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British Columbia Pharmacy Association
A voice for community pharmacy

July 21, 2017

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And To:

Brian Westgate
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1515 Blanshard Street
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BY EMAIL: PROREGADMIN@gov.bc.ca

Dear Madam/Sir:

Re: Telepharmacy Bylaw Amendments Posted for Comment April 24, 2017

The BC Pharmacy Association thanks the College of Pharmacists of BC for the opportunity to provide comments on the proposed amendments to the *Pharmacy Operations and Drug Scheduling Act* Bylaw and to the proposed Telepharmacy Standards of Practice, posted in April 2017.

BACKGROUND

People living in rural and remote places have comparatively poorer health outcomes. Many have a lower socioeconomic status, which evidence shows is strongly linked to poorer health status. In general, people living in rural and remote communities have poorer diets; a higher risk of crowded or unsafe housing; higher rates of smoking and obesity; poorer perinatal indicators; a higher risk of injury or death by accident or suicide; a higher risk of premature death from circulatory diseases; and overall have a life expectancy that is up to *seven years shorter* than that of a person living in a more populous

part of the province.[1] While a large percentage of the rural population identifies as Indigenous, (which tends to be a younger demographic with higher birth rates and greater health disparities),[2] the burden of poorer health is broadly distributed across the whole population (not simply among first nations communities) and this translates into almost 2000 more deaths in the north between 2007 – 2011 than the national average.[3]

The causes of these health inequities are complex, but access to care providers is a core problem. Patients may live on islands, with access determined by ferry schedules and weather patterns, or in places accessible only by poor roads or only one road in and out, which may be completely impassible during some or all of winter months. Bus service is limited or non-existent in many rural and remote communities. Many patients may also wrestle with language or cultural barriers. And in many rural and remote communities internet connectivity is inadequate: even with almost 200 internet providers in BC, there are still areas of the province without internet access.[4] Indeed, broadband deficits are a significant and ongoing barrier to access to heath care and treatment. While most people in BC do have high speed connectivity, approximately 6% of the population - this translates to 286,629 people[5] -- still do not.[6] (By way of comparison, Northern Health Authority serves 7% of the province's population.)

BCPhA Position

The objective of telepharmacy is to ensure enhanced access to pharmacy services in locations where such services would otherwise be difficult to access. The BCPhA supports this objective.

Since their launch in 2002, telepharmacy services have expanded to 11 remote telepharmacy sites in BC, each of which generally serve a population of less than 1000 people.

The loss of telepharmacies would reduce access to health care in rural and remote communities. The BCPhA commends the College for recognizing this risk and including some grandfathering provisions in these proposed bylaws. However, while grandfathering will go some way towards mitigating the systemic barriers to health care access discussed above, other provisions of the bylaws will nevertheless have a substantial adverse effect on the many British Columbians who live in rural and

[1] See BC Ministry of Health *Rural Health Systems in BC: A Policy Framework to Provide a System of Quality Care* available at http://www.health.gov.bc.ca/library/publications/year/2015/rural-health-policy-paper.pdf, pages 16 ("Rural Health Policy Paper")
[2] See Rural Health Policy Paper, pages 13-15
[3] See *Northern Health Authority 2015-2018 Service Plan* page 9 available at: https://www.northernhealth.ca/Portals/0/About/FinancialAccountability/2015-2018-Service-Plan.pdf
[4] See http://www2.gov.bc.ca/gov/content/governments/about-the-bc-government/communications-technology/internet-in-bc
[5] Based on a population of 4,777,157 as at July 2017. See *Quarterly population 1951-2017* at http://www2.gov.bc.ca/gov/content/data/statistics/people-population-community/population/population-estimates
[6] The BC government operates several programs and initiatives with the goal of 100% connectivity in BC by 2021. See http://www2.gov.bc.ca/gov/content/governments/about-the-bc-government/communications-technology/internet-in-bc

remote communities. The imposition of new requirements which are currently impossible to meet in some areas of the province will undermine provincial efforts to improve patient outcomes in areas that are already dealing with multiple systemic barriers to access to health services.

RECOMMENDATIONS

We have carefully reviewed the proposed amendments and standards and have the following comments:

1. The Definition of "Direct Supervision"

The definition of "direct supervision" requires that there be "real time audio and visual observation". As is well-known, there are still many parts of BC where the broadband connectivity is insufficient to enable a continuously streamed, open connection. Lytton, which is about halfway between Hope and Lillooet, only achieved high speed capability in January of this year.[7] Northern BC has much less service.[8] Indeed, Dease Lake has to work with Northern Health to ensure adequate internet capability, and this work is ongoing.[9] Obviously, this issue is well beyond the control of the registrants and dependent on decisions and investments made by provincial, federal and private sector stakeholders.[10]

The BC government operates several programs and initiatives with the goal of achieving 100% connectivity in BC by 2021, but today more than 6% of the province are still without adequate connectivity. This definition will have the inevitable effect of preventing a telepharmacy from opening in those places. It is unfair to the more than 286,000 British Columbians who are still without adequate connectivity for the College to create a new rule which is simply impossible to meet in the places where they live.

The BCPhA is also concerned about the employee and patient privacy issues associated with constant surveillance using a live stream. Video surveillance can have a detrimental effect on employee morale and psychological well-being. As noted by the Privacy Commissioner, video and audio surveillance systems are "inherently privacy invasive."[11] Moreover, having an open stream can increase the risk of inadvertent breaches of the privacy of employees or patients because of the constant nature of the surveillance. It should be noted that although the stated purpose of this rule is to supervise staff, not

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[7] http://www.northerndevelopment.bc.ca/news/improved-high-speed-internet-comes-to-lytton/

[8] See http://www.northerndevelopment.bc.ca/?s=connectivity

[9] see https://www.northernhealth.ca/Articles/Telepharmacy-update-*-Dease-Lake

[10] See http://www2.gov.bc.ca/gov/content/governments/about-the-bc-government/communications-technology/internet-in-bc and see http://www.ic.gc.ca/eic/site/028.nsf/eng/50044.html for projects in BC funded by the federal government.

[11] See the discussion in *Public Sector Surveillance Guidelines* available at https://www.oipc.bc.ca/guidance-documents/1601 and see also https://www.oipc.bc.ca/media/16910/ac-p16-01-surveillance-and-privacy-compliance-in-a-medical-clinic-final.pdf in which the Acting Commissioner observed "Video surveillance carries social impacts. It affects how we behave when we're being watched, inhibiting our freedom of expression, association and privacy – freedoms that are essential to a democracy. Individuals have a fundamental right to privacy, enshrined in our private and public sector privacy legislation"

to capture the images and conversations[12] of patients while they are in the telepharmacy site. However, mandating an open stream will likely capture patient images and conversations. As the Privacy Commissioner has warned, "cameras can easily capture images of people who are not targets, which would not be authorized under PIPA or FIPPA" because the tests of reasonableness or necessity would not be met.[13]

Guidelines from the Privacy Commissioner's office recommend that a surveillance should be used only if other less privacy invasive options have been assessed and found to be "substantially less effective than surveillance and the benefits of surveillance substantially outweigh any privacy intrusion."[14] Demonstrating that other options are substantially less effective is a key part of determining the necessity and reasonableness of surveillance (which is a core element of the lawfulness of the surveillance).

It is unknown whether the College has done any assessment of the privacy impact of these requirements to determine whether mandating "real-time" video surveillance is consistent with the privacy rights of patients and employees as set out in the applicable privacy laws.

Recommendation: amend the definition of "direct supervision" to remove the words "real-time" as follows:

"direct supervision" means ~~real-time~~ audio and visual observation by a full pharmacist of pharmacy services performed at a telepharmacy consistent with a pharmacy manager's responsibilities as set out in subsection 3(2).

2. The Definition of "rural and remote"

The BCPhA agrees that a definition of "rural and remote" is necessary, and that the RSA list should be the foundation for the definition so that it aligns with the definition that is already accepted by the province. This will enhance health sector coordination and support the College's objectives for collaborative practice and expanded scope.

However, it must not be overlooked that telehealth and telepharmacy are services that are intended to be made available to communities that do not have access to a physician *at all*, because they are *more*

[12] Note that images and conversations are separate and distinct categories of personal information: "For example, if a public body is considering implementing a surveillance system that collects video and audio footage, it should be able to demonstrate the purpose and the legal authority for both. This should include evidence that supports how each component fulfils the purpose for the collection." See https://www.oipc.bc.ca/guidance-documents/1601 at page 2.

[13] See page 1 of Guide to Using Overt Video Surveillance available at https://www.oipc.bc.ca/guidance-documents/2006

[14] See OIPC Public Sector Video Surveillance Guidelines available at https://www.oipc.bc.ca/guidance-documents/1601

remote than the communities that are listed for the purposes of the RSA.[15] It would make sense to avoid prohibiting these types of communities from any future opportunity to access telepharmacy services.

Recommendation: Amend the definition of "rural and remote community" as follows:

"rural and remote community" means

(a) a community that, as of April 1, 2016, has been given an A,B,C, or D. designation under the Rural Practice Subsidiary Agreement between the Government of BC, Doctors of BC and the Medical Services Commission; and

(b) any other community that is not included in the RSA list and that has no primary care providers or community pharmacy.

3. Who May Manage the Telepharmacy

Many sections of this proposed bylaw suggests that only the person who is the manager of the central pharmacy may be the manager of the telepharmacy. These amendments add substantial new compliance obligations for telepharmacies. Depending on the number of telepharmacies owned by the central pharmacy and the size of each telepharmacy, this could increase the workload for the manager of the central pharmacy to an impractical level, reducing the manager's ability to effectively manage each pharmacy.

Given the distance and travel time to the telepharmacies that may be required of the telepharmacy manager, it is possible that the telepharmacy manager may frequently be away from the central pharmacy. Therefore it may not be appropriate to have the same individual also responsible for managing the central site.

It is strongly recommended that the bylaw be amended to allow the owner the discretion to choose whether to have a separate manager for the telepharmacy or to have the manager of the central pharmacy also manage the telepharmacy.

a. Section 3(2)(p.1) makes the central pharmacy manager responsible for labelling in the telepharmacy.

Recommendation: Amend s. 3(1)(p.1) as follows:

ss. 3(1)(p.1) if the pharmacy is a ~~central~~ telepharmacy, ensure the correct and consistent use of each telepharmacy operating name as it appears on the telepharmacy license for all pharmacy identification on in labels, directory

[15] By way of example, Horsefly is over 60 km driving distance from Williams Lake where the nearest pharmacy is located. Seymour Arm, accessible only by boat or forestry service road, is a 66 km drive (over 40km is gravel road) from the nearest pharmacy, in Celista. Neither Horsefly nor Seymour Arm are RSA communities.

listings, signage, packaging advertising, and stationery associated with that telepharmacy;

b. Section 3(3): does not include a telepharmacy. The word "telepharmacy" should be added.

Recommendation: Amend s.3(1) as follows:

ss. 3(3) Subsection 2(p) does not apply to a hospital pharmacy, hospital pharmacy satellite, telepharmacy, or a pharmacy education site;

c. Section 11(1) makes the central pharmacy's manager responsible for ensuring the telepharmacy's compliance with the s. 11 requirements, and should be amended to permit different people to manage the community pharmacy and telepharmacy.

Recommendation: Amend s. 11(1) as follows:

ss. 11(1) In locations where a community pharmacy or telepharmacy does not comprise 100 percent of the total area of the premises, the ~~community pharmacy~~ manager ~~or of the central pharmacy manager in the case of or the telepharmacy,~~ must ensure that,…

d. Section 16.1(5) requires the manager of the central pharmacy or their designate to conduct the inspections and audits.

Recommendation: Amend ss. 16.1(5) as follows:

ss. 16.1(5) The manager ~~of a central pharmacy~~ or a full pharmacist designated by the manager, must…

4. The Telepharmacy License - The 25km requirement

Requiring any new telepharmacy to be at least 25km from the next nearest telepharmacy or community pharmacy makes little sense if the RSA list is meant to establish a clear definition for 'rural and remote community'. This distance appears to be "as the crow flies", rather than by road, fails to account for geography (limited road access, island communities, mountains or lakes which must be driven around, etc.) and in any case seems highly arbitrary. For example, Kootenay Bay/Riondel is 25km as the crow flies across the lake from the pharmacy in Kaslo. But to travel by road, a patient must drive 56km around the lake. Seton Portage is a mountainous 71.6 km drive to Lillooet.

Moreover, twelve of the RSA communities are islands, but no allowance appears to be made by the College for the additional challenges faced by island communities. This is inconsistent with the RSA

criteria, which are all clearly connected to the objectives of attracting health care providers to those communities in order to improve patient access to care.[16]

Most importantly, the 25km requirement simply renders irrelevant the methodology by which a community is designated as an RSA community and will permanently prohibit many of the communities that are currently on the list from eligibility for a telepharmacy. This makes the proposed definition of "rural and remote community" nonsensical and undermines the objective of enhancing collaborative practice.

We strongly recommend that the 25km requirement be deleted.

Recommendation: delete ss. 16(1)(b) as follows:

(b) ~~the proposed telepharmacy located at least 15 kilometers away from any other telepharmacy or community pharmacy~~

5. Telepharmacy Operation

Some of the new requirements will effectively prohibit any new telepharmacy from opening in the neediest rural and remote locations in BC.

a. **Section 16.1(1)** prohibits a telepharmacy from remaining open unless a full pharmacist at the central pharmacy is engaged in direct supervision, and a pharmacy technician is physically present at the telepharmacy site. The issues with internet bandwidth and connectivity were discussed above, but in addition this section appears to require the telepharmacy to have a pharmacy technician present at all times - even if a full pharmacist is present.

Given the extent of the staffing challenges in rural and remote communities, we assume this is an oversight. We recommend changing the words "pharmacy technician" to "registrant".

Recommendation: in ss. 16.1(1)(b) change the words "pharmacy technician" to "registrant" as follows:

ss. 16.1(1)(b) subject to subsection (2), a ~~pharmacy technician~~ registrant is physically present on duty at the telepharmacy;

b. **Section 16.1(3)** is redundant with ss. 11.1. This will create confusion because the language suggests a different standard will be applied. Section 11.1 is being amended to

[16] The system used to define RSA communities applies a sliding scale of points to a community based on many factors, including distance (and this is a minimum of 36km from a GP), but also including isolation and living factors such as community size, degree of latitude and distance from Vancouver. Road distances are used as a proxy for travel time assuming an average speed of 70km/hr. Communities accessible only by ferry are calculated by multiplying the water distance x8 and adding it to the applicable road distance.

clearly apply to a telepharmacy, so we recommend deleting ss. 16.1(3) in its entirety. In the alternative, refer to ss. 11.1

> **Recommendation: Delete ss. 16.1(3) in its entirety and renumber the subsequent subsections;**
>
> **or amend ss. 16.1(3) as follows:**
>
> ss. 16.1(3) A telepharmacy must have a security system that meets the requirements of ss. 11.1 ~~that prevents the public and non-pharmacy staff from accessing the professional services area and the dispensary area, including any area where personal health information is stored.~~

c. Subsection 16.1(5) requires the manager of the central pharmacy or a full pharmacist designated by the manager to inspect and audit the telepharmacy "at least four times per year, at no less than 2 month intervals". We understand it is the College's intention to ensure that inspections are done throughout the year rather than only during the summer. But conducting inspections in the dead of winter is often simply not reasonable. Rural and remote locations are by their nature not readily accessible. Places where the winters are long and difficult are even less accessible. The time required to travel to and from these sites and carry out these inspections is yet another reason why the manager of the central site and the manager of the telepharmacy site should not necessarily be the same person.

This requirement is will result in the creation of systemic barriers to access which don't exist today, contrary to the intent and purpose of the telepharmacy initiative.

> **Recommendation: reduce the minimum to at least 3 times per year to avoid the problem of winter weather or events such as the wildfires from preventing compliance:**
>
> **ss. 16.1(5)(a)** inspect and audit its telepharmacy at least 3 ~~4~~ times each year…

d. Subsection 16.1(7) prohibits a telepharmacy from providing pharmacy services for more than 30 days after its location ceases to be a rural and remote community, or a community pharmacy is established within the community or within 25km of the community.

With the greatest of respect, this provision will simply not support the enhanced access to health care in rural and remote communities that is the objective of the telepharmacy initiative. Automatically forcing closure within 30 days of ceasing to be a rural and remote community when there is clearly a continuing need for pharmacy services in the original community would impose substantial hardship on patients, forcing them to travel greater distances for care. This requirement is particularly harmful to remote communities where access is severely impacted by weather.

Forcing closure for any of the reasons in ss. (a)-(c) would also create unfair hardship for the operator and additional disincentives to the expansion of telepharmacy in the province. In no

other industry is a business required by law to cease operations if a competing business opens up nearby. Given the numerous challenges and substantial costs involved in opening and operating a telepharmacy in a remote location in BC, it is hard to imagine any business person taking on the additional risk that at any time their business could be ordered to shut due to some other person's business decision in some other community, with the full approval of the community pharmacy licensing committee of the College.

Recommendation: **delete ss. 16.1(7) in its entirety.**

~~ss.16.1(7) A telepharmacy must not continue to provide pharmacy services for more than 30 days after~~

~~(a) its location ceases to be a rural and remote community,~~

~~(b) a community pharmacy is established within the community, or~~

~~(c) a community pharmacy is established within 25 kilometers of the location of the telepharmacy.~~

e. **Subsection 16.1(9)** requires a pharmacy to connect to PharmaNet independently of the central pharmacy.

This raises the same issues discussed above about current levels of bandwidth and internet capacity in remote areas of the province. There is little point in imposing a requirement that currently cannot be met. We recommend that this provision be amended to account for these issues of local connectivity.

Recommendation: amend ss. 16.1(9) as follows:

(9) A telepharmacy must connect to PharmaNet independently of the central pharmacy with which it is associated, <u>unless such independent connection is not possible due to availability of internet access in the rural and remote community</u>.

HPA BYLAWS SCH. F. PART 6 TELEPHARMACY STANDARDS OF PRACTICE

1. "Direct, continuous, real-time observation" - Section 4 (4)

Subsection 4(4) requires telepharmacy staff to be under "direct, continuous real-time audio and visual observation and direction of a supervising pharmacist."

As stated elsewhere in these submissions, the requirement for real-time audio and visual observation is impossible to meet in some remote locations. We suggest that this provision be amended to remove the words "real-time" to account for the connectivity issues discussed above.

We are also concerned because this requirement suggests that the supervision be akin to continuous surveillance. We do not believe that the College could have intended that the pharmacy manager

constantly monitor the video screen as if she is a security guard. This would obviously make it impossible for the manager to also carry out any management duties in the central pharmacy, not to mention would be inconsistent with workplace privacy rights and employee dignity. We suggest that in the interests of clarity, the words "direct, continuous" also be removed.

Recommendation: remove the words "direct, continuous real-time" from ss. 4.(4):

ss. 4(4) Subject to subsection (5), telepharmacy staff may only perform the activities described in s. 4(1) of the Pharmacists Regulation while under ~~direct, continuous~~ ~~real-time~~ audio and visual observation and direction of a supervising pharmacist.

2. Prescription Processing - Section 6

Section 6(1) requires prescription processing to occur at the central pharmacy unless a full pharmacist is physically present on duty at the telepharmacy. This seems to contradict ss. 4(5) which permits a pharmacy technician to perform work within their scope without supervision, and especially in light of PPP-55 which allows technicians to process on site. We recommend amending s. 6(1) to add the words "or another registrant is acting within their scope of practice" at the end of the sentence.

Recommendation: amend ss. 6(1) as follows:

ss. 6(1) All prescription processing must occur at the central pharmacy unless a full pharmacist is physically present on duty at the telepharmacy <u>or another registrant at the telepharmacy site is acting within their scope of practice.</u>

3. Patient Counselling - Section 7

Section 7 requires patient counselling to be done "through a real-time audio and visual link." This raises the same bandwidth issues already discussed above. In any case we don't believe this is meant to require the counselling to be done *only* through continuous streaming internet connection because this would mean that unless a full pharmacist is on duty at the telepharmacy, the patient would have to chose between attending the telepharmacy in person and foregoing the pharmacist/patient consultation because it could not be done simply by phone. This is clearly inconsistent with the Community Pharmacy standards of Practice which permit patient counselling to be done by phone and thus is is unfair to the rural patient compared to the urban patient.

We recommend that s. 7 be amended to permit patient counselling to be done by streaming internet where possible, and otherwise in the same manner as is permitted in Part 1 of Schedule F.

Recommendation: amend s. 7 as follows:

s. 7 ~~Unless a full pharmacist is physically present on duty at the telepharmacy, the~~ The supervising pharmacist, <u>or the full pharmacist on duty at the telepharmacy site,</u> must provide full pharmacist/patient consultation by real-time audio and visual link, <u>where possible,</u> and otherwise in accordance with the requirements of Part 1 of Schedule F of the Health Professions Act Bylaws.

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4. Documentation - Section 8

Requiring original patient records to be moved quarterly doesn't make sense and puts the security of the records at risk. Paper records are at very high risk of loss or a privacy breach during a move; more frequent moves necessarily increases the risk. Telepharmacies will have to meet the security requirements of the telepharmacy bylaw, so the security of the records on the telepharmacy site will be maintained. Electronic copies of patient records are maintained at the central pharmacy where they may be accessed by the supervising pharmacist if necessary. If the College believes that mandatory transfer to the central site is nevertheless appropriate, we suggest making this an annual requirement, which will minimize the risk of a privacy breach occurring during transport.

> **Recommendation: delete ss. 8(2) or make it an annual requirement instead of a quarterly requirement.**

FORMS AND SCHEDULES

The forms and schedules should be amended to reflect the recommendations above.

The BCPhA thanks the College for the opportunity to provide these submissions.

A copy of these submissions will be posted on the BCPhA website.

Yours Sincerely,

Geraldine Vance
CEO

Cc:
Hon. Adrian Dix, Minister of Health