Health Care Sustainability

BC Pharmacy Association submission to the Select Standing Committee on Health

July 28, 2016

British Columbia Pharmacy Association

Executive Summary

From 2014 to 2015, the Select Standing Committee on Health asked for input and held public consultations on questions around the topics of end-of-life care, health-care services in rural, remote and isolated communities, interdisciplinary teams and addiction recovery programs. In October 2015, the committee released its report on physician-assisted dying, and followed up with a report on end-of-life care in May 2016. This summer, the committee is now focusing its attention on the remaining three questions:

- Improving health care in rural, remote and isolated communities;
- Creating cost-effective primary and community care through interdisciplinary teams; and
- Enhancing the effectiveness of addiction recovery programs

In our submission, the pharmacists of British Columbia offer a number of recommendations in these three areas that come from the unique perspective of health-care providers that are often the first point of contact for patients in many communities – especially rural and remote communities.

The BC Pharmacy Association is a not-for-profit voluntary organization representing more than 3,100 pharmacists and more than 900 community pharmacies across the province.

BC pharmacists dispense more than 70 million prescriptions annually. But more than dispensing medications, pharmacists in British Columbia have continued to advance primary care, serving the needs of patients in a cost-effective way through expanded scope of practice.

More than simply dispensing medications, pharmacists in British Columbia have continued to advance primary care, serving the needs of patients in a cost-effective way.

Starting in 1999, BC pharmacists have had the authority to provide emergency refill supplies of medication. A year later, BC pharmacists were the first to be granted independent authority to prescribe emergency contraceptives. In 2009, pharmacist scope of practice was expanded to include adapting prescriptions written by authorized prescribers as well as administering injections. During the 2014-15 flu season, pharmacists gave more than 430,000 flu shots – up from nearly 30,000 in 2009. Pharmacists are increasingly turning their attention to non-dispensing activities, such as assisting patients with chronic disease management to help them achieve the desired health outcomes. Earlier this year, the province recognized the important role that pharmacists play in helping patients quit smoking, making pharmacists the access point for the publicly supported smoking cessation program.

Despite many advances, pharmacists still remain an underutilized health-care resource in British Columbia. Over the years, pharmacists in British Columbia have submitted proposals to the government on clinical services and how to control drug expenditures by using the knowledge and skills of pharmacists. We have been disappointed that the opportunity to be part of the solution has been met with little to no response.

Declaring our intention to be recognized as an integral part of the health-care team is a key theme of this submission. Often health-care frameworks are developed around physicians and nurses.

However, by using other key members of the team, the government can reduce costs and improve the quality of care. Deploying the right resources for the right job will improve health outcomes and address sustainability.

Pharmacists are committed to working collaboratively with the government and other health-care partners to find solutions to deliver better care and better outcomes at optimal costs for British Columbians.

Improving health care in rural, remote and isolated communities

Question: How can we improve health and health-care services in rural British Columbia? In particular, what long-term solutions can address the challenges of recruitment and retention of health-care professionals in rural British Columbia?

In 2015, the BC Ministry of Health published a cross-sector policy discussion paper that identified the unique challenges BC faces in providing appropriate access to health care in rural areas of the province. These ranged from "geographic remoteness, long distances, low population densities, less availability of other providers and inclement weather conditions"[1].

Individuals in rural communities were found to have poorer health outcomes compared to their urban counterparts, a finding that is consistent with the rest of Canada. As the Commission on the Future of Health Care in Canada noted in its final 2002 report, people in rural parts of Canada face lower life expectancy than other parts of Canada and face higher disability rates. In remote northern communities, people are the "least healthy and have the lowest life and disability-free life expectancies." [2]

It has been found that problems accessing health services quite often stem from shortages in health providers in rural communities.

The Commission also noted that "keeping health care providers in rural areas is an ongoing problem, and territories compete to attract and retain the supply of health care providers they need."[3]

Moreover, while the Commission noted that rural health-care problems required immediate attention, there is little evidence to suggest that the challenges identified in providing adequate health care for Canadians living in rural and remote areas have improved greatly since its 2002 final report.

In BC, various governments have worked hard to address the issues related to attracting and retaining needed health-care professionals to rural communities, notably physicians. In 2001 the Joint Standing Committee on Rural Issues (JSC) was established to develop strategies to look at the challenges associated with providing physician service to rural communities across the province.

---

[1]British Columbia, Ministry of Health. (2015). *Rural health services in BC a policy framework to provide a system of quality care: Cross sector policy discussion paper*. Victoria, B.C.: Ministry of Health.
[2] Romanow, R. J. (2002). *Building on values: The future of health care in Canada* (Commission on the Future of Health Care in Canada.). Saskatoon, Sask.: Commission on the Future of Health Care in Canada.
[3] Ibid.

Through the JSC's efforts, the Rural Practice Subsidiary Agreement [4] (RSA) was established. The agreement designates 183 rural communities in the province where practicing physicians are eligible to receive financial incentives. The 183 communities are separated into three groupings for purposes of determining the level of incentives. Of the total, 124 communities are in the "A" ranking associated with highest need for support to attract and retain physicians.

The BCPhA believes the work of the JSC and the RSA are important models for how targeted programing can attract and retain crucial health practitioners to BC's under-serviced rural communities. These can provide insight into how programs can be developed to attract other health-care providers to fill primary care gaps that remain in rural communities.

BC's community pharmacists believe that government strategies aimed at fixing the rural health deficit are missing an important opportunity. Community pharmacists are an underutilized resource that is already present in the majority of BC's rural and remote communities.

There are currently 109 community pharmacies in the 124 communities designated in the RSA "A" group of communities. Communities in this group include such remote areas as Chetwyn, Fraser Lake and Port McNeill, to name a few. These communities are clearly challenged in having access to the health-care services they need.

Community pharmacists are an underutilized resource that is already present in every rural community.

Pharmacists have demonstrated the skills, training and clinical expertise necessary to deliver a broader range of primary care to rural patients. The BC Pharmacy Association has long believed that pharmacists can serve as community-based triage centres: helping resolve minor health issues and directing patients on to prescribers and acute care facilities if needed.

A clear demonstration of how the province has used community pharmacists as part of primary care service delivery is through immunizations. In 2009 when community pharmacists were first authorized to administer flu vaccines, 30,000 shots were given. During the 2014-2015 flu season, pharmacists gave more than 430,000 flu shots. And since 2009, pharmacists have demonstrated the ability to respond to communicable disease outbreaks, including H1N1, whooping cough and measles, providing immunizations to thousands of British Columbians.

There are now more than 3,400 pharmacists in BC authorized to give immunizations, and about 94 per cent of all pharmacies in the province have at least one pharmacist authorized to provide immunizations. Elsewhere, other provinces have integrated and used the expertise of community pharmacists to help deliver primary care to patients. The BC Pharmacy Association and its members stand ready to work with government to address the challenges of improving health care for rural British Columbians.

[4] Rural Practice Subsidiary Agreement. (n.d.). Retrieved July 26, 2016, from http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/physician-compensation/rural-practice-programs/rural-practice-subsidiary-agreement

Recommendation 1: Integrate community pharmacists into the provincial rural health-care planning process

The BCPhA applauds the BC government's development of a policy framework to improve rural health-care service delivery. However, it is concerning that while physicians and nurses are identified and included as integral members in the framework's list of health-care team members, pharmacists are not mentioned. This is a missed opportunity that, when addressed, can allow for further exploration on how health human resource needs can address the unique challenges of rural areas.

Integrating community pharmacists into the government's health-care planning for rural communities is essential. The pharmacists of BC call on the Ministry of Health to formally integrate community pharmacists into its official stakeholder engagement process and to add community pharmacy representation to its rural health-care planning teams.

Recommendation 2: Modernize and align the community pharmacy rural incentive program

As part of this process, the BC Pharmacy Association recommends that the Ministry of Health modernize its community pharmacy Enhanced Rural Incentive Program (2011/2012). The Association believes a review of this program is needed. As part of this review process, we recommend the 183 rural communities included as part of the RSA be adopted as part of the eligibility criteria for the community pharmacy rural incentive program. There should be alignment in location eligibility criteria for prescriber and pharmacist incentive programs.

Recommendation 3: Deploy technology to address the unique challenges of rural areas

Currently, pharmacists use technology to meet the needs of patients in remote areas. Called telepharmacy, the technology uses videoconferencing software to communicate with pharmacy assistants working in remote areas. This allows pharmacists to check off finished prescriptions and provide face-to-face counselling with patients via video. Launched in 2002, telepharmacy services have expanded to 11 remote telepharmacy sites in British Columbia. These remote locations being served generally have populations less than 1,000 people.

While praised by local doctors and residents, the future of telepharmacy in BC is very much in doubt. The College of Pharmacists of BC has put in place staffing requirements that telepharmacy operators are not able to meet because of the remoteness of these locations. Additionally, the College has identified federal legislative barriers related to dispensing of controlled substances that would require discontinuing telepharmacy services as they are currently offered.

The Association believes the loss of telepharmacies in the province would further restrict access to health care in rural and remote communities. While we respect the College's role in protecting the public, we believe there are ways to protect the public without losing an important access point to care for patients in remote areas.

We urge the Ministry of Health to direct the College of Pharmacists to work with telepharmacy operators and the Association to find solutions to protect the provision of pharmacy services in rural communities currently serviced by telepharmacies. The Association also encourages the government to assess where an expansion of telepharmacies could increase access to pharmacy services for rural communities.

Another use of technology that can help patients in rural areas is electronic prescribing. E-prescribing is an unrealized opportunity to improve efficiency and access to care in BC and across Canada. The Association is pleased the Ministry of Health has recently reactivated its work on the PharmaNet modernization program with Minister of Health Terry Lake's announcement this spring that the province has renewed its commitment to move this vital work forward.

One particularly important area in which the province can help is facilitating e-prescribing pilots in rural communities. Specifically, we urge the government to support seven e-prescribing pilots in early 2017. The Association commits to working with the Ministry of Health in recruiting pharmacies and pharmacists to help deploy such a pilot program.

In order to be prepared for broader implementation of e-prescribing in the province, regulatory and College of Pharmacists of BC bylaws will need to be amended. We urge the Committee to create a working group to identify and enable the needed regulatory changes.

Recommendation 4: Implement prescribing authority for minor ailments in rural communities

As part of its support to attract and retain physicians in rural communities, the Ministry of Health provides incentives to physicians practicing in 183 rural communities across the province. These designated communities have traditionally had difficulty meeting the health-care needs of its citizens.

The BC Pharmacy Association urges the BC government to implement policy changes that would permit pharmacists to prescribe for minor ailments and dispense the appropriate medications.

Implementing a program that allows BC pharmacists to prescribe for minor ailments is an important step toward improving access to primary care in rural and remote regions of the province.

A minor ailment is commonly defined as a self-limiting medical condition that will resolve itself on its own and can be reasonably self-diagnosed and managed without medical intervention. It is also generally accepted that lab tests are not needed to diagnose the condition; that treating the condition as a minor ailment will not mask underlying more serious health conditions; that medical and medication histories can reliably differentiate more serious conditions; and that only minimal or short-term follow-up with the patient is necessary. Minor ailments include common conditions like headaches, back pain, insect bites, diaper rash, cold sores, acne, athlete's foot, heartburn or indigestion and nasal congestion.

Pharmacists have the authority to treat minor ailments in a number of provinces in Canada and elsewhere. The BC Pharmacy Association believes implementing a program that permits BC pharmacists to prescribe for minor ailments in rural communities is an important step toward improving access to primary care in rural and remote regions of the province.

Creating cost-effective primary care through interdisciplinary teams

Question: How can we create a cost-effective system of primary and community care built around interdisciplinary teams?

In 2014, the Ministry of Health released its report "Setting Priorities for the B.C. Health System," which outlines the broad strategy and future direction of the British Columbia health-care system[5]. In it, the province identified the significant role of primary and community care for patients in BC. In fact, primary and community care deliver more than 30 million health-care services each year to BC's 4.5 million residents. This expenditure of primary and community care is approximately $5.4 billion annually.[6]

At the same time, the report acknowledged the need for change and suggested a consensus is developing around the critical impact that community based health care can have on improving patient and population health outcomes. Since that time, the Ministry of Health has developed comprehensive, strategic plans, directing the regional health authorities to establish a network of community based "primary care homes" across BC.[7]

While the BC Pharmacy Association agrees with this recognition of the important role of community care, we are concerned that solutions not be limited to only opportunities that physically co-locate various health practitioners in common physical spaces.

"The medical home is not a final destination; instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs."

- Dr. Linda Strand

As the province considers mechanisms to encourage greater use of interdisciplinary health teams, the Association recommends a focus on virtual care hubs with strong inter-professional collaboration.

Dr. Linda Strand, a pharmacist and university educator who has published extensively on the issue of how best to increase cooperation between health professionals in order to improve patient care, champions interdisciplinary health practice. She gives this description of a model primary care hub:

> "The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where

[5] *Setting priorities for the B.C. health system: Supporting the health and well-being of B.C. citizens, delivering a system of responsive and effective health care services for patients across British Columbia, ensuring value for money.* (n.d.).

[6] British Columbia, Ministry of Health. (2015). *Primary and Community Care In BC: A Strategic Policy Framework*. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf

[7] Ministry of Health – Strategic Initiatives Policy Objective 1 – Establish Primary Care Homes available at http://sgp.bc.ca/wp-content/uploads/2016/03/MOH-Primary-Care-Home.pdf

> they are, from the most simple, to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enables strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination; instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs."[8]

This model of inter-professional collaboration puts patients' needs first.

As the government has rightly noted, the consequences for patients in a fragmented health-care delivery system can range from merely inconvenient to downright dangerous.[9] British Columbians require greater sharing of information between the health-care providers overseeing their treatment regimens and paths to wellness.

Patients today commonly receive health care from multiple providers, whether for an acute episode or as part of the management of a chronic condition. A patient may be under the care of not only a pharmacist, nurse or physician, but also physiotherapists, dieticians and mental health workers all at the same time. Minister of Health Terry Lake has stated, "B.C. has more family doctors than ever — and more than the Canadian average — but we also face increased demand from an aging population. In addition, we have many doctors working fewer hours or in walk-in clinics rather than in full-service family practices. Good primary care is more than simply connecting a doctor and patient."[10]

Virtual primary care hubs — beyond the bricks and mortar — will facilitate access to the range of health practitioners British Columbians seek for treatment and health advice.

Yet, too often patients experience care as if it were provided not by a tightly integrated team of professionals, but rather a collection of individual providers offering disjointed, or even conflicting, advice.[11] Removing inefficiencies in the delivery of health-care services and leveraging existing health resources toward patient-centered care will enhance cost-effectiveness of the system and improve patient access to primary care.

Community pharmacists exist in every region of the province. But because health-care delivery is planned, managed and delivered through heath authorities there has been a failure to effectively integrate community pharmacists as a key patient resource. Virtual primary care hubs — beyond bricks and mortar — will facilitate access to the range of health practitioners British Columbians seek for treatment and for health advice.

---

[8] Defining the Medical Home. (n.d.). Retrieved July 26, 2016, from https://www.pcpcc.org/about/medical-home

[9] Wynia, M. K., & Classen, D. C. (2011). Improving Ambulatory Patient Safety. JAMA, 306(22). doi:10.1001/jama.2011.1820

[10] Lake, T. (2016, July 15). Health minister says teams are the future. *Kamloops This Week*. Retrieved from http://www.kamloopsthisweek.com/health-minister-says-teams-are-the-future/

[11] Schoen, C., Osborn, R., Squires, D., Doty, M., Pierson, R., & Applebaum, S. (2011). New 2011 Survey Of Patients With Complex Care Needs In Eleven Countries Finds That Care Is Often Poorly Coordinated. *Health Affairs*, 30(12), 2437-2448. doi:10.1377/hlthaff.2011.0923

Recommendation 1: Integrate community pharmacists into the province's Primary Care Home initiative

The BC Ministry of Health has made a bold commitment to ensuring the primary care needs of British Columbians are better met. The Ministry's Primary Care Home initiative[12] is designed to support physicians who provide full service primary care; to increase patient/physician attachment; and to facilitate interdisciplinary team practice.

The BC Pharmacy Association strongly supports the Ministry's objective to foster improved collaboration between primary care prescribers and pharmacists. Increasingly, best practices show that a key way to implement improved collaboration is through the creation of "virtual primary care hubs."

Moving beyond bricks and mortar centres and using existing community-based facilities, such as community pharmacies, extends scarce medical resources. Existing technology allows for the connectivity needed to deliver on the promise of interdisciplinary team-based care.

Recommendation 2: Use community pharmacists to meet primary care gaps

Another avenue to increase patient care through better use of community pharmacists is to initiate 'prescriber referral to pharmacist' services. This opportunity has not been explored in BC.

Pharmacists are well-equipped to provide medication reconciliation, patient counselling and coaching for individuals with chronic diseases. The Green Shield Canada-funded Pharmacist Health Coaching – Cardiovascular Program is an example of a community-based pharmacy service that is meeting primary care needs by providing chronic disease management to patients with high blood pressure and cholesterol.

Our Association is currently working with the Ministry of Health on revamping the existing medication review program to place greater emphasis on patient transitions in care (e.g. from hospital to community) and on patients with chronic health conditions who would benefit from additional support in managing their medication regimens.

The BC Pharmacy Association urges the province to pursue this and other programs to allow pharmacists to fill care gaps at the community level.

[12] Ministry of Health – Strategic Initiatives Policy Objective 1 – Establish Primary Care Homes available at http://sgp.bc.ca/wp-content/uploads/2016/03/MOH-Primary-Care-Home.pdf

Addiction recovery programs

Question: How can we enhance the effectiveness of addiction recovery programs?

While there are many facets to the care and recovery of individuals struggling with addiction, our recommendations focus on the value that pharmacists can bring to addiction recovery programs as medication experts.

The BC Pharmacy Association is as concerned as the province about the rise in opioid abuse and overdose deaths over the last year. Our experience in providing community-based methadone maintenance treatment (MMT) is a case study for how the province might serve British Columbians seeking treatment for opioid abuse.

MMT is internationally recognized as one of the most effective treatments for opioid addiction. From 2001/2002 to 2013/2014, the number of British Columbians accessing the MMT program grew nearly 100 per cent from approximately 8,000 to 15,467 patients.

The program requires pharmacists to interact with most patients every day in order to dispense methadone. This required patient-provider interaction gives patients working through opioid addiction ongoing contact with their health-care providers. In many of these cases the community pharmacist might be the most regular source of health support for individuals whose physician or other health-care provider sees them irregularly or who does not provide more extensive support.

In a 2015 report, Provincial Health Officer Dr. Perry Kendall concluded that patients on MMT and/or Suboxone have decreased mortality rates than those not on opioid substitution therapy. The report also noted that those who stay longer on opioid substitution therapy generally have better long-term health outcomes".[13]

Research shows that for every $1 spent on increasing access to treatment, an additional $76 is saved in lifetime benefits for a patient receiving MMT[14]. Community pharmacists are at the forefront of providing effective recovery support for opioid abuse. They are the lynchpin in the delivery of treatment for opioid addiction and provide a much-needed source of outpatient support.

Recommendation 1: Provide universal access to the overdose antidote naloxone

BC has been particularly hard hit with growing number of opioid overdoses. In April 2016, Dr. Perry Kendall declared the situation a public health emergency.

An essential tool in reducing deaths from opioid overdoses is the timely use of naloxone, which reverses the effects of opioid overdose, which includes slowed or stopped breathing. This potent antidote is intended to be used by the public when encountering a friend or relative who has overdosed. Making naloxone widely available is a crucial element in efforts to reduce overdose deaths. In March 2016, naloxone became available in British Columbia without a prescription.

---

[13] British Columbia., Office of the Provincial Health Officer. (2015). BC opioid substitution treatment system performance measures, 2013/2014. Victoria, B.C.: Office of the Provincial Health Officer.

[14] Zarkin, G. A., Dunlap, L. J., Hicks, K. A., & Mamo, D. (2005). Benefits and costs of methadone treatment: Results from a lifetime simulation model. *Health Econ*. *Health Economics*, 14(11), 1133-1150. doi:10.1002/hec.999

While naloxone kits are currently available at no cost to some British Columbians through the Take Home Naloxone program, this program is not available to all. The BC Pharmacy Association believes this presents a barrier to widespread use of the life-saving medication.

Last month the Ontario government made coverage of emergency naloxone kits universal for any individual who fits the eligibility criteria.

In Alberta, pharmacies can order no-cost naloxone kits that have been provided by Alberta Health Services. The kits contain naloxone, supplies and instructions and are covered for both Albertans with a valid health care card and individuals who use a pseudo-PHN for anonymity.

We urge the committee to advocate for universal coverage of naloxone for British Columbians.

There are a number of emerging options for naloxone. Community pharmacies are currently assembling kits that meet the College of Pharmacists of BC's guidelines and offering them for sale to individuals. Heath Canada is also at various stages of approval for manufactured naloxone kits, a nasal spray formulation as well as an auto-injector. Earlier this month, Federal Health Minister Jane Philpott ordered Health Canada to expedite a review of the nasal spray and allow importing of the nasal spray from the United States for an interim period while the review is underway.

Regardless of the formulation, we urge the Committee to advocate for universal coverage of naloxone for British Columbians. Pharmacists play a much-needed role in public education around the safe and proper administration of these products and response to opioid overdose.

Recommendation 2: Changes needed to the BC Methadone Maintenance Program

In the spring of 2015, the Ministry initiated a review of the MMT program. The BC Pharmacy Association made the following five recommendations in its June 2015 submission to MBPSD:

- **Create an opioid substitution treatment committee in the Ministry of Health**

  The Association recommends the creation of a multi-stakeholder oversight group to improve coordination of care between physicians and pharmacists in the treatment of patients enrolled in the Methadone Maintenance Treatment program. Specifically, membership would include representation from the College of Physicians and Surgeons of BC, the College of Pharmacists of BC, the Doctors of BC, the BC Pharmacy Association and Ministry of Health representatives responsible for physician and pharmacist services.

  The committee would have the authority to adjust clinical care guidelines and set provider standards for participation in the methadone maintenance treatment program.

- **Create an independent financial oversight group that is charged with looking at physician and pharmacist fee structures to ensure no inadvertent perverse incentives exist that result in compromised care for patients in the methadone maintenance program**

  The financial oversight group would be charged with looking at physician and pharmacist fee structures to ensure no inadvertent perverse incentives exist that result in compromised care for patients. The current siloed budgets in the Ministry do not allow for an integrated review of potential prescriber and pharmacist suspect billing practices.

- **Work with the College of Pharmacists of BC to evaluate the current training and licensing structure for all pharmacists involved in the delivery of opioid substitution medications**

  The BC Pharmacy Association believes the current training and licensing requirements no longer meet the needs of the growing population of patients with addiction issues. More rigorous standards for training and licensing need to be implemented.

- **Restructure the current Methadone Maintenance Payment Program that provides a patient-focused plan with a single payment for all clinical and dispensing services received by patients on methadone**

  Create a unique billing fee for patients enrolled in the opioid substitution therapy program. Regardless of the number of medications prescribed to a patient in the program, only a single fee would be charged by the pharmacist for their care of the patient. This, too, would reduce any unintended and perverse incentives that may be associated with providing service to this patient population.

- **Pursue a stepped approach to patient attachment to primary care physicians and community pharmacists for patients eligible for the province's opioid substitution program**

  The client population utilizing this addiction treatment is very diverse, highly complex, and variable. No single health-care provider can address all the needs of this heterogeneous population alone.

Conclusion

In this submission, the BC Pharmacy Association has offered eight recommendations to help improve the quality of care for British Columbians, whether they reside in rural areas or are facing recovery from addiction.

The Association asks the government to begin first by recognizing pharmacists as an important member in the health-care interdisciplinary team. To truly operationalize the role pharmacists can play, especially in rural areas, the government must enable systems, legislation and technology to allow pharmacists to practice at their fullest scope possible, to expand scope where necessary and to collaborate fully with other health-care practitioners.

Community pharmacists are ready and willing to participate in advancing the government's e-prescribing project. We urge the government to support seven e-prescribing pilots in early 2017 and can help recruit pharmacies for the project. Telepharmacies, a much-needed access point for patients in remote areas, must be able to operate. We ask the government to urge the College of Pharmacists of BC

to work with telepharmacy operators and the Association to find solutions. And we ask the government to support pharmacists' prescribing for minor ailments, which will help increase access to primary care in rural areas.

Community pharmacists are on the front lines of opioid addiction recovery, having been providers of the MMT program for many years. The BC Pharmacy Association believes community pharmacists are a key provider in helping patients overcoming opioid addiction and asks that the government adopt our five recommendations in changing the MMT program.

In addition to opioid addiction recovery, as British Columbia faces a public health opioid overdose epidemic, pharmacists have responded by training themselves to be providers and educators of naloxone kits to British Columbians. The Association urges the government to increase access to naloxone by covering this antidote through PharmaCare so that cost is not a barrier to helping save a life.

Community pharmacists are committed to delivering value to the health-care system and better outcomes for British Columbians.