MINUTES
Council Meeting
ALBERTA COLLEGE OF PHARMACISTS
April 27-28, 2017
Westin Hotel, Calgary

---

1. Introduction

1.1 Call to Order

President Pereira called the meeting to order at 12:55 p.m. She welcomed Barry Strader, ACP's Communication Director.

The business meeting of Council was held over two days. On Thursday, April 27, the meeting convened at 12:45 p.m. and recessed at 5:30 p.m. On Friday, April 28, the business meeting of Council reconvened at 8:00 a.m. and adjourned at 2:30 p.m. Following the business meeting, Council members joined participants attending ACP's Leadership Symposium April 28-29.

1.2 Roll Call

Registrar Eberhart called the roll and identified the following individuals in attendance:

- District 2 - Clayton Braun
- District 3 - Rick Hackman (Past President)
- District 3 - Taciana Pereira (President)
- District 4 - Stan Dyjur
- District 5 - Brad Couldwell (President Elect)
- District A - Kelly Boparai
- District B - Jennifer Teichroeb
- Al Evans - Public Member (Executive Member at Large)
- Mary O'Neill - Public Member

Non-Voting

- Neal Davies - Dean, Faculty of Pharmacy & Pharmaceutical Sciences

Absent with Regrets

- District 1 - Brad Willsey
- District 5 - Kamal Dullat
- Bob Kruchten – Public Member (attended Leadership Symposium April 28-29)
- Abanoub Graiss - APSA Representative

Also in attendance:

- Greg Eberhart – Registrar
- Dale Cooney - Deputy Registrar
- Lynn Paulitsch - Operations and Finance Director
- Leslie Ainslie - Executive Assistant
- Barry Strader - Communications Director
- Robyn Eeson, Auditor, KPMG (April 28, 1:30-2:00 pm)
- Kim Wieringa, ADM, Alberta Health (April 28, 11:00 am-12:30 pm)
- Chad Mitchell, Acting Executive Director, Alberta Health (April 28, 11:00 am-12:30 pm)

1.3 Invocation

Kelly Boparai read the invocation.

1.4 Adoption of the Agenda

1.4.1 Consent Agenda

MOTION: to approve the Consent Agenda report presented by Registrar Eberhart.
Moved by **Al Evans**/Seconded by **Brad Couldwell/**CARRIED

1.4.2 Additions to the Agenda

1.4.2.1 Update from Regional Meetings

- **April 11 Webinar** – approximately 20 people joined the webinar to discuss the Modernized Role Statements for Pharmacists and Pharmacy Technicians, and consideration of a name change for the college. Individuals actively participated in the discussions and numerous polls throughout the webinar. ACP received valuable feedback for participants.
- **April 20 Fort McMurray Regional Meeting** – 18 pharmacists and pharmacy technicians attended the regional meeting in Fort McMurray. The college received excellent input on the Modernized Role Statements for Pharmacists and Pharmacy Technicians, and the proposed name change for the college. The value of pharmacists' using their full scope of practice to provide primary care and chronic disease management was shared; resulting from the continued disruption and limited access to medical services since the fire of May 2016. Pharmacists are providing the continuity of care required by residents, as many medical services are provided by locums from Edmonton.

ACP will continue to engage with registrants at the Calgary regional May 5. The additional feedback received from the Calgary meeting, and the online survey, will be incorporated into the roles statements and provided for Council's review at the June meeting. Registrar Eberhart will provide Council with Version 3 of the role statements and slides from the regional meetings on the council portal.

MOTION: to approve the agenda as circulated to Council with additions.
MOVED by **Stan Dyjur**/Seconded by **Kelly Boparai**/CARRIED

1.5 Minutes from Previous Meetings

1.5.1 Minutes – March 2-3, 2017 Council Meeting

MOTION: to adopt minutes of the March 2-3, 2017 council meeting as presented.
Moved by **Kelly Boparai**/Seconded by **Jennifer Teichroeb**/CARRIED

1.6 Disposition of Directives

The Disposition of Directives was provided for information. President Pereira invited questions; however, none arose. Registrar Eberhart noted that the panel appointed by council to review a registration decision of the Registrar has not convened as the applicant has consistently sought adjournments to the proceedings. Additionally, the applicant has not paid the fee prescribed by Council. Depending on when and whether the applicant chooses to proceed with the appeal, a new panel of Council may need to be appointed.

MOTION: to accept the Disposition of Directives as information.
Moved by **Rick Hackman**/Seconded by **Jennifer Teichroeb**/CARRIED

2. Governance

2.1 ENDS and Executive Limitation Amendments

2.1.1 Policy E (Mega-End) – 2016 Annual Report

The Annual Report reflects the business undertaken by the College in 2016 and its achievements including the reporting required through the *Health Professions Act* and the Mega-End policy of Council. Council reviewed a draft of the 2016 Annual Report for tabling in the Legislature by Sarah Hoffman, Minister of Health. The audience addressed through the report is government, stakeholders, and partners. It was observed that while the content was good, the report was quite voluminous; which could detract readership uptake. It was suggested that this be taken into consideration when drafting the 2017 report.

MOTION: to approve the 2016 Annual Report and proceed with its publication.
Moved by **Brad Couldwell**/Seconded by **Jennifer Teichroeb**/CARRIED

2.2 Compliance Monitoring and Reports

2.2.1 Executive Limitations – Compliance Reports

External reporting is required for EL-4 Financial Condition-External Review. Presentations were made by external experts. The Registrar and other members of the administrative team excused themselves from the presentation and deliberation about the audited financial statements.

2.2.1.1 EL-4 – Financial Condition – External Review

Council reviewed the audited financial report from ACP's external auditors KPMG, for the year ending December 31, 2016. Robyn Eeson from KPMG, presented the external financial report to Council, and responded to questions from Council Members.

MOTION: to approve the external audited financial report for the fiscal year ending December 31, 2016.
Moved by **Al Evans**/Seconded by **Stan Dyjur**/CARRIED

2.2.2 Governance Policies – Compliance Reports

Governance Policies (GP policies) define how Council conducts itself. Council reviewed the following governance policies, reflecting on its compliance with each policy.

2.2.2.1 GP-1 Global Governance Process

MOTION: that Council is in compliance with Governance Policy GP-1 Global Governance Process.
Moved by **Jennifer Teichroeb**/Seconded by **Kelly Boparai/**CARRIED

2.2.2.2 GP-10 Council Linkage with Other Organizations

MOTION: that Council is in compliance with Governance Policy GP-10 Council Linkage with Other Organizations.
Moved by **Mary O'Neill**/Seconded by **Kelly Boparai**/CARRIED

2.2.2.3 GP-11 Council Planning Cycle and Agenda Control

MOTION: that Council is in compliance with Governance Policy GP-11 Council Planning Cycle and Agenda Control.
Moved by **Jennifer Teichroeb**/Seconded by **Kelly Boparai**/CARRIED

2.2.2.4 GP-12 Handling of Operational Complaints

MOTION: that Council is in compliance with Governance Policy GP-12 Handling of Operational Complaints.
Moved by **Rick Hackman**/Seconded by **Brad Couldwell**/CARRIED

2.3 Nominating Committee Report – Election of Officers

On behalf of the Nominating Committee, President Pereira submitted the name of Stan Dyjur for the position of President Elect. She called for nominations from the floor three times. None were received.

MOTION: that nominations cease for the position of President-Elect; and that Stan Dyjur be appointed as President-Elect by acclamation for the 2017-2018 council term, commencing July 1, 2017.
Moved by **Mary O'Neill**/Seconded by **Kelly Boparai**/CARRIED
Abstained: Stan Dyjur

On behalf of the Nominating Committee, President Pereira submitted the name of Mary O'Neill for nomination as the Executive-Member-at-Large. She then called for nominations from the floor three times. None were received.

MOTION: that nominations cease for the position of Executive-Member-at-Large and that Mary O'Neill be appointed as Executive-Member-at-Large by acclamation for the 2017-2018 council term, commencing July 1, 2017.
Moved by **Brad Couldwell**/Seconded by **Al Evans**/CARRIED
Abstained: Mary O'Neill

On behalf of the Nominating Committee, President Pereira suggested that a means to facilitate self-disclosure of interest in moving to officer positions be considered. This would support the work of the nominating committee; and would be an opportunity to nurture development and succession.

2.4 Ownership Linkage

2.4.1 Engagement with Albertans since Last Meeting

The following issues were introduced and discussed during this forum:

- Despite ACP's increased engagement and communication with the public, surprisingly there are still a vast number of Albertans and pharmacists who don't understand the role of pharmacists.
- Needs to be a shift in focus by pharmacists at the time of dispensing to assess whether or not the patient even needs the drug they have been prescribed.
- Is it appropriate and sanitary for groceries to be sold at the pharmacy counter?
- During pharmacy visits, pharmacists thanked ACP for modernizing the role statements because they clearly define the roles of both professions.
- The proposal to change the name of ACP is a topic of interest amongst both professions.

3. Legislated Responsibilities

3.1 Pharmacy Human Resources

The College has once again experienced extraordinary growth in the number of International Pharmacy Graduates (IPG) applications for entry-to-practice. Some of these candidates stay in Alberta; however, a large number are transferring to other jurisdictions. This trending is unsustainable, as it negatively impacts access to quality practicum sites. Demand for these sites are increasing with the new PharmD program at the University of Alberta, and the increased demand from pharmacy technician schools.

Council began discussing this issue last year as a result of the substantive increases in the registration of foreign candidates in Alberta. ACP was aware of registration policies in other provinces however, the processes that applicants went through, and the sequencing of those processes, differed between jurisdictions. Council considered the feasibility of a bridging program akin to that in BC and Ontario; however, chose not to adopt a policy direction prior to establishing if the increase in IPG applications was a trend or an isolated incident. Council also considered if this was of national significance and therefore an issue for NAPRA's consideration.

Registrar Eberhart suggested to NAPRA that it develop and deliver a national bridging program. Due to a number of larger issues on NAPRA's agenda, discussions at the national level have been deferred. Registrar Eberhart shared that during the first four months of 2017, the number of international students applying through the NAPRA IPG Gateway is even larger that it was the previous two years.

Registrar Eberhart, and ACP's Competence Director Debbie Lee met with Alberta Labour (responsible for provincial administration of trade agreements in the context of the movement of health professionals), and Alberta Health (Workforce Division). The key learnings from the meeting were:

- Mutual Recognition Agreements are no longer required with other provinces; however, professions are required to accommodate the movement of health professionals between provincial/territorial jurisdictions;

- All pharmacy candidates must be subject to the same requirements for entry-to-practice, regardless whether they are of national or international origin; and
- International candidates may be required to complete additional programming to prepare them for entry-to-practice;
    - This should be competency based; and based on practices of other professions, may include training in subjects such as the culture of the Canadian health system, jurisprudence, ethics, clinical care (depending on previous experience and training);
    - The costs of this should be on a cost-recovery basis, and should not be superfluous to the extent of being an impediment to entry-to-practice.

There is acknowledgement from Government that there are differences in culture, values, and training when candidates come from other parts of the world, and while through national processes there are means to establish academic equivalence, this does not address cultural and value issues.

At its last meeting, Council approved new rules for ACP's Structured Practical Training (SPT) program. It is too early to determine the impact of these on intern experiences, and accessibility.

Key points noted during this discussion were:

- ACP needs to better coordinate access to structured practical training (SPT) with the faculty;
- NAPRA should play a greater role facilitating access to bridging, as this is a national issue;
- We must ensure that all candidates are able to demonstrate understanding of ACP's Code of Ethics and Standards;
- Candidates should be required to demonstrate competence in context with the Scope of Practice in Alberta, and Alberta's health system;
- We must be confident that all candidates admitted to the clinical pharmacist register are able to demonstrate ethical conduct and compliance with our standards in context with our Scope of Practice and at a level satisfactory to the Council;
- We need to address the gap in what SPT was meant to be and what it is achieving;
- Is there a means to conduct an assessment at the conclusion of Level 3 of SPT, by an assessor external to anyone who has precepted a candidate?
    - A process is required to assess both candidates and preceptors;
    - Might this be a role that can be fulfilled by practice consultants;
- Should preceptors be referred to as assessors?

Council continues its commitment to ensuring the competence of individuals at entry-to-practice and will continue to enhance the policies, rules, and processes within the STP to ensure it provides a rigorous opportunity for candidates to observe, practice, and demonstrate skills required at entry-to-practice in context with pharmacist practice in Alberta.

3.2 Alberta's Electronic Health Record – Discussion with Kim Wieringa, ADM Health Information Systems Division and Chad Mitchell, Executive Director, Pharmaceuticals and Supplementary Health Benefits

Council met with Kim Wieringa and Chad Mitchell from Alberta Health to discuss Alberta's IT strategy over the next 4-5 years, e-prescribing, the integration of the community based health records (with a goal towards a common patient record), and the release of Alberta's patient health portal.

Key messages from Alberta Health's presentation include:

- The Integrated Health Record (IHR) is intended to provide the seamless flow of information across the continuum of care;
    - AH's goal is to provide an implementation plan, with shared commitment and ownership to execute the plan.
- A successful Integrated Health Plan requires:
    - A defined health information ecosystem,
    - Policies and regulations,
    - Change management and culture change, and,
    - Education and knowledge transfer.
- The proposed Central Information System (CIS) is an AHS solution:
    - A vendor for this solution should be announced by the end of June.
- There should be communication about the Personal Health Record sometime over the summer:
    - 23 of the most frequent lab tests should be available through the PHR by the end of May.
- A project is underway to integrate health information that is developed in the community:
    - Integration of physician records will roll out first,
    - 78 datasets have been agreed to be shared; and, specialist reports will be shared in a pdf format,
    - A community "encounter" digest is proposed to be delivered in the fall of 2017:
        - Data may be inconsistent resulting from the varied behaviours of physicians.
- Prescribe IT is a tool proposed by Canada Health Infoway, being piloted by Alberta Health to facilitate the transfer of a prescription from a prescriber to a pharmacy of a patient's choice:
    - There is a desire to have a common design across Canada so that vendors will engage and conform,
    - The design of the tool is completed:
        - Alberta has requested:
            - Authentic integration,
            - Prescriber authentication (e-sig),
            - Registry integration.

Of concern to Council is Alberta Health's commitment to Canada Health Infoway to pilot its e-prescribing platform "PrescribeIT" by this summer. Council expressed concern that "pharmacy" has not been legitimately involved in policy development to

this point. Council also expressed concern that Alberta Health's e-prescribing policy conflicts with the following principles for e-prescribing approved by Council.

- Patient Choice – patients must be able to exercise their choice of health professional/pharmacy; free of direction or influence by any product or service provider.
- Transmission – prescribing and dispensing data should be "pushed" from the prescriber or dispenser to a central hub that is Alberta's sole provincial repository of health information in a manner and format that ensures the security, integrity, and privacy of the information. Health professionals should be allowed to "pull" information from the system to provide services they are authorized to provide.
- Authentication and Validation – Alberta Netcare, as the sole repository for the collection of universal prescribing and dispensing data, must authenticate and validate all data received and transferred from it.

The Prescribe IT solution proposes direct transmission from physicians to the pharmacy, and the proposed value proposition is that it will facilitate faster processing of prescriptions and enable prescription to be ready for individuals when they arrive at the pharmacy. This proposition focuses on efficiency and speed; not patient care. This could conflict with Council's concern about the effectiveness of pharmacist assessment as a foundation to quality care. It is imperative that patients have an unfettered opportunity to choose their pharmacy.

In closing Council commented:

- ACP needs to stay engaged with Alberta Health, and Kim Wieringa should be invited back to Council,
- ACP should encourage and monitor the evolution of solutions for recording immunizations,
- ACP needs to facilitate pharmacist "readiness" for this solution, as it will impact workflow.

3.3 DRAFT Compounding and Repackaging Agreement for Services Delivered Outside of Alberta

Council approved a modified version of the ACP's "Compounding and Repackaging Agreement" required by Compounding and Repackaging Pharmacies that provide services to a licensed pharmacy located in British Columbia. Due to the interjurisdictional nature of this service, the modified agreement is more rigorous than that for services delivered to Alberta pharmacies, particularly with respect to privacy requirements. Subject to review by the College of Pharmacists in British Columbia, it is Council's intent that this model agreement will become a requirement effective June 1, 2017.

MOTION: to approve the modified Compounding and Repackaging Agreement in principle; subject to any major issues from British Columbia.
Moved by **Stan Dyjur**/Seconded by **Jennifer Teichroeb**/CARRIED

Registrar Eberhart advised Council that Health Canada forwarded correspondence enabling the compounding and repackaging of Controlled Substances by a Compounding and Repackaging Pharmacy, subject to it being a "licensed dealer"

under federal legislation. An agreement required by Compounding and Repackaging Pharmacies that provide services to Alberta licensed pharmacies is being amended, and will be made available to Compounding and Repackaging pharmacies in June.

MOTION: to amend the existing Compounding and Repackaging Agreement to enable Compounding and Repackaging Pharmacies qualifying with Health Canada as a licensed dealer, to compound and repackage Controlled Substances.
Moved by **Rick Hackman**/Seconded by **Al Evans**/CARRIED

3.4 DRAFT Policy – Satellite for Compounding and Repackaging

Council reviewed a DRAFT policy outlining the requirements for the operation of a satellite to a *licensed community pharmacy.* The purpose of the policy is to facilitate access to compounding and repackaging from within a single community pharmacy, where the area used for compounding and repackaging is disjointed from the area/location where other pharmacy services are provided. Council requested the removal of point 2 that required that the location of the satellite must facilitate the delivery of compounded or repackaged products to the parent community pharmacy within a maximum of 12 hours. Council approved the following policy:

1. A satellite for compounding and repackaging is deemed to be a dispensary operated for the sole purpose of compounding and repackaging for patients of the parent licensed community pharmacy.
    a. The name of the satellite must be identified as the "*Compounding and Repackaging Satellite for* 'parent community pharmacy name'".
2. If approval for the operation of a satellite is granted, a satellite license will be issued with the following conditions:
    a. The satellite may only be used to compound and repackage drugs for patients of the parent licensed community pharmacy.
    b. No direct patient care activities can occur.
4. An approved satellite for compounding and repackaging is considered a dispensary and records may be stored there without additional approval.
5. If there is public access between the dispensary of the community pharmacy and the satellite, or the satellite is in a different building, the policy and procedures of both the community pharmacy and satellite must ensure that the security of the drugs and/or records will be maintained during their transportation between licensed areas.
6. The satellite must:
    a. Have an appropriate security system which ensures all drugs are secured against theft, loss or diversion and restricts access to only authorized pharmacy personnel.
    b. Meet all of the licensure requirements to support the provision of compounding and repackaging pharmacy services.
7. Any variance to these requirements must be approved by the Registrar.
8. The requirements of this policy are also applicable if a renovation or relocation is required.

MOTION: to approve the policy permitting a satellite Compounding and Repackaging area/location to be disjointed from the location of **the community pharmacy** it serves.
Moved by **Mary O'Neill**/Seconded by **Rick Hackman**/CARRIED

Implementation of the policy may be deferred to the Fall.

3.5 Marijuana for Medical Use

On April 13th, the Federal Government introduced its legislation *The Cannabis Act*, to legalize cannabis and control the production, distribution, sale, and possession of non-medical cannabis across Canada, effective July 2018. As recommended by its National Taskforce on Legalization, there will be no change to access of cannabis for medical purposes at this time. Access to cannabis for medical use will continue under the *Access to Cannabis for Medical Purposes Regulations* (ACMPR).

Council reflected on the DRAFT position statement from NAPRA that states that pharmacy practitioners must not be involved in the distribution of cannabis for non-medical purposes. and that distributers of non-medical cannabis must not use terms such as dispensary or any pharmacy related symbols.

Council supports the views of NAPRA and its members, that only products that have gone through the drug approval process in Canada for safety, efficacy and quality, should be sold by pharmacists. These products have received a Drug Identification Number (DIN), a Natural Product Number (NPN), or a Drug Identification Number–Homeopathic Medicine (DIN-HM).

Council also reviewed ACP's policy respecting the sale of cannabis from pharmacies that states:

1. Marihuana, in any form, including any derivative, must not be produced in the premises of a licensed pharmacy.
2. None of the other activities referred to in Section 22 of the Access to Cannabis for Medical Purposes Regulations, SOR/2016- 230, may be conducted in a licensed pharmacy.
3. No licensee or proprietor of a licensed pharmacy may be a licensed producer as defined in the Access to Cannabis for Medical Purposes Regulations.
4. No regulated member of the college may be a licensed producer or responsible person in charge as defined in the Access to Cannabis for Medical Purposes Regulations at the same time that the regulated member engages in the practice of pharmacy.

Akin to the sale of alcohol or tobacco, and in the absence of a clinical indication for the use of recreational cannabis, Council stands firm in its policy that pharmacies in Alberta not be distribution sites for the control and sale of recreational cannabis products.

Deputy Registrar Cooney attended a conference in Toronto that presented practical evidence-based education on cannabinoids in clinical practice. The conference was organized by the Canadian Consortium for the Investigation of Cannabinoids (CCIC) through the University of Toronto Continuing Medical Education department. The intent was to assist Canadian health care professionals with the safe and effective use of cannabinoids in clinical practice. The conference was

attended by physicians, pharmacists, and a few other health professionals; representatives of some of the Licensed Producers authorized by Health Canada; policy makers and researchers; and a few patients who use cannabinoids for medical purposes. Below is an excerpt from Deputy Registrar Cooney's report to Council.

Review of Physiology and Pharmacology

Endocannabinoids, those occurring naturally in our system, include CB1 and CB2. CB1 activation reduces excess release of glutamate and prevents excitotoxic damage. CB1 receptors are complicated and change over time. Prior to puberty CB1 is very high on glutamate terminals and declines through adolescence, plateauing in adulthood. This explains some of the reasons that peak use of cannabinoids is between the ages of 15 and 24. Adults have more gaba neurons and therefore are more likely to experience increased anxiety with cannabis use.

CB2 reduces the release of pro-inflammatory cytokines and supresses neuroinflammation. CB2 receptors therefore appear to be associated with immune responses. When immune cells are quiet there are no CB2 receptors, but in an inflammatory response there is an increase in CB2 receptors. This is what offers hope and prompts studies and trials in conditions such as MS.

Cannabinoid receptors are distributed throughout the body. For example, there are several in the gut, which explains the benefits in nausea, chemo induced nausea, and stress induced GI problems. Decreased GI motility is a known action.

Cannabis contains two main cannabinoids that are studied, THC and CBD:

- THC – Tetrahydrocanabinol
    - THC exerts is effect primarily through activation of CB1
    - Is the most prevalent active ingredient
    - Is primarily responsible for the "high" that is associated with cannabis use
- CBD – Cannabidiol
    - Mechanism of action is unclear

      Does not bind to CB1 or CB2 receptors
    - Is the second most prevalent active ingredient
    - Is said to be "non-psychoactive" because the traditional "high" is not associated with products high in CBD
- Competing Hypothesis
    - As one increases the other always decreases
    - Health Canada believes that the ratio of THC:CBD will affect the pharmacologic response

Methods of Consumption:

Inhalation

- Smoking
- Vaporization

Ingestion

- Oils
- Tinctures (alcoholic extracts – not allowed in HC system)
- Edibles
- Sublingual spray (prescription nabiximols)

- Topical – balms, lotions or salves

Despite reports that individuals get benefit from chewing cannabis leaves, cannabinoid acids must be de-carboxilized by heat to become active

Pharmacokinetics

Cannabinoids have been used for millennia for a large variety of ailments and conditions. Cannabinoids have a very large therapeutic window and are therefore considered generally safe. Overdose is rare. There are some drug interactions, however because of the wide safety margin these are not usually significant. Most interactions are via CYP inductions therefore drugs that interact include Theophylline, Ketoconazole, and Warfarin (increased INR associated with cannabis smoking). Pharmacokinetic studies show that blood levels do not correlate well with effect. Correlations between blood levels and cognitive performance and between oral fluids (a common testing method) do not correlate well with dose. We also know that pharmacokinetics are different for frequent users of cannabis than for those who use infrequently or have never used. There are some studies that indicate that adrenaline may increase the release of stored THC. Examples: skydivers can have higher levels of THC despite abstinence for a long period of time; individuals have failed drug test conducted soon after they went to the gym.

Prescribing Cannabis

Screening tools are available. The College of Family Physicians of Canada publication from 2014 was recommended. In addition, CCIC has a checklist that is published and is available on-line.

When not to prescribe:

Dried cannabis is not appropriate for patients who:

- Are under the age of 25
- Have a personal history or a strong family history of psychosis
- Have current or past cannabis use disorder (CUD)
    - DSM-V-defines CUD as a problematic pattern of cannabis use leading to clinically significant impairment or distress
- Have an acute substance abuse disorder
- Have cardiovascular disease
- Have respiratory disease
- Are pregnant, planning to become pregnant or breastfeeding

Dried cannabis should be used with caution in patients who:

- Have a concurrent active mood or anxiety disorder
- Smoke tobacco
- Have risk factors for CV disease
- Are heavy users of alcohol or taking high doses of opioids, benzodiazepines or other sedating medications prescribed or over the counter

Licensed Producers

There are currently 41 Licensed Producers (LP) and over 300 strains of cannabis available in Canada.

Licensed producers may sell dried cannabis, oils, and seeds. All products must be labeled and listed on the LP's website with the Name, THC and CBD content. Differences in strains includes not only the THC:CBD ratio but also the inclusion of

other ingredients. Most common are a group called Turpines. The Turpines are what affect the taste and smell and are believed by many to affect the activity also. Health Canada has a department dedicated to regulating licensed producers. They have recently received funding for additional staff. There was criticism from some attendees, presumably from LP organizations, about the level of oversight. All appeared concerned that some smaller producers were not or could not meet the requirements. There was also universal concern about the operation of illegal dispensaries in many jurisdictions. Concern that LPs are unable to promote or educate their patients who instead go to local dispensaries for information.

Dosing

Dosing is extremely variable. It must be individualized depending on previous use, frequency and duration of use and condition being treated. Patients are often required to titrate to effect and may also find it beneficial to try several strains to discover what works best. Of note, there appears to be little help for patients in this process. There are a few entities associated with physician clinics or licensed producers who are available to assist patient in navigating the system after receiving an authorization from their physician

Current orders are based on grams of product that may be provided to patients. Speculation is that in 3-5 years we will be talking about MG of THC and/or CBD, i.e. provision is likely to include more prepared products rather than dried cannabis

There are two categories of cannabis plants as differentiated by patients, growers, LPs and dispensaries (Indica and Sativa). Indica is preferred for pain. Sativa is associated with stimulation. Some patients request Sativa for the day and Indica at night. THC levels do not differ between Indica and Sativa.

Indications Under Consideration for Use

- Chronic non-cancer pain
- Addiction – potential opioid replacement
- Post-Traumatic stress disorder
- Insomnia
- Cancer pain
- Nausea and other GI disturbances
- MS
- Migraines
- Epilepsy
- Pediatric Epilepsy
- Anxiety
- Depression
- Anorexia

There is anecdotal evidence, in some cases strong anecdotal evidence, for the use of cannabinoids in these conditions, however there are none that have strong evidence based clinical trials to support their use. The conclusion of many speakers described the need to conduct such trials.

Adolescent Use

There is a significant amount of evidence that cannabis can have a negative affect on adolescents. Speculation is grounded in the fact that their brains have not fully

developed. This is a huge challenge because the cannabis use often starts early and peaks in the teen years. Adolescents like cannabis because it helps them to relax, it alleviates stress, helps them to sleep and creates a euphoric feeling or "high." There is some evidence that starting to use cannabis between the ages of 13 and 15 affects the potential of future depression. Girls are at a higher risk than boys. Studies are ongoing at McGill

Driving

Driving after using cannabinoids has received a lot of attention. It is accepted that this will be a challenge because blood and saliva levels do not correlate well with impairment. Several tests are ongoing. Many prescribers and patients indicated that using higher percentage CBD products did not cause impairment. In addition, several referenced the fact that many prescription drugs such as opioids can cause impairment significant enough to impact one's ability to drive.

Deputy Registrar Cooney shared his thoughts on the take away learnings and considerations from the conference:

- He has supported the hypothesis that there is no medical cannabis, rather there is cannabis that is used for medical purposes and now questions this belief. High CBD low THC products are different than recreational strains and may meet the definition of medical cannabis?
- The Licensed Producers and the licensed producer system is more mature than realized and in his opinion, is likely to expand to something that is more similar to the pharmaceutical manufacturing system.
- There is enough anecdotal evidence for some conditions to support studies and use.
- We are likely to see a challenge regarding traditional prescription medications and their impact on the ability to drive as use of medical cannabis increases and legalization comes into effect.
- Pharmacists are going to be faced with patients who use cannabis for medical purposes who want information or want to obtain it at the pharmacy. However, pharmacists are "late to the party" and will have a lot of catching up to do to understand and provide patient education.
- Many patients choose to grow their own or designate someone to grow because they cannot afford to purchase the products grown or prepared by Licensed Producers. Coverage for what these individuals consider medicines is an issue and is likely to be an issue going forward.
- Legalization of cannabis for recreational use will not displace or replace the medical system.

ACP will continue to engage with other regulators to develop policy about the use of cannabis for medical use. Meanwhile, pharmacists should include screening for cannabis use, as it would for any other substances used for recreational purposes, when assessing individuals' health and drug therapy needs.

MOTION: that cannabis for recreational use not be sold from a pharmacy.
Moved by **Mary O'Neill**/Seconded by **Stan Dyjur**/CARRIED

MOTION: that sites that grow, distribute or sell cannabis for non-medical purposes be prohibited from using terms like "dispensary" or symbols like a "green

cross" that may lead the public to believe that the distribution site is a pharmacy, or that it has professional oversight from pharmacy professionals.
Moved by **Jennifer Teichroeb**/Seconded by **Al Evans**/CARRIED

3.6 Opiate Reduction

Deputy Registrar Cooney is a member of Alberta's Opiate Reduction Advisory Committee. Deputy Registrar Cooney briefed Council about the deliberations of the Committee, including policies that are being considered to impact the prescribing and use of opiates. He sought Council's input about two forms developed as tools to inform and guide prescribers and patients using opioids. In addition, Alberta Health sought Council's feedback on two opioid-related policies proposed for Alberta Health sponsored drug plans.

Alberta Health (AH) sponsors several drug/health benefit plans for Albertans including those for low-income Albertans, and coverage for seniors, Non-Group coverage, and palliative coverage (administered through Alberta Blue Cross). While AH-sponsored drug plans provide coverage for only about 20% of Alberta's population, about 50% of all prescriptions dispensed in Alberta are for AH drug plan recipients.

Public drug plan policies provide an opportunity to support opioid-related initiatives in Alberta. While much of the opioid crisis is fueled by illicit opioids, many deaths and emergency department visits are related to prescribed opioids. In some cases, the path to addiction and use of illicit opioids may have begun with prescription products. Drug program policies could aid in reducing adverse effects, overdoses, addictions and diversion.

- Opioid Naïve Policy: This policy would involve an electronic review of the patient's prescription history for opioid prescriptions (over the previous 180 days) to determine naiveté and would reject opioid claims where the total dose exceeds 90 oral morphine equivalent (OME) per day. The Alberta Blue Cross claims system would complete the history check (for government sponsored drug plan claims) and OME calculations. Should the dose be under 90 OMEs, the claim for the opioid-naïve patient would be processed but to a maximum of a 7-day supply. There would be an ability for pharmacists to enter an override code if they were aware that the patient was not naïve to opioids or that a 90+ OME dose may be appropriate. The policy would not apply to claims for Palliative Coverage recipients. If a claim was rejected, patients could still pay cash for the prescription.

- Duration Limit Policy: This policy would limit coverage of opioid prescriptions to a maximum 30-day supply. This policy is already in place for AH's low-income plans. Currently, for the other drug plans (Coverage for Seniors, Non-Group Coverage and Palliative Coverage), drug plan recipients may receive up to a 100-day supply at a time of chronically required prescriptions (including opioids). Processes to allow greater than a 30-day supply could be implemented, e.g., for Albertans travelling out of the province or working in remote parts of the province for extended periods of time. This policy would have cost implications to government (additional dispensing fees) patients (additional co-payments).

Council supports both tools to guide patients and prescribers on opioids; and the two policies proposed by Alberta Health. ACP will recommend to RxA that they advocate for CACP's and follow-ups for individuals requiring opiate treatment. Council considered additional policies that ACP might develop. At its June meeting, Council will further discuss these and other policy alternatives.

Council also considered Health Canada's proposed auxiliary warning labeling and packaging, and concerns about low dose codeine. Health Canada has suggested that if low dose codeine is taken away or not easy to access, it will be just another stepping stone to patients seek alternatives from the street. Council considered if ACP should write the Federal Government expressing Council's concern about low dose codeine, and to advocate again to our Minister of Health.

3.7 Committee Appointments

3.7.1 Competence Committee

Registrar Eberhart recommended that Council re-appoint Cheryl Harten and Teresa Hennessey to the Competence Committee. Cheryl will serve as Chair for a two-year term ending June 30, 2019. Teresa will serve as Vice-Chair for a one-year term ending June 30, 2018. He also recommended that Trevor Bills, Morenike Olaosebikan and Jill Hall be appointed to the Competence Committee for a three-year term effective July 1, 2017; with each term to expire June 30, 2020.

3.7.2 Hearing Tribunal Pool

Registrar Eberhart recommended that Council re-appoint Ahmed Rizwan, Christopher Heitland, Kevin Kowalchuk, Hugo Leung, Judi Parrott, Rakee Patel and Teryn Wasileyko to the Hearing Tribunal Poll, for a three-year term ending June 30, 2020. He also recommended that Mary Gunther, Sarah Gutenberg, Peter Macek, Anita McDonald, Don Ridley, Jennifer Teichroeb, and Tyler Watson be appointed to the Hearing Tribunal Pol for a three-year term effective July 1, 2017; with each term expiring June 30, 2020.

Registrar Eberhart also recommend that Council appoint Jim Johnston and Anita Warwick to the Section 65 Committee for a three-year term effective July 1, 2017; with each term to expire June 30, 2020.

MOTION: to approve the appointments and re-appointments to the Competence Committee, Hearing Tribunal Pool, and Section 65 Committee recommended by the Registrar.
Moved by **Rick Hackman**/Seconded by **Kelly Boparai**/CARRIED

3.8 Honourary Life Memberships

President Pereira introduced a nomination recommending that a Honourary Life Membership be awarded to Michael Bain. In presenting the nomination, she suggested that pending Council's decision, that the honour be awarded to Mike on June 21, 2017 at ACP's Celebration of Leadership, when Council installs the new President.

MOTION: to award Michael Bain with a Honourary Life Membership.
Moved by **Rick Hackman**/Seconded by **Jennifer Teichroeb**/CARRIED

4. Miscellaneous Business for Council's Consideration

4.1 Report from CCCEP

Art Whetstone, Executive Director of the Canadian Council on Continuing Education in Pharmacy (CCCEP) provided a summary from the Board of Directors Teleconference Meeting of February 21, 2017. Below are excerpts from the summary:

- The British Columbia Branch of the Canadian Society of Hospital Pharmacists (CSHP-BC) was approved as a CCCEP accredited provider. CSHP-BC has provided quality learning experiences for hospital and other pharmacists in British Columbia since 1949. In accordance with CCCEP's Accredited Provider policy, CSHP-BC will be on probation for the first two years. A probationary review will be conducted at the end of this period prior to granting ongoing accreditation as a provider. Educational events are a primary focus for the CSHP-BC Branch. The events are managed by a large Programs Committee comprised of a diverse group with pharmacists who work in academic and community/ hospital settings and who are involved in administrative, inpatient, and outpatient care roles. Previously learning activities were accredited provincially by the Faculty of Pharmaceutical Sciences at the University of British Columbia, on behalf of the College of Pharmacists of British Columbia. In 2016, the Faculty discontinued the accreditation of third party learning activities.
- The Board of Directors approved an Endorsement Policy. Endorsements will only be provided if CCCEP receives a request from a third party. Endorsement is defined as: the statement of support for a policy, proposal and/or recommendation(s) of another organization.

  CCCEP may consider endorsement of a policy, proposal and/or recommendation(s):
  1. That relate to a major initiative by the pharmacy community, such as the Blueprint for Pharmacy; and/or
  2. That relate to content, development and delivery of continuing professional or continuing education in pharmacy.

  CCCEP will not consider the endorsement of:
  1. Specific health, education products or services or technologies;
  2. Specific methods of treatment or patient care; or
  3. Learning activities and education programs, except through the CCCEP accreditation process.

  The policy also outlines the process for reviewing requests for endorsement and the general conditions for any endorsement that is given.
- The Board of Directors approved a motion to support-in-principle the Deprescribing Network's Recommendation 1 (that continuing education initiatives include information on deprescribing) and to encourage providers to include deprescribing information in their learning activities when the evidence on deprescribing is available.
- The total applications for accreditation were 86% of plan. New activity applications (91% of plan) and renewals (71% of plan) were below plan.

Renewals fell 40% over the same period last year. Special accreditations and extensions were higher than plan (433%) but delivery mode (83%) and administrative changes (0%) were lower than plan. Applications for the accreditation of conferences were higher (138%) than plan. While applications for accreditation vary from period to period, this is the first time in ten years in which applications were below plan for four trimesters in a row. The annual projection of applications for accreditation is based on an average of applications for the previous three years.

MOTION: to accept the report from CCCEP as information.
Moved by **Kelly Boparai**/Seconded by **Brad Couldwell**/CARRIED

4.2 Report from PEBC

A report from Kaye Moran, ACP's appointee to the Board of the Pharmacy Examining Board of Canada (PEBC), was submitted for information. The PEBC held its 2017 Annual Board Meeting on February 25, 2017 in Toronto. Standing committees met over the 3 days preceding this meeting. The report highlights issues addressed and recommendations made by the Board. Below are excerpts from the report:

- Appointments to the Board:
  - Canadian Association of Pharmacy Technicians – Robert Solek
  - Canadian Pharmacy Technician Educators Association – Melissa Benoit
  - Canadian Society of Hospital Pharmacists – Kim Abbass
  - Prince Edward Island College of Pharmacists – Leslie Heusdens
- 2017 Executive Committee:
  - President – Kendra Townsend
  - Vice-President – Janet MacDonnell
  - Past-President – Karen McDermaid
  - Executive Members: Omar Alasaly and Kaye Moran
- 2016 Statistics:
  - PEBC Pharmacist Register: There were 1805 names added to the Pharmacist Register by examination in 2016.
  - Pharmacist Qualifying Examination: A total of 2796 candidates wrote the Qualifying Examination-Part I (MCQ) in 2016, compared to 2843 in 2015. A total of 2519 candidates took the Qualifying Examination-Part II (OSCE) in 2016, compared to 2926 in 2015. There were a total of 22 candidates assessed for non-certification purposes.
  - Pharmacist Evaluating Examination: There was a decrease in the number of candidates writing this examination – 1907 in 2016, compared to 2049 in 2015.
  - Pharmacist Document Evaluation: A total of 1877 applicants in 2016 were ruled acceptable for admission into the Evaluating Examination, compared to 1788 in 2015.
  - PEBC Pharmacy Technician Register: There were 957 names added to the Pharmacy Technician Register by examination in 2016, bringing the total to 8514 since 2009.
  - Pharmacy Technician Qualifying Examination: A total of 1293 candidates took the Qualifying Examination-Part I (MCQ) in 2016, compared to 2000 in 2015 and 1294 took the Qualifying Examination-Part II (OSPE),

compared to 2181 in 2015. A total of 560 candidates wrote the Winter Qualifying Examination-Part I (MCQ) and 603 candidates took Part II (OSPE). A total of 733 candidates wrote the Summer Qualifying Examination-Part I (MCQ) and 691 candidates took Part II (OSPE).

- Pharmacy Technician Evaluating Examination: A total of 333 candidates wrote the Pharmacy Technician Evaluating Examination in 2016 at centres in Saskatchewan, Manitoba, Ontario, New Brunswick, Prince Edward Island, Nova Scotia, and Newfoundland, compared to 454 in 2015.

- Committee on Examinations - The Committee discussed the results of pilot security screening and scanning studies conducted in 2016 to enhance examination security at examination sites. PEBC will implement security screening and scanning as an operational standard in 2017. The Committee also continued discussions on the future impact on Pharmacy Technician Qualifying Examination sites once provincial deadlines have passed. PEBC continues to monitor evolving scopes of practice to ensure they are reflected in PEBC examination content. Work continues on developing new questions and stations to address new areas in the Pharmacist and Pharmacy Technician Qualifying Examination blueprints that are based on the revised NAPRA Entry-to- Practice Competencies. The Committee also considered revised examinations rules of conduct for the written/computer and performance examinations. In addition, the Committee discussed the implementation of a revised code of conduct for examination centre staff.
- Public Relations Committee - At the February 2017 meeting, the Public Relations Committee discussed communication strategies for encouraging CCAPP Pharmacy Technician graduates to take the Qualifying Examination to become registered pharmacy technicians. The Committee reviewed and suggested changes to the information sheets provided to CCAPP programs to enhance students' understanding of the Qualifying Examination and the importance of becoming a regulated pharmacy technician. The Committee also reviewed communication documents regarding the introduction of computer-based testing for candidates taking the Fall Pharmacist Qualifying Examination - Part I (MCQ) in 2017.
- Specialty Certification: PEBC continues to work with the Task Group for Specialization in Pharmacy to help better refine the definitions of specialty practice and to define a model of specialty practice. PEBC is also exploring potential involvement in specialty certification through the joint development of a business case with members of the Task Group.
- Implementation of Computer-Based Testing: At the 2016 Mid-Year Board meeting, Board Directors considered the benefits and costs of computer-based testing (CBT) and approved a plan to move forward with computer-based testing for the Pharmacist Qualifying Examination- Part I (MCQ) starting in the Fall of 2017. Implementation of computerized testing will permit optimization of exam delivery with enhanced security as a result of the CBT technology utilized in the exam delivery and enhanced candidate monitoring with video technology. For the Pharmacist Qualifying Examination - Part I which is currently a two-day exam, there will be time savings for candidates in the reduction from a two-day administration to one. Also, CBT testing will provide expanded access for candidates through a significant increase in the number of testing sites across Canada and a longer testing window allowing for improved scheduling options for candidates. This will minimize their need to travel or

accrue potential accommodation costs when sitting for the exam. Furthermore, the expanded access also increases convenience for those who need to schedule around work or other personal obligations or have a preference for taking examinations at particular times.

Registrar Eberhart commented that the pharmacy technician candidate pool is too small to maintain the evaluating exams to determine academic equivalency. A solution for the future must be considered.

MOTION: to accept the report from PEBC as information.
Moved by **Stan Dyjur**/Seconded by **Brad Couldwell**/CARRIED

5. Evaluation of Meeting

Council reflected on its; and each Council Member's personal performance, at the meeting.

5.1 Evaluation of Council Performance

Prior to the April meeting, Council members used a new tool for evaluating council member performance. In general, Council liked the tool as it provided an opportunity for council members to be reflective in a confidential way, however they suggested minor amendments. Council discussed one and other's personal evaluations and comments as a foundation to developing the agenda for board development in October. Registrar Eberhart will meet with Doug McNamara to follow-up on Council's suggestions for board development.

Following are specific comments and suggestions arising from Councillor's experience in using the evaluation tool:

- It was suggested that bullet #2 under "Governance Role" be divided into two questions:
    - The first addressing confidentiality; and,
    - The second addressing conflict of interest.
    - Council Members sought clarity about what information included on council agenda's was confidential. Registrar Eberhart confirmed that council meetings are typically open to registrants and the public, and that documents are public in nature; although in Alberta they are not subject to FOIP. He advised that there was a higher degree of confidentiality around the following types of documents and discussions:
        - "Privileged" – documents labelled privileged (often from legal counsel) are not public, and are to support council deliberations only. They must not be shared, distributed, disclosed, or discussed except amongst the Council and administrative leaders of the college;
        - "In Camera" – meetings are open only to voting Council Members and the Registrar; unless a motion is made to invite other individuals. The Registrar is excluded from such discussions when his/her performance is being discussed. A motion is required to commence and conclude an "In Camera" meeting. The discussion of "In Camera" meetings is confidential and does not include the taking of minutes. If a

motion is required as a result of an "In Camera", it should be made and recorded after the "in camera" meeting concludes;
    - "Closed Meetings of Council" are not open to observers, and do include the taking of minutes, including motions made. Documents shared during a closed meeting, may become public at the discretion of Council.
- It was suggested that the tool should incorporate a 10 point Likert scale, to accommodate greater reflection and variance. It was suggested that the root to each question be changed from "How well…" to "I am…" to better reflect personal reflection.
    - It was also suggested that clear policy was required about recording names of how Council Members voted. It was suggested that this should be clarified through our review of governance policy. The intent was that names not be included on the record unless a Council Member: abstained from voting; or,
    - Requested that their vote be recorded.
- Council reiterated its support for team development.

Council discussed opportunity for second year Council Members to participate in council orientation again, and the role that Past-Presidents could play in supporting Council. There was a suggestion that Council's Governance Policies might be posted on ACP's website.

To support active and informed engagement at council meetings, Council asked ACP to prepare a background or briefing document for issues where there are multiple documents per agenda item, in order to bring better focus to the discussions and decisions required of Council.

5.2 Self-Evaluation of Council Performance at this Meeting

President Pereira reminded Council Members to complete the electronic meeting evaluation form for collation and review at its next council meeting. The self-evaluation was facilitated through survey monkey. The link to the survey is on the Council agenda, and Leslie Ainslie will forward a link to the survey after the meeting.

5.3 Summary of Results for the March 2-3, 2017 Council Meeting

A summary of the March 2-3, 2017 council meeting evaluations was circulated with the agenda for information.

6. Adjournment

6.1 Forthcoming Events and Council Meeting Dates

6.1.1 June 21, 2017 – Council Meeting
6.1.2 June 21, 2017 – Celebration of Leadership and Installation of President
6.1.3 June 21-23, 2017 - Leadership Forum
6.1.4 October 4-6, 2017 – Council Meeting and Board Development

6.2 Adjournment

MOTION: that this meeting of Council be adjourned.
Moved by **Brad Couldwell**
Meeting was adjourned circa 2:30 p.m.