring this matter before Council for discussion at this point in time and that she considered it important to look at the possibility of having the President serve a two-year term on Council and secondly, to look at the possibility of adding a dedicated pharmacy technician position on the Executive Committee.

Past Presidents were asked for their perspective on the two-year year term and most commented that flexibility to accommodate the personal situations of individuals may result in more interest in serving in the position. Council noted that no change was necessary to the by-laws for a President to serve a second term if they choose to run for election.

Council held a fulsome discussion on the two issues introduced by Ms. Moustacalis. There were several comments and questions from the floor including: consideration as to what would happen if the President was elected for a two-year term but was serving his/her last year of his current term on Council; a suggestion that there should be limit on how long a member can serve on the Executive Committee; the existence of a democratic process meant that Council elected the candidate with the right skills every time; the by-laws do not preclude a President or member from running for subsequent terms; the position of President requires extensive time commitment; the norm has been for Presidents to serve a one-year term; concern that a two-year term could possibly discourage a suitable candidate from running because of time commitment; a two-year term should not be mandatory, two-years would allow for continuity; difficult to assume the position of Past President if term on Council is over; potential for a member to have to wait a long time to assume the position of President.

President Vaillancourt thanked Council members for participating in the discussion and for the feedback on this agenda item.

13. Unfinished Business

Noting that Mr. Leung's term would be expiring at the end of this Council year, the President invited him to address Council. Mr. MacDonald and Mr. Organ indicated they would not be seeking re-election and both members were also invited to address Council.

There was no other 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 3:13 p.m. and to reconvene on Monday, September 18, 2017, or at the call of the President. CARRIED.

Ushma Rajdev
Council and Executive Liaison

Régis Vaillancourt
President

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Ontario College of Pharmacists
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COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Nancy Lum-Wilson, CEO & Registrar

TOPIC: Election of Members to Council

ISSUE: Election Results for 2017

BACKGROUND:

- Per the by-laws, elections were held in Districts M (3 seats), N (by-election; 1 seat), P (2 seats) and T (by-election; 1 seat).
- There were two candidates for election for the two seats in District P - Ms. Rachelle Rocha and Mr. Doug Stewart – and accordingly, both candidates were acclaimed.
- The Scrutineers' Report and Poll results are attached for Districts M, N and T for Council's Information.

RECOMMENDATION: **Receive the Election results for Information**

Ontario College of Pharmacists
Putting patients first since 1871

August 3, 2017

To the President and Members of Council of the Ontario College of Pharmacists:

We, the undersigned scrutineers, hereby certify that we attended the College commencing at 9.00 a.m. on Thursday, August 3. 2017, and verified the votes in the elections for Council for 2017.

The results (in alphabetical order) are as follows:

District M Election (3 seats):
- Nagib (Kyro) Abdelmaseh
- Magued (Mike) Hannalah
- Laura Weyland

District N By- election (1 seat):
- Juanita Smith

District T By-Election (1 seat):
- Ruth-Ann Plaxton

Dr. Zubin Austin
Scrutineer

Dr. Wayne Hindmarsh
Scrutineer

Ontario College of Pharmacists
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Poll Result

2017 Council Elections
Report date: Wednesday 02 August 2017 17:01 EDT

District M

District M Election – 2017
As at Poll close: Wednesday 02 August 2017 17:00 EDT
Number of voters: 813 · · Percentage voted: 26.29
Ranked by votes

	Candidate	Votes	%
1	Laura Weyland	488	60.02
2	Magued (Mike) Hannalah	250	30.75
3	Nagib (Kyro) Abdelmaseh	232	28.54
4	David Windross	181	22.26
5	Abed Mitha	174	21.40
6	Jayesh Tailor	148	18.20
7	Joseph Saad	120	14.76
8	Dhiraj Verma	107	13.16

District N

District N By- Election – 2017
As at Poll close: Wednesday 02 August 2017 17:00 EDT
Number of voters: 488 · · Percentage voted: 22.55
Ranked by votes

	Candidate	Votes	%
1	Juanita Smith	256	52.46
2	Karim Ragheb	139	28.48
3	Sanjiv Maindiratta	93	19.06

District T

District T By-Election – 2017

As at Poll close: Wednesday 02 August 2017 17:00 EDT
Number of voters: 191 · · Percentage voted: 10.47
Ranked by votes

	Candidate	Votes	%
1	Ruth-Ann Plaxton	81	42.41
2	Bonnie Dickson	53	27.75
3	Cassandra Johnston	29	15.18
4	Kim Gauley	28	14.66

Ontario College of Pharmacists
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COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Elections Committee

TOPIC: Consideration of slate of candidates for Council Elections

ISSUE: Council Member preferences to Chair or serve on College Committees for the 2017-2018 Council year

BACKGROUND: The Elections Committee is formed pursuant to College by-laws and comprises the President, one elected member and one public member of Council. The duty of the Elections Committee is to invite expressions of interest in sitting on and chairing Committees from all members of Council, seek candidates for the offices of President and Vice-President and where there are not sufficient expressions of interest to fill every Committee, recruit additional Committee members sufficient to fully constitute every Committee.

ANALYSIS: The Committee is pleased to note a high degree of interest in serving Council, and our Report attachment reflects this range of interest. We hope that by circulating this material, Council members will be better able to fully consider the candidates, as well as decide on their own involvement. It is to be remembered that the College officers, Executive Committee members and Committee Chairs must be elected by Council, and the Report from the Nominating Committee and Committee Chairs appointing remaining members of our statutory and standing committees must be approved by Council.

Also, per the by-laws, during the elections process, names can be withdrawn or members nominated in addition to the election slate being presented. Based on the above, all members are involved in the process.

Conflicts

- Any Committee which refers matters to Discipline would be a source of potential conflict. The *Pharmacy Act* however, is quite clear that no member of the Discipline Committee can serve on the Accreditation Committee.

- Also, because of its power to refer a matter to the Fitness to Practise Committee, it may not be appropriate for a member of the Investigations, Complaints & Reports Committee to serve on the Fitness to Practise Committee.

NOTE: As in previous Council meetings, after the election of the President and Vice-President, Executive Committee and Committee Chairs has taken place, the Council meeting will proceed according to the Agenda and adjourn early on the first day, after which, the Nominating Committee and Chairs of the Statutory and Standing Committees will convene to discuss the appointments. ***Every effort will be made to appoint members according to their preferences; however, it should be noted that members will also be appointed to committees where a need is identified.***

The finalized slate will be provided to Council for approval the following day.

RECOMMENDATION: The attached slate of candidates is being commended for Council's consideration.

CANDIDATES FOR ELECTION:

Candidate for President: Christine Donaldson/Régis Vaillancourt

Candidate for Vice President: Christine Donaldson/Laura Weyland

Candidates for Election to the Executive Committee:

President, Vice President, Past President, (*i.e. four members of Council who are members of the College) and 3 public members*

Elected Members:

Christine Donaldson (President or Vice President)
Esmail Merani (Past President)
Régis Vaillancourt (President or Past President)
Laura Weyland (Vice President)
Rachelle Rocha
Doug Stewart

Public Members:

Kathy Al-Zand
Linda Bracken
Christine Henderson
Javaid Khan
Elnora Magboo
Sylvia Moustacalis
Joan A Pajunen
Joy Sommerfreund
Wes Vickers

Candidates For Election Of Committee Chairs:

ACCREDITATION & DPP:	Christine Donaldson/ Régis Vaillancourt
DISCIPLINE:	Doug Stewart/Ravil Veli
FINANCE AND AUDIT:	Gerry Cook/Javaid Khan
FITNESS TO PRACTISE:	Kathy Al-Zand
INVESTIGATIONS, COMPLAINTS & REPORTS COMMITTEE:	Rachelle Rocha/Joan A Pajunen/Ravil Veli/ Laura Weyland
PATIENT RELATIONS:	Joy Sommerfreund
QUALITY ASSURANCE:	Tracey Phillips
REGISTRATION:	Ravil Veli

Committee Preferences 2017-2018

	EXECUTIVE 4 Elected 3 Public (to include President, VP, immediate Past President)	ACCREDITATION At least: 2 Elected 2 Public 2 NCCM DRUG PREPARATION PREMISES (same members as Accreditation)	DISCIPLINE At least: 6 Elected 6 Public 5 NCCM	FINANCE & AUDIT At least: 3 Elected 1 Public	FITNESS TO PRACTISE At least: 2 Elected 2 Public 1 NCCM	INQUIRIES, COMPLAINTS & REPORTS At least: 5 Elected 5 Public 7 NCCM	PATIENT RELATIONS At least: 2 Elected 3 Public 1 NCCM	QUALITY ASSURANCE At least: 2 Elected 3 Public 3 NCCM	REGISTRATION At least: 2 Elected 2 Public 1 NCCM 1 Dean 1 Rep of PT Program in Ontario Accredited by CCAPP
ELECTED MEMBERS									
H – Régis Vaillancourt	P	C	•		•				
H – Christine Donaldson	P or VP	C				•			
K – Esmail Merani	•		•	•					
K – Tracey Phillips*								C	
L – Billy Cheung		•				•			•
L – James Morrison		•			•	•			
L – Sony Poulose		•					•		•
M – Mike Hannalah*		•				•		•	•
M – Kyro Maseh			•			•	•		•
M – Laura Weyland	VP					C			
N – Gerry Cook*				C		•			
N – Leigh Smith*		•					•	•	
N – Karen Riley		•	•					•	•
T – Ruth-Ann Plaxton					•			•	
TH – Goran Petrovic						•	•		
P – Rachelle Rocha	•	•	•			C		•	
P – Doug Stewart	•		C	•			•		
	EXECUTIVE	ACCREDITATION & DPP	DISCIPLINE	FINANCE & AUDIT	FITNESS TO PRACTISE	ICRC	PATIENT RELATIONS	QUALITY ASSURANCE	REGISTRATION

• – would like to be a member ***C – would like to chair*** ***P – President*** ***VP – Vice President*** ** or appoint wherever needed*

(s. 8.28 of the by-laws) ***Maximum Number of Non-Council Committee Members.*** *Council shall not appoint more members to a Committee that are not Council members than the number of Council members that it appoints to the Committee. However, a failure to comply with this provision does not affect the validity of the decisions made by the Committee.*

Committee Preferences 2017-2018

	EXECUTIVE 4 Elected 3 Public (to include President, VP, immediate Past President)	ACCREDITATION At least: 2 Elected 2 Public 2 NCCM DRUG PREPARATION PREMISES (same members as Accreditation)	DISCIPLINE At least: 6 Elected 6 Public 5 NCCM	FINANCE & AUDIT At least: 3 Elected 1 Public	FITNESS TO PRACTISE At least: 2 Elected 2 Public 1 NCCM	INQUIRIES, COMPLAINTS & REPORTS At least: 5 Elected 5 Public 7 NCCM	PATIENT RELATIONS At least: 2 Elected 3 Public 1 NCCM	QUALITY ASSURANCE At least: 2 Elected 3 Public 3 NCCM	REGISTRATION At least: 2 Elected 2 Public 1 NCCM 1 Dean 1 Rep of PT Program in Ontario Accredited by CCAPP
PUBLIC MEMBERS									
Kathy Al-Zand	•		•		C		•		
Linda Bracken *	•		•				•	•	
Christine Henderson	•		•		•	•			
Robert Hindman			•			•			•
Javaid Khan	•		•	C	•				
James MacLaggan*									
Elnora Magboo*	•	•	•			•		•	
Sylvia Moustacalis	•		•				•	•	
Joan A Pajunen	•		•			C			
Shahid Rashdi			•		•			•	
Joy Sommerfreund	•	•				•	C		
Dan Stapleton							•		
Ravil Veli			C			C			C
Wes Vickers	•		•		•				•
DEANS									
Heather Boon, U of T					•	•			•
David Edwards, U of W									
	EXECUTIVE	**ACCREDITATION & DPP**	**DISCIPLINE**	**FINANCE & AUDIT**	**FITNESS TO PRACTISE**	**ICRC**	**PATIENT RELATIONS**	**QUALITY ASSURANCE**	**REGISTRATION**

Ontario College of Pharmacists
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COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Council

TOPIC: Cannabis for Medical Purposes

ISSUE: Role of Pharmacy

BACKGROUND:

- Legal access to cannabis for medical purposes is federally regulated. Under rules established through the *Access to Cannabis for Medical Purposes Regulations* (ACMPR), an individual who requires cannabis for medical purposes may access cannabis by registering with a licensed producer, registering with Health Canada to produce a limited amount for their own medical purposes, or designating someone else to produce it for them.[1]

- The most recent Health Canada figures show that the number of Canadians registered to purchase cannabis for medical purposes has tripled over the past year, with almost 168,000 users being registered by the end of March 2017.[2]

- In April 2017, the federal government introduced the *Cannabis Act* which, on commencement, will regulate the production, distribution and sale of cannabis for non-medical purposes.[3] Health Canada has indicated that "The current program for access to cannabis for medical purposes would continue under the new Act".[4]

- In response to the legislation, the National Association of Pharmacy Regulatory Authorities (NAPRA) adopted the position (see attached) that pharmacy practitioners must not be involved in the distribution of cannabis for non-medical purposes. NAPRA recognizes that members will continue to discuss the regulatory safeguards necessary for pharmacy professionals to dispense cannabis for medical purposes. In the interim, pharmacists will continue to be involved in providing patients with information and guidance.[5]

- In June 2017, the OCP Council endorsed NAPRA's position and discussed the issue of cannabis for medical purposes and the role of the profession with respect to the following questions:
  1. Should the OCP take a position on where cannabis should be distributed in Ontario; and
  2. If yes, what information is required to make an informed decision?

- The consensus of Council was that in the context of the College's public protection mandate, a statement specific to the distribution of cannabis for medical use should be made. In order to inform such a statement, more information was needed on the following issues: the experience of other jurisdictions; formulations; the position of other health regulators; expectations of pharmacists if dispensing; labelling; inspection processes; risk assessment; public perception/protection; and models for medical use.

- The following information has been compiled to assist Council to determine the content of such a statement. Given the amount of material available on the topic, and the rapidity of change in this area, the note is not meant to be an exhaustive review of the subject, but to provide members with sufficient information to make a decision. There is no consensus on terminology in the referenced materials and the terms 'cannabis' or 'marijuana' are sometimes used to describe the same substance. The information provided here is specific to distribution of cannabis for medical purposes. Footnoted references are listed at the end of the document.

DISCUSSION:

- The Controlled Substances and Tobacco Directorate at Health Canada has provided information for health professionals on the use of cannabis and cannabinoids for medical purposes utilizing international reviews and peer-reviewed literature. In providing this information the Directorate emphasizes that: "Cannabis is not an approved therapeutic product and the provision of this information should not be interpreted as an endorsement of the use of this product, or cannabis generally, by Health Canada."[6]

- Canadians have had legal access to cannabis for medical purposes since 2001. The distribution of cannabis for medical purposes has come about as a result of legal challenges, not clinical research. Cannabis does not have a Drug Product Monograph or a Notice of Compliance authorizing sale in Canada.[7]

- Cannabis for medical purposes is "authorized" by physicians and distributed directly to patients by mail-order from licensed distributers according to rules established under the ACMPR. There is no prescription written in the traditional sense.

WHAT IS CANNABIS FOR MEDICAL PURPOSES?

Although derived from the same plant, there are important differences between cannabis used for either medical or non-medical purposes.

Chemical content

- There are ~500 distinct compounds found in cannabis. Delta-9-tetrahydrocannabinol (THC) is the main psychoactive component of cannabis and cannabidiol (CBD) is the most abundant non-psychoactive phytocannabinoid contained in cannabis.
- Medical users may seek out strains and forms that can provide symptomatic relief (sometimes through higher levels of CBD), while non-medical users may predominantly seek out those with psychoactive effects (i.e. strains with higher THC).[8]
- Cannabidiol (CBD) is without euphoriant properties and acts as an antagonist to the psychoactive effect of THC.[9] CBD exerts antipsychotic, anxiolytic, anti-seizure, as well as anti-inflammatory properties. Thus, cannabis that is high in CBD and low in THC is an effective therapy in a variety of conditions including epilepsy. [10,11]
- An understanding of how specific strains of medical cannabis can offer benefits for specific ailments is appreciated by those authorizing the use of cannabis for medical purposes. Appropriate strains of cannabis for medical purposes can vary depending on symptoms and medical history. For example, it is recommended that patients with a history of mood and anxiety disorders use strains with a low THC content. Additional research is required in this area to improve prescribing practices.[12]
- Although there is no legal requirement for licensed producers to follow strain and THC recommendations, many colleges (including the College of Physicians and Surgeons of Ontario) recommend the inclusion of THC amounts when authorizing cannabis for medical purposes.[13]

Health risks of smokable vs. other forms

- There are differences in the presence and content of different cannabinoids between cannabis extract, vapor, and smoke. In fact, cannabis smoke contains many compounds not observed in either the extracts or vapor, including a number which are known or suspected carcinogens or mutagens.[14]
- Many patients have concerns about medical cannabis smoke, which contains many of the same carcinogenic chemicals as tobacco smoke.[9]
- Vapourization of cannabis has been explored as an alternative to smoking. The potential advantages of vapourization include the formation of a smaller quantity of toxic by-products such as carbon monoxide, polycyclic aromatic hydrocarbons (PAHs), and tar, as well as a more efficient extraction of Δ9-THC from the cannabis material.[15]
- There are no clinical studies on the use of cannabis edibles (e.g. cookies, baked goods) or topicals for therapeutic purposes. It has been repeatedly noted that the psychotropic side effects associated with the use of cannabinoids have been found to limit their therapeutic utility.[16]
- Edible cannabis products can lead to increased risks due to increased potency and also represent an increased risk of accidental or unintentional ingestion, particularly by children. This view is supported by the experience in Colorado, where the availability of edible products led to a rise in the number of accidental or unintentional overdoses (non-fatal).[17]

What is currently offered to medical cannabis users in Canada?

- The ACMPR addresses substances including dried marijuana, marijuana oil, or fresh marijuana buds or leaves that can be smoked, vaporized, ingested in food or in a tea.
- Synthetic phytocannabinoids and cannabis-derived formulations are available with a prescription in Canada: dronabinol (discontinued – not due to safety reasons)[18] nabilone, and nabiximols (*Appendix 1*). These products contain THC and therefore, do have varying degrees of psychoactive effects. These medications each have a corresponding drug identification numbers (DIN) and are sold in pharmacies (with the exception of dronabinol).
- Up until 2016, the department of Veterans Affairs reimbursed up to 10 grams of dried cannabis per day, as identified by the authorizing physician.[19] Between 2008-09 and 2015-16 the number of veterans receiving funding for cannabis for medical purposes increased from 5 to 1762. The cost increased from $19,088 to $21 million in 2015-16, and up to $31 million between April and September 2016.
- At the end of 2016, VAC revised the reimbursement policy to establish a limit of 3 grams per day of dried cannabis, or its equivalent in fresh cannabis or cannabis oil. The VAC also established a maximum rate of up to $8.50 per gram.[20]

WHAT IS THE POSITION OF GOVERNMENT?

Access to Cannabis for Medical Purposes

- Health Canada has published a document for health care practitioners to complete in order to authorize the use of cannabis for medical purposes for an applicant under their professional treatment. Whether used or not, the information contained in the document must be gathered by the health practitioner (required under section 8 of the ACMPR).

- The information is sent directly to a licensed producer and if the applicant wishes to change producers, a new application is required as a producer must keep the original medical document on file. The period of use authorized by the medical professional cannot exceed 1 year.[21]

Position of Provincial Governments

- Access to cannabis for medical purposes is not included in the provisions of the *Cannabis Act* and is not a topic for provincial consideration or decision-making. Consultations are underway or concluded in several provinces on issues related to the distribution of non-medical cannabis.

WHAT IS THE POSITION OF PHYSICIANS?

- The Canadian Medical Association (CMA) has indicated that there is insufficient evidence to support the use of marijuana for clinical purposes. The CMA urges Health Canada to support the development of rigorous research on the effects, both positive and adverse, that the use of marijuana for medical purposes will have.[22]

- The Federation of Medical Regulatory Authorities of Canada has not articulated a recent position on this issue; however, a 2013 article found on their website contains a quote that "physicians should not be asked to prescribe substances whose claims of effectiveness and safety have not been established with clinical research." The article goes on to state "It is our firm view that medical marijuana should be subject to the same regulatory requirements as prescription pharmaceuticals."[23]

Examples of the Approach of Provincial Physician Regulators

- The College of Physicians and Surgeons of Ontario has a policy *Marijuana for Medical Purposes* which acknowledges that there is limited conclusive evidence for its safety and effectiveness as a medical treatment. The policy outlines the expectations of the college when a physician authorizes the use of cannabis for medical purposes in accordance with the principles articulated in the College's Practice Guide and according to other relevant College policies:
    - Before prescribing, the physician must assess the appropriateness for the patient. The physician must not prescribe to patients under the age of 25 unless all other conventional therapeutic outcomes are exhausted. The patient must provide informed consent.
    - When prescribing, the physician must determine a safe and effective dose depending on the circumstances of the patient. The physician must monitor the patient for any emerging risks or complications.[24]

- The College of Physicians and Surgeons of Alberta *Standard of Practice* permits physicians to choose not to treat patients with cannabis in accordance with the Code of Ethics and standard of practice with respect to moral or religious beliefs. Physicians who choose to treat patients with cannabis for medical purposes are required to: register with the College; attempt conventional therapies first; and assess patients with respect to risk of addiction. Physicians are not permitted to dispense or provide cannabis or apply to become a licensed producer.[25]

WHAT IS THE POSITION OF PHARMACISTS?

- The Canadian Pharmacists Association (CPhA) believes that the best way to enhance patient safety, education and appropriate access to cannabis for medical purposes is through pharmacist dispensing and management, while promoting the use of non-smokable products as opposed to smokable forms.[26] The CPhA has created a new pharmacy practice resource to assist pharmacists and address commonly asked questions about cannabis for medical purposes.[27]

- In January, 2016, the Ontario Pharmacists Association (OPA) launched a survey to its members asking for input on whether or not pharmacy should play a role in the distribution

of cannabis for medical purposes. In total, 671 pharmacists, representing all membership categories and postal code districts, participated in the survey. Respondents were asked the following question:

- "Notwithstanding any remuneration model, do you believe that pharmacies should be involved with the sale and/or distribution of medical marijuana?"
- Overall, 63.9% answered "Yes", 19.6% answered "No", and 16.9% answered "Undecided".

WHAT IS THE ROLE OF THE PHARMACIST, IF ANY?

- In 2016, the College engaged a consultant to provide recommendations to the College regarding access to cannabis for medical purposes.

- In his recommendations, Dr. Thiessen acknowledged that all medicines require best practices and recommended that the College avoid a chemical-specific regulatory position. In addition, he recommended:
  1. That the OCP take a pro-active position for pharmacists and technicians, alerting them to remain current in their understanding about cannabis (marijuana), and to follow through with the expectation of providing customary optimal individualized patient care that, in this case, ensures the array of potential cannabis-associated pharmacokinetic and pharmacodynamics interactions do not compromise present and future therapy. A functional solution for this expectation is to have the College champion the development of suitable education programs for pharmacists and technicians; and

  2. That, given the growing pervasiveness of non-medical and medical cannabis use, pharmacists, pharmacies and proprietors be alerted to an altruistic opportunity and be encouraged by the OCP to develop a more dynamic societal care role in advancing public health. Specifically, it is recommended that tangible opportunities be created to engage patients and the public of all ages about the facts surrounding marijuana.

- NAPRA advises that external pressures must not result in the bypassing of critical checks and balances that preserve the integrity of the health care system.

ASSESSMENT OF HEALTH IMPACTS

- Cannabis may increase the risk of bleeding when taken with blood thinners, affect blood sugar levels, or cause low blood pressure. It may also increase the amount of drowsiness when combined with medications that affect the CNS.[28]

What is the Current Evidence on the Health Effects of Cannabis and Cannabinoids?

- A consensus report compiled by the *Committee on the Health Effects of Marijuana* noted that there are no accepted standards of risk to help guide individuals with respect to the short- and long-term health effects (harm and benefits) of cannabis use.[29]

  The Committee's results show *Conclusive or substantial evidence* for the following **positive** impacts:
  - Treatment of chronic pain in adults (cannabis);
  - Anti-emetics in the treatment of chemotherapy-induced nausea and vomiting (oral cannabinoids); and
  - Improvement of patient-reported multiple sclerosis spasticity symptoms (oral cannabinoids).

  Based on a statistical association, the Committee's results show *substantial evidence* for the following **negative** impacts*:*

- Maternal cannabis smoking and lower birth weight of offspring;
- Cannabis smoking and worse respiratory symptoms including more frequent chronic bronchitis;
- Cannabis use and an increased risk of motor vehicle crashes;
- Cannabis use and the development of schizophrenia and other psychoses;
- Being male and smoking cigarettes and the progression from use to problem cannabis use;
- Increased frequency of use and the progression to developing problem cannabis use;
- Cannabis use at an earlier age and the development of problem cannabis use.[30]

WHAT IS THE PUBLIC PERCEPTION?

- In those U.S. states where medical use is permitted, there is a trend to higher rates of reported non-medical use; however, it is likely that the higher rates of use are also predictive of stronger public support for medical use.[31]

Task Force on Cannabis Legalization and Regulation Report

- Stakeholders who responded to the Task Force Report and addressed the notion of cannabis for medical purposes agreed on the legitimacy of cannabis for medical use; however, there were two different perspectives on whether a separate system was required for medical access:
    1. The dominant view is that a separate system is required to preserve medical access in recognition that use is for medical purposes and occurs under the supervision of a physician. Additional key concerns relate to ensuring that young people who require access for medical purposes will continue to receive cannabis for treatment; avoiding the stigma associated with having to purchase cannabis for medical purposes from a non-retail medical outlet; and ensuring continuity of supply.

    2. The other view is that there is no need for a separate system and that broad access will ensure that those who require cannabis for a medical purpose will be able to acquire it legally. Support for this perspective was seen from members of medical community who have concern about authorizing a substance that is not an approved medicine.

- The Task Force recommends that the separate medical access framework should be maintained, monitored and evaluated in five years.[32]

Canadians for Fair Access to Medical Marijuana (CFAMM)

- CFAMM is a national non-profit organization dedicated to protecting and improving the rights of Canadian patients. With the assistance of a patient advisory board, the organization's mission is to ensure fair access to cannabis for medical purposes.[33]

- In response to the Ontario government consultation on access to cannabis for non-medical purposes, CFAMM recommended that "pharmacies have exclusive authority to retail medical cannabis in the province." The rationale for this recommendation was that it would create a clear distinction between cannabis for medical or recreational purposes and ensure that patients receive education on safe and effective use".[34]

ARE THERE CONCERNS RELATED TO THE CURRENT MEDICAL DISTRIBUTION SYSTEM?

Allard v. Canada

- The current regulations (ACMPR) came into effect as a result of a legal challenge in 2016 associated with a prohibition on personal cultivation in the previous regulations. The plaintiffs in the case argued that the availability of cannabis for medical purposes from Licensed Producers (LP) is sporadic, with many either out of stock or not accepting new customers, necessitating the ability to self-produce.
- The judge determined that restrictions on growing cannabis for medical purposes were unconstitutional and ordered the government to revise the regulations to make it easier and more affordable for people to access marijuana for medical purposes.[35,36]
- The court's disposition did not generally address or confirm the characterization of access to cannabis for medical purposes from LPs.

WHAT ARE THE MODELS FOR MEDICAL USE?

- The model for medical use may include the following components:
  1. Qualifying condition
  2. Physician authorization
  3. Limits on dose
  4. Dispensary type (pharmacy, state-licensed dispensary, 'other' distribution centre
  5. Restrictions on location
  6. Home cultivation
  7. Restrictions on dosage form; and
  8. Insurance coverage.

- Canada requires a person who wishes to obtain cannabis for medical purposes from a licensed producer to:
  - Consult with a health care practitioner;
  - Obtain a medical document
  - Register and order with a licensed producer; and
  - Receive cannabis for medical purposes via mail order.

What is the Inspection Process?

- In Canada, the *Office of Medical Cannabis* in the *Legalization and Regulation Branch of Health Canada* ensures that cannabis for medical purposes is produced, sold and distributed according to the ACMPR.
- Inspections are conducted to assess and monitor compliance and all facilities are inspected as cultivation begins and before a license to sell products to the public is issued.[37]

What are the Labelling Requirements?

- In Canada, the *ACMPR* sets out the requirements for product labels that licensed producers must meet. The label is required to include the producer's identifying information, product information including type of product, brand name, lot number, storage conditions and packaging date along with an expiry date, if any.[38]
- The label will also include the net weight of the products and percentage of THC or CBD. If the product is in oil form sold in a capsule, the number of capsules or units as well as net weight is also required.[39]

WHAT IS THE EXPERIENCE OF OTHER COUNTRIES?

- The U.S. has the most mature distribution systems in place for cannabis for medical purposes. Detail on the type of distribution system in place is available at *Appendix 2*. Only 6 of 30 legalized U.S. jurisdictions require pharmacy/pharmacist participation in distribution.
  - A full review of U.S. states, showing which aspects of the components of the model for medical distribution are included or required is at *Appendix 3*.
  - 29 states in the U.S. and Washington D.C. have legalized cannabis for medical purposes. In the U.S., patients may only access cannabis for medical purposes with a physician authorization or prescription given only to individuals with one or more of the qualifying conditions specified by state legislations. These legislations also limit the amount of cannabis for medical purposes an individual may obtain and possess at a given time.
  - 6 states require pharmacist involvement in the distribution process:
    - In Connecticut a board-certified pharmacist must be onsite to dispense the product from a medical cannabis dispensary. The substance may be inhaled or ingested by any other means.[40]
    - In Minnesota, a pharmacist is the only one who can dispense cannabis. Medical cannabis cannot be sold in plant form for smoking.
    - New York requires a state-licensed pharmacist to be on the premises. Medical cannabis cannot be sold in plant form for smoking.[41]
    - Three additional states, Louisiana, Ohio and West Virginia are utilizing pharmacy professionals in program development or requiring a pharmacist to be on site. These systems are not yet implemented although it appears that medical cannabis will not be sold in plant form for smoking.

  - None of these 6 states have legalized non-medical cannabis.
  - Most states where cannabis for medical purposes is legal allow home cultivation and have restrictions on the location of the distribution centres. None of the states with pharmacist involvement in distribution permit home cultivation.

- Cannabis is legal for medicinal use in the following countries: Australia, Canada, Chile, Columbia, Germany, Jamaica, Mexico, Philippines, Puerto Rico, Spain, Turkey and more than one-half of U.S. states.[42] See *Appendix* 4 for more information on the status of medical cannabis in other countries.

COMPARISON BETWEEN CANNABIS AND PRESCRIPTION CANNABINOID MEDICATIONS

	Cannabinoid (Generic name)	Registered name	Principal constituents/ Source	Official status in Canada	Approved indications	Onset (O)/ Duration of action (D)	Route of admin.	Availability on provincial/ territorial formulary
Cannabinoids Rx	Dronabinol[#]	Marinol®[#]	Synthetic Δ9-THC	Approved[#]	AIDS-related anorexia associated with weight loss; Severe nausea and vomiting associated with cancer chemo-therapy	O: 30 - 60 min D: 4 - 6 h	Oral	MB[#]; NB[#]; NS[#]; ON[#]; PE[#]; QC[#]; YT[#]
	Nabilone	Cesamet®	Synthetic Δ9-THC analogue	Approved	Severe nausea and vomiting associated with cancer chemo-therapy	O: 60 - 90 min D: 8 - 12 h	Oral	AB; BC; MB; NB; NL; NS; NT; NU; ON; PE; QC; SK; YT.
	Nabiximols (THC+CBD and other minor cannabinoids, terpenoids, and flavonoids)	Sativex®	Botanical extract from established and well-characterized *C. sativa strains*	Approved*	*	O: 15 - 40 min D: 2 - 4 h	Oro-mucosal spray	NS.
Plant product	Cannabis (smoked)	N/A	*C. sativa* (various)	Not an approved product	N/A	O: 5 min D: 2 - 4 h	Smoking	N/A
	Cannabis (vapourized)	N/A	*C. sativa* (various)	Not an approved product	N/A	O: 5 min D: 2 - 4 h	Inhalation by vapourizer	N/A
	Cannabis (oral edible)	N/A	*C. sativa* (various)	Not an approved product	N/A	O: 30 - 60 min D: 8 - 12 h	Oral	N/A
	Cannabis (topical)	N/A	*C. sativa* (various)	Not an approved product	N/A	N/A	Topical	N/A

[#] Product has been discontinued by the manufacturer (post-market; as of February 2012; not for safety reasons)

* For Sativex®, the following marketing authorizations apply:

- **Standard marketing authorization:** Adjunctive treatment for symptomatic relief of spasticity in adult patients with multiple sclerosis who have not responded adequately to other therapy and who demonstrate meaningful improvement during an initial trial of therapy.
- **Marketing authorization with conditions:** Adjunctive treatment for symptomatic relief of neuropathic pain in adult patients with multiple sclerosis; and adjunctive analgesic treatment in adult patients with advanced cancer who experience moderate to severe pain during the highest tolerated dose of strong opioid therapy for persistent background pain.

STATUS OF SALES/DISPENSING OF CANNABIS FOR MEDICAL PURPOSES BY U.S. STATE[43]

Dispensing Cannabis for Medical Purposes – A review*

1. Alaska – medical is legal – but no provision for dispensaries
2. Arizona – state-licensed dispensaries (~10k patients; ~100 dispensaries)
3. Arkansas – state-licensed dispensaries (licensing program in process as of June 2017)
4. California – state-licensed dispensaries
5. Colorado – licensed medical marijuana centers
6. Connecticut – state licensed dispensaries; but only licensed pharmacists are permitted to obtain a dispensary license
7. Delaware – state-licensed compassion centers (3)
8. Florida – state-licensed medical marijuana treatment centers (7 - mail order if necessary)
9. Hawaii – state-licensed medical marijuana dispensaries – program underway and no retail operations as yet (~15,000 patients registered)
10. Illinois – state-licensed medical cannabis dispensaries (~53 in the state)
11. Louisiana – in process: pharmacy board creates special pharmacy permit (~10 permits)[44]
12. Maine – state-licensed dispensaries (~8)
13. Maryland – state-licensed: approval process underway (~102 applications to dispense)
14. Massachusetts – state-licensed medical marijuana dispensaries (~10)
15. Michigan – only caregiver to patient sales permitted: newly created medical marijuana board in process and applications for licensing to be submitted starting in December 2017
16. Minnesota – ~8 state-licensed cannabis patient centers: a pharmacist must be employed by a manufacturer to distribute medical cannabis, including a review and assessment and calculation of daily dosage
17. Montana – state-licensed dispensaries (until recently, limited # patients per provider)
18. Nevada – state-licensed dispensaries (~9)
19. New Hampshire – state-licensed alternative treatment centers (~4)
20. New Jersey – state-licensed alternative treatment centers (~6)
21. New Mexico – state-licensed non-profit producers (~35)
22. New York – state-registered organizations (~5 with each operating 4 locations): a state-licensed pharmacist is to be on premises and directly supervising
23. North Dakota – program in development (~8 dispensing centres)
24. Ohio – board of pharmacy to establish standards and procedures
25. Oregon – state-licensed dispensaries (~28)
26. Pennsylvania – 27 companies approved to open ~81 dispensaries
27. Rhode Island – state-licensed medical marijuana compassion centres (~3)
28. Vermont – state-licensed dispensaries (~5)
29. Washington – state-licensed dispensaries (~1500)
    Washington D.C. – state-licensed dispensaries
30. West Virginia – Board of Health to implement program: a pharmacist or physician to be on site (~30)

*****States generally identify an upper limit on the number of dispensaries that may be licensed, and then there is a lag time until they are approved and operationalized.

CANNABIS FOR MEDICAL PURPOSES: MODEL FOR USE

State	Non-medical legal	Qualifying conditions	Physician authorization/ prescription	Limits on dose	Pharmacist involvement in distribution	State-licensed dispensary	Other dispensary type	Distribution centre location restrictions	Home Cultivation	Restrictions on dosage form of cannabis	Insurance coverage/ subsidy
Alaska	✓	✓	✓	✓			✓		✓		
Arizona		✓	✓	✓		✓		✓	✓[45]		
Arkansas		✓	✓	✓		✓		✓			
California	✓	✓	✓	✓		✓		✓	✓		
Colorado	✓	✓	✓	✓			✓		✓		
Connecticut		✓	✓	✓	✓	✓					
Delaware		✓	✓	✓			✓	✓			
Florida		✓	✓	✓			✓				
Hawaii		✓	✓	✓		✓			✓		
Illinois		✓	✓	✓		✓		✓			✓
Louisiana		✓	✓	✓	✓		✓	✓		✓	
Maine	✓	✓	✓	✓		✓		✓	✓		
Maryland		✓	✓	✓		✓		✓			
Massachusetts	✓	✓	✓	✓		✓			✓[45]		
Michigan		✓	✓	✓			✓		✓		
Minnesota		✓	✓	✓	✓		✓	✓		✓	✓
Montana		✓	✓	✓		✓		✓	✓		
Nevada	✓	✓	✓	✓		✓		✓	✓		
New Hampshire		✓	✓	✓			✓	✓			
New Jersey		✓	✓	✓			✓	✓	✓		
New Mexico		✓	✓	✓			✓		✓		
New York		✓	✓	✓	✓	✓		✓		✓	✓
Ohio		✓	✓	✓	✓		✓	✓		✓	
Oregon	✓	✓	✓	✓		✓		✓	✓		
Pennsylvania		✓	✓	✓		✓				✓	
Rhode Island		✓	✓	✓			✓	✓	✓		
Vermont		✓	✓	✓		✓		✓	✓		
Washington	✓	✓	✓	✓		✓		✓	✓		
Washington D.C.	✓	✓	✓	✓		✓		✓			
West Virginia		✓	✓	✓	✓[46]		✓	✓		✓	

Appendix 4

IMPLEMENTING A SYSTEM FOR THE USE OF CANNABIS FOR MEDICAL PURPOSES

In most countries where cannabis for medical purposes has been legalized, there is a significant lag between approval of the use of cannabis for medical purposes and the development of a production and distribution system, as indicated below.

- Australia's implementation of access to cannabis for medical purposes is evolving, and it is intended that both physicians and pharmacists will be involved in providing cannabis for medical purposes to patients. Australia implemented legislation permitting domestic production only in October 2016 and access to the substance is through special access or an authorized prescriber.[47]

- Although cannabis for medical purposes was legalized in 2015, Chilean pharmacies only began distributing cannabis for medical purposes in a pilot project in May of this year. Prior to that, users were required to import it or purchase is from a limited number of farms setup by a charity.[48]

- Columbia legalized cannabis for medical purposes in 2016, limiting sales and distribution for medical purposes to cannabis oil only. Production is underway in collaboration with a Canadian firm.[49]

- Germany approved a law permitting medical use in March, 2017. A state-regulated program to cultivate a crop for medical use is underway.[50] A program is already in place, permitting the purchase of cannabis flowers and extract from pharmacies.[51]

- Jamaica has created a *Cannabis Licensing Authority* to regulate the use of cannabis for medical, therapeutic and scientific purposes.[52] The country is in the process of approving licenses to cultivate and process cannabis.[53]

- Mexico has approved cannabis for medical purposes and proposes distribution at pharmacies, dispensed with a doctor's prescription.[54]

- In the Philippines, a House of Representatives Committee has endorsed the use of cannabis for medical purposes; however, regulations are still to be developed.[55]

- In in January 2017, two years after regulations to permit the cultivation, manufacturing and distribution were adopted, two dispensaries opened in Puerto Rico to dispense cannabis for medical purposes.[56]

- Spain has legal access to drugs containing non-psychoactive CBD preparations. Access to cannabis containing THC is through cannabis social clubs that exploit a legal grey area to provide access.[57]

- The cultivation of cannabis for medical and scientific purposes has been approved in Turkey.[58]

- As of February 2017, more than one half of U.S. states permitted physicians to recommend cannabis for medical purposes to patients and approximately 20% of Americans lived in states where cannabis for medical purposes can be sold to adults.[59] As of July 2017 that number grew to 30 states plus Washington D.C. although not every program is up and running.[60]
  - Three states have mandated pharmacist involvement in dispensing cannabis for medical purposes (New York, Minnesota, Connecticut).[61] New York and Minnesota have limited the dosage forms of dispensed cannabis for medical purposes to tablet, liquid, and vaporized dosage forms. In these states, medical dispensaries are not permitted to sell smokable and edible forms of cannabis.[62]
  - Three additional states, Louisiana, Ohio and West Virginia are utilizing pharmacy professionals in program development or requiring a pharmacist to be on site.

- In **New York**, an individual with an active New York State pharmacist licence and directly supervising the activity within the facility must be on site.[63]

- In **Connecticut**, only a pharmacist may apply for and receive a dispensary license.[64]
  - Cannabis is a Schedule II drug in Connecticut. This means that it goes through the same process as other controlled substances in Connecticut, meaning it's tracked through the Connecticut Prescription Monitoring and Reporting System (CPMRS), a state-wide database updated weekly with patients' prescription data.
  - The CPMRS allows participants to include notes about the effects of cannabis on a patient's symptoms and conditions, as well as how cannabis interacts with other drugs the patient might be taking.

- In **Minnesota** licensed manufacturers are permitted to set up distribution facilities for a total of eight across the state.
  - Minnesota legislation requires:[65]
    - Employees licensed as pharmacists be the only employees to distribute the medical cannabis to a patient.
    - Prior to distribution of any medical cannabis, the manufacturer shall ensure that any employee licensed as a pharmacist has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner.
  - Pharmacists select and dispense the cannabis product, while physicians identify who is eligible. They decide the amount of THC and CBD – which control the psychoactive effects of cannabis.

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National Association of Pharmacy Regulatory Authorities ®
Association nationale des organismes de réglementation de la pharmacie

Cannabis for Medical and Non-Medical Purposes: NAPRA Position Statement on the Role of Pharmacy Practitioners

July 2017

On April 13, 2017, the Government of Canada proposed the Cannabis Act, which would create a strict legal framework for controlling the production, distribution, sale, and possession of cannabis across Canada. The proposed legislation focuses primarily on cannabis for non-medical purposes; the current program for accessing cannabis for medical purposes would continue under the new Act.

NAPRA's position is that pharmacy practitioners must not be involved in the distribution of cannabis for non-medical purposes. Distribution sites for non-medical cannabis must not be permitted to use terms such as "dispensary" or pharmacy-related symbols such as a green cross, which may lead the public to believe that the distribution site is a pharmacy or that it has professional oversight from pharmacy practitioners.

Suppliers of cannabis for any purpose must follow the federal Good Production Practices required by the Access to Cannabis for Medical Purposes Regulations (ACMPR), or equivalent quality standards yet to be developed. Packaging, labelling, and shipping standards must also be equivalent to those set out in the ACMPR in order to ensure secure supply chains, appropriate product labelling, and child-resistant packaging.

NAPRA also urges decision-makers to restrict advertising and marketing of cannabis, so as not to promote consumption.

For many years, pharmacists have been at the forefront of smoking cessation, helping patients to quit using tobacco. Cannabis smoke contains many of the same carcinogenic chemicals found in tobacco smoke. NAPRA's position is that smoked cannabis products should be subject to the same provincial or territorial legislation as smoked tobacco products.

On November 30, 2016, the final report of the Task Force on Cannabis Legalization and Regulation was published. In addition to recommending that access to cannabis for medical purposes continue to be made available through the ACMPR, the report discussed the future possibility of pharmacy distribution of cannabis for medical purposes. We are aware that some pharmacy groups are advocating for this. As pharmacy regulators, we insist that external pressures must not result in the bypassing of critical checks and balances that preserve the integrity of our health care system, and ultimately, the health of Canadians. NAPRA's members continue to discuss the regulatory safeguards necessary for pharmacy professionals to dispense cannabis for medical purposes. In the interim, pharmacists will continue to be involved in providing patients with information and guidance.

NAPRA's members urge the federal government to consult with NAPRA, early in the process, if there is consideration of pharmacy distribution in the future.

Ontario College of Pharmacists
Putting patients first since 1871

COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Opioid Task Force

TOPIC: Opioid Strategy

ISSUE: Development of a comprehensive and collaborative opioid strategy that aligns with national and provincial opioid-related goals.

BACKGROUND:

- The abuse and misuse of opioids, including prescription narcotics and other controlled substance medications, is a serious public health and safety issue in Ontario.
- Overdose deaths due to medical and non-medical opioid drug use are now the third leading cause of accidental death in Ontario[1].
- There has been a federal and provincial focus on implementing strategies to address opioid-related issues that are affecting provinces across the country.
- 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, which concluded with a Joint Statement of Action to Address the Opioid Crisis.
- Ontario's commitment to Action was to implement an Opioid Strategy that focuses on enhancing data collection, modernizing prescribing and dispensing practices and connecting patients with high quality addiction treatment services.
- Ontario has also developed a Narcotic Strategy to support and promote the proper use of narcotics and other controlled substances and reduce drug abuse and addiction.
- The 2017 Ontario budget referenced the opioid crisis and committed to acting on Ontario's Opioid Strategy including modernizing pain management practices.
- In March 2017, recognizing the opportunity to collaborate to improve opioid-related outcomes, Council endorsed the establishment of an Opioid Task Force to develop an Opioid Strategy that will identify short, medium and long term initiatives and outcomes.
- The composition of the Task Force included a hospital pharmacist, a pharmacy technician, a community pharmacist, a public member of Council and a family physician who is a medical advisor with the College of Physicians and Surgeons of Ontario.

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ANALYSIS:

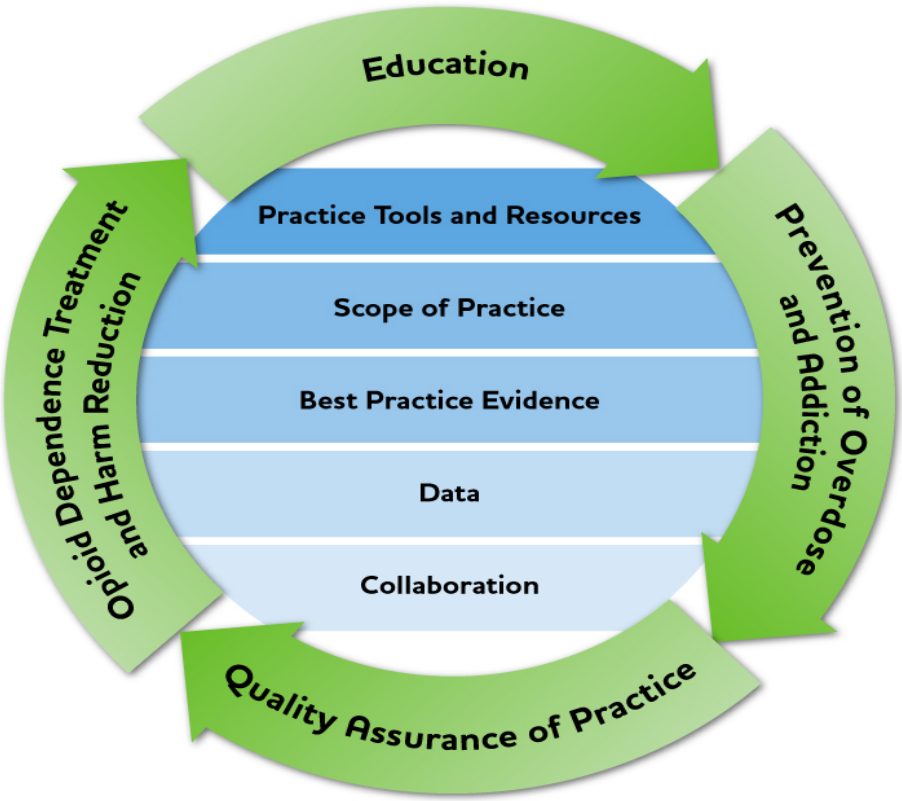
- The goal of the Task Force was to guide the development of a College Opioid Strategy (the Strategy) (Appendix A) that aligns with provincial and national strategies.

- To support the development of the Strategy the Task Force invited multiple presenters to provide context and background information regarding opioid-related issues, including:
    - Dr. Tara Gomes from the Ontario Drug Policy Research Network to present statistics related to opioid-related deaths and interpretation of current opioid trends.
    - Nancy Lum-Wilson, Registrar, Ontario College of Pharmacists, to present the national (National Association of Pharmacy Regulatory Authorities) Opioid Strategy approved at the April 2017 NAPRA Board meeting.
    - Sylvia Hyland from the Institute for Safe Medication Practice (ISMP) to present on opioid-related projects currently underway.
    - Managers Tina Perlman, Community Practice, Judy Chong, Hospital Practice and Maryan Gemus, Investigations and Resolutions to present current and future (planned) initiatives with respect to opioids and opioid-related issues that have been identified by each department.

- The Task Force reviewed and considered information presented and existing provincial and national opioid strategies to inform the development of the Strategy.

- The Strategy identifies four strategic priorities, each supported by the same five strategic areas of focus that will guide initiatives under each priority in response to the opioid crisis.

Ontario College of Pharmacists: Strategy to Address Opioid Misuse and Abuse in Ontario



- The Task Force also created a logic model outlining proposed initiatives to support each arm of the Strategy and corresponding short, medium and long term goals. The model will be used to support development of the work plan and evaluation

Implementation

- College staff will form an internal working group that will analyze and prioritize the initiatives identified by the Task Force.

- An external working group with appropriate expertise will be established to support implementation and operationalization of the identified initiatives. Sub-groups will be formed from the larger group where specific expertise is required.

- The external working group will include consideration of the patient experience.

- Initiatives under the Strategy have been reviewed and considered in the proposed 2018 budget.

NEXT STEPS:

- The Strategy will serve to inform the outcomes that will drive the development and evaluation of initiatives that the College will undertake in relation to this issue.

- Progress on opioid-related initiatives will be reported to Council quarterly through the Registrar's Report.

Appendix A

Ontario College of Pharmacists:
Strategy to Address Opioid Misuse and Abuse in Ontario

Ontario is facing a serious public health and safety issue related to the abuse and misuse of opioids, including prescription narcotics and other controlled substances. Opioid misuse is the third leading cause of accidental death in Ontario and opioid-related causes of death continue to increase each year. A comprehensive strategy, that considers the complexity of both health and social factors related to opioid abuse and misuse, is needed to address this challenging issue.

Pharmacy professionals play an important role in the procurement and distribution of narcotic and controlled substances for use in patient care and therefore have a professional responsibility to take action to decrease the burden of current opioid issues faced by society. As medication experts, pharmacists are in a unique role to support the appropriate use and access to narcotic and controlled substances and collaborate with other health care professionals.

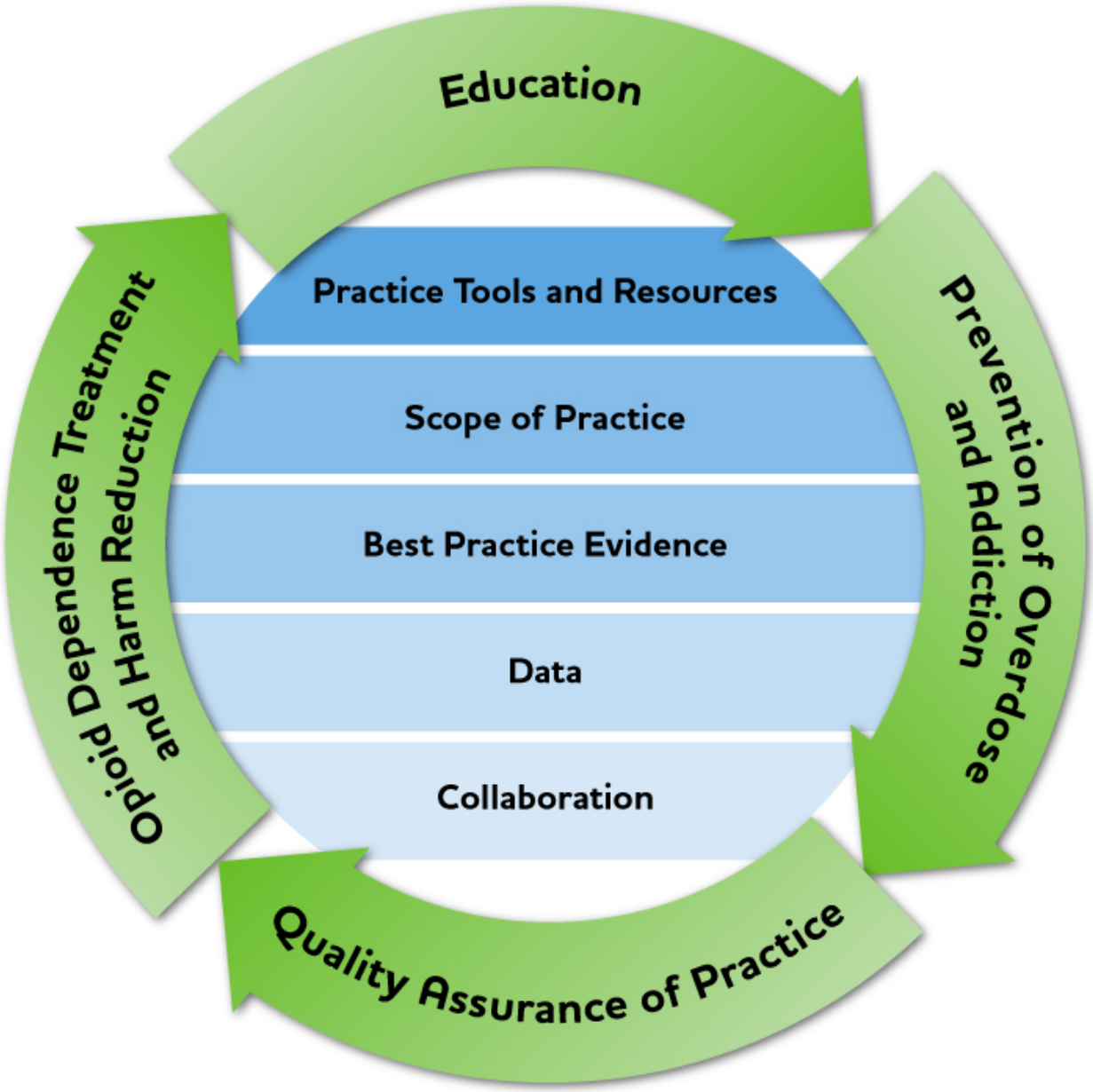
The Ontario College of Pharmacists recognizes that no single initiative will “fix” Ontario’s opioid-related issues and is committed to implementing a comprehensive opioid strategy that will align with national and provincial opioid-related goals. To ensure that a sustainable and effective approach is taken to addressing opioid-related issues, the College has developed a multi-pronged strategy to simultaneously address relevant areas of practice.

This strategy will support the College in meeting its mandate to serve and protect the public’s interest by:

- advancing opioid-related education for pharmacy professionals,
- improving harm reduction strategies and delivery of opioid dependence treatment,
- preventing overdose and addiction by supporting evidence-based and appropriate dispensing practices, and
- strengthening oversight of the provision of narcotic and controlled drugs to patients and the security of drug distribution.

Opioid Strategy

The opioid strategy has identified four strategic priorities, each supported by the same five strategic areas of focus that will guide initiatives under each priority in response to the opioid crisis.



STRATEGIC PRIORITIES – *Outlines the four high-level areas related to opioid issues that the Ontario College of Pharmacists can affect as a regulator to ensure consistency in the consideration and implementation of opioid-related activities.*

1. Education for Pharmacy Professionals Regarding Opioid Related Issues

To provide optimal patient care, pharmacy professionals require access to appropriate continuing education, training and resources regarding the treatment of conditions such as acute and chronic pain and the identification of patients at risk for opioid dependence or misuse. Ongoing education is required to ensure that pharmacy professionals have the knowledge, skills and competence to confidently make pharmacologic and therapeutic decisions regarding opioid therapy, as well as the ability to effectively communicate this information to other healthcare professionals and patients. To support comprehensive treatment of patients receiving therapy with opioids, pharmacy professionals also need appropriate training around common indications and comorbidities that may affect a patient's opioid use such as pain management, mental health issues and opioid use disorder.

GOAL: The Ontario College of Pharmacists will collaborate with relevant stakeholders to ensure that educational and training opportunities and resources to support appropriate opioid dispensing and pain management treatment are available and communicated to pharmacy professionals.

2. Opioid Dependence Treatment and Harm Reduction

Optimal delivery of opioid dependence treatment by pharmacy professionals requires the development, identification and communication of resources to support evidence-based treatment and integrate a holistic approach to therapy that decreases the stigma surrounding substance abuse and harm reduction. This includes ensuring an increased awareness and knowledge regarding dual treatment of comorbid conditions such as mental health issues, additional services available to support patients with substance abuse disorders and of cultural awareness to support the provision of culturally sensitive care. Pharmacy professionals are also well positioned to integrate harm reduction strategies into the current pharmacy practice environment to support increased patient access to services and decrease the negative consequences of drug use.

GOAL: The Ontario College of Pharmacists will assist pharmacy professionals by developing updated guidance to support practice related to opioid dependence treatment and in identifying additional resources to support the treatment of opioid use disorder and implementation of harm reduction strategies.

3. Prevention of Overdose and Addiction

As healthcare professionals, pharmacists and pharmacy technicians have a duty to ensure that patients are not harmed by their medications and receive benefit from therapy, as well as more broadly to protect public safety. This includes providing patient-centred care and supporting appropriate prescribing and dispensing of opioids. To meet this goal, pharmacy professionals require a supportive practice environment that encourages and enables multidisciplinary collaboration and emphasizes patient-centred care as a priority. In addition, pharmacists require accurate and current information about a patient's prescription history. As medication experts, pharmacists must take a stewardship role with respect to opioid prescriptions. Pharmacists are responsible for providing recommendations on opioid dosing and conversion and non-opioid treatment options for pain management to ensure patients are receiving appropriate therapy based on their individual circumstances and for identifying patients at risk of dependence or misuse. This requires communication between all members of the patient's care team (which can be formal or informal) to ensure that goals and messages communicated to the patient are aligned.

GOAL: The Ontario College of Pharmacists will build on and align with the National Association of Pharmacy Regulatory Authorities (NAPRA) Standards of Practice and additional supplementary documents to support standards of practice and competencies for pharmacy professionals that enhance patient care around opioid issues. The College will also engage government in discussions regarding the need for access to electronic health records and system-wide data analysis.

4. Quality Assurance of Practice

The primary mandate of health regulatory colleges is public protection, which is achieved by holding pharmacy professionals accountable for the safe, effective and ethical delivery of pharmacy services. Public protection with respect to opioid-related pharmacy services requires monitoring and enforcement around the provision of opioids to patients and the security of opioid distribution. To ensure that practice requirements are understood and being met the College must focus on opportunities to improve monitoring and enforcement of opioid procurement and distribution by pharmacies, narcotic security and control in pharmacies and the return and destruction of opioids. This can be achieved through collaboration with federal and provincial governments to access data that can inform College activities, better use of data from College programs, identification of measurable indicators and building capacity in College staff that support front-line pharmacy professionals.

GOAL: The Ontario College of Pharmacists will monitor and enforce the security of opioid distribution and the provision of opioids to patients using data to inform and measure College actions and identify and focus on high-risk practices.

Strategic Areas of Focus – *Outlines five different levers that the College will employ to support the achievement of the Strategic Priorities.*

1. Practice Tools and Resources

The College will collaborate to identify gaps and needs in practice and ensure that both internal and external tools and resources are communicated to pharmacy professionals to support the provision of appropriate opioid-related services, including pain management.

2. Scope of Practice

The College will consider how to optimize pharmacy professionals' scope of practice to best support patient outcomes and access to services.

3. Best-Evidence Practice

The College will support pharmacy professionals in the application of the best available evidence, best practices and current prescribing guidelines around pain management.

4. Data

The College will commit to using relevant and current data to inform College activities.

5. Collaboration

The College will continue to build collaborative relationships with other health regulators, educators, government and other relevant healthcare organizations and leaders to support integrated and patient-centred care.

Ontario College of Pharmacists
Putting patients first since 1871

COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Finance and Audit Committee

TOPIC: 2018 Operating and Capital Budget

ISSUE: Approval of the 2018 Operating and Capital Budget

BACKGROUND:

- The 2018 budget supports fulfillment of the initiatives set out in the third and final year of the current strategic plan. Council will undertake a strategic planning process in the spring of 2018 to set the direction and priorities for 2019 onward.

- In the past few years, revenue has exceeded expenses with cumulative surpluses amounting to $2.4 million. The surpluses have been assigned to one of three reserves – Investigations and Hearings Reserve, Contingency Reserve and Fee Stabilization Reserves, with total reserve funds now equal to $8.5 million, approximately 50% of current year annual expenses.

- Continued growth in membership has enabled the College to maintain current member fee levels for the past three planning cycles.

ANALYSIS:

- The Council planning session scheduled for next year will align with government initiatives aimed at redefining accountabilities of health regulatory colleges. The new plan will set the stage for future work of the College.

- Following the development of a new operations plan to support the 2019 strategic plan, fee levels will be adjusted to meet expense expectations. (Medication error reporting subscriptions to be incorporated into the 2019 budget.)

- The Executive Summary and attached budget schedules outline the assumptions respecting membership volumes and College activity. Excess expenses over revenue budgeted for 2018 will be drawn from the Reserves.

RECOMMENDATION: **That Council approve the attached Operating and Capital Budget drawing down on Reserves as necessary to cover the shortfall of revenue against expenses.**

EXECUTIVE COMMITTEE RECOMMENDATION AND COMMENTS (if any):

Ontario College of Pharmacists
Proposed 2018 Budget – Executive Summary

The following pages provide an overview of the projected financial status for the College at the end of the 2017 operating year and the proposed revenue and expenditures for 2018.

Review of Projected 2017

Revenue is projected to come in on budget with slight variations against budget in a couple of areas. Technician levels were accurately predicted for the first time since the creation of the class of registrant in 2010. Other registration levels and community pharmacy sales and relocations will be marginally higher than originally anticipated.

Expenses are projected to come within 1.6% of budget. Most committee expense categories will be in line with budget, however, prosecution costs for discipline are projected to be higher than budgeted due to an increasingly complex case load and a couple of highly contested cases. For personnel costs, savings realized in staff group benefits through a change in carrier in 2016 will be offset by steep increases when renewal rates take effect later this year while training and development costs will continue to be focused on specified performance improvement. Conference attendance and employee education/training will also come in slightly below budget for 2017.

Cost of administering the regulatory programs will come in on budget with variations throughout the expense categories. Consulting activity for Quality Assurance was not incurred as expected as regulations were delayed and communication initiatives were attained in a more cost effective manner than budgeted. While legal costs for regulation drafting will exceed budget, some significant breakthroughs were achieved in 2017 such as amendments to the *Drug and Pharmacies Regulation Act* through the *Protecting Patients Act*. The Medication Error Reporting initiative approved by Council will result in increased costs for Practice Initiatives.

Costs for College operations will be less than budgeted with technology-related consulting and license/maintenance costs not materializing as planned. Property costs will be lower than budgeted due to higher rental income.

The cumulative impact of the variances noted above is a $65,000 deficit after capital by year end as opposed to a budgeted shortfall of $290,000.

Overview of 2018 Operating Budget

In June of this year Council confirmed its commitment to the operational objectives that support the strategic priorities set by Council March 2015. The Mid-Year Report Card reflected the status of various strategies and the specific initiatives planned to increase the relevance and value of both the profession and the College as regulator. The 2018 budget sets out the financial impact of the strategies and initiatives.

Revenue - Schedule A

Revenue is budgeted to increase by $500,000 due to continued growth in the number of registrants and pharmacies. No extraordinary volume variations are anticipated for 2018. While legislative amendments to enable the discontinuance of undergraduate student registration is now in force, the regulations to remove studentship and introduce an intern class of registrant for both pharmacists and technicians is not expected until later in 2018. Deferring fee adjustments to the 2019 budget cycle will enable a more thoughtful consideration of how revenue is collected from the various registrant streams including flow through funding for medication error reporting subscriptions for pharmacies and any new spending required to fulfil the objectives of the next strategic plan.

Expenses – Schedules B, C, D, E

Expenses are broken down into four schedules:

- Schedule B - Council and Committee
- Schedule C – Personnel
- Schedule D – Regulatory Programs
- Schedule E – Operations

Schedule B – Council and Committee

Schedule B reflects the costs of committee and Council activity. Also included are the costs of prosecuting registrants and corporations referred to Discipline. Discipline prosecution and committee costs, as well as the recoveries, are reflected separately but in one cost area for ease of reference. All other regulatory program administration costs are budgeted under schedule D. Discipline costs represent the majority of this expense category. The complexity of the caseload continues to climb resulting in an increased number of discipline hearing days budgeted for 2018. Additionally, the proportion of contested hearings is increasing as penalties for egregious conduct increase to reflect society's expectations of professional regulation. Legal motions related to regulatory authority are more frequently raised delaying and complicating what might otherwise be routine disciplinary proceedings. As Ministry regulations to support the *Protecting Patients Act* are not expected until later in 2018, the budget assumes all cases, including those relating to sexual abuse, will continue to be investigated and adjudicated by College discipline panels. Demands on the ICRC are expected to continue and the Quality Assurance Committee will further develop elements of the new program once the regulations are in force. Council strategic planning activity will impact costs for 2018 as external facilitators will be used to gather input in advance of the planning session, facilitate discussions at Council, and generate a report to capture Council's intent.

Schedule C – Personnel

This expense category accounts for the highest proportion of college expenses and increases. As communicated to Council in June, a realignment of internal departments took place earlier this year. In addition to regrouping the current staff complement, the need to build capacity through additional staffing was identified in several areas.

The 2018 salary budget reflects two components. Firstly, a provision of 3.5% of current year salary is provided for a combination of COLA and merit as well as equity adjustments related to the organizational realignment. This equates to approximately $330,000.

The remaining $545,000 increase when compared with 2017 budget relates to an increase of 7.5 FTE (fulltime equivalent) staff in several functional areas of the College including policy, investigations, complaints, assessments, CQI and admin/office support. The largest increases are in policy and I&R. The newly formed Strategy and Policy department will now be comprised of four experienced policy analysts assigned to manage a growing portfolio of new initiatives identified in the mid-year report card including CQA (Med error reporting), opioid strategy, scope of practice strategy, *Protecting Patients Act*, cannabis, governance review and data analytics to measure the impact regulatory initiatives have on health indicators. Two of the 7.5 FTE positions are budgeted in I&R to address the increasing complexity of cases. As the proportion of Registrars Investigations to complaints increases, the effort required to investigate and prosecute members increases. Adding resources at this time will enable the college to maintain timeliness of dispositions in accordance with statutory expectations.

Recognizing that activities and costs need to be effectively managed to make greater use of the resources available, a focused effort to assess work processes and seek efficiency improvement is required and resources are provided for in the 2018 budget. Wherever practical, positions will be filled on a temporary contract basis to provide the greatest flexibility moving forward as efficiencies are realized.

Benefit costs will increase due to additional new staff as well as premium increases for employee group benefits.

Schedule D – Regulatory Programs

Expenses associated with administration of regulatory programs are expected to rise in several areas. Consulting costs for evaluation of the Pharmaceutical Jurisprudence examination, infusion clinic expertise and hospital assessment skills training are anticipated in 2018. Fifty-thousand dollars has been set aside for strategic engagement/outreach with the public to further our Patients First mandate. Research on alternative methods for applicants to prove language proficiency is budgeted to ensure the College's approach is defensible and continues to reflect contemporary practices. The first full year of the PACE program (Practice Assessment of Competence at Entry), replacing the previous SPT (Structured Practical Training) will bring costs for entry to practice back to previous levels. Likewise with the Quality Assurance (QA) Program. The College discontinued components of the old QA program in 2016 and has been developing and testing elements of the new program throughout 2017. 2018 will be the first full year of administration of peer coaching and assessment. Ongoing costs of implementing the Medication Error Reporting by community pharmacies to an independent third party will continue throughout 2018 with province-wide rollout scheduled for January 2019. An increase to the number of members monitored by the Workplace Stress and Health Program by the Centre for Addiction and Mental Health is expected as the current volumes suggest a significant underrepresentation when compared to other health professions.

Schedule E – Operations

Operations costs will increase in two areas, namely, consulting and property. Consulting support is anticipated in human resources as we seek to measure and improve employee engagement and implement an HRIS system and in Business and Technology processes to hone our

CQI/KPI setting techniques and outsource specific technology development. Property costs will increase over prior years as the College recently assumed occupancy of previously tenanted space at 186 St. George. Accordingly, for 2018, the College will be assuming a higher proportionate share of operating expenses and rental income will decline.

Capital

Capital expenditures for 2018 of $410,000 include replenishment of computer hardware including laptops, desktops and servers as well as software license upgrades for CITRIX and Exchange. New audio conferencing units are planned for all meeting rooms along with new microphones to facilitate the increased number of recorded sessions and remote meeting attendance. An accessibility ramp/lift is budgeted for the new meeting space on the first floor of 186 St George to provide the greatest flexibility in planning and supporting public meetings. The space will be ready for occupancy in the fall of 2017 but the cost of external wheelchair access was deferred due budget constraints.

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Ontario College of Pharmacists
Summary - Budget 2018

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
REVENUE - "Schedule A"	17,468,445	17,470,200	17,966,550	(1,755)	-0.01%	496,350	2.84%	498,105	2.85%
EXPENDITURES									
Schedule "B" - Council & Committee Expenses	2,418,153	2,281,500	2,800,600	136,653	5.99%	519,100	22.75%	382,447	15.82%
Schedule "C" - Personnel	11,676,681	11,898,200	12,955,177	(221,519)	-1.86%	1,056,977	8.88%	1,278,496	10.95%
Schedule "D" - Regulatory Programs	1,400,396	1,427,500	1,630,182	(27,104)	-1.90%	202,682	14.20%	229,786	16.41%
Schedule "E" - Operations	1,661,079	1,827,800	1,896,622	(166,721)	-9.12%	68,822	3.77%	235,543	14.18%
TOTAL EXPENDITURES	17,156,309	17,435,000	19,282,581	(278,691)	-1.60%	1,847,581	10.60%	2,126,272	12.39%
EXCESS OF REVENUE OVER EXPENDITURES	312,136	35,200	(1,316,031)	276,936	786.75%	(1,351,231)	-3838.72%	(1,628,167)	-521.62%
Capital Expenditures	*(378,082)*	*(325,000)*	*(410,500)*	(53,082)	16.33%	(85,500)	26.31%	(32,418)	8.57%
Surplus (Deficit) After Capital Expenditures	(65,946)	(289,800)	(1,726,531)	223,854	-77.24%	(1,436,731)	495.77%	(1,660,585)	2518.10%

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SCHEDULE A
Revenue

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
Pharmacist Fees	9,485,000	9,592,500	9,795,000	(107,500)	-1.12%	202,500	2.11%	310,000	3.27%
Pharmacy Technician Fees	1,839,100	1,850,000	1,918,000	(10,900)	-0.59%	68,000	3.68%	78,900	4.29%
Community Pharmacy Fees	4,317,070	4,288,400	4,489,100	28,670	0.67%	200,700	4.68%	172,030	3.98%
Hospital Pharmacy Fees	791,500	787,500	795,000	4,000	0.51%	7,500	0.95%	3,500	0.44%
DPP Revenue	7,500	7,500	7,500	0	0.00%	0	0.00%	0	0.00%
Professional Health Corporation	92,875	74,000	108,900	18,875	25.51%	34,900	47.16%	16,025	17.25%
Registration Fees and Income	710,400	660,300	653,050	50,100	7.59%	(7,250)	-1.10%	(57,350)	-8.07%
Investment Income	225,000	210,000	200,000	15,000	7.14%	(10,000)	-4.76%	(25,000)	-11.11%
TOTAL REVENUE	17,468,445	17,470,200	17,966,550	(1,755)	-0.01%	496,350	2.84%	498,105	2.85%

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SCHEDULE B

Council & Committee Expenses

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
Council	86,000	112,000	120,000	(26,000)	-23.21%	8,000	7.14%	34,000	39.53%
Committees:									
Accreditation	70,000	70,000	70,000	0	0.00%	0	0.00%	0	0.00%
DPP	10,000	20,000	15,000	(10,000)	-50.00%	(5,000)	-25.00%	5,000	50.00%
Discipline - Committee Expenses	285,115	285,000	320,000	115	0.04%	35,000	12.28%	34,885	12.24%
Discipline - Prosecution	1,700,000	1,460,000	1,865,000	240,000	16.44%	405,000	27.74%	165,000	9.71%
Reimbursement - Discipline Costs	(120,000)	(120,000)	(140,000)	0	0.00%	(20,000)	16.67%	(20,000)	16.67%
Total Discipline	1,865,115	1,625,000	2,045,000	240,115	14.78%	420,000	25.85%	179,885	9.64%
Executive	22,000	30,000	32,000	(8,000)	-26.67%	2,000	6.67%	10,000	45.45%
Finance & Audit	9,000	9,000	9,000	0	0.00%	0	0.00%	0	0.00%
Fitness to Practice	70,451	72,000	95,000	(1,549)	-2.15%	23,000	31.94%	24,549	34.85%
ICRC	156,253	163,000	165,000	(6,747)	-4.14%	2,000	1.23%	8,747	5.60%
Patient Relation	16,000	27,500	25,500	(11,500)	-41.82%	(2,000)	-7.27%	9,500	59.38%
Quality Assurance	85,289	83,000	155,600	2,289	2.76%	72,600	87.47%	70,311	82.44%
Registration	27,500	50,000	38,500	(22,500)	-45.00%	(11,500)	-23.00%	11,000	40.00%
Special Committees	545	20,000	30,000	(19,455)	-97.28%	10,000	50.00%	29,455	5404.59%
Total Committees	2,332,153	2,169,500	2,680,600	162,653	7.50%	511,100	23.56%	348,447	14.94%
Total Council and Committee	2,418,153	2,281,500	2,800,600	136,653	5.99%	519,100	22.75%	382,447	15.82%

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SCHEDULE C
Personnel

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
Salaries	9,641,361	9,692,200	10,567,989	(50,839)	-0.52%	875,789	9.04%	926,628	9.61%
Benefits	1,693,573	1,784,000	1,982,733	(90,427)	-5.07%	198,733	11.14%	289,160	17.07%
Other Personnel *(Education, training, professional dues)*	341,747	422,000	404,455	(80,253)	-19.02%	(17,545)	-4.16%	62,708	18.35%
Total Personnel Costs	11,676,681	11,898,200	12,955,177	(221,519)	-1.86%	1,056,977	8.88%	1,278,496	10.95%

SCHEDULE D
Regulatory Programs

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
Association Fees - NAPRA	129,532	130,000	135,000	(468)	-0.36%	5,000	3.85%	5,468	4.22%
Communication Initiatives	85,110	120,000	161,000	(34,890)	-29.08%	41,000	34.17%	75,890	89.17%
Consulting - Regulatory	10,000	35,000	50,000	(25,000)	-71.43%	15,000	42.86%	40,000	400.00%
Donations, Contributions and Grants - partnerships	200,000	200,000	150,000	0	0.00%	(50,000)	-25.00%	(50,000)	-25.00%
DPP Inspection Costs	2,500	2,500	2,500	0	0.00%	0	0.00%	0	0.00%
Election Expenses	5,000	5,000	5,000	0	0.00%	0	0.00%	0	0.00%
Examinations, Certificates and Registration	183,500	188,500	194,000	(5,000)	-2.65%	5,500	2.92%	10,500	5.72%
Government Relations	42,000	42,000	42,000	0	0.00%	0	0.00%	0	0.00%
Language Proficiency	0	0	37,500	0	0.00%	37,500	0.00%	37,500	
Legal - Regulatory	220,000	180,000	195,000	40,000	22.22%	15,000	8.33%	(25,000)	-11.36%
Practice Assessment of Competence to Entry	75,250	91,000	104,500	(15,750)	-17.31%	13,500	14.84%	29,250	38.87%
Practice Input Initiatives	158,500	80,000	155,000	78,500	98.13%	75,000	93.75%	(3,500)	-2.21%
Professional Development Remediation	3,662	0	25,870	3,662		25,870		22,208	606.44%
Professional Health Program	146,000	160,000	188,000	(14,000)	-8.75%	28,000	17.50%	42,000	28.77%
Quality Assurance - Program Administration Costs	139,342	193,500	184,812	(54,158)	-27.99%	(8,688)	-4.49%	45,470	32.63%
Total Regulatory Programs	1,400,396	1,427,500	1,630,182	(27,104)	-1.90%	202,682	14.20%	229,786	16.41%

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SCHEDULE E
Operations

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
Association Fees -General	24,000	15,000	25,000	9,000	60.00%	10,000	66.67%	1,000	4.17%
Audit	25,600	20,000	23,100	5,600	28.00%	3,100	15.50%	(2,500)	-9.77%
Bank Charges	398,379	401,000	410,500	(2,621)	-0.65%	9,500	2.37%	12,121	3.04%
Consulting - Operation	96,269	180,500	161,000	(84,231)	-46.67%	(19,500)	-10.80%	64,731	67.24%
Courier/Delivery	5,279	7,000	6,200	(1,721)	-24.59%	(800)	-11.43%	921	17.45%
Donations, Contributions and Grants - Others	5,000	5,000	10,000	0	0.00%	5,000	100.00%	5,000	100.00%
Information Systems Leasing & Maintenance	294,000	321,000	313,165	(27,000)	-8.41%	(7,835)	-2.44%	19,165	6.52%
Insurance - E & O	5,600	6,000	6,000	(400)	-6.67%	0	0.00%	400	7.14%
Legal - Operation	5,000	5,000	5,000	0	0.00%	0	0.00%	0	0.00%
Niagara Apothecary	24,228	28,200	25,928	(3,972)	-14.09%	(2,272)	-8.06%	1,700	7.02%
Office Equipment Leasing & Maintenance	25,135	26,000	26,000	(865)	-3.33%	0	0.00%	865	3.44%
Postage	28,201	30,000	27,000	(1,799)	-6.00%	(3,000)	-10.00%	(1,201)	-4.26%
Property	162,896	203,300	240,149	(40,404)	-19.87%	36,849	18.13%	77,253	47.42%
Publications-Pharmacy Connection & Annual Report	49,500	52,500	55,500	(3,000)	-5.71%	3,000	5.71%	6,000	12.12%
Subscriptions	8,098	10,300	7,200	(2,202)	-21.38%	(3,100)	-30.10%	(898)	-11.09%
Supplies/Stationery	18,250	18,000	18,440	250	1.39%	440	2.44%	190	1.04%
Telecommunications	165,763	181,000	183,460	(15,237)	-8.42%	2,460	1.36%	17,697	10.68%
Travel	319,881	318,000	352,980	1,881	0.59%	34,980	11.00%	33,099	10.35%
Total Operations	1,661,079	1,827,800	1,896,622	(166,721)	-9.12%	68,822	3.77%	235,543	14.18%

SCHEDULE A.1

Revenue Projection

	Account Code	@$	Projected 2017 #	Projected 2017 $	*2017 Budget #*	*2017 Budget $*	*2018 Budget #*	*2018 Budget $*	Var. 2017 Projected to 2017 Budget		Var. 2018 Budget to 2017 Budget		Var. 2018 Budget to 2017 Projected	
Pharmacist Renewal - Part A	3000	600	14,569	8,741,400	14,800	8,880,000	15,100	9,060,000	(138,600)	-1.56%	180,000	2.03%	318,600	3.64%
Pharmacist Renewal - Part B	3006	300	908	272,400	900	270,000	925	277,500	2,400	0.89%	7,500	2.78%	5,100	1.87%
Pharmacist- Late Payment Fees:				29,950		20,000		20,000	9,950	49.75%	0	0.00%	(9,950)	-33.22%
Part A - New Registration:														
Pharmacist A-New Registration,Mar 10 to Aug 31	3003	600	500	300,000	500	300,000	500	300,000	0	0.00%	0	0.00%	0	0.00%
Pharmacist A - New Registration, Sep 1 to Dec 31	3005	300	450	135,000	400	120,000	450	135,000	15,000	12.50%	15,000	12.50%	0	0.00%
Pharmacist - Reinstatement	3009	250	25	6,250	10	2,500	10	2,500	3,750	150.00%	0	0.00%	(3,750)	-60.00%
Total Pharmacist Fees				9,485,000		9,592,500		9,795,000	(107,500)	-1.12%	202,500	2.11%	310,000	3.27%
Pharmacy Technician - Renewal	3010	400	4,250	1,700,000	4,300	1,720,000	4,520	1,808,000	(20,000)	-1.16%	88,000	5.12%	108,000	6.35%
Pharmacy Technician - Late Payment Fees				9,100		0		0	9,100	0.00%	0	0.00%	(9,100)	-100.00%
Pharmacy Technician -New Registration,Mar 10 to Aug 31	3008	400	250	100,000	250	100,000	215	86,000	0	0.00%	(14,000)	-14.00%	(14,000)	-14.00%
Pharmacy Technician - New Registration, Sep 1 to Dec 31	3011	200	150	30,000	150	30,000	120	24,000	0	0.00%	(6,000)	-20.00%	(6,000)	-20.00%
Total Pharmacy Technician Fees				1,839,100		1,850,000		1,918,000	(10,900)	-0.59%	68,000	3.68%	78,900	4.29%
DPP Inspection Fee	3121	2,500	3	7,500	3	7,500	3	7,500	0	0.00%	0	0.00%	0	0.00%
Pharmacy Renewal	3100	940	4,203	3,950,820	4,160	3,910,400	4,340	4,079,600	40,420	1.03%	169,200	4.33%	128,780	3.26%
RDL Opening - Application Fee	3114	250	5	1,250	0	0	0	0	1,250	0.00%	0	0.00%	(1,250)	-100.00%
RDL Opening - Issuance Fee	3119	750	5	3,750	0	0	0	0	3,750	0.00%	0	0.00%	(3,750)	-100.00%
Lock & Leave - Application Fee	3120	250	4	1,000	0	0	0	0	1,000	0.00%	0	0.00%	(1,000)	-100.00%
Pharmacy Opening - Application Fee	3103	500	180	90,000	150	75,000	180	90,000	15,000	20.00%	15,000	20.00%	0	0.00%
Pharmacy Opening - Issuance Fee	3115	750	180	135,000	150	112,500	180	135,000	22,500	20.00%	22,500	20.00%	0	0.00%
Pharmacy Acquisition - Application Fee	3101	500	150	75,000	180	90,000	180	90,000	(15,000)	-16.67%	0	0.00%	15,000	20.00%
Pharmacy Acquisition - Issuance Fee	3116	250	150	37,500	180	45,000	180	45,000	(7,500)	-16.67%	0	0.00%	7,500	20.00%
Pharmacy Relocation - Application Fee	3102	500	17	8,500	50	25,000	50	25,000	(16,500)	-66.00%	0	0.00%	16,500	194.12%
Pharmacy Relocation - Issuance Fee	3117	250	21	5,250	50	12,500	50	12,500	(7,250)	-58.00%	0	0.00%	7,250	138.10%
Pharmacy Reinspection Fee	3105	1,000	9	9,000	18	18,000	12	12,000	(9,000)	-50.00%	(6,000)	-33.33%	3,000	33.33%
Total Community Pharmacy Fees				4,317,070		4,288,400		4,489,100	28,670	0.67%	200,700	4.68%	172,030	3.98%
PHC														
Certification of Authorization - New	3106	1,000	22	22,000	20	20,000	30	30,000	2,000	10.00%	10,000	50.00%	8,000	36.36%
Certificate of Authorization - Renewals & Late Payment	3109	300	233	69,900	180	54,000	263	78,900	15,900	29.44%	24,900	46.11%	9,000	12.88%
HPC - Late Payment fee				975		0		0	975	0.00%	0	0.00%	(975)	-100.00%
Total Certificate of Authorization (PHC)				92,875		74,000		108,900	18,875	25.51%	34,900	47.16%	16,025	17.25%
Hospital Pharmacy Fees														
Pharmacy Renewal	*3130*	3,500	225	787,500	225	787,500	226	791,000	0	0.00%	3,500	0.44%	3,500	0.44%
Pharmacy Opening - Application Fee	*3131*	2,000	1	2,000	0	0	1	2,000	2,000	0.00%	2,000	0.00%	0	0.00%
Pharmacy Opening - Issuance Fee	*3132*	2,000	1	2,000	0	0	1	2,000	2,000	0.00%	2,000	0.00%	0	0.00%
Total Hospital Pharmacy Fees				791,500		787,500		795,000	4,000	0.51%	7,500	0.95%	3,500	0.44%
Filing Fee - Pharmacist	3303	300	800	240,000	700	210,000	675	202,500	30,000	14.29%	(7,500)	-3.57%	(37,500)	-15.63%
Filing Fee - Pharmacy Technician	3311	300	400	120,000	300	90,000	300	90,000	30,000	33.33%	0	0.00%	(30,000)	-25.00%
Pharmacists Application Fee	3304	75	900	67,500	900	67,500	950	71,250	0	0.00%	3,750	5.56%	3,750	5.56%
Student Application Fee	3299	75	700	52,500	700	52,500	700	52,500	0	0.00%	0	0.00%	0	0.00%
Intern Application Fee	3300	75	400	30,000	450	33,750	450	33,750	(3,750)	-11.11%	0	0.00%	3,750	12.50%
Pharmacy Technician Application Fee	3312	75	400	30,000	400	30,000	350	26,250	0	0.00%	(3,750)	-12.50%	(3,750)	-12.50%
JP Exams - Pharmacist	3307	100	1,100	110,000	1,200	120,000	1,200	120,000	(10,000)	-8.33%	0	0.00%	10,000	9.09%
JP Exams - Pharmacy Technician	3314	100	450	45,000	400	40,000	400	40,000	5,000	12.50%	0	0.00%	(5,000)	-11.11%
JP Exams - Late Fees & Other Miscellaneous Fees				15,400		16,550		16,800	(1,150)	-6.95%	250	1.51%	1,400	9.09%
Total Registration Fees				710,400		660,300		653,050	50,100	7.59%	(7,250)	-1.10%	(57,350)	-8.07%
Investment Income	3400			225,000		210,000		200,000	15,000	7.14%	(10,000)	-4.76%	(25,000)	-11.11%
Grand Totals Revenue				17,468,445		17,470,200		17,966,550	(1,755)	-0.01%	496,350	2.84%	498,105	2.85%

2018 Budget and Projections

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Presentation to September 2017 Council

Background

- Entering the third and final year of our current Strategic Plan
- Council affirmed commitment to advancing Priorities

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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. Premises: Current authority and others i.e. long-term care, family health teams. Members: 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.

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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.

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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.

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Strategic Planning Timeline

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Background continued

- Council Strategic Planning Session scheduled for spring of 2018
- Council responding to society's changing expectations
- New leadership influence on execution and vision
- Additional capacity needed to meet demands
- Reserve values at maximum target of 4-6 months operating expense (based on 2017)

Summary – Overview 2017

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
REVENUE - "Schedule A"	17,468,445	17,470,200	17,966,550	(1,755)	-0.01%	496,350	2.84%	498,105	2.85%
EXPENDITURES									
Schedule "B" - Council & Committee Expenses	2,418,153	2,281,500	2,800,600	136,653	5.99%	519,100	22.75%	382,447	15.82%
Schedule "C" - Personnel	11,676,681	11,898,200	12,955,177	(221,519)	-1.86%	1,056,977	8.88%	1,278,496	10.95%
Schedule "D" - Regulatory Programs	1,400,396	1,427,500	1,630,182	(27,104)	-1.90%	202,682	14.20%	229,786	16.41%
Schedule "E" - Operations	1,661,079	1,827,800	1,896,622	(166,721)	-9.12%	68,822	3.77%	235,543	14.18%
TOTAL EXPENDITURES	17,156,309	17,435,000	19,282,581	(278,691)	-1.60%	1,847,581	10.60%	2,126,272	12.39%
EXCESS OF REVENUE OVER EXPENDITURES	312,136	35,200	(1,316,031)	276,936	786.75%	(1,351,231)	-3838.72%	(1,628,167)	-521.62%
Capital Expenditures	*(378,082)*	*(325,000)*	*(410,500)*	(53,082)	16.33%	(85,500)	26.31%	(32,418)	8.57%
Surplus (Deficit) After Capital Expenditures	(65,946)	(289,800)	(1,726,531)	223,854	-77.24%	(1,436,731)	495.77%	(1,660,585)	2518.10%

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Overview of financial position at Y/E 2017

- Revenue forecast to come in on budget
- Total expenditures forecast to come in 1.6% below budget
- Forecast is $312,000 surplus before capital, ($65,000) after capital

Summary – Budget 2018

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
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EXPENDITURES									
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Schedule "C" - Personnel	11,676,681	11,898,200	12,955,177	(221,519)	-1.86%	1,056,977	8.88%	1,278,496	10.95%
Schedule "D" - Regulatory Programs	1,400,396	1,427,500	1,630,182	(27,104)	-1.90%	202,682	14.20%	229,786	16.41%
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2018 Budget - Overview

Increased spending budgeted in

- Council and Committee expenses
- Personnel
- Regulatory Program Administration

Schedule B – Council & Committee Expenses

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
Council	86,000	112,000	120,000	(26,000)	-23.21%	8,000	7.14%	34,000	39.53%
Committees:									
Accreditation	70,000	70,000	70,000	0	0.00%	0	0.00%	0	0.00%
DPP	10,000	20,000	15,000	(10,000)	-50.00%	(5,000)	-25.00%	5,000	50.00%
Discipline - Committee Expenses	285,115	285,000	320,000	115	0.04%	35,000	12.28%	34,885	12.24%
Discipline - Prosecution	1,700,000	1,460,000	1,865,000	240,000	16.44%	405,000	27.74%	165,000	9.71%
Reimbursement - Discipline Costs	(120,000)	(120,000)	(140,000)	0	0.00%	(20,000)	16.67%	(20,000)	16.67%
Total Discipline	1,865,115	1,625,000	2,045,000	240,115	14.78%	420,000	25.85%	179,885	9.64%
Executive	22,000	30,000	32,000	(8,000)	-26.67%	2,000	6.67%	10,000	45.45%
Finance & Audit	9,000	9,000	9,000	0	0.00%	0	0.00%	0	0.00%
Fitness to Practice	70,451	72,000	95,000	(1,549)	-2.15%	23,000	31.94%	24,549	34.85%
ICRC	156,253	163,000	165,000	(6,747)	-4.14%	2,000	1.23%	8,747	5.60%
Patient Relation	16,000	27,500	25,500	(11,500)	-41.82%	(2,000)	-7.27%	9,500	59.38%
Quality Assurance	85,289	83,000	155,600	2,289	2.76%	72,600	87.47%	70,311	82.44%
Registration	27,500	50,000	38,500	(22,500)	-45.00%	(11,500)	-23.00%	11,000	40.00%
Special Committees	545	20,000	30,000	(19,455)	-97.28%	10,000	50.00%	29,455	5404.59%
Total Committees	2,332,153	2,169,500	2,680,600	162,653	7.50%	511,100	23.56%	348,447	14.94%
Total Council and Committee	2,418,153	2,281,500	2,800,600	136,653	5.99%	519,100	22.75%	382,447	15.82%

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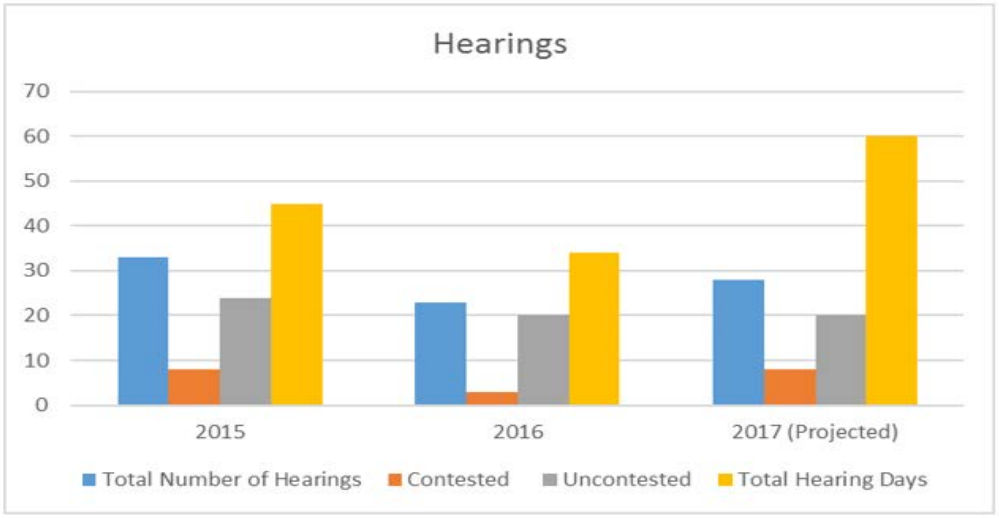
Council and Committee

- Discipline costs
  - Complexity of cases increasing
  - Increase in contested cases
    - Transparency impact
    - Higher penalties to reflect society's expectations



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Council and Committee continued

- Discipline activity is unavoidable
- Commitment to timeliness targets
- Expand meeting space and staff support to facilitate increase in hearing days per year
- Strategies being explored to contain/manage prosecution costs

Council and Committee continued

- Previous QA program wound down in 2015
  - 240 members were assessed each year in old program
  - Program costs on average $500,000 annually
  - Costs per assessed member approx. $2,100
- New QA program in early stages of implementation
  - First full year of site based practice assessments has reached 3,000 pharmacist members (technicians to follow)
  - Costs for initial site based assessment incorporated into facility inspections
  - Committee to focus on development of the elements of the new program; costs for new program to be considered as part of this initiative
  - New program expected to achieve significant reduction in cost per assessed member

Schedule C – Personnel

SCHEDULE C
Personnel

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
Salaries	9,641,361	9,692,200	10,567,989	(50,839)	-0.52%	875,789	9.04%	926,628	9.61%
Benefits	1,693,573	1,784,000	1,982,733	(90,427)	-5.07%	198,733	11.14%	289,160	17.07%
Other Personnel *(Education, training, professional dues)*	341,747	422,000	404,455	(80,253)	-19.02%	(17,545)	-4.16%	62,708	18.35%
Total Personnel Costs	11,676,681	11,898,200	12,955,177	(221,519)	-1.86%	1,056,977	8.88%	1,278,496	10.95%

★ *Variance against 2017 projections vs. variance against 2017 budget relate primarily to Benefits and Other Personnel.*

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College Personnel

- Salary Cost increases - $875,700 higher than 2017 budget
  - $330,000 = 3.5% of projected 2017 budget for
    - Equity adjustments related to organizational realignment
    - Cost of Living and Merit increases
  - $545,000 to add 7.5 full-time equivalent staff (FTEs)
    - Policy development and analysis – 2 FTEs
    - Investigations & Resolutions – 2 FTEs
    - Admin support – Exec Office/Policy -1 FTE
    - Assessments - multiple shifts of P/T equivalent to 1 FTE
    - Facilities – increased meeting days and office space 1 FTE
    - Business processes (CQI/Projects) .5 FTE (half year not half person)

College Personnel continued

- Additional new FTE justification
  - Investigations and Resolutions
    - Investigations more complex; require pharmacy knowledge
    - Discontinue use of external Investigative firm – replace with full time contract investigator

Year	Number of Investigators	Starting Files	New Files	Disposed Files	Ending Inventory (Active Files at December 31st)
2014	3.5 (+1 ext)	128	79	83	124
2015	5.5 (+1 ext)	124	100	116	108
2016	5.5 (+1 ext)	108	121	102	127
2017	5.5 (+.5 ext)	127	115 (61)	96 (56)	146 (132)

College Personnel continued

- Increased transparency resulting in new work streams to process and monitor criminal backgrounds
- Complaint intakes continue to rise

	Intakes Received	Complaint Files Opened	Average # of days from Receipt of Intake to Complaint Filed
2015	308	228	45
2016	382	264	59
2017 (as of June 30)	285	133	78

College Personnel continued

- Policy
  - Increased expectation for detailed policy analysis
  - Increased focus on evidence/data to drive policy and decision making
  - Increase in # of strategic initiatives being simultaneously pursued, some externally/others internally driven
    - CQA (Medication Error Reporting)
    - Opioid Strategy
    - Scope of Practice Strategy
    - Protecting Patients Act
    - Cannabis
    - Governance Review
    - FIPPA abortion exclusion (emerging issue)

College Personnel continued

- Benefits increase of $198,000 over 2017 budget ($298,100 over 2017 projected)
  - change in group benefits provider in 2017 (significant underrun in 2017 with premiums returning to normal in 2018)
  - Impact of salary increases and increased FTE count
- Other Personnel
  - Increased staff count
  - Focused education, training, conferences, professional dues

Schedule D – Regulatory Programs

SCHEDULE D
Regulatory Programs

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
Association Fees - NAPRA	129,532	130,000	135,000	(468)	-0.36%	5,000	3.85%	5,468	4.22%
Communication Initiatives	85,110	120,000	161,000	(34,890)	-29.08%	41,000	34.17%	75,890	89.17%
Consulting - Regulatory	10,000	35,000	50,000	(25,000)	-71.43%	15,000	42.86%	40,000	400.00%
Donations, Contributions and Grants - partnerships	200,000	200,000	150,000	0	0.00%	(50,000)	-25.00%	(50,000)	-25.00%
DPP Inspection Costs	2,500	2,500	2,500	0	0.00%	0	0.00%	0	0.00%
Election Expenses	5,000	5,000	5,000	0	0.00%	0	0.00%	0	0.00%
Examinations, Certificates and Registration	183,500	188,500	194,000	(5,000)	-2.65%	5,500	2.92%	10,500	5.72%
Government Relations	42,000	42,000	42,000	0	0.00%	0	0.00%	0	0.00%
Language Proficiency	0	0	37,500	0	0.00%	37,500	0.00%	37,500	
Legal - Regulatory	220,000	180,000	195,000	40,000	22.22%	15,000	8.33%	(25,000)	-11.36%
Practice Assessment of Competence to Entry	75,250	91,000	104,500	(15,750)	-17.31%	13,500	14.84%	29,250	38.87%
Practice Input Initiatives	158,500	80,000	155,000	78,500	98.13%	75,000	93.75%	(3,500)	-2.21%
Professional Development Remediation	3,662	0	25,870	3,662		25,870		22,208	606.44%
Professional Health Program	146,000	160,000	188,000	(14,000)	-8.75%	28,000	17.50%	42,000	28.77%
Quality Assurance - Program Administration Costs	139,342	193,500	184,812	(54,158)	-27.99%	(8,688)	-4.49%	45,470	32.63%
Total Regulatory Programs	1,400,396	1,427,500	1,630,182	(27,104)	-1.90%	202,682	14.20%	229,786	16.41%

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Regulatory Programs

- New spending associated with
  - Strategic engagement/outreach with the public to further our Patients First mandate
  - Investigation of alternative methods for assessing applicant fluency
  - Implementation of Medication Error Reporting program
  - Increase in members monitored through CAMH's Workplace Stress and Health Program

Schedule E - Operations

	2017 Projected	2017 Budget	2018 Budget	Var. 2017 Projected to 2017 Budget $	Var. 2017 Projected to 2017 Budget %	Var. 2018 Budget to 2017 Budget $	Var. 2018 Budget to 2017 Budget %	Var. 2018 Budget to 2017 Projected $	Var. 2018 Budget to 2017 Projected %
Association Fees -General	24,000	15,000	25,000	9,000	60.00%	10,000	66.67%	1,000	4.17%
Audit	25,600	20,000	23,100	5,600	28.00%	3,100	15.50%	(2,500)	-9.77%
Bank Charges	398,379	401,000	410,500	(2,621)	-0.65%	9,500	2.37%	12,121	3.04%
Consulting - Operation	96,269	180,500	161,000	(84,231)	-46.67%	(19,500)	-10.80%	64,731	67.24%
Courier/Delivery	5,279	7,000	6,200	(1,721)	-24.59%	(800)	-11.43%	921	17.45%
Donations, Contributions and Grants - Others	5,000	5,000	10,000	0	0.00%	5,000	100.00%	5,000	100.00%
Information Systems Leasing & Maintenance	294,000	321,000	313,165	(27,000)	-8.41%	(7,835)	-2.44%	19,165	6.52%
Insurance - E & O	5,600	6,000	6,000	(400)	-6.67%	0	0.00%	400	7.14%
Legal - Operation	5,000	5,000	5,000	0	0.00%	0	0.00%	0	0.00%
Niagara Apothecary	24,228	28,200	25,928	(3,972)	-14.09%	(2,272)	-8.06%	1,700	7.02%
Office Equipment Leasing & Maintenance	25,135	26,000	26,000	(865)	-3.33%	0	0.00%	865	3.44%
Postage	28,201	30,000	27,000	(1,799)	-6.00%	(3,000)	-10.00%	(1,201)	-4.26%
Property	162,896	203,300	240,149	(40,404)	-19.87%	36,849	18.13%	77,253	47.42%
Publications-Pharmacy Connection & Annual Report	49,500	52,500	55,500	(3,000)	-5.71%	3,000	5.71%	6,000	12.12%
Subscriptions	8,098	10,300	7,200	(2,202)	-21.38%	(3,100)	-30.10%	(898)	-11.09%
Supplies/Stationery	18,250	18,000	18,440	250	1.39%	440	2.44%	190	1.04%
Telecommunications	165,763	181,000	183,460	(15,237)	-8.42%	2,460	1.36%	17,697	10.68%
Travel	319,881	318,000	352,980	1,881	0.59%	34,980	11.00%	33,099	10.35%
Total Operations	1,661,079	1,827,800	1,896,622	(166,721)	-9.12%	68,822	3.77%	235,543	14.18%

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Operations

- Expenses generally in line with previous year(s)
  - Consultant costs associated with
    - HRIS system implementation
    - Employee Engagement assessment and ongoing measurement
    - Key Performance Indicators – goal setting/measurement to tie to performance management and organizational performance
    - outsourced technology development
  - Property cost increases as college assumes first floor of 186 for additional meeting space
  - Increased business travel associated with stakeholder meetings

Capital

- 3 year refresh of desktops/laptops
- License upgrades for CITRIX and Exchange
- New audio conferencing units - all boardrooms; new microphones – council chambers
- Accessibility ramp for new meeting space 1st floor 186 St. George (increase capacity to hold simultaneous discipline proceedings)

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COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Finance and Audit Committee

TOPIC: Appointment of Auditors for 2017

ISSUE: The Finance and Audit Committee is required to make recommendations to Council on the appointed or reappointment of the auditors annually.

BACKGROUND:

- Clarke Henning LLP has provided auditing and financial services to the College since 2008.
- The audit and financial services were taken to market in 2014; Clarke Henning LLP was selected to continue to provide audit services to the College.

ANALYSIS:

- The Finance and Audit Committee considered the benefits of maintaining continuity with the firm; the Committee is satisfied with the service the College is receiving from OCP's new account manager, Liana Bell (Ms. Bell took over the account from Vinay Raja).
- The Committee agreed the firm continues to meet the College's requirements and therefore recommends Clarke Henning be reappointed for fiscal year 2017.

RECOMMENDATION: **That Clarke Henning LLP Chartered Accountants be appointed as Auditors for the College for the fiscal year 2017.**

EXECUTIVE COMMITTEE RECOMMENDATION AND COMMENTS (if any):

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COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER, 2017

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Registration Committee

TOPIC: Draft Pharmacy Act Regulations (Registration)

ISSUE: The draft General Regulation requires Council approval to post for member consultation.

BACKGROUND:

- In June 2016, Council was advised of the necessity for updating the registration regulations in order to implement a mechanism for pharmacy technician graduates to register and practice to scope post-graduation, while completing the remaining registration requirements for full registration. It was proposed that while the revision was undertaken, the regulations be re-written to emphasize the desired regulatory outcomes in order to respond to practice evolution and change through an outcomes-based approach.

- In September 2016, Council approved the recommendations of the Registration Committee to: 1) eliminate the student class of registration and implement a single provisional class of registration for pharmacists and pharmacy technicians post-graduation to permit applicants to practice under supervision while they complete their remaining registration requirements; and 2) to implement a requirement that registration candidates complete a police background check.

- It was subsequently determined that regulation changes were not required to require police background checks, and that requirement could be stated as a matter of policy. Efforts to develop such a policy are underway and Council will be advised of the policy prior to implementation.

- The changes to the registration requirements eliminates unnecessary steps in the registration process, and aligns with the College's role of assessing competency for entry to the profession.

- In preparation for the proposed changes to the *Pharmacy Act* regulations, the *Drug and Pharmacies Regulation Act* [s. 149 (1)] was updated to align with the intended approach in conjunction with other changes needed for the implementation of Bill 87 – *Protecting Patients Act*.

  The DPRA [s. 149 (1)] (once proclaimed) will read (sections c and d updated):
  Dispensing of drugs
  ….no person shall compound, dispense or sell any drug in a pharmacy other than,
  a) a pharmacist;

b) an intern acting under the supervision of a pharmacist who is physically present;,

c) a student who is in the course of fulfilling the educational requirements to become a member of the College, acting under the supervision of a pharmacist who is physically present; or

d) a pharmacy technician or an intern technician acting under the supervision of a pharmacist who is physically present

- A high-level framework and rationale for the proposed changes to the Regulation is provided below (Appendix 1). The table addresses changes to the registration and quality assurance components of the regulation, and related changes to the controlled acts, as well as other minor housekeeping changes in other parts of the regulation. Consultation will focus on the changes to registration and quality assurance.

- Following the approval of Council, the proposed regulations will be posted on the College's consultation page for 60 days for member review. A consultation report, including a summary of feedback, will be presented to Council for consideration in December 2017.

- The proposed draft regulation is attached separately.

ANALYSIS:

- The College mandates two graduated, provisional classes of registration (student/intern) for candidates preparing to become licensed pharmacists; however, there is no graduated or provisional class of registration for pharmacy technicians. Many requirements for pharmacy students and interns are duplicated throughout the registration process, including evidence of language proficiency, declaration of good character, work authorization under the Immigration and Refugee Act, professional liability insurance and completion of Structured Practical Training.

- Pharmacy technician graduates who are unable to register until completing all entry exams and practical assessment/training, are unable to practice to full scope during this transition and may be denied access to practice opportunities until fully registered.

- Section 29(1) of the Regulated Health Professions Act provides for students of a profession to practice to the scope of their profession, but Section 149 (1) of the Drug and Pharmacies Regulation Act (DPRA) restricted dispensing to specified members of the College.

- Recent changes to the DPRA support the Colleges intention to change the classes of registration by enabling students who are not members of the College to dispense and allowing for the addition of intern technician members of the College.

RECOMMENDATION: Recommend that Council approves the draft registration regulation for member consultation.

EXECUTIVE COMMITTEE RECOMMENDATION AND COMMENTS (if any):

Appendix 1

Pharmacy Act: General Regulation Revision Framework

1. Regulations will be outcomes-based and high level rather than specific.
2. Council approved standards, policies and guidelines will be utilized to address issues wherever possible.
3. The regulations will support practice evolution and change.

REGULATION PART	APPROACH	RATIONALE
PART I: INTERPRETATION		
DEFINITIONS	Definitions incorporated to address program changes in practice assessments and the addition of hospital pharmacy oversight to the College's role.	A practice of assessment of competence is included in the registration renewal process. Incorporates the definition of hospital and institutional pharmacy in the *Drug and Pharmacies Regulation Act* [s. 121(1)(a)
PART II: GENERAL PROVISIONS RE CERTIFICATES OF REGISTRATION		
CLASSES OF CERTIFICATES OF REGISTRATION	To remove the class of 'registered pharmacy student' and implement an "intern" class to permit the post-graduate registration of pharmacy technicians. Transitional language/dates to be determined	The College requires a mechanism to register pharmacy technician graduates post-graduation but prior to completing all other registration requirements so that they may continue to practice to full scope under supervision prior to full registration. Duplicate requirements in the registration process for students and interns are removed, streamlining the registration process while ensuring that requirements are met. The provisions of the *Drug and Pharmacies Regulation Act* [s. 149 (1)] were updated in May, 2017 to support this approach. Aligns with the practice of other regulators. The DPRA revisions, along with the provisions of the *Regulated Health Professions Act* [s. 29(1)] provide the authority for students who are not registered with the College to practice to the scope of the profession under supervision, while enrolled in an education program.
TWO-PART REGISTER	The two part register is moved forward from Quality Assurance to Registration, and expanded to permit the addition of pharmacy technicians to either Part A or Part B. Time frame and practice hour requirements are moved to registration from quality assurance (see below). The time frame and practice hour requirements are replaced with the requirement to demonstrate competence through a practice assessment.	The public requires transparency to identify members who are licensed to provide direct patient care (Part A) and College resources are focused on members whose practice most impacts health outcomes and patient safety. The college requires a mechanism to include pharmacy technicians in both Parts of the register, and to permit members to transfer between Parts as necessary. The assessment of a member in the work place is a better measure of proficiency than simply requiring a member to note a number of practice hours. This approach is in line with the College's focus on providing members with practice advice and support to improve practice and expand scope activities.
APPLICATION FOR CERTIFICATE OF REGISTRATION	No change	
REQUIREMENTS FOR ISSUANCE OF A CERTIFICATE OF REGISTRATION, ANY	Language proficiency requirements are revised to highlight the desired outcome to speak, read, write and comprehend English or French with reasonable fluency to meet the standards of practice of the profession.	The applicant will be required to demonstrate language proficiency that meets or is equivalent to NAPRA standards

REGULATION PART	APPROACH	RATIONALE
CLASS	All applicants must meet the language proficiency and conduct requirements as a non-exemptible requirement for issuance of a certificate and on an ongoing basis. Specificity with respect to validity of the application and timeframes will be removed	It is in the public interest to implement measures to protect public safety. Administrative details will be addressed in policy wherever possible
TERMS, ETC., OF EVERY CERTIFICATE	This part is aligned to the requirements for the issuance of every certificate. The language is updated and simplified to the extent possible, requirements restated as outcomes, and details that are removed will be addressed in policy	On an ongoing basis, all of the requirements for issuance of a certificate must be met, including those for both language and conduct. The section is revised to remove redundancies and to focus on the desired outcome of fair, objective, transparent and impartial registration practices. The onus is on the member to advise the Registrar when they no longer satisfy the requirements for registration.
PART III: REGISTRATION – PHARMACISTS		
ADDITIONAL REQUIREMENTS	The additional requirements are restated as outcomes. Details are removed to permit the College to outline administrative requirements in supporting documents that can be revised and updated as practice evolves. Includes the completion of an assessment in pharmaceutical jurisprudence, ethics and professionalism through approved assessment mechanisms. Reference to structured practical training is replaced with the concept of Practice Assessment of Competence at Entry (PACE).	To be supported by policies and detailed protocol documents that outline the process for completion and evaluation. The introduction of higher-level outcome-based language supports the focus on the assessment of candidates utilizing Council-approved mechanisms including structured examinations and site-based evaluations. Competency based practice assessment replaces the formative assessment and training model and will be required unless competency is demonstrated through completion of an approved pharmacy education program.
MOBILITY FROM OUTSIDE CANADA	This section is removed.	The College will rely on a common approach for all International Pharmacy Graduate applicants (1st time pass of qualifying examination, or completion of an approved International Pharmacy Graduate program).
TERMS, CONDITIONS AND LIMITATIONS, PART B PHARMACIST	The language in this section is updated.	Detail will be moved into policy and supported by fact sheets.
PART IV: REGISTRATION – REGISTERED PHARMACY STUDENTS		
ADDITIONAL REQUIREMENT MOBILITY WITHIN CANADA TERMS, CONDITIONS AND LIMITATIONS	This class of registration is removed.	Eliminates redundancy of registration requirements that currently exist with the student and intern classes of registration. Students will be able to practice under the provisions of the *Regulated Health Professions Act* [s. 29 (1) (b)] and *Drug and Pharmacies Regulation Act* [s.149 (1)]
PART IV: REGISTRATION – INTERN (renumbered)		
ADDITIONAL REQUIREMENTS	Changes reflect elimination of student class as well as changes consistent with the additional requirements for registration as a pharmacist.	Streamlined and aligned to the requirements for registration as a pharmacist. Allows for supervised practice post graduation (including completion of a bridging program if required) while completing additional requirements to demonstrate competency for full registration.

REGULATION PART	APPROACH	RATIONALE
TERMS, CONDITIONS AND LIMITATIONS	Change to section title only	Clarifies which class of registration the conditions apply
PART V: REGISTRATION – PHARMACY TECHNICIANS [renumbered]		
ADDITIONAL REQUIREMENTS	Transitional language is removed where it is no longer needed. Requirements are restated as outcomes – applicants will demonstrate knowledge and competence through council-approved mechanisms. Details are removed to permit the College to outline administrative requirements in supporting documents that can be revised and updated as practice evolves. Includes the completion of an assessment in pharmaceutical jurisprudence, ethics and professionalism through approved assessment mechanisms. Reference to structured practical training is replaced with the concept of Practice Assessment of Competence at Entry (PACE).	Time frames for completing the transitional programs are ended. To be supported by policies and detailed protocol documents that outline the process for completion and evaluation. The introduction of higher-level outcome-based language supports the focus on the assessment of candidates utilizing Council-approved mechanisms including structured examinations and site-based evaluations. Competency based practice assessment replaces the formative assessment and training model and will be required unless competency is demonstrated through completion of an approved program.
MOBILITY WITHIN CANADA	The mobility provisions are combined and consolidated All applicants must meet same requirements.	All applicants are to be in 'good standing' and meet the same requirements for registration as a pharmacist, an intern, an intern technician, or pharmacy technician. These include the language proficiency and conduct provisions.
TERMS, CONDITIONS AND LIMITATIONS	Section title changed This section reflects requirement that in settings outside of a community pharmacy, pharmacy technicians may practice without direct on-site pharmacist supervision. Changes needed to add Part B class of registration of pharmacy technicians	Clarifies which class of registration the conditions apply To align practice with the addition of hospital oversight via the revisions to the DPRA regulations. Pharmacy Technicians are able to register in Part A or Part B and terms, conditions and limitations reflect the necessary requirements.
PART VI: REGISTRATION — INTERN TECHNICIANS [new]		
ADDITIONAL REQUIREMENTS	The additional requirements are restated as outcomes. Details are removed to permit the College to outline administrative requirements in supporting documents that can be revised and updated as practice evolves. Includes the completion of an assessment in pharmaceutical jurisprudence, ethics and professionalism through approved assessment mechanisms. Reference to structured practical training is replaced with the concept of Practice Assessment of Competence at Entry (PACE).	To be supported by policies and detailed protocol documents that outline the process for completion and evaluation. The introduction of higher-level outcome-based language supports the focus on the assessment of candidates utilizing Council-approved mechanisms including structured examinations and site-based evaluations. Competency based practice assessment replaces the formative assessment and training model and will be required unless competency is demonstrated through completion of an approved program.
TERMS, CONDITIONS AND LIMITATIONS, INTERN TECHNICIANS	Sets out restrictions for intern technician practice	Provides safeguards (such as supervised practice) appropriate for a provisional certificate of registration, until full evidence of competency is demonstrated through College approved examinations and assessments.
PART VII: MOBILITY WITHIN CANADA		
MOBILITY WITHIN	Mobility applies to all Canadian applicants with a	All applicants are to be in 'good standing' and meet the

REGULATION PART	APPROACH	RATIONALE
CANADA	certificate of registration equivalent to any of the classes defined in this regulation. Therefore the mobility provisions are combined and consolidated in the draft regulations All applicants must meet same additional requirements for mobility purposes.	same mobility requirements for registration as a pharmacist, an intern, an intern technician or a pharmacy technician. These include the language proficiency, conduct provisions and jurisprudence and ethics requirements.
PART VIII; QUALITY ASSURANCE [see Quality Assurance Regulation Briefing Note for this section]		
PART IX: SUSPENSIONS, RESIGNATIONS, REINSTATMENTS, ETC. [renumbered]		
ADMINISTRATIVE SUSPENSIONS	Streamlines language and provides additional clarification on lifting suspensions. Time frames are adjusted	Clarifies the source of suspension as either failing to provide information or failing to provide evidence of insurance. Ensures public safety and protection through more immediate action by the Registrar
DEEMED RESIGNATIONS	Streamlines language	
RETURN OF CERTIFICATE, ETC.	Reflects advances in technology	
REINSTATMENT	Simplifies language	Removes the requirement for practice hours and relies on an approved method to demonstrate currency of practice, consistent with requirement for all members.
REINSTATMENT PURSUANT TO ORDER	No change	
REINSTATMENT PURSUANT TO ORDER	No change	
PART X NOTICES OF MEETINGS AND HEARINGS [renumbered]		
PART XI ADVERTISING [renumbered]		
PART XII – CONTROLLED ACTS [renumbered]		
INTERPRETATION	Definitions now include Part A Pharmacy Technicians to reflect application of the two-part register to this class of registration.	
CONTROLLED ACTS	Eliminates reference to registered pharmacy students and includes appropriate reference to Part A Pharmacy Technicians	Authority for controlled acts needs to reflect new classes of registration. Pharmacy students will be able to practice under the provisions of the *Regulated Health Professions Act* [s. 29 (1) (b)] and *Drug and Pharmacies Regulation Act* [s.149 (1)]
PART XIII – INSPECTION OF DRUG PREPARATION PREMISES [renumbered]		
TEMPORAL APPLICATION	Removed temporary language that is no longer applicable.	
INSPECTIONS	Removed temporary language that is no longer applicable	

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COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Quality Assurance Committee

TOPIC: Draft Pharmacy Act Regulation (Quality Assurance)

ISSUE: The draft General Regulation requires Council approval to post for member consultation.

BACKGROUND:

- In 2015, the College introduced practice assessments to evaluate an individual practitioner's performance in their practice sites. The practice assessments are designed to increase adherence to practice standards, with the goal of providing support through coaching and mentoring to improve health outcomes for patients, specifically in the areas of patient assessment, decision making, communication / education and documentation.

- In June 2016, Council was advised of the necessity for updating the quality assurance regulations in order to extend the QA program to pharmacy technicians and incorporate them into the two-part register to be consistent with the approach for pharmacists. In addition to adding technicians, it was proposed that the quality assurance process shift from an hourly reporting of practice, to a confirmation of competence, supported by member self-assessment and an evaluation of practice at the member's practice site.

- In September 2016, Council considered and approved the recommendations of the Quality Assurance Committee to continue the two-part register and incorporate pharmacy technicians, and to shift from an hourly reporting of practice as confirmation of competence to self-declaration in conjunction with practice based assessment.

- The proposed approach assures greater transparency to the public, supports accountability and effective management of members, and allows for more efficient use of resources by focusing on members whose practice most impacts patient health outcomes and safety.

- Over the last year, the program continued to evolve to encompass the new approach to peer and practice assessments, and the regulations were drafted in alignment with the program redesign.

- In July 2017, the Quality Assurance Committee reviewed and approved the changes that relate to the quality assurance program in the proposed regulations.

- A high-level framework and rationale for the proposed changes to the regulation is provided below (Appendix 1). The table addresses changes to the quality assurance and registration components of the regulation, and related changes to the controlled acts, as well as other minor housekeeping changes in other parts of the regulation. Consultation will focus on changes to quality assurance and registration.

- Following the approval of Council, the proposed regulations will be posted on the College's consultation page for 60 days for member review. A consultation report, including a summary of feedback, will be presented to Council for consideration in December 2017.

- The proposed draft regulation is attached separately.

ANALYSIS:

- The Quality Assurance Program consists of three components:
    1. Self-assessment;
    2. Practice assessment (on site); and
    3. Knowledge assessment OR audit of a learning portfolio that demonstrates knowledge application.

- The components of the Quality Assurance Program within the regulations are already stated at a high level, reflecting the requirements of the *Regulated Health Professions Act*; therefore, few changes were required in the regulations to remove specificity, reflect outcomes, and support the new program design, including self-assessment, knowledge assessment and on-site member assessments.

- The program will no longer depend on random selection of participants for review. The administrative requirements for assessments will be defined by the Quality Assurance Committee and published on the College's website at least three months before the member is directed to undergo an assessment, which allows for maximum program flexibility.

RECOMMENDATION: Recommend that Council approves the draft General Regulation for member consultation.

EXECUTIVE COMMITTEE RECOMMENDATION AND COMMENTS (if any):

Appendix 1

Pharmacy Act: General Regulation Revision Framework

1. Regulations will be outcomes-based and high level rather than specific.
2. Council approved standards, policies and guidelines will be utilized to address issues wherever possible.
3. The regulations will support practice evolution and change.

REGULATION PART	APPROACH	RATIONALE
PART VIII: QUALITY ASSURANCE		
GENERAL	An assessment is defined to include a practice or peer assessment or reassessment as applicable. Removes program requirements defined in the *RHPA*	Aligns to the model of quality assurance adopted by the College that focuses on the member at his or her practice site to evaluate performance while providing patient care. Eliminates redundancy between the Act and regulations.
CONTINUING PROFESSIONAL DEVELOPMENT	Language changed to refer to members, instead of pharmacists	Allows for inclusion of pharmacy technicians within the regulation.
TWO PART REGISTER FOR PHARMACISTS	This section has been moved into the Registration section of the Regulation and language changed to refer to all members and to refer to declaration of competence rather than hours.	Consolidates all registration related requirements into one area of the regulation.
SELF-ASSESSMENTS [new]	Provides specific reference to self-assessment as a component of the program, and the expectation to submit self-assessment records to the College upon request.	Aligns the regulation with all components of the program. Self-assessment was previously embedded within continuing professional development – this approach provides transparency of all requirements.
PRACTICE AND PEER ASSESSMENTS	The quality assurance program redesign has been evolving to evaluation of performance at a member's practice site. The regulations support the inclusion of an assessment of knowledge. This section identifies the circumstances that will trigger either a practice or peer assessment or both. The circumstances will be posted prior to implementation	Section is streamlined and aligned to the requirements expected of the member to maintain information and provide records as requested. By addressing the outcomes expected, details of process are removed from the regulation and the College has the flexibility to create program requirements in policy or through guidelines. This continues the authority of the Quality Assurance Committee to direct the Registrar to transfer a member to Part B of the register in the event that the member fails to undergo the required assessment.
PANEL REQUIREMENTS	No change other than to align to the appropriate section of the Code	Ensures that any changes to the Code will inform the application of this regulation without additional regulatory changes required.

Pharmacy Act, 1991
Loi de 1991 sur les pharmaciens

ONTARIO REGULATION 202/94
GENERAL

Consolidation Period: From July 19, 2013 to the e-Laws currency date.

Last amendment: O. Reg. 225/13.

This Regulation is made in English only.

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PART I
INTERPRETATION

DEFINITIONS

1. In this Regulation,

"bridging program" means an educational program approved by the Registration Committee that is designed to ensure that applicants have the knowledge, skill, ability and judgment that are required to meet the standards of practice of the profession.

"direct supervision" means supervision that is provided by a person who is physically present on the premises where the practice that is being supervised is being carried out;

"pharmacy" has the same meaning as in subsection 1 (1) of the *Drug and Pharmacies Regulation Act* and includes a hospital pharmacy and an institutional pharmacy pursuant to subsection 121 (1) (a) of the *Drug and Pharmacies Regulation Act*;

"pharmacy accredited as a community pharmacy" means a pharmacy for which a certificate of accreditation of the community pharmacy class has been issued under O. Reg. 264/16.

"practice assessment of competence" means a practical assessment pursuant to a model approved by the Registration Committee that measures the ability of an applicant to satisfy the standards of practice of the profession.

"remote dispensing location" has the same meaning as in subsection 1 (1) of the *Drug and Pharmacies Regulation Act*.

PART II
GENERAL PROVISIONS RE CERTIFICATES OF REGISTRATION

CLASSES OF CERTIFICATES OF REGISTRATION

2. (1) The following are prescribed as classes of certificates of registration:

1. Pharmacist.
2. Intern.
3. Pharmacy Technician.
4. Intern Technician.

(2) Every certificate of registration as a pharmacist, intern or pharmacy technician that was in existence the day before this Regulation comes into force is continued as the equivalent certificate of registration with the same status under this Regulation until such time as it otherwise ceases to be effective.

(3) Every certificate of registration as a registered pharmacy student that was in existence the day before this Regulation comes into force will be deemed to have expired on the day this Regulation comes into force.

(4) Where an applicant has completed any of the requirements for the issuance of a certificate of registration as they existed the day before this Regulation comes into force, the applicant will be deemed to have satisfied the equivalent requirement or requirements for the issuance of a certificate of registration under this Regulation.

TWO-PART REGISTER

3. The College's register of members shall have a Part A (patient care) and a Part B (no patient care).

4. Every intern and intern technician shall be listed in Part A.

5. (1) Every pharmacist and pharmacy technician shall be listed in either Part A or Part B.

(2) Upon being issued a certificate of registration, a pharmacist or a pharmacy technician shall ask to be listed in Part A or Part B by completing and submitting the form provided by the Registrar.

(3) Every year at the time of paying the annual membership fee, a pharmacist or a pharmacy technician shall ask to renew his or her listing in Part A or Part B or for a transfer to the other Part.

(4) A pharmacist or pharmacy technician who asks to renew a listing in Part A must provide a declaration of competence to provide patient care in the form approved by the Registration Committee.

(5) If a pharmacist or pharmacy technician fails to submit the declaration referred to in subsection (4) the Registrar may,

(a) give the member notice of intention to transfer the member to Part B, and

(b) transfer the member to Part B, if the member fails to provide the declaration within 30 days from the date notice was given.

6. (1) A pharmacist or pharmacy technician may ask for a transfer between Parts at any time by completing and submitting the form provided by the Registrar.

(2) If a pharmacist or pharmacy technician asks for a transfer from Part A to Part B, the Registrar shall transfer the member to Part B.

(3) If a pharmacist or pharmacy technician asks for a transfer from Part B to Part A, the Registrar may transfer the member to Part A if the member successfully completes a practice or peer assessment.

(4) If the Registrar proposes to reject a request for a transfer to Part A, the request shall be referred to a panel of the Registration Committee.

(5) If a panel rejects a request to be listed in Part A, the member may appeal to another panel of the Registration Committee.

(6) No member of a panel that rejects a request to be listed in Part A shall sit on a panel hearing an appeal of that decision.

(7) A member whose request for a transfer is referred to a panel of the Registration Committee under subsection (4) or (5) shall be given a reasonable opportunity to make written submissions to the panel before the panel makes a decision.

APPLICATION FOR CERTIFICATE OF REGISTRATION

7. A person may apply for a certificate of registration by submitting a completed application in the form provided by the Registrar together with any supporting documentation requested by the Registrar and the applicable fees.

REQUIREMENTS FOR ISSUANCE OF CERTIFICATE OF REGISTRATION, ANY CLASS

8. (1) The following are requirements for the issuance of a certificate of registration of any class:

1. The applicant must be able to speak, read, write and comprehend English or French with reasonable fluency to meet the standards of practice of the profession.
2. The applicant must not have been found guilty of any offence in any jurisdiction.
3. The applicant must not be the subject of a current proceeding in respect of any offence in any jurisdiction.
4. The applicant must not have been the subject of a finding of professional misconduct, incompetence or incapacity or any like finding in Ontario or any other jurisdiction in relation to pharmacy or any other profession or occupation and must not be the subject of any current professional misconduct, incompetence, or incapacity proceeding or any like proceeding in Ontario or any other jurisdiction in relation to pharmacy or any other profession or occupation.
5. The applicant must be a Canadian citizen or permanent resident of Canada or must hold the appropriate authorization under the *Immigration and Refugee Protection Act* (Canada) to permit the applicant to engage in the practice of the profession in Ontario.
6. The applicant's past and present conduct must afford reasonable grounds for the belief that the applicant,
    i. will practise the profession with decency, honesty and integrity, and in accordance with the law,
    ii. does not suffer from any physical or mental condition or disorder that could affect his or her ability to practise the profession in a safe manner,
    iii. has sufficient knowledge, skill, ability and judgment to engage competently in the practice of the profession authorized by the certificate of registration, and
    iv. will display an appropriately professional attitude.
7. The applicant must provide evidence satisfactory to the Registrar that the applicant will have professional liability insurance in the amount and in the form as required by the by-laws as of the anticipated date for the issuance of his or her certificate of registration.
8. The applicant must pay any fees required under the by-laws for the issuance of the certificate of registration for which the applicant applied.

(2) The requirements under paragraphs 1, 6 and 8 of subsection (1) are non-exemptible.

(3) An applicant shall be deemed not to have satisfied the requirements for the issuance of a certificate of registration if the applicant makes a false or misleading statement or representation in his or her application or supporting documentation.

TERMS, ETC., OF EVERY CERTIFICATE

9. Every certificate of registration is subject to the following terms, conditions and limitations:

1. The member must continue to satisfy the requirements of subsection 8 (1).
2. The member shall immediately notify the Registrar in writing if the member no longer satisfies any of the requirements of subsection 8 (1).
3. A member who fails to maintain professional liability insurance in the amount and in the form as required by the by-laws shall immediately cease to engage in the practice of the profession until such time as the member obtains professional liability insurance.

PART III
REGISTRATION — PHARMACISTS

ADDITIONAL REQUIREMENTS

10. (1) The following are additional requirements to those in section 8 for the issuance of a certificate of registration as a pharmacist:

1. The applicant must have obtained a minimum of a baccalaureate degree in pharmacy,
   i. from a Canadian program accredited by the Canadian Council for Accreditation of Pharmacy Programs, or a program that is accredited by another accrediting body approved by Council, or
   ii. from a program that does not meet the requirements of subparagraph i, and the applicant passes an evaluation approved by Council, and,
      A. successfully completes a bridging program, or another program approved by Council, or
      B. successfully completes the qualifying examination of the Pharmacy Examining Board of Canada for pharmacists, or another examination approved by Council, on the applicant's first attempt.
2. The applicant must have obtained the degree referred to in paragraph 1 no more than two years prior to submitting an application for the issuance of a certificate of registration as a pharmacist, but this time limit shall not apply if the applicant,
   i. undergoes a review of his or her practice conducted in a manner approved by the Registration Committee, meets any requirements regarding continuing education or remediation set by a panel of the Registration Committee, and pays the required fees; or
   ii. successfully completes the qualifying examination of the Pharmacy Examining Board of Canada for pharmacists, or another examination approved by Council, within two years of submitting an application for the issuance of a certificate of registration as a pharmacist.
3. No more than two years prior to submitting an application for the issuance of a certificate of registration as a pharmacist, the applicant must have successfully completed an assessment in pharmaceutical jurisprudence, ethics and professionalism approved by the Registration Committee.
4. No more than two years prior to submitting an application for the issuance of a certificate of registration as a pharmacist, the applicant must have successfully completed a practice assessment of competence.
5. The applicant must have successfully completed the qualifying examination of the Pharmacy Examining Board of Canada for pharmacists, or another examination approved by Council,
   i. within the first three attempts,
   ii. on the fourth attempt, if the applicant first successfully completes any further education or training required by the examining body responsible for the administration of the examination or by a panel of the Registration Committee, or
   iii. on any subsequent attempt, if the applicant first obtains a new degree that meets the requirements of subparagraph 1(i).

(2) The following are additional requirements to those in section 8 for the issuance of a certificate of registration as a pharmacist to an applicant who previously held a certificate of registration as a pharmacist in Ontario:

1. The applicant must successfully complete the assessment in pharmaceutical jurisprudence, ethics and professionalism referred to in paragraph 3 of subsection (1); and
2. The applicant must undergo a review of his or her practice conducted in a manner approved by the Registration Committee, meet any requirements regarding continuing education or remediation set by a panel of the Registration Committee, and pay the required fees.

(3) The requirements of subsection (1) are non-exemptible.

TERMS, CONDITIONS AND LIMITATIONS, PART B PHARMACISTS

11. (1) Every certificate of registration of a pharmacist listed in Part B is subject to the following terms, conditions and limitations:

1. The member shall not provide any care to a patient, whether direct or indirect.
2. The member shall not perform any controlled act.
3. The member shall not supervise that part of the pharmacy where drugs are kept.
4. The member shall not be the designated manager of a pharmacy.
5. The member shall not supervise the practice of the profession by another person.
6. The member shall, while working in a pharmacy or any other environment where patient care is being provided, clearly identify himself or herself as a non-practising pharmacist.

(2) Despite subsection (1), a pharmacist listed in Part B may perform a controlled act and provide care to a patient with the prior written approval of the Registrar provided that,

(a) the sole purpose of doing so is to assist the member in preparing to meet the requirements specified in subsection 6 (3); and

(b) the member is under the direct supervision of a member who is registered as a pharmacist in Part A.

(3) Subject to subsection (4), an approval provided by the Registrar under subsection (2) must not exceed six months.

(4) Where the Registrar is satisfied that it is appropriate to do so, the Registrar may extend the term of the approval provided under subsection (2), but in no case may the combined term exceed one year, unless a panel of the Registration Committee approves a further extension.

PART IV
REGISTRATION — INTERN

ADDITIONAL REQUIREMENTS

12. (1) An applicant who satisfies the requirements of section 8 and the educational requirements of paragraphs 1 and 2 of subsection 10 (1), but has not successfully completed all of the requirements of paragraphs 3, 4 and 5 of subsection 10 (1), is qualified for the issuance of a certificate of registration as an intern.

TERMS, CONDITIONS AND LIMITATIONS, INTERNS

13. (1) Every certificate of registration as an intern is subject to the following terms, conditions and limitations:

1. When practising in a pharmacy accredited as a community pharmacy, other than a remote dispensing location, the member shall only engage in the practice of the profession while under the direct supervision of a member holding a certificate of registration as a pharmacist listed in Part A.
2. When practicing in any other location, the member shall only engage in the practice of the profession while under the supervision of a member holding a certificate of registration as a pharmacist listed in Part A.
3. The member shall not supervise that part of the pharmacy where drugs are kept.
4. The member shall not delegate a controlled act.

(2) A certificate of registration as an intern automatically expires on the earlier of,

(a) the date on which the member is issued a certificate of registration as a pharmacist; and

(b) one year from the date on which the member's certificate of registration as an intern was issued, unless a panel of the Registration Committee specifies otherwise.

PART V
REGISTRATION — PHARMACY TECHNICIANS

14. (1) The following are additional requirements to those in section 8 for the issuance of a certificate of registration as a pharmacy technician:

1. The applicant must have obtained a pharmacy technician certificate or diploma, or a university degree in pharmacy,
   i. from a Canadian program accredited by the Canadian Council for Accreditation of Pharmacy Programs, or a program that is accredited by another accrediting body approved by Council, or
   ii. from a program that does not meet the requirements of subparagraph i, and the applicant passes an evaluation approved by Council, and,
      A. successfully completes a bridging program, or another program approved by Council, or

B. successfully completes the qualifying examination of the Pharmacy Examining Board of Canada for pharmacy technicians, or another examination approved by Council, on the applicant's first attempt.

2. The applicant must have successfully obtained the certificate, diploma or degree referred to in paragraph 1 no more than two years prior to submitting an application for the issuance of a certificate of registration as a pharmacy technician, but this time limit shall not apply if the applicant,

   i. undergoes a review of his or her practice conducted in a manner approved by the Registration Committee, meets any requirements regarding continuing education or remediation set by a panel of the Registration Committee, and pays the required fees; or

   ii. successfully completes the qualifying examination of the Pharmacy Examining Board of Canada for pharmacy technicians, or another examination approved by Council, within two years of submitting an application for the issuance of a certificate of registration as a pharmacy technician.

3. No more than two years prior to submitting an application for the issuance of a certificate of registration as a pharmacy technician, the applicant must have successfully completed an assessment in pharmaceutical jurisprudence, ethics and professionalism approved by the Registration Committee.

4. No more than two years prior to submitting an application for the issuance of a certificate of registration as a pharmacy technician, the applicant must have successfully completed a practice assessment of competence.

5. The applicant must have successfully completed the qualifying examination of the Pharmacy Examining Board of Canada for pharmacy technicians, or another examination approved by Council,

   i. within the first three attempts,

   ii. on the fourth attempt, if the applicant successfully completes any further education or training required by the examining body responsible for the administration of the examination or by a panel of the Registration Committee, or

   iii. on any subsequent attempt, if the applicant first obtains a new certificate, diploma or degree that meets the requirements of subparagraph 1(i).

(2) The requirements of subsection (1) are non-exemptible.

TERMS, CONDITIONS AND LIMITATIONS, PHARMACY TECHNICIANS

15. Every certificate of registration as a pharmacy technician is subject to the following terms, conditions and limitations:

1. When practising in a pharmacy accredited as a community pharmacy, other than a remote dispensing location, the member shall only engage in the practice of the profession while under the direct supervision of a member holding a certificate of registration as a pharmacist listed in Part A.

2. When practicing in any other location, the member shall only engage in the practice of the profession while under the supervision of a member holding a certificate of registration as a pharmacist listed in Part A.

3. In a pharmacy accredited as a community pharmacy, the member shall not supervise that part of the pharmacy where drugs are kept.

4. The member shall not delegate a controlled act.

5. The member shall not provide information or education relating to drug use, either to or for a patient, where the provision of the information requires therapeutic knowledge, clinical analysis or clinical assessment.

16. (1) Every certificate of registration as a pharmacy technician listed in Part B is subject to the following additional terms, conditions and limitations:

1. The member shall not provide any care to a patient, whether direct or indirect.

2. The member shall not perform any controlled act.

3. The member shall not supervise the practice of the profession by another person.

4. The member shall, while working in a pharmacy or any other environment where patient care is being provided, clearly identify himself or herself as a non-practising pharmacy technician.

(2) Despite paragraphs 1 and 2 of subsection (1), a pharmacy technician listed in Part B may perform a controlled act and provide care to a patient with the prior written approval of the Registrar provided that,

(a) the sole purpose of doing so is to assist the member in preparing to meet the requirements specified in subsection 6 (3); and

(b) the member is under the direct supervision of a member who is registered as a pharmacist in Part A.

(3) Subject to subsection (4), an approval provided by the Registrar under subsection (2) must not exceed six months.

(4) Where the Registrar is satisfied that it is appropriate to do so, the Registrar may extend the term of the approval provided under subsection (2) but in no case may the combined term exceed one year unless a panel of the Registration Committee approves a further extension.

PART VI
REGISTRATION — INTERN TECHNICIANS

17. (1) An applicant who satisfies the requirements of section 8 and the educational requirements of paragraphs 1 and 2 of subsection 14 (1), but has not yet successfully completed all of the requirements of paragraphs 3, 4 and 5 of subsection 14 (1), is qualified for the issuance of a certificate of registration as an intern technician.

TERMS, CONDITIONS AND LIMITATIONS, INTERN TECHNICIANS

18. (1) Every certificate of registration as an intern technician is subject to the following terms, conditions and limitations:

1. The member shall only engage in the practice of the profession while under the direct supervision of a member holding a certificate of registration as a pharmacist listed in Part A or a pharmacy technician listed in Part A.
2. The member shall not supervise that part of a pharmacy where drugs are kept.
3. The member shall not delegate a controlled act.
4. The member shall not provide information or education relating to drug use, either to or for a patient, where the provision of the information requires therapeutic knowledge, clinical analysis or clinical assessment.

(2) A certificate of registration as an intern technician automatically expires on the earlier of,

(a) the date on which the member is issued a certificate of registration as a pharmacy technician; and

(b) one year from the date on which the member's certificate of registration as an intern technician was issued, unless a panel of the Registration Committee specifies otherwise.

PART VII
MOBILITY WITHIN CANADA

19. (1) Subject to subsection 22.18 (3) of the Health Professions Procedural Code, an applicant to whom section 22.18 of the Health Professions Procedural Code applies will be deemed to have satisfied the following requirements if, for each jurisdiction where the applicant holds an out-of-province certificate, the applicant provides a certificate, letter or other evidence satisfactory to the Registrar or a panel of the Registration Committee, confirming that the applicant is in good standing in that jurisdiction:

1. the requirements of paragraphs 1, 2, 4, and 5 of subsection 10 (1), where the applicant applies for a certificate of registration as a pharmacist,
2. the requirement of paragraphs 1 and 2 of subsection 10 (1), where the applicant applies for a certificate of registration as an intern,
3. the requirements of paragraphs 1, 2, 4 and 5 of subsection 14 (1), where the applicant applies for a certificate of registration as a pharmacy technician, or
4. the requirement of paragraphs 1 and 2 of subsection 14 (1), where the applicant applies for a certificate of registration as an intern technician.

(2) Without in any way limiting the generality of subsection (1), "good standing" shall include the fact that,

(a) the applicant is not the subject of any discipline or fitness to practise order or of any proceeding or ongoing investigation or of any interim order or agreement as a result of a complaint, investigation or proceeding; and

(b) the applicant has complied with the continuing competency and quality assurance requirements of the regulatory authority that issued the out-of-province certificate to the applicant.

(3) An applicant referred to in subsection (1) shall be deemed to have met the requirements of paragraph 1 of subsection 8 (1) where the requirements for the issuance of the applicant's out-of-province certificate included language proficiency requirements equivalent to those required by that paragraph.

PART VIII
QUALITY ASSURANCE

GENERAL

20. In this Part,

"assessment" means an assessment carried out under section 82 of the Health Professions Procedural Code and includes a practice or peer assessment and reassessment, as applicable;

"assessor" means an assessor appointed by the Committee under section 81 of the Health Professions Procedural Code;

"Committee" means the Quality Assurance Committee.

21. This Part does not apply to,

(a) interns,

(b) intern technicians, or

(c) members who are listed in Part B.

22. The Committee shall administer the quality assurance program.

CONTINUING PROFESSIONAL DEVELOPMENT

23. A member shall,

(a) participate in continuing professional development activities, and maintain a portfolio of such activities, in accordance with the guidelines established by the College, and

(b) submit a copy of the portfolio to the College or to an assessor on request.

SELF-ASSESSMENTS

24. A member shall,

(a) participate in self-assessment activities, and keep records of such activities, in accordance with the guidelines established by the College, and

(b) submit a copy of the records to the College or to an assessor on request.

PRACTICE AND PEER ASSESSMENTS

25. (1) A member shall be required to undergo a practice or peer assessment or both if,

(a) in response to a request made under section 23(b) or 24(b), the member does not provide the requested information, or the portfolio or records provided do not demonstrate that the member has engaged in adequate continuing professional development or self-assessment activities, or

(b) the member is directed to undergo an assessment on the basis of other criteria specified by the Committee and published on the College's website at least three months before the member is directed on the basis of such criteria.

(2) If a member fails to undergo a required assessment, the Committee may direct the Registrar to transfer the member to Part B after giving the member a reasonable opportunity to make written submissions.

PANEL REQUIREMENTS

26. (1) A panel of the Committee may exercise any of the powers of the Committee under this Part or section 80.2 of the Health Professions Procedural Code.

(2) A panel of the Committee shall be composed of at least three members appointed by the chair of the Committee from among the Committee members, at least one of whom shall be a member of the Council who was appointed by the Lieutenant Governor in Council.

(3) Three members of a panel constitute a quorum.

PART IX
SUSPENSIONS, RESIGNATIONS, REINSTATEMENTS, ETC.

ADMINISTRATIVE SUSPENSIONS

27. If a member fails to provide the College with information about the member in the manner and form required by the by-laws the Registrar may,

(a) give the member notice of intention to suspend the member's certificate of registration, and

(b) suspend the member's certificate of registration, if the member fails to provide the information within 30 days from the date notice was given.

28. If a member fails to provide the College with evidence that the member holds professional liability insurance in the amount and form required under the by-laws within 14 days from the date notice was given, the Registrar shall,

(a) immediately give the member notice of intention to suspend the member's certificate of registration, and

(b) suspend the member's certificate of registration, if the member fails to provide the evidence within 14 days after the notice is given.

29. (1) The Registrar shall lift a suspension under section 27 or 28 upon being satisfied that the member,

(a) has filed the required information or evidence, as the case may be, with the College in accordance with the requirements of the by-laws, and

(b) has paid any fees required for lifting the suspension.

(2) If the Registrar suspends a member's certificate of registration under section 24 of the Health Professions Procedural Code for failing to pay a fee, the Registrar shall lift the suspension upon being satisfied that the member,

(a) has paid all amounts owed to the College,

(b) holds professional liability insurance in the amount and in the form required by the by-laws, and

(c) has paid any fees required for lifting the suspension.

DEEMED RESIGNATIONS

30. If a member's certificate of registration is suspended,

(a) for failure to pay a fee required by the regulations or by-laws, and the suspension continues for a period of 120 days, or

(b) under section 27 or 28, and the suspension continues for a period of 60 days,

the member shall be deemed to have resigned on the day immediately following the last day of the suspension period set out in (a) or (b), as applicable.

RETURN OF CERTIFICATE, ETC.

31. A member who resigns, or whose certificate of registration is suspended or revoked shall, if so requested, immediately return to the College his or her certificate of registration.

REINSTATEMENT

32. (1) Subject to subsections (2) and (3), a former member who resigned or was deemed to have resigned may apply to have his or her certificate of registration reinstated by,

(a) submitting a completed application to the Registrar in the form provided by the Registrar,

(b) paying,

(i) the required reinstatement fee,

(ii) the annual fee for the year in which the certificate of registration is to be reinstated, if not previously paid,

(iii) the annual fee for the year in which the former member resigned, if not previously paid, unless the Registrar is satisfied that the former member did not engage in the practice of the profession in Ontario during that year, and

(iv) any other amounts owed by the former member to the College including, but not limited to, any penalty or late fees that were due at the time that he or she ceased to be a member, any costs or expenses ordered to be paid under section 53.1 of the Health Professions Procedural Code, any costs awarded to the College by a court and any amount owing to the College under a by-law or former regulation made under the Act, and

(c) providing evidence satisfactory to the Registrar that the applicant will have professional liability insurance in the amount and in the form as required by the by-laws as of the anticipated date of reinstatement of his or her certificate of registration.

(2) It is a condition of reinstatement that the Registrar be satisfied that,

(a) the applicant is not ineligible for any reason set out in section 33, and

(b) the applicant meets the requirements of section 8.

(3) An application for reinstatement under subsection (1) may not be submitted more than three years after,

(a) the date on which the former member resigned, or

(b) in the case of a former member who was deemed to have resigned under section 30, the date on which the former member was suspended where that suspension resulted in the deemed resignation;

33. (1) A former member is ineligible for reinstatement if the former member,

(a) held a certificate of registration as an intern or intern technician at the time he or she ceased to be a member,

(b) was, at the time he or she ceased to be a member, or at any time since then, the subject of,

(i) a proceeding for professional misconduct, incompetence or incapacity in Ontario or any like proceeding in any other jurisdiction in relation to the practice of the profession or another profession, other than a proceeding that was completed on its merits in which the allegations were found not to have been proven;

(ii) an inquiry or investigation by the Registrar, a committee or a panel of a committee of the College, which resulted in the member's resignation or that was not completed on its merits, other than an inquiry or investigation the result of which was a determination that no further action should be taken against the member, or

(iii) a proceeding in respect of,

(A) any criminal offence in any jurisdiction,

(B) any offence relating to the use, possession or sale of drugs in any jurisdiction,

(C) any offence arising in any jurisdiction relating to the practice of the profession or any other profession or occupation, or

(D) any offence under the *Controlled Drugs and Substances Act* (Canada);

(c) was, at the time he or she ceased to be a member,

(i) the subject of, or in breach of, an outstanding order or requirement of a committee or a panel of a committee of the College;

(ii) in violation of a decision of a panel of the Inquiries, Complaints and Reports Committee or any predecessor committee, including a decision requiring the member to attend to be cautioned; or

(iii) in breach of any written agreement with or undertaking provided to the College; or

(d) had, at the time he or she ceased to be a member, terms, conditions or limitations on his or her certificate of registration, other than those applicable to all members of the class of certificate of registration he or she previously held and those applicable to all members of the Part in which he or she was previously listed.

(2) Nothing in this Part prevents a former member who resigned or was deemed to have resigned from making any number of applications for reinstatement or from making an application for a new certificate of registration.

Reinstatement, two-part register

34. (1) Subject to subsections (2) and (3), a former member who meets the conditions for reinstatement in section 32, may be reinstated in Part A if the former member,

(a) was previously listed in Part A at the time of his or her resignation,

(b) asks to be listed in Part A in his or her application for reinstatement, and

(c) provides to the Registrar a declaration of competence to provide patient care in the form approved by Council.

(2) A former member shall not be reinstated in Part A if, at the time of his or her resignation, the former member had been selected for but had not yet taken part in, or had failed to successfully complete, an assessment under the College's Quality Assurance Program.

(3) A former member who meets the conditions for reinstatement in section 32, may be reinstated in Part B if,

(a) the Registrar determines that the former member does not qualify for reinstatement in Part A pursuant to subsections (1) or (2), or

(b) the former member asks to be listed in Part B in his or her application for reinstatement.

REINSTATEMENT, PURSUANT TO ORDER

35. If a former member's certificate of registration is ordered to be reinstated by a panel of the Discipline Committee or of the Fitness to Practise Committee, the Registrar shall reinstate the certificate of registration upon payment of,

(a) the required reinstatement fee; and

(b) the annual fee for the year in which the certificate of registration is to be reinstated, if not previously paid.

PART X
NOTICES OF MEETINGS AND HEARINGS

NOTICE OF MEETINGS

36. (1) The Registrar shall ensure that notice of every Council meeting that is required to be open to the public under the Act is given in accordance with this section.

(2) The notice must be published at least 14 days before the date of the meeting in a daily newspaper of general circulation throughout Ontario.

(3) The notice must be in English and French.

(4) The notice must contain the following information:

1. The date, time and place of the meeting.

2. A statement of the purpose of the meeting.

(5) The Registrar shall provide the information contained in the notice to every person who requests it by telephone.

NOTICE OF HEARINGS

37. (1) The Registrar shall ensure that the information concerning an impending hearing by a panel of the Discipline Committee to deal with allegations of professional misconduct or incompetence made against a member is given, in accordance with this section, to a person who requests the information.

(2) The information shall be given,

(a) at least 14 days before the date of the hearing, if the request is received 14 days before the date of the hearing; or

(b) as soon as possible after the request is made, if the request is received after that time but before the date of the hearing.

(3) The information given shall be as follows:

1. The name of the member against whom the allegations have been made.

2. The member's principal place of practice.

3. The date, time and place of the hearing.

4. A statement of the purpose of the hearing.

(4) The Registrar shall provide the information in French to a person who requests that the information be provided in French, wherever reasonably possible.

PART XI
ADVERTISING

ADVERTISING

38. (1) In this section,

"advertisement" includes an announcement, directory listing or other form of communication similar to an advertisement;

"drug services" means one or more of the compounding, dispensing or sale by retail of drugs or the provision of information or advice with respect to drugs.

(2) A member shall not, through any medium, publish, display, distribute or use, or permit, directly or indirectly, the publication, display, distribution or use through any medium of, an advertisement relating to drug services that,

(a) is false, misleading or deceptive, whether as a result of the inclusion of information or the omission of information;

(b) is not readily comprehensible to the persons to whom it is directed;

(c) is not dignified and in good taste;

(d) contains anything that cannot be verified;

(e) contains testimonials, comparative statements or endorsements;

(f) contains a reference to a member's area of practice or to a procedure or treatment available from a member practising in the pharmacy, unless the advertisement discloses whether or not the member has an area of expertise and, if the member does have such an area of expertise, the particular expertise;

(g) contains references to a particular brand of equipment used to assist in providing drug services;

(h) contains information that is not relevant to the choice of a pharmacist; or

(i) contains any representations as to the safety or effectiveness or an indication for use of any drug referred to in Schedule I established by the regulations under the *Drug and Pharmacies Regulation Act*.

(3) An advertisement by a member that includes price information relating to drugs referred to in Schedule I established by the regulations under the Drug and Pharmacies Regulation Act shall include the price information for at least 15 different drugs, 10 of which each belong to a different one of the following drug classifications:

1. Anti-infective agents.

2. Antineoplastic agents.

3. Autonomic agents.

4. Blood formation and coagulation drugs.

5. Cardiovascular drugs.

6. Central nervous system drugs.

7. Diagnostic agents.
8. Electrolytic, caloric and water balance drugs.
9. Cough preparations.
10. Eye, ear, nose and throat preparations.
11. Gastrointestinal drugs.
12. Gold compounds.
13. Heavy metal antagonists.
14. Hormones and substitutes.
15. Oxytocics.
16. Skin and mucous membrane preparations.
17. Spasmolytics.
18. Unclassified therapeutic agents.
19. Vitamins.

(4) Where an advertisement by a member includes price information relating to drugs referred to in Schedule I established by the regulations under the *Drug and Pharmacies Regulation Act*, the advertisement shall include at a minimum the following information with respect to each drug:

1. The quantity of the drug being advertised at the advertised price.
2. The total cost for the drug to the purchaser including any dispensing fee.
3. The time period during which the advertised price will be available.

(5) An advertisement by a member that includes price information relating to drugs referred to in Schedule I established by the regulations under the *Drug and Pharmacies Regulation Act* shall include, in addition to the price information referred to in subsection (4), the following information with respect to each advertised drug:

1. The strength of the drug.
2. The brand name of the drug.
3. The dosage form of the drug.

(6) Where an advertisement by a member includes price information relating to drugs referred to in Schedule I established by the regulations under the *Drug and Pharmacies Regulation Act*, equal prominence shall be given to each drug and, for each of those drugs, equal prominence shall be given to all the information required under subsections (4) and (5).

PROFESSIONAL MISCONDUCT RE ADVERTISING

39. It is professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code for a member who advertises price information with respect to a drug referred to in Schedule I established by the regulations under the *Drug and Pharmacies Regulation Act* to charge any purchaser, including the executive officer under the *Ontario Drug Benefit Act* more for the drug than the member has advertised, pursuant to paragraph 2 of subsection 28 (4), as the total cost for the drug to the purchaser including any dispensing fee.

CLARIFICATION RE APPLICATION OF PART

40. Nothing in this Part prohibits a member from publishing, displaying, distributing or using, or permitting directly or indirectly the publication, display, distribution or use of, an advertisement that relates solely to the co-payment or dispensing fee charged by the member for supplying a drug that is a listed drug product under the *Ontario Drug Benefit Act* to an eligible person under that Act.

PART XII
CONTROLLED ACTS

INTERPRETATION

41. In this Part,

"adapt" means to change a patient's prescription respecting,

(a) the dose of the prescribed drug,

(b) the dosage form of the prescribed drug,

(c) the directions for use of the prescribed drug, or

(d) the route of administration for taking the prescribed drug,

but does not include therapeutic substitution;

"Part A pharmacist" means a member who holds a certificate of registration as a pharmacist and who is listed in Part A of the register;

"Part A pharmacy technician" means a member who holds a certificate of registration as a pharmacy technician and who is listed in Part A of the register;

"prescriber" means a person who is authorized under the laws of a province or territory of Canada to give a prescription within the scope of his or her practice of a health profession;

"prescription" means a direction from a prescriber directing the dispensing of a drug or mixture of drugs for a specific patient;

"renew" means to provide a patient with a prescription that repeats a prescription previously provided to that patient;

"therapeutic substitution" means the substitution of a drug that contains chemically different active ingredients that are considered to be therapeutically equivalent.

42. (1) Where the provisions of this Part are inconsistent with a law of Canada respecting prescriptions, including those related to a targeted substance, the law of Canada shall prevail and the provisions of this Part to the extent they are inconsistent with that law shall not apply.

(2) Where the provisions of this Part are inconsistent with the provisions of the *Narcotics Safety and Awareness Act, 2010*, the provisions of that Act shall prevail and the provisions of this Part, to the extent they are inconsistent with that Act, shall not apply.

CONTROLLED ACTS

43. A member shall not perform a controlled act under paragraph 2, 3, 4 or 5 of subsection 4 (1) of the Act except in accordance with this Part.

44. (1) For the purposes of paragraph 2 of subsection 4 (1) of the Act, a member referred to in subsection (2) who meets all the requirements of subsection (3) is authorized to perform the following acts:

1. Administering a substance specified in Table 1 to this Regulation by injection to a patient.
2. Administering a substance specified in Table 2 to this Regulation by inhalation to a patient.

(2) A Part A pharmacist and an intern are authorized to perform an act provided for in subsections (1) and (4), subject to the terms, conditions and limitations imposed on his or her certificate of registration.

(3) A member may only perform an act provided for in subsection (1) if he or she complies with the following:

1. The member may only perform the act for the purpose of patient education and demonstration, and before performing the act,
   i. must explain that purpose to the patient or his or her authorized agent, and
   ii. must receive an informed consent from the patient or his or her authorized agent.
2. The member shall ensure that he or she only performs the act in an environment that is clean, safe, private and comfortable for the patient.
3. The member shall ensure that appropriate infection control procedures are in place.
4. The member must possess sufficient knowledge, skill and judgment respecting the substance to be administered, and sufficient understanding of the condition of the patient, to be able to administer the substance safely.
5. The member must consider whether administering a substance by injection or inhalation to the patient is appropriate, given the known risks and benefits to the patient and the safeguards and resources available to safely manage the outcome after administration and any other relevant circumstances.
6. The member must maintain a patient record that includes,
   i. the name and address of the patient,
   ii. the name and address of the member,
   iii. the date the act was performed,
   iv. the name, strength (where applicable) and quantity of the substance that the member administered to the patient,
   v. the circumstances relating to the administration of the substance to the patient and any adverse reaction experienced by the patient, and
   vi. confirmation that an informed consent was given by the patient or his or her authorized agent.

(4) For the purposes of paragraph 2 of subsection 4 (1) of the Act, a Part A pharmacist and an intern are authorized to administer influenza vaccine by injection to a patient who is five years of age or older, if the Part A pharmacist or intern,

(a) administers the vaccine in accordance with Ontario's Universal Influenza Immunization Program as described on the Ministry's website;

(b) receives an informed consent from the patient or his or her authorized agent; and

(c) meets all the requirements of paragraphs 2 to 6 of subsection (3).

45. (1) For the purposes of paragraph 3 of subsection 4 (1) of the Act, a member referred to in subsection (3) who complies with the other requirements of this section is authorized to prescribe the following specified drugs:

1. Varenicline Tartrate.
2. Bupropion Hydrochloride.

(2) A drug mentioned in subsection (1) may only be prescribed by a member for the sole purpose of smoking cessation.

(3) A Part A pharmacist and an intern are authorized to perform the act provided for in subsection (1), subject to the terms, conditions and limitations imposed on his or her certificate of registration.

(4) A member may only prescribe a drug under this section if he or she,

(a) possesses sufficient knowledge, skill and judgment respecting the drug and the patient's condition to prescribe the drug for the patient;

(b) has considered whether prescribing the drug for the patient is appropriate, given the known risks and benefits of prescribing the drug for the patient and other relevant factors respecting the patient;

(c) gives the prescription to the patient or his or her authorized agent;

(d) advises the patient or his or her authorized agent, at the time of giving the prescription, that he or she may elect to take it to a pharmacy of his or her choosing for dispensing;

(e) notifies the patient's primary care provider (if any) within a reasonable time, that the member prescribed a drug for the patient and provides details respecting the prescription; and

(f) complies with the additional requirements under sections 47 and 48.

46. (1) For the purposes of paragraph 4 of subsection 4 (1) of the Act, a member referred to in subsection (3) who complies with the other provisions of this section is authorized to perform the following acts:

1. Adapting a patient's prescription.
2. Renewing a patient's prescription for the purpose of continuity of care.

(2) Subsection (1) does not authorize a member referred to in subsection (3) to adapt or renew a prescription for a controlled substance as defined in the *Controlled Drugs and Substances Act* (Canada) or a drug designated as a monitored drug by the regulations under the *Narcotics Safety and Awareness Act, 2010*.

(3) A Part A pharmacist and an intern are authorized to perform an act provided for in subsection (1), subject to the terms, conditions and limitations imposed on his or her certificate of registration.

(4) A member may only perform an act provided for in subsection (1) if he or she complies with the following:

1. The member must either possess the patient's prescription to be adapted or renewed or,
    i. receive a copy of the prescription directly from the pharmacy where the prescription was dispensed to the patient,
    ii. be satisfied based on verbal confirmation from a pharmacist at the pharmacy where the prescription was dispensed to the patient as to the existence and details of the prescription, or
    iii. have access to the medical record that contains information about the prescription.
2. If the member is renewing a prescription, he or she must not prescribe a quantity of the drug that exceeds the lesser of,
    i. the quantity that was originally prescribed, including any refills that were authorized by the prescriber, and
    ii. a six months' supply.
3. The member must, within a reasonable time, notify the prescriber identified on the prescription adapted or renewed by the member, as well as the patient's primary care provider if the member knows that the patient has such a care provider other than the prescriber, providing details about the patient's prescription, when the member,
    i. renews a patient's prescription, or
    ii. adapts a patient's prescription, if, in the member's opinion,
        A. adapting the prescription is clinically significant in relation to the patient, or

B. the notification is necessary to support the patient's care.

4. At the time that the member adapts or renews the patient's prescription, the member must advise the patient or his or her authorized agent,

   i. that he or she is entitled to the prescription, and

   ii. that he or she may take the prescription to a pharmacy of his or her choosing for dispensing.

5. The member must comply with the additional requirements under sections 47 and 48.

47. A member who performs an act provided for in section 45 or 46 must ensure that the following information is recorded on the prescription:

1. The name and address of the patient for whom the drug is prescribed.
2. The name, strength (where applicable) and quantity of the prescribed drug.
3. Directions for the use of the drug, including its dose, frequency, route of administration and any special instructions.
4. The name, address, telephone number and College registration number of the member issuing the prescription.
5. The date the prescription was issued by the member.
6. If applicable, reference to the prescription that the member adapted or renewed, including the name and contact details of the original prescriber.
7. The number of refills that the member authorized, if applicable.
8. Any other information required by law.

48. A member who performs an act under section 45 or 46 must maintain a patient record that includes details of the member's rationale for his or her decision to act under section 45 or 46 and the following information, if applicable:

1. Reference to, or a copy of, the patient's prescription that the member renewed or adapted, including the name and contact information of the prescriber.
2. A copy of the prescription that the member gave to the patient or his or her authorized agent under clause 45 (4) (c) or that the member gave to the patient or his or her authorized agent to take to a pharmacy of their choosing under paragraph 4 of subsection 46 (4).
3. A record of the results of laboratory or other tests that the member considered in making the decision to act under section 45 or 46.
4. The date on which the member notified the following persons, as applicable, and the method by which the notification occurred:

   i. The patient's primary care provider notified under clause 45 (4) (e) or paragraph 3 of subsection 46 (4).

   ii. The patient's prescriber notified under paragraph 3 of subsection 46 (4).

49. (1) For the purposes of paragraph 5 of subsection 4 (1) of the Act, a member referred to in subsection (2) who meets all the requirements of subsection (4) is authorized to perform the act of piercing a patient's dermis with a lancet-type device to obtain blood.

(2) A member who is a Part A pharmacist, an intern or a Part A pharmacy technician is authorized to perform the act provided for in subsection (1), subject to the terms, conditions and limitations imposed on his or her certificate of registration.

(3) A Part A pharmacy technician shall not perform the act provided for in subsection (1) unless,

(a) a Part A pharmacist is physically present on the premises at the time when the pharmacy technician performs the act; and

(b) the Part A pharmacy technician is under the direction of a Part A pharmacist at the time when the pharmacy technician performs the act.

(4) A member may only perform the act provided for in subsection (1) if he or she complies with the following:

1. The member may only perform the act for the purpose of demonstrating the appropriate use of lancet-type devices for the patient's self care and education or for the patient's self monitoring of his or her chronic disease, and before performing the act,

   i. shall explain that purpose to the patient or his or her authorized agent, and

   ii. shall receive an informed consent from the patient or his or her authorized agent.

2. The member shall ensure that he or she only performs the act in an environment that is clean, safe, private and comfortable for the patient.
3. The member shall ensure that appropriate infection control procedures are in place.

4. The member must possess the knowledge, skill and judgment respecting the performance of the act and understand the condition of the patient, to perform it safely and effectively.

5. The member must consider whether performing the act on the patient is appropriate, given the known risks and benefits to the patient and the safeguards and resources available to safely manage the outcome and any other relevant circumstances.

6. The member must maintain a patient record that includes,

   i. the name and address of the patient and the member,

   ii. the date the act was performed, and

   iii. confirmation that an informed consent was given by the patient or his or her authorized agent.

PART XIII
INSPECTION OF DRUG PREPARATION PREMISES

INTERPRETATION

50. (1) In this Part,

"designated member" means,

(a) the member designated for a drug preparation premises in accordance with section 55, or

(b) where only one member engages in or supervises drug preparation activities at or in connection with a drug preparation premises, that member;

"drug" means a substance or a preparation containing a substance referred to in clauses (a) to (d) of the definition of "drug" in subsection 1 (1) of the *Drug and Pharmacies Regulation Act*, but does not include,

(a) a substance or preparation referred to in those clauses that is manufactured, sold or represented for use in animals or fowl, or

(b) a substance or preparation referred to in clause (e), (f), (g), (h) or (i) of that definition;

"drug preparation activities" means reconstituting, diluting or otherwise preparing a drug or combining, admixing or mixing together two or more substances, at least one of which is a drug, to create a final product for the purposes of the sale or provision to another person, other than pursuant to or in anticipation of a prescription;

"drug preparation premises" means any place where a member engages in drug preparation activities, or where drug preparation activities take place that a member supervises, but does not include,

(a) a pharmacy in respect of which a valid certificate of accreditation has been issued under the *Drug and Pharmacies Regulation Act*,

(b) a premises in respect of which a valid establishment licence has been issued under the *Food and Drugs Act* (Canada), or

(c) a hospital or a health or custodial institution approved or licensed under any general or special Act;

"inspector" means a person appointed by the College to carry out an inspection on behalf of the College;

"supervise" means to supervise either directly or indirectly.

(2) Anything that may be done by the College under this Part may be done by the Council or by a committee established under clause 94 (1) (i) of the Health Professions Procedural Code.

INSPECTION

51. (1) All drug preparation premises are subject to inspection by the College in accordance with this Part.

(2) In carrying out an inspection of a drug preparation premises under subsection (1), the College may also require any or all of the following:

1. Inspection, examination or testing regarding any equipment, instrument, materials or any other thing that may be used in the drug preparation premises.

2. Examination and copying of books, accounts, reports, records or similar documents that are, in the opinion of the College, relevant to the member's practice with respect to the drug preparation activities at or in connection with the drug preparation premises.

3. Inquiries or questions to be answered by the member that are relevant to the member's practice with respect to the drug preparation activities at or in connection with the drug preparation premises.

4. Direct observation of a member in his or her practice with respect to drug preparation activities at or in connection with the drug preparation premises.

52. An inspector may, on the production of information identifying him or her as an inspector, enter and have access to any drug preparation premises at reasonable times and may inspect the drug preparation premises and do any of the things mentioned in subsection 51 (2) on behalf of the College.

53. (1) It is the duty of every member engaging in or supervising drug preparation activities at or in connection with drug preparation premises that are subject to an inspection to,

(a) submit to an inspection of the drug preparation premises in accordance with this Part;

(b) promptly answer a question or comply with a requirement of the inspector that is relevant to an inspection under this Part; and

(c) co-operate fully with the College and the inspector who is conducting an inspection of a drug preparation premises in accordance with this Part.

(2) A member shall not engage in or supervise drug preparation activities at or in connection with a drug preparation premises where an inspector has been denied entry or access.

54. (1) No member shall commence engaging in or supervising drug preparation activities at or in connection with drug preparation premises unless the member has previously given notice in writing to the College in accordance with subsection (3) of the member's intention to do so.

(2) Where a member has provided notice in writing to the College in accordance with subsection (1) and the drug preparation premises have not passed an inspection or passed an inspection with conditions within the previous five years, the College shall ensure that an inspection of the drug preparation premises is performed within 60 days from the day that the College receives the member's notice.

(3) The notice required in subsection (1) shall include the following information, submitted in the form and manner required by the College:

1. The full name of the member giving the notice and the full name of the individual or corporation who is the owner or occupier of the drug preparation premises, if he or she is not the member who is required to give notice under this section.
2. The full address of the drug preparation premises.
3. The date when the member first began engaging in or supervising drug preparation activities at or in connection with the drug preparation premises or the proposed date when the member intends to begin engaging in or supervising drug preparation activities at or in connection with the drug preparation premises.
4. Any other information the College requires that is relevant to an inspection of the drug preparation premises conducted under this Part.

55. Where two or more members engage in or supervise drug preparation activities at or in connection with a drug preparation premises, the members shall designate a member as the designated member for the drug preparation premises, and shall immediately notify the College of the designated member's identity.

56. All drug preparation premises are subject to an inspection by the College once every five years after the initial inspection of the premises or more often if, in the opinion of the College, it is necessary or advisable to do so.

57. (1) After an inspection of a drug preparation premises, the College shall determine, in accordance with the accepted standards of practice, whether the drug preparation premises pass, pass with conditions or fail.

(2) In determining whether drug preparation premises pass, pass with conditions or fail an inspection, the College may consider,

(a) the inspection results provided to the College by the inspector;

(b) information provided by one or more members engaging in or supervising drug preparation activities at or in connection with the drug preparation premises respecting the inspection, including the answers given by them in response to inquiries or questions asked by the inspector;

(c) the information contained in a notice given by a member under subsection 54 (1) or (3);

(d) any submissions made by the member or members engaging in or supervising drug preparation activities at or in connection with the drug preparation premises that are relevant to the inspection; and

(e) any other information that is directly relevant to the inspection of the drug preparation premises conducted under this Part.

(3) The College shall deliver a report, in writing and in accordance with section 39 of the *Regulated Health Professions Act, 1991*, to the individual or corporation that is the owner or occupier of the drug preparation premises and to the designated member for the drug preparation premises, within a reasonable time after the inspection is completed.

(4) Any report made by the College respecting an inspection of drug preparation premises where a member is engaging in or in respect of which the member is supervising drug preparation activities shall make a finding that the drug preparation

premises passed, passed with conditions or failed the inspection and shall provide reasons where the drug preparation premises passed with conditions or failed the inspection.

(5) Any report made by the College that finds that drug preparation premises failed an inspection or passed with conditions is effective on the day that it is received, in accordance with section 39 of the *Regulated Health Professions Act, 1991*, by the designated member for the drug preparation premises.

(6) The designated member who receives a report made by the College that finds that a drug preparation premises failed an inspection or passed with conditions shall promptly provide copies of the report to all members engaging in or supervising drug preparation activities at or in connection with the drug preparation premises.

(7) A member shall not engage in or supervise drug preparation activities at or in connection with a drug preparation premises that fail an inspection until,

(a) the College delivers a report indicating that the drug preparation premises passed a subsequent inspection, or passed with conditions; or

(b) after considering submissions under subsection (9), the College substitutes a finding that the drug preparation premises pass or pass with conditions.

(8) A member shall not engage in or supervise drug preparation activities at or in connection with drug preparation premises that pass an inspection with conditions except in accordance with the conditions set out in the report until,

(a) the College delivers a report indicating that the drug preparation premises passed a subsequent inspection; or

(b) after considering submissions under subsection (9), the College substitutes a finding that the drug preparation premises pass.

(9) A member may make submissions in writing to the College within 14 days from the date on which a report made by the College that finds that the drug preparation premises passed with conditions or failed the inspection becomes effective in accordance with subsection (5).

(10) The College may or may not elect to reinspect the drug preparation premises after receiving a member's submissions, but no more than 60 days after a member provides his or her submissions, the College shall do one or more of the following:

1. Confirm its finding that the drug preparation premises failed the inspection or passed with conditions.
2. Make a report and find that the drug preparation premises passed with conditions.
3. Make a report and find that the drug preparation premises passed the inspection.

(11) Drug preparation premises that fail an inspection or pass with conditions may be subject to one or more further inspections within a reasonable time after the College delivers its report, at the request of a member, any other person to whom the College gave the report, or at any time at the discretion of the College.

(12) Where, as a result of an inspection carried out under this Part, a report made by the College finds that a member's knowledge, skill or judgment is unsatisfactory, the College may direct the Registrar to refer the report to the Quality Assurance Committee.

(13) Where, as a result of an inspection carried out under this Part, a report made by the College finds that a member may have committed an act of professional misconduct or may be incompetent or incapacitated, the College may direct the Registrar to refer the report to the Inquiries, Complaints and Reports Committee.

PART XIV
FUNDING FOR THERAPY AND COUNSELLING

58. In this Part,

"member" includes a former member.

59. (1) The alternative requirements that must be satisfied in order for a person to be eligible for funding under clause 85.7 (4) (b) of the Health Professions Procedural Code are prescribed in this section.

(2) A person is eligible for funding for therapy or counselling if,

(a) there is an admission made by a member in a statement to the College or in an agreement with the College that he or she sexually abused the person while the person was a patient of the member;

(b) a member has been found guilty under the *Criminal Code* (Canada) of sexually assaulting the person while the person was a patient of the member;

(c) there is a statement, contained in the written reasons of a committee of the College given after a hearing, that the person, while a patient, was sexually abused by a member; or

(d) there is sufficient evidence presented to the Patient Relations Committee to support a reasonable belief that the person, while a patient, was sexually abused by a member.

(3) For the purposes of clause (2) (d), and without limiting the generality of that clause, the following kinds of evidence may support a reasonable belief that a person, while a patient, was sexually abused by a member:

1. Evidence of reports made with respect to the member under subsection 85.1 (1) or 85.2 (1) of the Health Professions Procedural Code.
2. Evidence that corroborates the person's allegations of sexual abuse by the member.

(4) A person is not eligible under subsection (2) unless, at the time the sexual abuse occurred, the person was a patient of the member and the member was practising in Ontario.

(5) Despite subsections (2), (3) and (4), a person is eligible for funding for therapy or counselling under this Part only if,

(a) the person submits an application for funding to the Patient Relations Committee in the form provided by the College and, in the application, the person names the member who is alleged to have sexually abused the person;

(b) the person adheres to the procedures followed by the Patient Relations Committee when determining whether the person has satisfied the requirements for eligibility for funding; and

(c) the person provides such other information as is required by the Patient Relations Committee.

(6) A decision by the Patient Relations Committee that a person is eligible for funding for therapy or counselling does not constitute a finding against the member and shall not be considered by any other committee of the College dealing with the member.

Ontario College of Pharmacists
Putting patients first since 1871

COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Nancy Lum-Wilson, CEO and Registrar

TOPIC: Report to September 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 June 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, and presented to Council in a Report Card format in June for confirmation to support the budget development process. Attached for Council's information is an update of progress made on the various strategic directions since the June 2017 Council meeting.

Following the September Council meeting, we will begin preparing for the spring Strategic Planning session, details of which will be communicated to Council in December.

Ministry/Government Activities

During this reporting period, I have continued to meet with officials from multiple branches of the Ministry to inform them of our work and explore alignment of our strategic priorities with those of the Ministry.

Senior team members and I have had meetings with representatives from the Minister's Office, Ontario Public Drug Programs, Health Workforce Planning & Regulatory Affairs, and Laboratories and Genetics branches of the Ministry to explore possible regulatory changes needed to enable pharmacists to provide additional patient care services to improve patient outcomes, building on the expanded scope initiatives first announced under the *Regulated Health Professions Statute Amendment Act, 2009* (Bill 179). In addition, I have had meetings with the Strategic Policy and Planning Branch to discuss the Opioid Strategy. While the Ministry wants to understand what changes may be necessary for pharmacy to have greater impact on patient outcomes, they have stated they are not intending to initiate scope changes in the immediate future. They have however encouraged the College to continue with further analysis using the new Model for the Evaluation of Scopes of Practice in Ontario (MESPO) framework,

which we are pursuing. As a result of these discussions I have arranged quarterly meetings with Health Workforce Planning & Regulatory Affairs branch which will complement my monthly meetings with Ontario Public Drug Programs branch.

We have also established new relationships with the Hospital branch and set regular meetings with staff from the Health Capital Investment branch and Cancer Care Ontario to collectively manage and evaluate the impact of the College's oversight of hospital pharmacies.

Meetings with Health Quality Ontario have continued as we further our work to develop quality standard indicators related to opioids and pharmacy practice more broadly within the health system.

Legislative Initiatives

Bill 87, *Protecting Patients Act 2017*

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).

As reported at the June Council Meeting, the Bill received Royal Assent on May 30, 2017. It is anticipated that extensive consultations will be held that will focus on the development of regulations and will provide the College with the tools to address ongoing public protection issues through bylaws and policies.

In addition, the Ministry has communicated a need to modernize the *RHPA,* because there is a perspective that it is no longer fit for purpose. College staff have been invited to participate in this dialogue through the McMaster Health Forum to be held at the end of September on Modernizing the Oversight of the Health Workforce in Ontario.

Federal/Provincial Initiatives

Opioid Crisis

There has been ongoing work stemming from the November 2016, two-day summit the Federal Health Minister Jane Philpott and Ontario Health Minister Eric Hoskins convened regarding the opioid crisis in Canada. Noted below are some significant measures that have been undertaken.

In Ontario, Eric Hoskins, Minister of Health and Long-Term Care, Dr. David Williams, Chief Medical Officer of Health and Dr. Dirk Huyer, Chief Coroner for Ontario, announced the launch of the Interactive Opioid Tracker, to gather accurate data on the impact of opioid use.

The information in the Interactive Opioid Tracker provides over 10 years (2003-2016) of information on opioid-related emergency department visits, hospitalizations and deaths in Ontario. It will assist to better understand the scope and scale of the opioid problem and support the development of targeted policies and interventions.

On June 12, 2017, Dr. Hoskins announced further measures to combat the opioid crisis including new front-line addiction and mental health workers for every community in the province and the distribution of 80,000 additional naloxone kits per year to front-line organizations. Other initiatives announced as part of the government's Opioid Strategy include:

- Stricter controls on the prescribing and dispensing of opioids, including fentanyl patches
- Expanding access to opioid substitution therapy

- Funding for three supervised injection services sites in Toronto and an additional site in Ottawa

On August 29, the Ministry of Health and Long-Term Care announced an investment of $222 million over three years to enhance the province's opioid strategy by building on previous commitments that will help ensure people with opioid addictions have access to holistic supports that address the full spectrum of needs. This includes adding more front-line harm-reduction workers, expanding the supply of naloxone and creating new rapid access addiction clinics in every region of the province.

In order to support the Ministry's effort to inform the opioid strategy with consistent and evidence-based data from the Narcotic Monitoring System, the Ontario Public Drug Programs established a Prescription Monitoring Leadership Roundtable (PMLR) with representatives from the regulatory bodies of the prescribing and dispensing professions (medicine, dentistry, nursing and pharmacy) as well as representatives from Health Quality Ontario, Health Analytics and Strategic Planning. This group has started to meet on a monthly basis and will oversee and develop strategies such that potentially inappropriate prescribing and dispensing practices are identified and handled appropriately.

Health Canada consulted on proposed changes to the Food and Drugs Regulations related to opioids over the summer. The proposed amendments would expressly permit the Minister of Health to add or amend terms and conditions to an authorization for the sale of an opioid and require that a patient information handout and warning sticker accompany all prescription opioids at the time of sale. The College participated in development of a response by the National Association of Pharmacy Regulatory Authorities (NAPRA) on the proposed changes, supporting the objective to better inform patients of the risks associated with opioids, but to identify concerns with the proposed approach and request an amendment that would allow pharmacists to use their professional judgement to determine how best to provide patients with this kind of information.

The College's Opioid Task Force is presenting a proposed strategy to Council in September with a goal of aligning our work with national and provincial efforts. I have also kept the Ministry informed of the work of the Task Force to advise on areas where pharmacy could make a contribution.

Cannabis

In April 2017, the federal government introduced the *Cannabis Act*, which will legalize and regulate cannabis across Canada by July 2018. The federal plan calls on the provinces and territories to establish a framework to regulate the distribution, sale and consumption of recreational cannabis, among other matters.

On July 12, 2017, Ontario's Attorney General announced an online survey for public input on the federal government's plans in five key areas:

1. setting a minimum age for having, using and buying cannabis
2. deciding where people can use cannabis
3. keeping our roads safe
4. regulating cannabis sales
5. planning public education

College staff attended a consultation session at which time the need for research and a public health focus was emphasized.

The Ontario Legalization of Cannabis Secretariat will host a series of expert forums and engagement sessions over the summer on the potential impacts of cannabis legalization. The province will hear from a broad range of participants including municipal partners, public health experts, law enforcement, community agencies, youth advocates, Indigenous communities and licensed producers.

Canada's Premiers have also established a Provincial-Territorial Working Group on Cannabis Legalization that will report by November 1, 2017 and identify best practices to cannabis legalization and regulation, guided by the objectives of reducing harm, protecting public safety, and reducing illicit activity. The Premiers also sent a warning to Ottawa that there are challenges associated with the federal government's proposed implementation date of July 1, 2018 and an extension may be required.

Recent investigative media coverage (attached) has raised issues around the challenges that Health Canada is experiencing regarding the safety of the supply chain.

Self-Care Product Regulation
In early June, I participated in Health Canada's public consultation session to discuss the modernization of self-care product regulation. Health Canada is examining the feedback and determining next steps in developing the regulations. Meetings on this issue were also held between NAPRA and the Natural and Non-prescription Health Products Directorate and we anticipate further consultation will occur as this initiative progresses.

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 July 19 and discussed matters of mutual concern among the member colleges. Among these were *The Protecting Patients Act* and discussion on how RHPA Colleges can implement some of the complex amendments to this Bill.

Additionally, the AGRE (Advisory Group for Regulatory Excellence) colleges continue to develop elements of a proposed governance model that aligns with best practices of regulatory authorities across the globe. While the highlights of the proposed model have been shared with Council earlier this year, a presentation by the College of Nurses is planned for December Council.

Other Stakeholder Meetings

Ontario Pharmacists Association (OPA)
In June I had the opportunity to attend the OPA's annual professional development conference with our President and gave one of two presentations the College provided during the conference. These interactive workshops were well received and allowed the College to introduce the Scope of Practice Strategy and Continuous Quality Assurance for Medication Safety framework with pharmacists and pharmacy technicians in attendance.

As well, senior staff from the OPA and the College have met several times over the summer to discuss our current scope of practice initiatives and explore opportunities for collaboration to improve patient outcomes. The OPA has confirmed their interest in continuing to provide professional development activities that support the education needs of pharmacy professionals so they can practice to the standard of the profession.

Fall Regional Meetings

Plans are underway to host a series of regional meetings this fall. These meetings – which will be held in Toronto (Oct. 10), Ottawa (Oct. 12), London (Oct. 26) and Sudbury (Nov. 1) – are an important opportunity for us to meet face to face with professionals throughout parts of the province. Under the theme *"Putting patients first: our common goal"*, this year's fall regional meetings will provide an update on key College initiatives and priorities as well as timely information relevant to pharmacy practice and our collective commitment to quality and safe patient care. Updates will focus on the Continuous Quality Assurance (CQA) Program for Medication Safety, Opioid Strategy, Shared Responsibility and Practicing to Standard, Practice Assessments and regulatory updates.

This year we are providing two opportunities to join by live webcast (Toronto and London dates) so that members have additional options to participate if they are not able to attend a meeting in person. Webcast presentations will be archived on our website shortly after the regional meetings have concluded.

Miscellaneous Items

Transfer of Value from the Private Sector to Healthcare Professionals

Health Minister Hopkins has made a commitment to strengthening transparency across the health care system with respect to the relationship between pharmaceutical companies and health care professionals. Consultation with stakeholders, including regulatory colleges, regarding mechanisms of and responsibility for reporting fees, grants and other forms of payment has begun. Evidence is being gathered regarding the impact of such transfers of value on professional judgement, as well as the potential for real or perceived conflicts of interest for health professionals.

Injectable Sodium Bicarbonate Shortage

In early June, Pfizer Canada announced a drug shortage and voluntary recall of injectable sodium bicarbonate which resulted in a critical shortage of the product and the potential for a large number of patient care services to be impacted, particularly in hospital settings. Fortunately there are well established processes in place both nationally and provincially to respond to drug shortages and steps to minimize the impact were quickly initiated. Throughout the summer, Judy Chong our Manager, Hospital Practice, served as our liaison with NAPRA for management at the national level and with the Ministry for the provincial response.

In Ontario, the Ministry's Emergency Operations Centre (MEOC) was activated in order to provide a single point of contact and coordination for the provincial health system and to establish an action plan. As part of this process, the College participated in weekly status update meetings and served as a communication conduit to members through our website and eConnect. Hospitals were able to manage the shortage without significant issue and based on the increased availability of the product by early August the Ministry was able to deactivate the MEOC.

Health Canada Consultation on Adverse Drug Reporting changes

Health Canada has proposed changes to the Food and Drug Regulations and Medical Devices Regulations making it mandatory for health care institutions to report serious adverse drug reactions (ADR's) and medical device incidents. In response to the release of a consultation paper and request for feedback on specific issues related to the new reporting requirements, the college contributed to a submission by NAPRA. The proposal is focused on acute care hospitals and on serious unexpected ADR's in the institution's control.

Safe Access Zones Legislation

After reports of heightened security and privacy concerns in an Ottawa clinic, Ontario announced a plan to introduce legislation in Fall 2017 that, if passed, would provide safe access zones at specified facilities that offer women's reproductive services to support safety, privacy and dignity of women and safety of health care providers. The legislation would address the establishment of safe access zones around facilities, as well as homes and offices of specified health care providers, defining prohibited activities including those related to harassment of health care providers outside of access zones, and penalties for breaching prohibitions. Ontario has communicated that any legislative solution must balance the rights of patients and providers with that of the fundamental charter right for freedom of expression. Similar legislation exists in British Columbia and Newfoundland and Labrador. .

***Freedom of Information and Protection of Privacy Act* (FIPPA) Abortion Records Exclusion**

The College participated in Ministry consultations regarding the exclusion of abortion records from the provisions of FIPPA. Proposed amendments would address the recent Ontario Superior Court ruling, which held that the current exclusion of records relating to the provision of abortion services under FIPPA breached *Charter* rights to freedom of expression by precluding meaningful public discussion on a matter of public interest. The Court has suspended its decision for 12 months to allow the Ministry the opportunity to respond. The recommended changes to FIPPA would allow public access through FIPPA to certain abortion related records that *do not* contain identifying information, or information that could threaten the health or safety of individuals or the security of a facility or other building. The purpose of the proposed amendments would be to allow access to statistical and other non-identifying abortion related information relating to the provision of abortion services that would support meaningful public debate.

Ontario College of Pharmacists
Putting patients first since 1871

Strategic Priorities 2015 - 2018

Progress Update – September 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

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 – Transparency, Accountability, Excellence						
Outcomes/KPI	**Activity**	**Strategic Initiatives Focus**			**Last Quarter Accomplishments (March – May 2017)**	**Noteworthy Accomplishments this Quarter (June – August 2017)**
		PF	**EC**	**CQI**		
Fair and objective assessment framework.	Refine assessment tools and activities. Premises: Current authority and others i.e. long-term care, family health teams. Members: Pharmacists - at entry, in practice, (site based and standardized). Pharm techs – as above.	High	Med	High	• Data collection matrix and survey instruments for PACE Phase I evaluation finalized. • Backlog of QA coaching sessions have been addressed and QA coaching sessions now occurring within 6-8 weeks of identification. • QA assessment tool finalized and cut score session with subject matter experts completed. • 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. • Sterile compounding training for hospital and community practice advisors completed. • BUD guidance document developed to support implementation of Sterile Compounding.	• Performance indicators for the pharmacy technician practice assessment have been identified. • Scheduling of Practice Assessments has met target of 60% for this period; ratio of member to pharmacy assessments reached 1.3 to 1 for scheduled assessments. • CPA consistency with Ideal Assessment model based on measures document reached 90%. • Feedback survey for complaints introduced. 26 responses received (2015/2016 council year), representing an 18% response rate. 58% of complainants reported being very or somewhat satisfied while 35% of complainants reported being very or somewhat dissatisfied with the process. • On-line complaint intake form launched to improve efficiency. • Implementation plan for I&R related changes stemming from the *Protecting Patients Act* developed.

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 – Transparency, Accountability, Excellence						
Outcomes/KPI	**Activity**	**Strategic Initiatives Focus**			**Last Quarter Accomplishments (March – May 2017)**	**Noteworthy Accomplishments this Quarter (June – August 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	• HPDB data submission completed and the process streamlined.	• Discipline Committee implemented standardized tools for 1) deliberation, 2) credibility and 3) penalty orders for allegations related to sexual misconduct. • Standardized tools and best practices for conducting investigations into allegations of sexual abuse introduced relating to 1) interviewing vulnerable witnesses, 2) investigation plans, and 3) completing a witness statement. • Incorporated a standardized harm assessment rating in the ICRC's deliberations and dispositions. • Standardized template for penalty orders provided for use by college prosecutors. • Secured Policy Manager to add capacity/expertise.
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	• None.	• Standardized criteria for selection of coaches, assessors and mentors developed. Resource catalogue for remediation based on identified gaps now available to committee.

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 – Transparency, Accountability, Excellence						
Outcomes/KPI	**Activity**	**Strategic Initiatives Focus**			**Last Quarter Accomplishments (March – May 2017)**	**Noteworthy Accomplishments this Quarter (June – August 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	• 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.
					• Decision-making tool to support application of the Code of Ethics published in Pharmacy Connection.
						• Conflict of Interest guidance and communication;
						  • YTD website pageviews: 29,830
						  • impressions (reach) of Pharmacy Connection (including a spread poster insert): 24,580
						  • 10 stories have been featured in bi-weekly eConnect email newsletter, reaching approximately 26,000
						  • social media channels in this quarter, with a three-month reach of 187,000 Twitter impressions and 692,000 Facebook impressions
						  • posters distributed to 200 professionals at the OPA conference
						• Completed 1910 pharmacist member assessments as of August 18, 2017 (61% of 2017 target of 3150).
						• 2 presentations delivered to hospital pharmacists regarding professional expectations.
						• 1 presentation delivered at OPA conference.

Pharmacy Technicians consistently practising 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	• Initiated first of several presentations to hospital pharmacy technicians regarding professional responsibility.	• Draft QA regulations finalized for September 2017 Council consideration. • Conflict of interest guidance and communication, as above. • 2 presentations delivered to hospital pharmacy technicians regarding professional expectations.

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 – Transparency, Accountability, Excellence						
Outcomes/KPI	**Activity**	**Strategic Initiatives Focus**			**Last Quarter Accomplishments (March – May 2017)**	**Noteworthy Accomplishments this Quarter (June – August 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	• As of May 12, 2017, 982 pharmacy assessments completed (44% of 2017 target of 2250). • Post Assessment Feedback Survey reflects that 96% indicated that they had a better understanding of some key operational processes. • Gap analysis document developed and posted on website to facilitate practice change to meet NAPRA Sterile Compounding standards by Jan 2019.	• Completed 1631 pharmacy assessments as of August 18, 2017 (72% of 2017 target of 2250). • Completed 116 hospital pharmacy assessments as of August 18, 2017 (70 % of 2017 target of 165).
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	• None.	• Digital Health Drug Repository data connected to 2 provincial clinical viewers (Clinical Connect and Connecting Ontario) and began to onboard community pharmacies. • Engagement with Canada Health Infoway at launch of PrescribeIT electronic prescription transmission so that NAPRA Pharmacy Practice Management Standards are strongly considered for incorporation. • Established relationship with Health Quality Ontario. Secured a commitment to cooperate on data collection and establishment of indicators for pharmacy.

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 (March – May 2017)**	**Noteworthy Accomplishments this Quarter (June – August 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	• Scope of Practice Strategy developed to set out intention on engagement of registrants to practice to scope through interprofessional collaboration.	• Scope of Practice Strategy communicated to stakeholders in Pharmacy Connection - workplan established. • Workplan established for Opioid Strategy, commitment to existing operational initiatives that support the strategy.
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	• None.	• Met with the coordinator of the Extension of Community Healthcare Outcome Program (ECHO); confirmed that pharmacists' participation is welcomed and encouraged. • OCP facilitated access to links to ECHO's chronic pain opiates program through OCP's website and practice tools. • The program now included in community practice assessors' toolkits.

Mysterious symptoms and medical marijuana: patients are looking for answers

In less than a year, the government will legalize recreational marijuana. But, as **Grant Robertson** reports, growers may already be pushing for profits at the expense of customers' health

Scott Wood had been losing weight for weeks, and it was starting to scare him. His skin developed strange blistering rashes, his muscles ached constantly, and his lungs burned. He couldn't stop coughing, and he was spitting up gobs of thick, clear mucous that looked like Vaseline.

But the worst day came in October when Mr. Wood, 53, a family man and military veteran, collapsed at the grocery store. "I walked about five feet, and I couldn't get a breath," he said. "I was down on my hands and knees in the parking lot."

He ended up in the emergency room that week – the first of seven trips to the ER over a span of six months – but the doctors couldn't figure out what was wrong. It was only later that he began to suspect what was really going on.

Mr. Wood, a former military police officer, had been consuming medical marijuana that, unbeknownst to him, was contaminated with several dangerous pesticides banned by Health Canada.

A doctor had prescribed the marijuana from a federally regulated drug company in September to treat a serious back injury Mr. Wood suffered while serving. At first, it was a godsend, allowing him to stop taking opioid painkillers and get on with his life.

Then, suddenly, in a matter of weeks, "my health went sideways," he said.

He stopped taking the marijuana soon after the mysterious symptoms began. It wasn't for another few months that the company supplying his prescription, Organigram Inc., revealed a problem: nearly all of its products from the previous year were unfit for consumption, and were being recalled due to chemical contamination.

The company, one of about 50 federally licensed medical marijuana producers in Canada, had been caught selling products tainted with two banned pesticides:

myclobutanil, a chemical used to kill mildew, and bifenazate, an insecticide prohibited for use on certain types of plants, including cannabis.

The recall has impacted thousands of people, and raised questions about oversight and quality control inside Canada's new federally regulated medical marijuana sector – particularly as the government prepares to legalize the drug for recreational use next year, creating a multibillion-dollar industry. It is one of the most sweeping new policy decisions the federal government has undertaken in years, ending nearly a century of prohibition on cannabis.

In a bid to minimize concerns about the recall, Organigram told its customers there was nothing to be concerned with: the risk of adverse health consequences, it said, was "remote." The company, which grows the product at an indoor facility in Moncton, N.B., said it had no idea how banned pesticides got into its products.

But to Mr. Wood and others who had become seriously ill, something was wrong.

"When I heard that response, I thought, 'Come on – you have almost a year's worth of marijuana, and you don't know?' As a former police officer and investigator, when you give an answer like that, it doesn't sound very credible. Especially when you're in a business that is dealing with people's health," Mr. Wood said.

"Basically, my thoughts were, okay, let's see if that's true or not."

So Mr. Wood gathered his remaining prescriptions, and those of a military colleague whose health had also taken a turn for the worse. Instead of returning them in the recall, he reached out to The Globe and Mail, which arranged for the prescriptions to be tested at a federally licensed laboratory that is among the most experienced facilities in the country at screening for pesticides.

The results of the tests shocked him. Mr. Wood's prescriptions not only contained the two banned pesticides that triggered Organigram's original recall eight months ago, the samples also contained three additional pesticides that are outlawed by Health Canada for safety reasons.

In addition to the myclobutanil and bifenazate that were previously known, Mr. Wood's samples contained significant amounts of imazalil, tebuconazole, and a carbamate pesticide.

Imazalil is used to eradicate root rot, and is not to be inhaled. Tebuconazole attacks fungi outbreaks, but can damage the endocrine system in humans. Carbamate pesticides kill bugs by targeting and disrupting their nervous systems.

But the number of banned pesticides found in the product wasn't the only problem.

In one of Mr. Wood's samples, the level of bifenezate detected was nearly double the amount Organigram claimed was present in the recall – back when the company told patients there was nothing to worry about.

The results have called into question the inner workings of Canada's booming marijuana sector since Health Canada began doling out highly coveted production licences four years ago, while reassuring consumers that companies in the lucrative new industry would not be allowed to put profits ahead of safety.

The tests have also ignited a bitter war of words between Mr. Wood and the company, which disputes his findings.

Organigram sent product samples from its own archives to be screened at a lab of its choosing, and said those tests showed no signs of any additional pesticides.

Not satisfied with that response, though, and growing increasingly concerned about the problem of illicit pesticide use inside a supposedly quality-controlled industry, Health Canada conducted an unannounced inspection of Organigram's facility, and gathered archive samples of its own to have screened.

Those tests, completed in August, also did not find the additional pesticides contained in Mr. Wood's samples, raising questions about the discrepancy between the results.

The company believes the new allegations are false. Mr. Wood believes customers aren't being told the truth about what they were exposed to – that the archive samples kept in storage at Organigram have been whitewashed, and don't match up with what people like him actually consumed.

Through social media, Mr. Wood has assembled a database of hundreds of people across Canada who are all reporting the same mysterious health problems: searing abdominal pains, fatigue, blistering rashes, painful aching muscles, lung problems, constant nausea, and – curiously – coughing up a strange clear, thick, mucous.

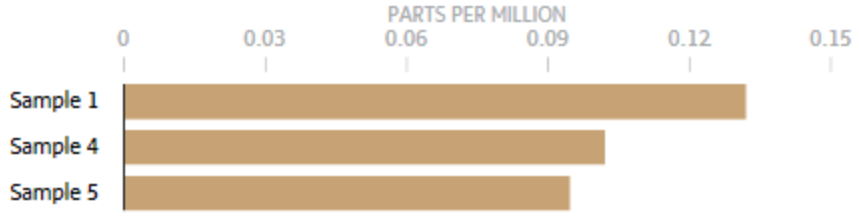
"You've got all these people, they don't know each other, they all have the same symptoms," Mr. Wood said. And while there has been no determination, "Something's not right. Somebody needs to look into this."

Additional pesticides

Eight prescriptions of medical marijuana that an Organigram customer submitted for testing revealed three additional banned pesticides in the products. The company issued a recall eight months ago when it was caught selling prescriptions tainted with two banned pesticides, myclobutanil and bifenazate. But the independent tests showed the presence of imazalil, tebuconazole, and a carbamate – making a total of five banned pesticides.

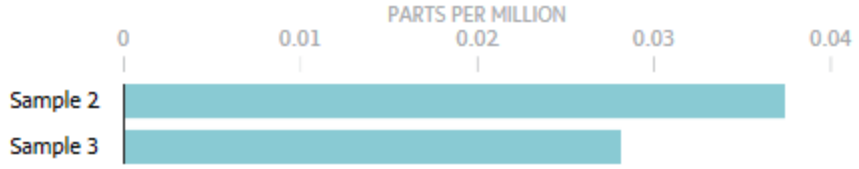
Imazalil

Used to prevent root rot. Banned for use on cannabis.
Long-term health impacts not known.



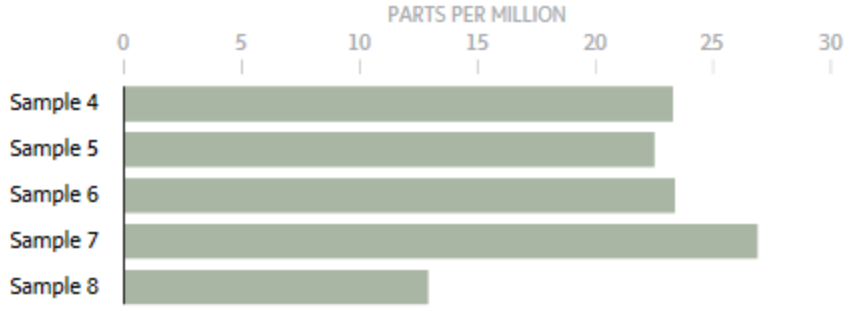
Tebuconazole

Used to control fungi outbreaks. Can disrupt the endocrine system.
Banned for use on cannabis.



Carbamate

A family of pesticides that kill insects by targeting their nervous system.
Banned for use on cannabis.



Sample	Lot number	Sample	Lot number
Sample 1	8721782947735980-1590	Sample 5	196-2008
Sample 2*	9073912095109254	Sample 6	186-1925
Sample 3*	9073912095109254	Sample 7	186-1933
Sample 4	7998044658844992-1727	Sample 8	66776317-77985134

*Same lot, two samples.

THE GLOBE AND MAIL, SOURCES: MB LABORATORIES LTD., ANANDIA LABS

'These are not trace amounts'

When MB Labs, based in Sidney, B.C., received the products from Mr. Wood for testing, the lab examined each sample to ensure they had not been tampered with.

Seven of the eight containers were still factory sealed, while one prescription had been opened and partially consumed – the one Mr. Wood was taking at the time his symptoms forced him to stop.

The lab inspected and photographed the containers using the same procedures it employs when handling evidence for the B.C. Supreme Court. The packaging on the seven unopened containers was intact, MB Labs said, including the foil seal on each bottle. All eight samples were then screened for any signs of foul play, looking for evidence of recently added substances – which would set off alarm bells in the chemical analysis. New contaminants would show up in purer form than the others present.

Nothing irregular was detected in the analysis.

"There was no tampering that we could see," said Wendy Riggs, director of MB Labs. "We are perfectly prepared to testify to that."

Though it was forced to recall a year's worth of production spanning nearly all of 2016, Organigram has denied any knowledge that banned pesticides were in its products. The company said it conducted an internal investigation in February, and was unable to determine where the chemicals came from.

This apparent lack of quality control in the new industry, which was created in 2013, is a problem that has implications far beyond patient safety in the billion-dollar medical marijuana sector. With the federal government preparing landmark legislation to legalize cannabis for recreational use in 2018, Health Canada has said it will rely upon licensed producers such as Organigram to supply the new retail market.

This new business could be worth as much as $10-billion, based on some estimates, and is expected to create a surge in consumption among Canadians when the government moves to sell it openly, much like beer and wine.

The rapid onset of this new industry has encouraged companies to expand quickly. As a result, some offer financial incentives to their staff for producing bigger and higher yielding crops.

Those very bonus structures could – theoretically – encourage employees to break the rules if a crop worth hundreds of thousands of dollars or more is threatened by an infestation of mites or mildew, a common problem when growing the plants indoors in large-scale operations.

"Did we have employees that were incentivized to get a higher yield? Of course," said Dennis Arsenault, the former CEO of Organigram.

"Were there employees that could have been incentivized [to use banned pesticides], either to save their job, either to increase yields, [or] to show competence? Yeah, of course. But have I been able to catch them? No."

Mr. Arsenault stepped aside as CEO after the Organigram recall was announced, following an investigation undertaken by the company, which failed to get to the bottom of the problem. He now sits on the board of directors.

"Where I felt that it was possible was a mid-level manager who, maybe having trouble doing his job, cuts a couple of corners. That to me was what was plausible," he said.

"I think you have to draw the conclusion that someone put it there... We couldn't find the guilty person."

But Organigram isn't the only company with problems. Its recall is one of four known instances of banned-chemical use to hit the industry in the past eight months.

Amid these recalls, it has become easy for companies to tell Health Canada they have no idea how the banned chemicals got into their products. Two of the four recalls – at Organigram, and at rival producer Mettrum – have been dismissed in this fashion, with no determination of how consumers were put at risk.

Health Canada is only now coming to the realization that tougher enforcement is needed.

"Pesticides can be a very powerful ally to food and medicine production, but they have to be used with knowledge and a great deal of care," said Ms. Riggs at MB Labs.

"Because although they may get you out of a pickle and get a crop off the field, they could leave your ultimate client down the line in a great deal of harm. And that is something that has been lost.... There's just too much money riding on these crops."

Despite the fact that such pesticides are strictly banned due to concerns about their impact on human health, and there is no acceptable amount that is allowed under Health Canada regulations, in several of the recalls that have taken place, companies have played down the problem for consumers.

When Organigram announced its recall, the company said the levels detected were only "trace amounts," suggesting there is nothing to be concerned about.

Worried consumers who phoned the company were also informed that such pesticides were sometimes used on food. This explanation omits the fact that many pesticides are designed to be broken down and neutralized by enzymes in the digestive system. Inhaling those same pesticides can be dangerous, and is warned against by the chemical manufacturers.

Organigram said the "trace" levels involved in its recall included myclobutanil concentrations of up to 20 parts per million (ppm), and bifenazate of up to 12 ppm.

While those numbers may sound minuscule, they are not.

Pesticide expert Rodger Voelker, director of Portland-based Oregon Grower's Analytical, a laboratory that helped uncover illegal pesticide use in Oregon and Colorado, where marijuana is legal, said the levels showing up in Canada are far too high.

"These are not trace amounts," Mr. Voelker said of the levels stated by Organigram, and found in Mr. Wood's prescriptions.

What consumers don't know is the term "trace amount" has no real meaning, and companies therefore use it however they want.

"Can you do anything about it? No, because 'trace' is not a legally binding word. So they'll say that as long as they can get away with it."

Among microbiologists, the term "trace amount" usually means a substance that can be detected through chemical analysis, but is too faint to be properly measured. Mr. Voelker, who called the pesticide problem "an emerging public health threat" that governments have not fully considered as they prepare to legalize the drug, argued that trace amounts are usually much smaller than one part per billion, which is equal to 0.001 parts per million. By that measure, the Organigram samples don't come close to being trace levels, he said.

The tests conducted by MB Labs on Mr. Wood's prescriptions turned up myclobutanil levels as high as 13.9 ppm, and bifenazate levels of 23.7 ppm.

The carbamate compound was detected at 26.9 ppm, while imazalil was found at 0.13 ppm, and the tebuconazole at 0.03 ppm.

While those latter two figures may also seem miniscule, Mr. Voelker insisted they are not, particularly since even small amounts of a harmful chemical can have a profoundly negative impact.

"These numbers are egregious," he said. "On an instrument, that's a pretty damn big signal."

His read of the data is that pesticides were applied to the plants in question. "It is extraordinarily unlikely to see numbers like some of these numbers as a result of indirect [accidental] application," Mr. Voelker said.

Ms. Riggs at MB Labs came to the same conclusion. Her analysis of the data is that the pesticide use was intentional – over a sustained period of time – even though Organigram has denied any knowledge of their use.

"The pattern that shows up here is deeply disturbing," Ms. Riggs said.

'We now consider this matter closed'

Though Organigram has already been caught selling products containing two banned pesticides, the company denies further chemicals could have been present.

When informed of Mr. Wood's test results, Organigram CEO Greg Engel immediately suggested the samples could have been manipulated, and that the company wasn't to blame.

As evidence, Mr. Engel said Organigram's own safety packaging – including its tamper-resistant seal – can be easily tampered with.

"I have very real concerns," Mr. Engel told The Globe about the findings. It would be "very easy for an unscrupulous individual to remove our product, replace with tainted product and then place a new tamper-resistant heat seal on the product."

Mr. Engel then said he believed the former customer was intentionally trying to hurt his company.

But there were several problems with the CEO's claim.

Mr. Engel said the customer in question told Organigram in a Jan. 25 e-mail that he would not return his recalled product, and wanted to have it tested. However, the customer was unsure how much was left. To Mr. Engel, this implied the containers had been opened.

Mr. Engel also said the patient had spoken "numerous times" with Organigram's head of customer service, Kathy Cyr, and had made "threats" toward the company.

However, Mr. Wood said he never sent any such e-mail to the company and never spoke with Ms. Cyr, though he requested to speak with her, but was denied by Organigram.

Mr. Wood provided The Globe and Mail with e-mails, recordings of phone calls, and copies of his phone records. His instinct to catalogue every interaction with the company came from his policing days, he said.

The Globe and Mail reviewed this information – including a 53-minute recorded phone call Mr. Wood held with an Organigram senior executive in January to seek more information about the chemicals found in the recall.

When Mr. Engel was asked about that phone call, the CEO said he had no record of it taking place. It was only after Mr. Engel was told that The Globe listened to a recording of the call that Mr. Engel changed his position: yes, in fact that phone call did take place.

Then, when he was informed that there was no record of an e-mail on Jan. 25 – a central piece of the company's argument that the samples could not be trusted – Mr. Engel backtracked, saying the e-mail didn't exist. It was actually a phone call, he said.

Yet, no such call – incoming or outgoing – shows up in Mr. Wood's phone records.

Mr. Wood is upset by the company's reaction.

"People are sick. I want to know what I was exposed to, so that I can seek proper medical treatment," he said. "If they want to investigate me, I welcome their investigation."

While these inconsistencies were being sorted out, Organigram sent product samples from its internal archives for testing. Mr. Engel says the samples came from the same product lots that Mr. Wood would have consumed.

Those tests, conducted at Vancouver's Anandia Labs, confirmed the presence of the two banned pesticides involved in the original recall – myclobutanil and bifenazate – but came back negative for the additional three MB Labs found – imazalil, tebuconazole and carbamate.

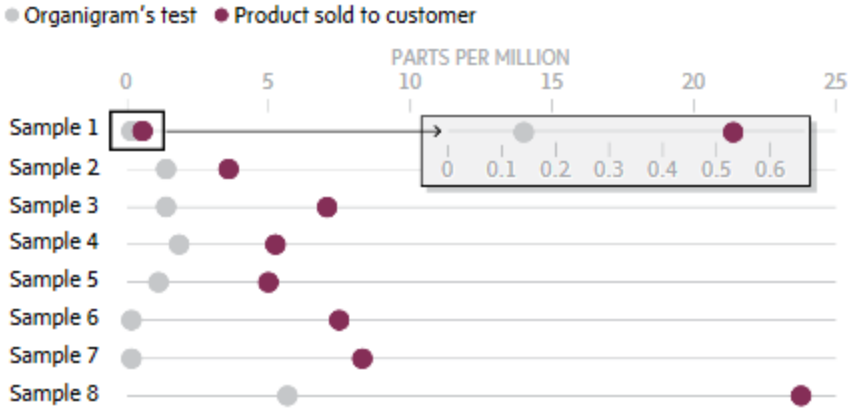
"We now consider this matter closed," Mr. Engel said in an e-mail to The Globe, refusing to discuss the matter further

Higher concentrations of banned pesticides than reported

After Organigram was caught selling product containing bifenazate and myclobutanil, both banned pesticides, The Globe and Mail conducted its own tests on products shipped to customers. The tests revealed higher levels of those two chemicals than Organigram's tests. In one sample, the level of bifenezate detected, 23.770 ppm, was far higher than the level reported by the company during its recall.

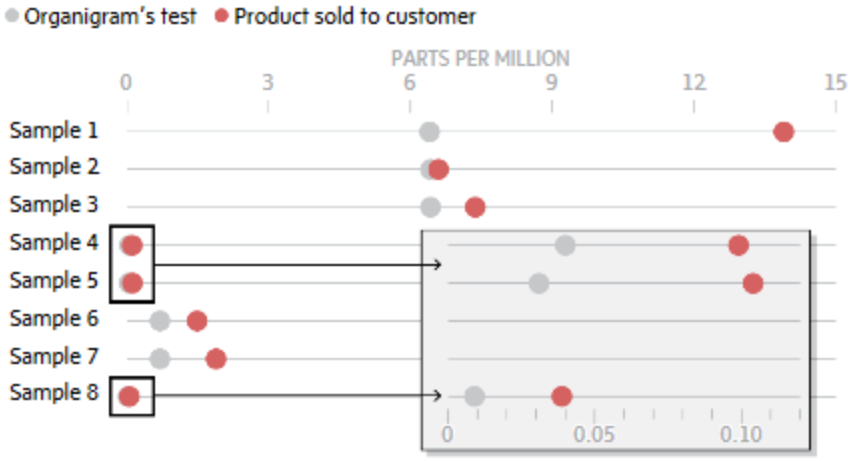
Bifenazate

Used to kill mites. Banned for use on cannabis. Health impacts uncertain.



Myclobutanil

Used to kill mildew infestations on plants. Banned for use on products that are inhaled. Health impacts uncertain.



Sample	Lot number	Sample	Lot number
Sample 1	8721782947735980-1590	Sample 5	196-2008
Sample 2*	9073912095109254	Sample 6	186-1925
Sample 3*	9073912095109254	Sample 7	186-1933
Sample 4	7998044658844992-1727	Sample 8	66776317-77985134

*Same lot, two samples.

THE GLOBE AND MAIL, SOURCES: MB LABORATORIES LTD., ANANDIA LABS

Dangerous chemicals, difficult to find

Health Canada does not consider the matter of pesticides in the industry closed. The department and the laboratories involved believe there is an explanation for the discrepancies in the test results, and that any potential problems should not be so easily dismissed.

Different labs can find different things, depending on the experience of the technicians, the accuracy of the equipment being used, and whether the samples being tested came from exactly the same plants – or not.

Mr. Engel told The Globe that the facility Organigram chose for its tests, Vancouver's Anandia Labs, uses the highest standards in Canada, implying that Organigram's results were of the highest possible accuracy.

But Jonathan Page, head of Anandia, said that's not necessarily the case.

"Our equipment is standard equipment," Mr. Page said of the lab that began operating last summer. "We are among the most sensitive, but we didn't invent a new machine that gives us an order-of-magnitude higher sensitivity than other labs."

Mr. Page said it's possible his lab tested archived samples that came from different plants in the harvest than the ones that went into the prescriptions of Mr. Wood and others.

"We didn't find those compounds and another lab did, and at fairly high levels," Mr. Page said. "Were there differences between the sample we tested and what was tested elsewhere?"

Mr. Page said he'd be less skeptical had Organigram not already been caught selling product containing banned pesticides – then claimed it was unable to determine the root of the problem.

"Let's face it, they didn't get to the bottom of it," Mr. Page said.

Ms. Riggs at MB Labs says her facility has more than 30 years of experience screening for pesticides, and certain compounds can be hard to isolate.

Her lab began specializing in imazalil more than a decade ago when it began showing up illicitly on greenhouse vegetables.

"Imazalil sulfate is a bugger," Ms. Riggs said. "It was a compound the greenhouse industry for vegetables snuck in to deal with root rot – because it worked. It wasn't legal, but they brought it in anyway. And we knew at the time because of its chemistry that it was a difficult compound to find."

Ms. Riggs said there would be obvious signals if the products had been tampered with.

"A cooked sample usually stands out," Ms. Riggs said. "What happens is you have a chemical profile that indicates that the chemical is in a purer state" than it should be.

"It is extremely difficult for someone to do so, without leaving some kind of a footprint behind."

Health Canada told The Globe and Mail it was not unusual to see differing results between labs, since their approaches can differ.

"Depending on the methodologies used, validation of data, and precision of equipment, it is possible and not unexpected to have different results from different laboratories," the department said in a statement.

A new breed of drug companies

Mr. Engel was named CEO in March, part of an effort by Organigram to turn the page on its pesticide recall problems, which had disrupted operations and hindered the company's stock price, upsetting investors.

In hiring the new CEO, Organigram told investors it landed an industry veteran, which was true.

Prior to joining Organigram, Mr. Engel had previously served as CEO of a rival medical marijuana company, B.C.-based Tilray Inc.

However, during Mr. Engel's time at Tilray, lobbying records show the company held backroom discussions with the B.C. government in an effort to gain permission to use myclobutanil, which is banned in Canada and the United States for use on cannabis, tobacco and other combusted plants due to numerous health concerns, including the discovery that it emits hydrogen cyanide when heated.

According to the B.C. lobbyists registry, Tilray asked the B.C. government for help in getting federal approval for "emergency use" of the pesticide when dealing with mildew infestations, and also for "long term" use. The conversation was never intended to be public.

A Tilray spokesman said the effort was later halted when Health Canada created a list of approved alternative fungicides that should be used instead of the banned pesticide.

The effort would not have had much chance of succeeding, though. The manufacturer, Dow AgroSciences, does not consider myclobutanil safe for use on plants such as cannabis. When inhaled, the compound enters the bloodstream directly through the lungs, without being broken down by the digestive system. No studies have been done to

determine whether it is safe to be smoked, and Dow AgroSciences strictly warns against inhalation.

The lobbying documents are an interesting glimpse inside the industry, since the use of pesticides – legal or otherwise – is rarely discussed in the open.

When medical marijuana companies like Organigram meet with investors, they tout themselves not as weed growers or pot heads, but sophisticated pharmaceutical businesses concerned with the health of their clients.

Given the spate of pesticide recalls this year, it's a sales pitch that doesn't always reflect reality.

At an investor conference in Toronto in April, Mr. Engel pitched Organigram to a crowd of several hundred potential shareholders from Bay Street investment firms, telling them about the company's focus on producing high-quality medicine.

From there, the CEO focused on how big the market was going to be once legalization arrived in Canada, and how companies like his stood to profit.

The medical marijuana market was a few billion dollars now, he said. But the industry payday from legalization could be worth much more.

Even better for the industry, Mr. Engel told the audience, is the Canadian government had chosen companies like Organigram to supply this lucrative new market.

"Licensed producers are the preferred source for safe product," he told the audience. He did not mention the pesticide problems Organigram had encountered.

Lab data blacked out

Patients who consumed the tainted marijuana are now searching for answers about their health. Some former Organigram customers, like Wayne Jory, are worried.

Mr. Jory, a 55-year-old homebuilder and father, was never a marijuana smoker. He was prescribed Organigram's products starting in late 2014 after surgery to repair a herniated disc. He disliked the morphine he was given after the operation and found medical marijuana had fewer side effects.

Mr. Jory researched the industry carefully before settling on Organigram, selecting the company because they touted their product as safe, organic, and pesticide-free.

For a while there were no problems. But in May, 2016, Mr. Jory began to notice his lungs burning for days on end, his heart racing inexplicably, and pain shooting through his muscles. He soon began shedding weight – dropping 40 pounds from his 215-pound frame in only a few months. He felt tired all the time, and was dogged by severe, inexplicable bouts of nausea.

"Simple tasks like climbing stairs seemed to drain all my energy. My joints were aching," he said. "I could barely climb a ladder, and when I did, I felt unstable and dizzy."

His doctor was baffled. X-rays on Mr. Jory's lungs came back negative, as did basic blood tests.

"The fatigue was unreal," Mr. Jory said. "In January I went back to my doctor, he ordered more blood tests, and I was told that if I lost any more weight I'd have to get myself to the hospital."

Mr. Jory soon learned about the Organigram recall. Once the problem came to light, his doctor wanted to know exactly how much of the chemicals Mr. Jory had been exposed to, but the company only gave vague numbers for the whole recall, not specifics.

Mr. Jory then filed a request to Health Canada through Access to Information, seeking to know the exact chemical content of each product lot he ingested.

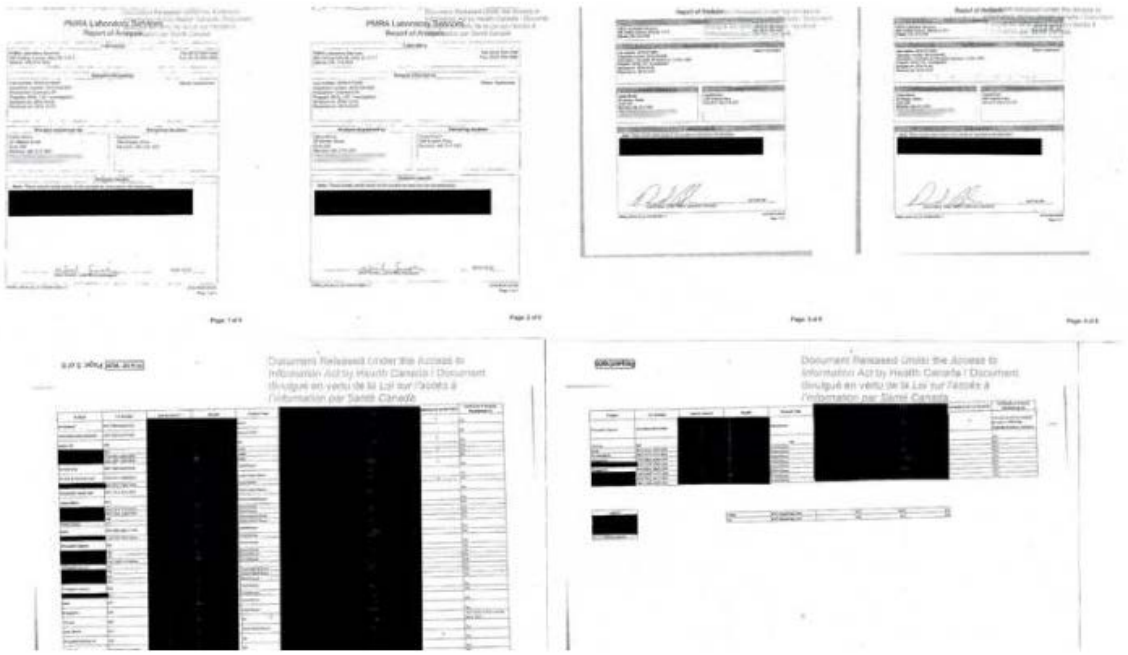
He was surprised to learn in May that he was not entitled to such information.

Mr. Jory was told by the Access to Information and Privacy commissioner for Health Canada that the data he sought was being withheld because it "could result in material financial loss" to a third party.

In his case, that third party was Organigram.

Instead, Mr. Jory received numerous pages of records with the information blacked out, citing privacy laws that, in his case, protected the company – not the consumer.

"They basically just want to bury this," Mr. Jory said. "And I understand why – it's everybody's dirty laundry."



Wayne Jory tried to find out the exact levels of banned pesticides he ingested by unknowingly consuming tainted medical marijuana so he could seek better medical advice. But when he filed a request through Access to Information, he was denied by Health Canada. Instead, Mr. Jory received several blacked out pages.

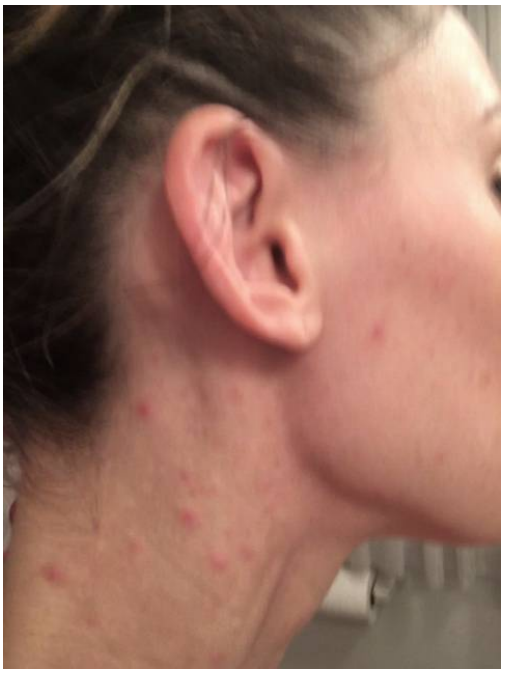
(Note: Contact information for specific individuals listed on the forms has been blurred by The Globe and Mail).

Patients who contact Health Canada complaining of health problems are told to file an Adverse Reaction Report, which is how the government tracks problems with prescription drugs. However, these filings are usually just anecdotal reports that are used for data-keeping purposes.

The Globe has talked to more than a dozen patients who say nothing happens when you file such a report.

Nicolette Lutz of Listowel, Ont., submitted two reports to Health Canada after falling ill from medical marijuana that was later recalled by Organigram.

Her symptoms included abdominal pains, constant burning in her lungs and throat, and a strange buildup of mucous. She couldn't eat, she itched constantly and her skin broke out in painful cyst-like sores across her neck, arms, chest and stomach.



Nicolette Lutz said she suffered several symptoms, including severe abdominal pain and painful cyst-like sores that covered her upper body.Photo courtesy Nicolette Lutz

"The worst was the abdominal pain," said Ms. Lutz, 35, who turned to medical marijuana reluctantly to help with chronic insomnia, and assumed it was safe because it was federally regulated.

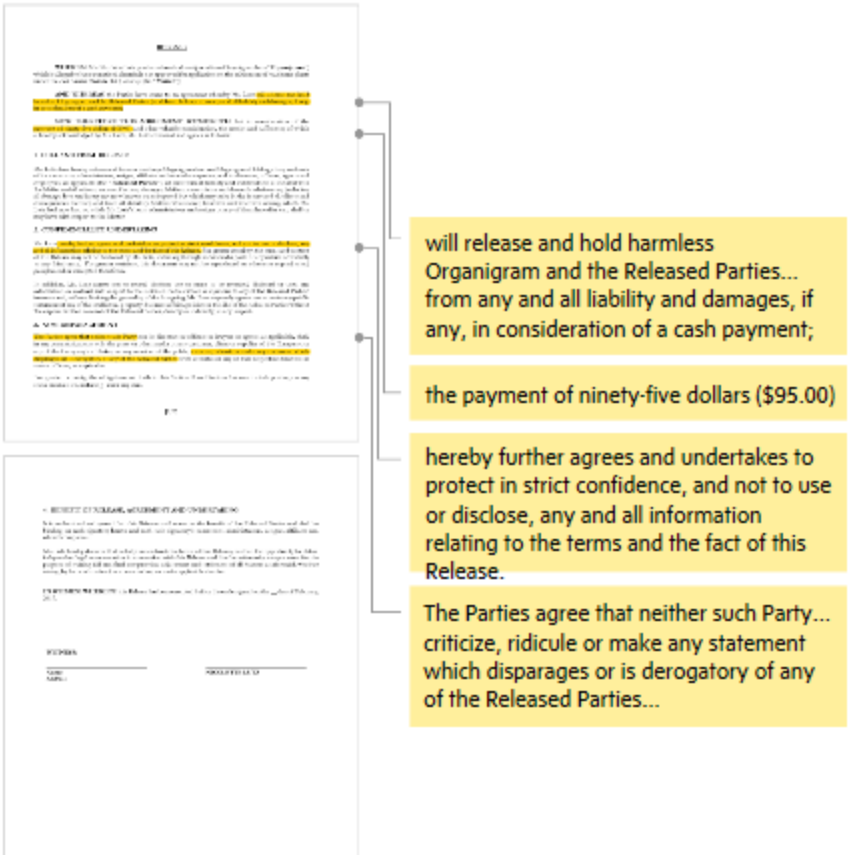
"There was one night, my husband was sitting beside me on the bed just holding my hand, trying to help me breathe, because I felt like I was going to pass out. It was just so incredibly bad."

Ms. Lutz never heard from Health Canada, and doesn't know if they read the reports she filed. She later e-mailed the department directly to warn them she thought something was seriously wrong with the product, but received a standard response with some links to the government's website.

When she e-mailed Organigram in February to complain about her symptoms, she was offered a refund, but was told she would have to sign a legal release form.

In exchange for a $95 refund, Ms. Lutz would have to agree to "hold harmless Organigram ... from any and all liability and damages."

The form included a "confidentiality undertaking" that would prevent her from discussing the matter publicly, and a "non-disparagement" agreement – which stated she could not "criticize, ridicule or make any statement which disparages or is derogatory" toward Organigram or its directors, including posts on social media.



She didn't sign the form. Eight months after her symptoms emerged, many of the problems persist. Unable to find answers with her local doctor, she is travelling to a clinic in Seattle next week that specializes in toxicology.

She persisted. But Mr. Jory says some people have given up.

"There are others that are too tired to fight," Mr. Jory said. "We're talking about people with cancer. They've got all these other health issues and this was just added on top and they don't have the energy to fight it."

The Globe contacted Health Minister Jane Philpott's office several times this year to ask whether the government plans to look into the health problems some patients are reporting, or at least re-examine the public statement issued by the department that said the risk of adverse health consequences from the recall is "remote," when the evidence suggests that is not the case.

Ms. Philpott's spokesman has said repeatedly the Minister has no comment.

Following the recall, Health Canada attached new conditions to Organigram's operating licence requiring that a licensed laboratory test all of its products.

"Prior to the release and sale of all of our products, we provide the test data to Health Canada for their review," Mr. Engel said this week. "Following their review we are then in a position to release the product for sale."

But Mr. Jory said more should be done, including an investigation into the health problems people have suffered. Things would be different, he said, if the people who are now sick had bought the product off the street, where there are no regulations or supposed oversight. But people like him thought they were buying a government regulated medicine that was safe to consume.

He wonders what will happen if the problems aren't solved by the time the government legalizes marijuana for recreational use next year, when consumption in Canada is expected to rise sharply.

"When this stuff becomes recreational, they're going to be shooting it out the door because they can't keep up to the demand," Mr. Jory said. "It's just asking for problems."

Mr. Wood sympathizes.

"Medically, there's a lot of people looking for answers," he said. "I had a military guy tell me he was using [the recalled product] every day. He's a combat veteran with PTSD. Why should a combat veteran who risks his ass come home, get poisoned, and then the Health Minister says we have no comment?" Mr. Wood said.

New safety measures

Health Canada announced a few months ago that it will now require all of the roughly 50 federally regulated medical marijuana companies to submit to mandatory pesticide testing before products can be sold, to ensure they are clean, and that consumers can trust the industry.

When The Globe informed Health Canada of the test results showing previously unreported pesticides in Mr. Wood's prescription, the department responded swiftly, asking to examine the data.

"As the department responsible for regulating medical cannabis, Health Canada is very interested in the information you have collected," the department said in an e-mail.

"The department takes the information you shared seriously."

A week later, after speaking directly with MB Labs about how the tests were conducted, Health Canada said it was making several more changes to the way the industry and Organigram operates.

"Since learning of the results of tests conducted by MB Labs, Health Canada has taken a number of additional actions."

Health Canada said the lab used by Organigram for its newly mandated safety testing, which is located in New Brunswick, will now be required to screen for a wider array of pesticides – including the same ones that showed up in Mr. Wood's tests.

The lab has added "imazalil and tebuconazole to the testing for more than 70 pesticides that it currently conducts," Health Canada said.

The department said it is now also taking steps to address discrepancies in results from different labs across the country, so more situations don't emerge where one lab is unable to detect pesticides that another could.

"Health Canada is preparing to provide a standard laboratory methodology for pesticide testing in cannabis to licenced producers, which can be used by all third-party laboratories. This should reduce the likelihood of discrepancies between laboratories," the department said.

"We would like to thank you for bringing this information to our attention."

While those are promising steps, Mr. Wood said what those affected need most now is better medical advice – from toxicologists or other specialists who can assist them.

He has since travelled to the United States in search of assistance, and has paid thousands of dollars out of pocket for testing and treatment at the Mayo Clinic. He doesn't want to end up in the ER again.

"I'm 53 years old and I was a fit person. So I want to know what is wrong with me," he said.

Grant Robertson is an investigative reporter at The Globe and Mail.
grobertson@globeandmail.com

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COUNCIL BRIEFING NOTE
MEETING DATE: SEPTEMBER 2017

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Nancy Lum-Wilson, CEO and Registrar

TOPIC: Reporting by Committees

ISSUE: Receipt of annual reports of statutory and standing committees of the College.

BACKGROUND:

- Attached for Council's information are annual reports of the statutory and standing committees of the College.

ANALYSIS:

- As per section 11 of the Code (*Health Professions Procedural Code*, Schedule 2, *Regulated Health Professions Act 1991*), each statutory committee of the College is required to "monitor and evaluate their processes and outcomes and shall annually submit a report of its activities to the Council". This requirement is also reflected in the College's By-Law No. 4. In an effort to provide a complete overview, reports from the standing committees of the College are also included for Council's information. It is to be noted that none of the material in the reports is new and is a re-cap of what has occurred and been reported since the previous Council year.

EXECUTIVE COMMITTEE RECOMMENDATION AND COMMENTS (if any):

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Committee Annual Report

Accreditation Committee – September 2016 to August 2017

Committee Role: The Drug and Pharmacies Regulation Act (DPRA) provides the Accreditation Committee with its authority regarding the issuance and annual renewal of pharmacy licenses (certificates of accreditation) that are required in order to operate a pharmacy in Ontario. The Committee reviews all issuance and renewal applications that the Registrar proposes to deny and directs the Registrar to either issue/renew, refuse or to impose terms, conditions and limitation on the certificate of accreditation.

The Accreditation Committee also considers assessment results of pharmacies identified by staff based on the level of risk. The Committee may conclude a matter if all issues previously identified have been addressed and the Committee is satisfied that compliance has been achieved. The Committee has the authority to order a re-assessment at cost to the pharmacy to verify that all issues addressed on the pharmacy's Action Plan have been implemented and are effective.

Where the Accreditation Committee has reason to believe that a pharmacy or its operation fails to conform to the requirements of the DPRA and the regulations or to any term, condition or limitation to which its certificate of accreditation is subject, or that an act of proprietary misconduct has been committed, the Committee may refer the person who has been issued a certificate of accreditation, the designated manager of the pharmacy or the director(s) of a corporation which has been issued a certificate of accreditation to the Discipline Committee for a hearing and determination.

Members: Tracey Phillips (Chair), Lavinia Adam, Billy Cheung, Michelle Filo (until December 2, 2016), John Laframboise (until January 11, 2017), Elnora Magboo (from January 11, 2017), James Morrison, Joy Sommerfreund, Tracy Wiersema

Meetings Held: October 26, 2016; February 22, 2017; May 3, 2017; June 1, 2017; June 27, 2017; August 2, 2017

Key Highlights: This year, the committee considered a number of applications for renewal of certificates of accreditation which were forwarded to them by the Registrar. Each of these renewal applications were forwarded because of concerns regarding the past and/or present conduct of the applicant (owner/director). The Committee's review of these applications provided them with the opportunity to validate the policy they have in place, which helps to streamline the administration of the annual accreditation renewal process. The Policy authorizes the Registrar to use the authority of the Accreditation Committee in defined circumstances to renew certificates for pharmacies where there is concern about the past and/or present conduct of an "owner" and the conduct is limited to matters that are currently before the Discipline Committee of the College but not yet decided. The review process also reinforced to the committee members the importance of ownership consideration within the ICRC and Discipline panel processes so that Accreditation Committee can rely on the decisions of these adjudicating committees in such matters. This year's process also provided these applicants with the awareness that consideration of an owner's/director's conduct is part of the College's role related to issuance of accreditation certificates

For statistics relating to committee considerations, please refer to the College's annual report.

Ongoing Work: The Committee will continue with its review of assessment reports and consider any issuance and renewal applications that the Registrar forwards to them.

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Committee Annual Report

Discipline Committee - September 2016 to August 2017

Committee Role: Panels of the Discipline Committee hear allegations of professional misconduct or incompetence against members, as well as allegations of proprietary misconduct in relation to the operation of a pharmacy. The majority of matters are resolved by way of an uncontested hearing in which the member admits to the allegations and the supporting facts, and the member and College make joint submissions as to the appropriate sanction. In circumstances where the member denies the allegations, the College is required to prove its case by presenting evidence to the panel, following which the panel will make a determination in relation to each allegation. Upon making findings of professional misconduct or incompetence against a member, the panel has the authority to revoke, suspend or limit the member's certificate of registration or the corporation's certificate of accreditation, impose a fine, and/or reprimand the member.

Information about any current allegations or previous findings of professional misconduct or incompetence relating to a member are outlined on the College's Public Register, including any terms, conditions, or limitations imposed on a member's certificate of registration.

Members: Douglas Stewart (Chair), Chris Aljawhiri, Kathy Al-Zand, Jennifer Antunes, Ramy Banoub, Heather Boone, Linda Bracken, Jocelyn Cane, Charles Chan, Gerry Cook, Carol-Ann Cushnie (until July 29, 2017), Fel dePadua, Dina Dichek, Christine Donaldson, Dave Edwards, Debbie Fung, Jim Gay, Sherif Gourgui (until June 14, 2017) Jillian Grocholsky, Andrew Hanna, Mike Hannalah, Najmusdian Hassam (until May 17, 2017) Christine Henderson (from May 16, 2017) Javaid Khan, Rachel Koehler, Fayez Kosa, Andrea Laschuk, Chris Leung, Jon MacDonald, James MacLaggan, Jaime McDonald, Esmail Merani, Cara Millson, Sylvia Moustacalis, Don Organ, Joan Pajunen (from March 20, 2017), Akhil Pandit Pautra, Chintan Patel, Goran Petrovic, Kelly Pogue, Sony Poulose, Shahid Rashdi, Karen Riley, Mark Scanlon, Jeannette Schindler, Connie Sellors, Regis Vaillancourt, Ravil Veli, Wes Vickers and David Windross

Committee Meetings Held: November 4, 2016, April 18, 2017 and July 17, 2017

Panel Meetings Held: 52 Pre-Hearing Conferences, 6 Motions, 24 Uncontested Hearings, and 6 Contested Hearings (until September 18, 2017).

Key Highlights: The Discipline Committee held an additional meeting this year in order to provide another opportunity for the Committee to meet as a whole to share individual panel experiences, discuss issues of common concern, and to receive an update from Independent Legal Counsel (ILC) regarding recent jurisprudence, Bill 87 and the potential impact the new provisions in the RHPA will have on the Committee. The Committee has continued to engage in the processes it implemented last year to improve efficiency and reduce costs. These include: 1) scheduling two pre-hearing conferences in a day to better use monetary and time resources; 2) using laptops for panel members as an alternative to taking handwritten notes; 3) scheduling Case Management Conferences a month before a contested hearing with the goal of using hearing time more effectively by ensuring both parties are aware of any procedural issues, witnesses are scheduled, and the parties have met their disclosure requirements. Oral reprimands are now recorded in the hearing transcript. The Decisions Working Group established benchmarks for the time to issue decisions for both contested and uncontested

hearings, and guidelines were created for how to meet the benchmarks. A tool for deliberation was also finalized and has been implemented by Panels. With respect to Panels deciding on a penalty related to a finding of sexual abuse, a chart has been developed for Panels to use when deciding on an appropriate order. On November 28, 2016, in collaboration with the Ontario College of Social Workers and Social Services Workers, the College hosted an education session on Credibility Assessment and Reasons Writing for members of the Committee. The session was delivered by Richard Steinecke and Erica Richler from Steinecke Mecuria Leblanc LLP.

For statistics relating to Discipline Committee proceedings, please refer to the College's annual report.

Ongoing Work: The Committee is reviewing its templates, its Reference Guide, Rules of Procedure (ROP) and other Committee resources against the amendments to the RHPA currently in force and will make the necessary changes to these documents and resources to reflect the new and anticipated amendments. The committee continues to identify additional areas for improvement.

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Committee Annual Report

Drug Preparation Premises (DPP) Committee - September 2016 to August 2017

Committee Role:

The DPP Committee considers all matters relating to the operation of drug preparation premises in Ontario. The DPP Committee is responsible for oversight of DPPs including ensuring requirements defined in legislation and policy and inspection criteria are adhered too. The committee reviews DPP inspection reports and makes decisions on inspection outcomes.

Members: Tracey Phillips (Chair), Lavinia Adam, Billy Cheung, Elnora Magboo, James Morrison, Joy Sommerfreund, Regis Vaillancourt (ex-officio), Tracy Wiersema

Meeting Held: February 22, 2017

Key Highlights:

The committee reviewed four re-inspection reports and one re-location report. All five sites met the requirements to operate as a DPP and were given a pass.

Ongoing Work:

The Committee continues to follow up with the DPPs. Annual inspections are being planned for all DPPs. The inspection criteria for sterile compounding have been aligned across all practice sites. Scope of DPP activities are being reviewed.

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Committee Annual Report

Executive Committee - September 2016 to August 2017

Committee Role: The Executive Committee exercises all the powers and duties of the Council between Council meetings that require urgent attention. It reviews correspondence and other information coming to the College, considers reports and recommendations from other Committees and fulfills specific financial and compensation related duties set out in the by-law. Their facilitation role is to coordinate the business of Council rather than to act as a gatekeeper.

The Executive Committee is comprised of the President, the Vice President, the immediate Past President, an elected member of Council as well as three public members. The Committee is resourced by the CEO and Registrar.

Members*:* Régis Vaillancourt (President and Chair), Christine Donaldson (Vice President), Esmail Merani (Past President), Sylvia Moustacalis, Joy Sommerfreund, Laura Weyland, Kathy Al-Zand

Meetings Held: November 24 2016, March 2 2017, March 29 2017, April 10 2017, May 25 2017 and August 31 2017.

Key Highlights: The Committee was not required to address any urgent matters between Council meetings during this reporting period however, listed below are some of the issues which executive put their mind to for Council's subsequent consideration and decision.

Late 2016, following a tragic incident linked to a compounded medication error, the College reviewed how medication incident reporting is addressed in practice and what resources are available to improve and strengthen existing measures. At the December 2016 Council meeting, there was unanimous support by Council of a recommendation by the Committee that the College require mandatory reporting of medication incidents to an external body. A task force was subsequently established to examine this subject and to develop the elements of a model for Council consideration.

In November 2016, a summit, convened by Federal Health Minister Jane Philpott and Ontario Health Minister Eric Hoskins, was held to address the ongoing opioid crisis in Canada. Given the importance of this issue, Council considered and supported the Executive Committee's recommendation to create an Opioid Task Force to support the development of a College Opioid Strategy that aligns with provincial and national strategies.

The Committee was also engaged, and continues to be engaged, in the deliberation of the issue of cannabis and what role the profession will play while governments at both the federal and provincial level establish the framework for legalization.

The Protecting Patients Act, 2016, (formerly known as Bill 87), aimed at further protecting patients by strengthening and reinforcing Ontario's zero tolerance policy on sexual abuse of patients by any regulated health professional received Royal Assent on May 30, 2017. The intent and overall objectives contained in the Bill align with the College's own values and commitment to transparency and accountability. Extensive consultations to address ongoing public protection issues will be held over the next several months and the Executive Committee anticipates being involved in this initiative as it progresses. In view of this, and in anticipation of

consequential changes to the College's processes and practices, the Executive Committee also focused on the issue of governance.

Starting in November 2016, the Committee commenced deliberation of a strategy that would build on existing efforts to achieve integration of pharmacy technicians within practice. Given that pharmacy technicians play an important role in enabling pharmacists to maximize their clinical role as medication therapy experts, it was clear to the Committee that a broader strategy that includes initiatives to optimize the scope of practice of both the pharmacists and the pharmacy technicians, was needed. At its meeting in June, Council endorsed the elements of the Executive's proposed Strategy which includes the establishment of an Advisory Committee that will provide regular progress updates to Council as the Strategy is implemented.

Another important initiative was the introduction of a competency assessment screen for Non-Council Committee Members. As well, to strengthen its governance processes, going forward, Council members will be expected to participate in a year end assessment to evaluate how they, as well as Council as a group, performs. The results of the evaluation will assist Council in understanding and recognizing what is working well and identifying areas for improvement as it advances the College's mandate to serve and protect the public interest.

Ongoing Work*:* The Committee will continue to fulfill the obligations set out in statute, the by-law and the governance manual.

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Committee Annual Report

Finance and Audit Committee - September 2016 to August 2017

Committee Role: The Finance and Audit Committee (FAC) is responsible for supervising and making recommendations regarding College assets and liabilities. The committee reviews and recommends to Council the annual operating and capital budget, monitors and reports on the financial status and directs the audit process.

Members: Javaid Khan (Chair), Linda Bracken, Gerry Cook, Esmail Merani, Doug Stewart

Meetings Held: January 5, February 27, August 15, August 22, 2017

Key Highlights:

At its first meeting on January 5th, the FAC was provided with a committee orientation, as well as a presentation by the College's auditors, Clarke Henning. During discussion, it was agreed that the FAC set a routine three year interval for review of financial policies. The committee requested that background information presented to Executive Committee to assist them in fulfilling their compensation review duties be shared with the FAC and the committee reviewed the 11 month operating statements. There was discussion around opportunities to increase awareness of how pharmacy technicians can be used in practice and a request that this topic be brought to the attention of the Executive Committee.

The committee met again on February 27th to review the audited financial statements. The committee was pleased that no irregularities were detected through the audit. It was noted that the cost of doing practice assessments is largely reflected through salary costs. In discussion on the Investigations and Hearings Reserve Fund, it was explained that through ongoing analysis and managed distribution of caseload, costs of prosecution per case have been reduced. With respect to the Contingency Reserve Fund, the FAC agreed to reserve values as proposed by Clarke Henning. The committee approved a motion to recommend to Council that the audited financial statements be accepted.

The committee met again on August 15th to consider the 2018 operating and capital budget prepared by management. The FAC probed various elements of the executive summary seeking to gain greater understanding of the rationale that supported the budget values. Staff were asked to expand on the explanations provided to improve transparency and clarity. The meeting discussions demonstrated the valuable screening role that FAC serves in the overall governance of the College. The committee met again by teleconference on August 22nd to finalize the budget recommendation.

Ongoing Work:

The committee will continue to focus on ensuring that sufficient funds are available to meet the objectives set out in the strategic plan and to respond to possible shifts in regulatory frameworks being explored by government in response to public input.

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Committee Annual Report

Fitness to Practise Committee - September 2016 to August 2017

Committee Role: After conducting inquiries into a member's health, the Inquiries Complaints and Reports Committee can refer a member to the Fitness to Practise Committee for incapacity proceedings.

The Fitness to Practise Committee may hold a hearing to determine whether a member is incapacitated, and if so whether terms, conditions or limitations should be placed on the member's certificate of registration, or whether the member's certificate of registration should be suspended. When a member is referred to the Fitness to Practise Committee, this information is available to the public through the Public Register. At the end of the Fitness to Practise process, only the information necessary to protect the public is available through the Public Register. Unlike disciplinary proceedings, incapacity proceedings are not public.

The majority of proceedings before the Fitness to Practise Committee result in a voluntary admission by the member of incapacity, which is supported by a medical opinion. In many instances of voluntary admissions, the member has enrolled in a monitoring contract with the Ontario Pharmacy Support Program (OPSP) offered through the Centre for Addiction and Mental Health (CAMH). The OPSP provides case management, and monitoring services for our members. The primary objective is to ensure that members receive appropriate treatment and monitoring and remain in stable recovery thereby allowing them to practise safely when they return to a practice environment. The OPSP is available to all College members, and can be accessed anonymously by the member, or can be facilitated by the College.

In these cases, the member's case is still reviewed by the Committee, but the College and the member may seek to waive the notice and procedural requirements set out in the applicable legislation, which require that a hearing into the member's capacity be convened before the Committee. Instead, the member may enter into a Memorandum of Agreement with the College ("MOA") agreeing she or he is incapacitated and the resulting terms, conditions or limitations to be placed on the member's certificate of registration. Through the MOA, both parties authorize a Panel of the Committee to issue a Consent Order finding the member to be incapacitated without a formal hearing.

Members: Kathy Al-Zand (Chair), Carol Cushnie (until July 29, 2017) Dina Dichek, James Morrison, Goran Petrovic and Mark Scanlon

Meetings Held: November 25, 2016

Panel Meetings Held: 1 consent order review on July 18, 2017.

For statistics relating to Fitness to Practise proceedings, please refer to the College's annual report.

Key Highlights: At its meeting on November 25, 2016 the Committee reviewed and approved the *Execution of Consent Orders* policy.

Ongoing Work: The Committee will continue to review its procedures to ensure that they are in keeping with best practices, and reflect the changing landscape of how regulatory bodies address incapacitated members.

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Committee Annual Report

Inquiries, Complaints and Reports Committee - September 2016 to September 2017

Committee Role: The Inquiries, Complaints and Reports Committee ("ICRC") is a screening committee that conducts investigations into Member-specific issues related to professional misconduct, incompetence, and incapacity from various sources including formal complaints, mandatory reports, and other information that comes to the attention of the Registrar.

The committee Chair appoints panels, consisting of at least three members of the ICRC, including at least one public member. Chairs of each ICRC panel (appointed by the committee Chair) finalize the written decisions and reasons of the ICRC for each matter.

Unless the ICRC decides to refer specified allegations of professional misconduct to the Discipline Committee or to conduct an incapacity investigation, complaints decisions are reviewable by the Health Professions Appeal and Review Board.

Members: Laura Weyland (Chair), Elaine Akers, Kathy Al-Zand, Kalyna Bezchlibnyk-Butler Linda Bracken, Billy Cheung, Gerry Cook, Carol Cushnie (until July 29, 2017), Christine Donaldson, Ronald Farrell (until October 26, 2017), Andrea Fernandes, Michelle Filo (until January 2, 2017), Sherif Guorgui (until June 14, 2017), Frank Hack, Naj Hassam (from October 5, 2016 until May 17, 2017), Bonnie Hauser, Christine Henderson (from May 16, 2017), Mary Joy, Javaid Khan, Elizabeth Kozyra, John Laframboise (until January 11, 2017), Curtis Latimer, Chris Leung, Jon MacDonald, James MacLaggan, Elnora Magboo (from January 26, 2017), Dean Miller, James Morrison, Sylvia Moustacalis, Joan Pajunen (from March 20, 2017), Akhil Pandit Pautra, Goran Petrovic, Kelly Pogue, Sony Poulose, Shahid Rashdi, Saheed Rashid, Satinder Sanghera, Richard Sigesmund, Joy Sommerfreund, Dan Stringer, Asif Tashfin, Ravil Veli, Wes Vickers, Tracy Wiersema, Debra Willcox

Meetings Held: October 13, 2016 (Orientation), April 11, 2017 (Mid-year Meeting)
Panel Meetings Held: Full-day Panel Meetings – 32; Panel Teleconferences – 15

Key Highlights:

- The ICRC has continued to use the dispositions recommended by the Advisory Group on Regulatory Excellence. In the 2016-2017 council year, the ICRC has issued 61 decisions requiring posting on the College's Public Register, where the member has been required to complete a specified continuing education or remediation program (SCERP) and/or receive a Caution.

- For files where the ICRC has required the member to complete a SCERP, the ICRC has begun identifying gaps in a member's practice, using a tool developed by the College's Professional Development & Remediation Program. Using the tool, ICRC panels identify areas of deficiency in the member's practice. is The data collected will be analyzed to identify trends and flag areas where educational resources may be needed for the membership.

- In the 2015-2016 council year, the ICRC struck a working group to review its Risk Assessment Tool (RAT), which panel members use when reviewing files, assessing risk, and deciding on their final disposition. The working group finalized a second version of the RAT in April 2017 and it has been implemented in the ICRC decision-making process.

- In conjunction with the College's initiative of Continuous Quality Assurance for Medication Safety, which will include a requirement for the anonymous reporting of medication incident data, the ICRC has been classifying matters relating to a medication incident according to harm, in order to collect data for future reporting.

- For decisions issued in the 2015-2016 council year, complainants have been asked to complete a survey to provide the College with feedback on their experience with the complaint process. As of the date of this report, the College has received 26 responses, which represents an 18% response rate. When asked about their level of satisfaction with the College's complaints process, 58% of complainants reported being very or somewhat satisfied while 35% of complainants reported being very or somewhat dissatisfied.

For additional statistics relating to ICRC activity, please refer to the College's annual report.

Ongoing Work:

The implementation of Bill 87, also known as the *Protecting Patients Act*, will be a focus for the 2017-2018 council year. The ICRC's orientation session will include training for panels on new provisions of the RHPA that apply to their processes, including consideration of interim suspension of members and the withdrawal of complaints.

An online complaint form has recently been launched, which will increase the efficiency in which complaints are processed when they are initially received.

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Committee Annual Report

Patient Relations Committee - September 2016 to August 2017

Committee Role: The Patient Relations Committee (PRC) advises Council with respect to the Patient Relations Program, defined as "a program to enhance relations between members and patients". This includes measures for preventing and dealing with sexual abuse of patients, specifically the requirement for the College to have a Sexual Abuse Prevention Plan, as well as the provision of funding for therapy and counselling to a patient who has been sexually abused.

Members: Joy Sommerfreund (Chair), Linda Bracken, Fel DePadua, Sylvia Moustacalis, Goran Petrovic, Doug Stewart

Meetings Held: December 2, 2016, May 11, 2017, August 14, 2017

Key Highlights: A review of the activities of the Communications department is considered at each meeting. The most recent focus has been on the advancement of the College's mandate through social and digital communications: successes to date and emerging opportunities.

The committee reviewed and discussed the recommendations of the *Minister's Task Force on the Prevention of Sexual Abuse to Patients and the RHPA* in order to inform the College's feedback to the Ministry and the Federation of Health Regulatory Colleges of Ontario (FHRCO) regarding next steps on these recommendations. The committee subsequently considered the Ministry's intended implementation of the *Protecting Patients Act*, particularly related to the function of this committee.

The committee received information and provided input regarding College activities related to preventing and dealing with the sexual abuse of patients, including:

- opportunities for education of pharmacy professionals regarding the *Protecting Patients Act*, particularly at the fall district meetings and at the college/university level;
- the need to update policies on accessing funding by patients who have been sexually abused; and
- methods to improve public access to College information and resources regarding sexual abuse of patients.

The committee also discussed opportunities related to engaging patients and providing them with more information on the roles and the scope of practice of pharmacy professionals, for example through videos. The committee supported College participation in a "Citizen's Advisory Group" to better understand the perspectives and concerns of patients with respect to safe, quality health care.

The committee approved one application for therapy and counselling by a patient who was found to have been sexually abused by a pharmacist.

Ongoing Work: The Committee continues to provide guidance and feedback on the College's patient-focused communications. As the government moves to implement the *Protecting Patients Act* and develop its accompanying regulations, the committee will provide advice to the College on action needed to support and complement these legislative achievements. This will include a definition of a patient for the purpose of determining sexual abuse and expanded funding for such patients.

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Committee Annual Report

Quality Assurance Committee - September 2016 to August 2017

Committee Role: The Quality Assurance Committee has oversight of the quality assurance program which includes maintenance of a learning portfolio, two-part register and practice review (including self-assessment and peer review) and remediation. The Committee is continually reviewing the program and appoints quality assurance assessors. The Committee reviews peer review reports and requires those individuals whose knowledge, skill and judgement have been assessed and found to be unsatisfactory to participate in specified continuing education or remediation programs. The Committee can also direct the Registrar to impose terms, conditions or limitations for a specified period on the certificate of registration of a member whose knowledge, skill and judgement has been assessed or reassessed and found to be unsatisfactory or who has been directed to participate in specified education or remediation and has not completed those programs successfully.

The Committee may sit as a panel to consider any matter arising out of a peer review, or any matter relating to the imposition of terms, conditions or limitations on a member's registration.

Members: Jon MacDonald (Chair), Tina Boudreau, Linda Bracken, Mary Joy, Elnora Magboo, Sylvia Moustacalis, Tracey Phillips, Sony Poulose, Sarah Woodworth-Giroux

Meetings Held: November 10, January 5, March 30, May 29, July 18

Key Highlights: The Quality Assurance (QA) Committee established the QA Redesign Advisory Group last year. This group, together with the QA Committee, are evaluating and re-designing the QA program, for both pharmacists and pharmacy technicians. This year, the QA Committee accomplished the following goals:

- A standards-based practice and peer assessment that aligns with the practice assessment model, in particular by assessing practitioners in their place of practice, was introduced.
- A standardized QA peer assessment was created to ensure fairness and objectivity in the assessment of practitioners.
- Individualized development for those who have demonstrated a gap in competence is provided through peer coaches.

The model for demonstration of competency has been further defined, indicating that two QA activities (practice assessment and knowledge assessment) will comprise the assessment process. In addition, the Committee has revised the QA regulations.

For statistics relating to QA Committee considerations, please refer to the College's annual report.

Ongoing Work: The Committee will be engaged in developing QA coaching and assessment processes for pharmacy technicians and hospital pharmacists. In addition, the Committee will be working on the proposed knowledge assessment activities (both the knowledge examination and the audit of learning portfolios).

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Committee Annual Report

Registration Committee - September 2016 to August 2017

Committee Role: The Registration Committee fulfils its duty to maintain registration practices that are transparent, objective, impartial and fair, and free of unintentional mobility barriers by overseeing the development of registration requirements. These include examinations and assessments, recommendations to Council on changes to the registration requirements defined in legislation and policy, and monitoring and reporting on registration programs that the College administers and/or approves as part of the registration process.

Panels of the Registration Committee are responsible for reviewing all applications the Registrar proposes to deny due to registration policy and directs the Registrar to either register the applicant (with or without any additional training, education or examinations, terms conditions or limitations) or to deny registration. All decisions of the Registration Committee panels are appealable to the Health Professions and Review Appeal Board.

Members: Christine Donaldson (Chair), Heather Boon, Billy Cheung (appointed January 20), Carole Cushnie (resigned July 29), Michelle Filo (resigned January 2), Jillian Grocholsky, Sharon Lee, Deep Patel, Marie Pomainville (appointed January 20), Ravil Veli, Wes Vickers

Meetings Held: November 10, March 21, July 12
Panel Meetings Held: September 28, October 26, November 23, December 15, January 24, February 22, March 22, April 25, May 24, June 27, July 26, August 30

Key Highlights:

- The Committee reviewed all of its policies that direct the Registrar on how to proceed with an application that meets specific criteria without having it referred to a Panel, and rescinded or amended policies following analysis of trends, and giving consideration to the introduction of Practice Assessment of Competence at Entry (PACE) as the practice-based registration requirement.
- In March, Registration Committee approved in principle, the development of a standards-based framework for demonstration of language proficiency at entry to practice through individualized evidence, and approved a formal review of the Jurisprudence registration requirement.
- In July, Registration Committee approved the police background checks required for registration (any class), and recommended updated Registration Regulations to Council for approval.

For statistics relating to registration panel considerations, please refer to the College's annual report.

Ongoing Work:

The Committee continues to oversee implementation of PACE for Pharmacists, development of PACE for Pharmacy Technicians, implementation of police background checks, development of a standards-based framework for demonstration of language proficiency at entry to practice, and formal review of the Jurisprudence registration requirement.