HANSARD

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STANDING COMMITTEE

ON

HEALTH

Tuesday, December 10, 2019

LEGISLATIVE CHAMBER

Pharmacists' Role in Health Care and Scope of Practice

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HEALTH COMMITTEE

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[Hugh MacKay replaced Keith Irving]
[Claudia Chender replaced Tammy Martin]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Pharmacy Association of Nova Scotia (PANS)

Allison Bodnar - Chief Executive Officer

Dr. Curtis Chafe - Chair, Board of Directors

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, DECEMBER 10, 2019

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Hon. Gordon Wilson

VICE-CHAIR
Suzanne Lohnes-Croft

SUZANNE LOHNES-CROFT (The Chair): Order. I call this meeting to order. This is the Standing Committee on Health. My name is Suzanne Lohnes-Croft. I am the member for Lunenburg and Acting Chair.

I'd like to note that we have a substitution today. Ms. Chender will substitute for Ms. Martin for the NDP caucus.

Today we will hear from the Pharmacy Association of Nova Scotia regarding the pharmacists' role in health care and the scope of practice.

I'd like to remind people to put their phones on vibrate or turn them off. In case of emergency, please exit through the back door, walk down the hill to Hollis Street, and gather in the courtyard of the Art Gallery of Nova Scotia.

I will ask members to introduce themselves.

[The committee members and witnesses introduced themselves.]

THE CHAIR: Ms. Bodnar.

ALLISON BODNAR: Thank you for the opportunity to appear today to provide information on the role that pharmacists, pharmacy technicians, and pharmacies should play to help address the large and growing burden of health care in Nova Scotia.

Everyone in this room understands that the residents of Nova Scotia are, on average, older and sicker than the rest of Canadians and that the costs of addressing health care needs of our residents under current models of care is unsustainable. With tens of thousands of Nova Scotians without any access to health care, and thousands without timely access, growing rates of chronic disease, and a lack of traditional primary care providers, our system is facing a crisis - a crisis that must be addressed now.

If we're going to be successful in meeting the health care needs of Nova Scotians into the future, we must develop a new model of health care. The structure of our health care system in Nova Scotia and in Canada is over half a century old, and very little has changed in that time. Can you imagine any other sector that's still operating today the way it did 60 years ago? Our provider-focused approach to health care is not working. If we want to reduce the burden of the health care system, then we must put patients first and design a system that not only treats the sick but equally encourages individuals to stay well and keeps those with minor or moderate disease as healthy as possible.

In order to do this, we must utilize all health care providers, technology, and resources available in the most effective and efficient way. While my remarks will be focused on what pharmacy can do, I believe that utilization of all health care providers is critical and that the success of any new collaborative and multi-entry point system is the underlying infrastructure to ensure that patients and their providers have all of the resources at their disposal to ensure effective care and communications.

Pharmacies and their teams have two key strengths that should be capitalized in a new model. Firstly, pharmacists are without exception experts in medication, and their scope of practice has evolved to reflect this. Secondly, pharmacies are accessible to everyone throughout Nova Scotia, often where other providers are not.

Pharmacists are the medication experts. While some may still see the role as pharmacists filling a physician's order by counting the appropriate number of pills and putting a label on a bottle, this can't be further from the truth and the legal and ethical obligations on them. Every time a prescription is filled in Nova Scotia, pharmacists are required to ensure that the medication prescribed is appropriate for the patient, given their history, personal preferences, and other medications prescribed or otherwise. If a pharmacist does not believe the prescription is appropriate, they cannot fill it, regardless of the prescriber's or patient's desire. This role is often misunderstood by patients, prescribers, and policy-makers and is not utilized to the fullest extent in the system.

Let's talk about drug shortages for a moment. While we could discuss this alone for an entire session, I think we can all agree that drug shortages are becoming a larger and larger problem in our health care system. There are currently over 2,000 drugs on the national drug shortages database with approximately five new ones being added daily. This is a major problem for patients, but also for pharmacists and other prescribers. Pharmacists report having to deal with a shortage several times every day. Pharmacists have the legal authority to substitute a drug for another, and they are the most knowledgeable to do so; yet in most cases, there is no compensation to take on this task.

While we can discuss the causes and possible fixes to drug shortages, I think we can agree that it makes little sense to force a patient back to the original prescriber when a pharmacist can most effectively provide the service, and that pharmacists should be compensated for the work and effort expended to help patients navigate the issues and find appropriate solutions.

Pharmacists' medication expertise is also not being fully utilized in areas like opioid stewardship, antimicrobial resistance, and de-prescribing. As the medication experts, and often the last point of contact with the patient before they commence any drug regimen, pharmacists are in a unique position to take on a much larger role in these areas. One role that we have suggested is in acute opioid prescribing.

Pharmacists could be utilized to ensure that first opioid prescriptions are not filled for more than the appropriate length, as determined by best medical practices, and to provide a follow-up pain assessment to determine what additional pain relief, if any, is required. Pharmacists could be utilized to help taper individuals off opioids in a safe and effective manner as well.

Pharmacy can do a lot in this area, but to fully utilize pharmacy as a resource, Health Canada would need to amend the Controlled Drugs and Substances Act to include pharmacists as practitioners, which would allow them to adapt, reduce, or substitute controlled substances. I understand that Health Canada is open to this change if the provinces are interested in utilizing pharmacists in this manner.

Our second advantage is accessibility. With over 300 pharmacies located throughout Nova Scotia open for extended hours, pharmacists are the most accessible health providers in Nova Scotia. Residents in Nova Scotia visit a pharmacy on average 24 times per year. Imagine the opportunities to help patients with their health. Combining accessibility with our medication expertise and scope of practice, pharmacies can and should be utilized as another entry point to the health care system.

Pharmacists have the legal authority to assess and prescribe for a variety of minor conditions, prescribe prescription renewals, provide immunizations, conduct point-of-care lab tests, order lab tests related to the management of medications, and help patients manage chronic conditions such as diabetes and hypertension - two of the most prevalent and costly chronic diseases in Nova Scotia.

With appropriate infrastructure in place, we envision pharmacy as a third tier in the system, managing minor or less urgent issues and managing chronic diseases while having the collaboration and referral mechanisms in place to refer to other providers as necessary.

I'm thrilled to say that yesterday, December 9th, PANS and the government made a first and important step down this road. Yesterday, we signed an agreement that will, starting in 2020, allow Nova Scotia residents, at no charge to them, to obtain the following services at pharmacies throughout Nova Scotia: patients who need to have a prescription renewed will be able to get up to a six-month renewal; women who have uncomplicated urinary tract infections, one of the leading causes of ER visits in Canada, will be able to have them treated by their pharmacist; individuals who suspect they have shingles will be able to have that assessed and medication prescribed by their pharmacist; and women looking for birth control will now be able to get it at their pharmacy.

This is a terrific first step and one we are very proud of. We understand the trust that has been put in the profession and we know that pharmacists will live up to that trust and, in doing so, help to improve access to our health care system and improve health outcomes for Nova Scotians. There is so much more that pharmacy can do, and I would like to focus on just a couple of them: chronic disease and public health immunizations beyond flu.

Canadian research from 2017 on hypertension suggests that Nova Scotia could save up to $490 million over 30 years if it invested in pharmacists to manage hypertension. Hypertension Canada agrees and recommends pharmacists be engaged to do this. Why has pharmacy been successful in hypertension management and other chronic diseases, as well? It's simple: accessibility combined with medication expertise.

Pharmacists have the opportunity to regularly connect with patients and we know that change, particularly lifestyle and health change, requires regular check-ins and support. Pharmacy teams are uniquely positioned to do this. We see this today in our anticoagulation management project, as well. Patients love the convenience of getting their blood tested, reported on, and medications adjusted right there in the pharmacy. We can be successful in keeping these chronic disease patients healthy and out of acute care because we make it easy for them. I think that's an important lesson for all health care design.

The last area I would like to speak to is the underutilization of pharmacy in public health immunization. Pharmacy has been successfully delivering flu immunizations for six years, increasing our delivery from just over 80,000 shots in the first year to 150,000 last season. Pharmacists have the scope of practice to deliver all publicly funded immunizations and numerous other vaccines, as well; yet, as a system, we have not capitalized on pharmacists' scope and pharmacies' accessibility to improve vaccination rates.

Engaging pharmacists to provide immunizations like pneumococcal vaccine for seniors, tetanus, MMR, HPV, and creating an expanded flu program for school-aged children and their families would help get Nova Scotia closer to achieving Canadian immunization targets.

Once again, I thank you for the opportunity to appear before you today as it truly represents a turning point for pharmacy, patients, and the Nova Scotia primary health care system.

THE CHAIR: Thank you, Ms. Bodnar. We will now open up for questions. This is a reminder to wait for me to state your name so that the microphones may be turned on.

We will start with the PC caucus for 20 minutes. Mr. LeBlanc.

COLTON LEBLANC: Thank you very much for your presence here this afternoon. It's great to continue the discussion on health care which obviously affects so many across this province. It's great to hear you call it what it is: we're in a crisis. For the past six years, the government has had time to take action to improve access to primary care. I don't know if I should be delighted or surprised with the timing of this announcement. Nonetheless, I'm optimistic that this is an announcement that will have a positive outcome for patients across this province.

You spoke of having proper infrastructure in place. What type of infrastructure would you envision be in place for the pharmacists to continue to expand their scope?

ALLISON BODNAR: I think principally we need to develop a communications infrastructure and a patient file sharing mechanism. I am well aware of the OPOR and its future plans, but we're a long way off from that in community practice, whether that's physicians or pharmacists.

Right now, we are in the antiquated world of every time a pharmacist does a visit with a patient for a primary care service, we actually have to write out a fax, put it in the fax machine, and fax it to the doctors whose staff scan it into the file. That's how it gets recorded. We need an integrated system. They need to know what we're doing, and we need to know what they're doing. We need to have immediate access to a lab; we need an efficient communication vehicle between the parties.

Right now it is a bit frustrating. We had hoped, I guess maybe years ago, that the drug information system would sort of act as a tool, but because it resides as a separate system outside of an EMR - an electronic record - it requires another step. It requires them to leave their EMR and go to another system, search for whatever they think might be in there and search for the various tabs on the DIS, and then go back into their system. That's inefficient for them. We can't ask them to be constantly looking through that.

[1:15 p.m.]

We need a system where we have a common record. I think there are ways to do that, but the more services we do, the more critical this becomes, because they need to know. If we've treated someone for a urinary tract infection - yes, they are going to get a fax within 24 hours, but if they miss that fax, that creates an incomplete record. So it's really important as we think about OPOR, we think about how providers can better collaborate in communities. I'm not talking about housing them all in a building; I'm talking about how we can have community practitioners collaborate. We need to have a system that enables effective communication and file sharing.

COLTON LEBLANC: I think the announcements that were made are certainly going to benefit those without a family practitioner, those who are inconvenienced by the wait times to see a family practitioner or obligated to go to an emergency room.

You spoke about documentation or a communication vehicle for those with a family doctor, but how would you envision such a model for patients who don't have a family practitioner?

ALLISON BODNAR: I think it's similar. Right now, when a patient doesn't have a family physician, we provide that same documentation. We provide them a physical copy to take with them should they see any practitioner later. Again, inefficient - I'm a patient, I lose my stuff all the time. Relying on patients to remember to bring that and keep that complete is not the right way.

Again, this gets back to One Patient One Record - and I really mean one patient and one record. I don't mean where we all write to our own files and then we selectively choose what comes from our files into our record. We write and it gets recorded into a single record so that all people within the care team - whenever that may happen - get access to a complete record so that they can provide the most effective care.

COLTON LEBLANC: When this program is fully implemented in the new year, what will the experience be like coming into a pharmacy? If I walk into a pharmacy at my local grocery store, how am I going to be greeted? How are things going to be set in place? How has the government supported your association to ensure that pharmacists have the adequate resources and infrastructure to do so? There may be some in the province that do not have enough room for assessment rooms, for example.

ALLISON BODNAR: Pharmacists prescribing has been in place since 2011. The College of Pharmacists since that time has had standards in place for appropriate consultation in assessment rooms. By and large - and there may be a couple of exceptions out there that I'm just not aware of - every pharmacy has at least one consultation room now that meets all of the privacy standards. You can't see through it, soundproof to the ceiling of the building, regardless of height. They've actually just instituted additional

requirements for the purposes of more types of assessments so ensuring that we have all of the tools at hand in the assessment room.

What I can tell you is that many pharmacies that are looking down this path are looking to a second assessment room already; we have a number of pharmacies that have already constructed this. I envision that as we move through this process and the volumes increase, there will be absolute demand and necessity to have additional assessment rooms.

I think we're at the early stages, and I think that's why starting with a few and having it grow is the right approach to this. I think if you went and just said, here's your scope of practice, we're going to fund you to do everything tomorrow, I think you would find that, oh, we need three or four assessment rooms, nobody has them, how do we build up to that quickly?

What we're doing here is a stepped approach. Let's start, we'll build, and we're going to get feedback from patients on what they want the experience to be. Do they want it to look different? We're going to be doing some focus groups, ensuring that patients are comfortable so that they want to get these services where they want them.

We don't just want patients who don't have a doctor and don't have timely access. In my opening remarks I alluded to creating more access and entry points to the system; if we encourage, as a system, as a government, patients with these types of conditions to go to their pharmacies, then there are spots available for the family physicians to take more urgent needs. That's what we really want to do: to move the less urgent and complicated to other providers, whether those be nurse practitioners, nurses, pharmacists, paramedics - we all have a role to play - and then we allow the family physicians to take on the patients who really need to see them.

COLTON LEBLANC: What I'm concerned about is, like you said, you don't want everybody to go to the pharmacy. I'm concerned that there might be an influx of people going there and then there might be some barriers and people being turned away. I'm hoping that it won't happen.

The money figure that was announced yesterday - the $9 million, which is roughly $1.8 million per year - were you consulted in any way to come up with that figure; if so, or if not, what's expected from your association if the funds are used up within the first six or nine months?

ALLISON BODNAR: Let's be clear, that was just an estimate based on what I'll call our best guesses of utilization based on other provinces and other services and how they have ramped up over the years. We have the flu shot here, as an example - I mentioned we started at 80,000 and we did 150,000 - so that was a nice incremental growth year over year and so we have that. In other provinces where they do renewals or they do UTIs or contraception, we do have some data on growth, so those are best guesses on utilization over the course of the five-year agreement.

So, yes, this has been a negotiation that's been in play now for quite some time. Our contract actually expired almost three months ago and so we've been working since the Fall of 2018 on coming up with a model that we could all live with. In addition to new services, there were some cuts on some other sides of things, so this was a give and take, but the real goal here was to take that first step into primary care and see where that leads us.

COLTON LEBLANC: With an expanding scope of practice comes training and continued learning. Is it the college that oversees the continued learning aspect or the new training of the scope, or is it the association?

ALLISON BODNAR: When the College of Pharmacists, who's the regulator, implement an expanded scope of practice, they do so based upon what pharmacists are already being trained to do and what are already being educated to do. They don't add a new scope of practice that our pharmacists have not been trained for. Pharmacists in pharmacy school have been getting contraception and UTI education as part of the curriculum for 10-plus years.

Those are ready to go, so there is no mandatory education. There is no certification required. What we have is the general practice standard in this province which says: pharmacists, you must keep up to date and current with everything you do, and if you are not able to practise at that level, then you must take whatever courses or training - do whatever you need to do - to make yourself capable or don't practise in that area. That's a standard that is put on pharmacists for their entire scope of practice, whether that be dispensing in certain disease states or whether it's chronic disease management or giving an injection; they have this obligation on them.

Again, there are no set standards. Some other provinces have done that - you cannot prescribe birth control unless you take courses A, B, and C. Our college takes a different approach. It takes a professional judgment approach that says you're a professional, you have to make those decisions. We have created programs for all of this and said to those either (a) you graduated before it was part of the curriculum or (b) it was part of your curriculum 20 years ago, and because it wasn't your scope, you haven't done it, so you need some refreshing. Yes, we have programs available, and pharmacists are signing up to take those.

COLTON LEBLANC: I found a table that compares the scopes of practice of pharmacists across our country. It seems that Alberta has green checkmarks along the way. I guess mostly what I've noticed here is it had to do with Schedule 1 drugs in Nova Scotia. What would you like to see within the scope of practice to continue to grow in Nova Scotia, and what barriers exist for that to happen?

ALLISON BODNAR: One of the key barriers right now - as I mentioned to you, there are a couple of things. Our scope of practice for dispensing alone requires us to ensure that it is the right medication for that person at this time given everything. That includes labs. If this patient is due for a blood test to monitor their condition and they don't have it and they show up to either have a prescription dispensed or, let's say, they're out of their prescription and they need it renewed, we need a lab test.

We have the legal authority in this province to order them. We do not have the operational authority. It hasn't been operationalized, so pharmacists can't actually order any lab tests so that causes a delay. It causes us to send the patient back to their physician or to track down the physician and ask them to put an order in place for it.

Again, it's an inefficiency that's becoming more and more critical to the work we do every day in dispensing, but it will be very important for renewals. It's incredibly important for chronic disease management, because those are the patients that you really need regular check-ins to make sure that what you're doing is working.

I would say the inability to order labs is one of the key issues. The other is the whole documentation and information sharing and making sure other providers have the information at hand when and where they want it.

I'll give you an example from labs. We can do point-of-care test labs. Our INR project, as an example - great project. Patients love it, it's efficient, but we send those lab tests by fax to the physician and so they rest in their fax file for that patient. All other lab tests they receive come through the portal and are in their lab list. Our point-of-care tests don't end up in their lab lists, so they really don't know on a quick glance that we've done a test. If we've been working with them, they might remember this patient is in that program so they're going to go look in their fax file and check the results there.

Again, it's an inefficient process for sharing information. I think if we're truly going to create a collaborative model, we have to find better means of sharing information between providers.

COLTON LEBLANC: A study or survey said that 98.6 per cent of the respondents have at least one of the five major risk factors that can lead to chronic disease in Canada, which goes hand in hand with managing chronic conditions and preventive health care. I think that's part of the evolving model of health care in our province: putting more emphasis on prevention and how we can slow down the overflow of diseases and illnesses in our system.

Can you speak a little bit on the roles of pharmacists? I know you spoke about it a little bit, but in the roles of managing chronic conditions and the screening and managing of those?

ALLISON BODNAR: There's some great research and I'm happy to leave copies that you can distribute, or you can go onto our We Need Pharmacy page on our website - all this research is there as well.

There has been very good research done in Canada around chronic disease management by pharmacists. I'll point to the benefits of pharmacist care in hypertension specifically. The study that was done was out of Alberta. It was a controlled study and then it was evaluated by researchers out of Memorial University in Newfoundland to actually work out the economic impact of that.

They did that and they came to the conclusions - and this is for Nova Scotia alone - that if pharmacists were able to practise to their full scope, they could save $490 million over 30 years. More importantly, they could significantly reduce adverse cardiovascular events like stroke, angina, heart failure - reducing these incidents in the 17,000s. Under usual care, they would estimate in that time period there would be 45,000 cases. Under full-scope care by pharmacists, there would be 28,000. That's a huge reduction. Also, kidney failure events and in saved-life years - almost 30,000 saved-life years in that 30-year period.

[1:30 p.m.]

This is huge, and this is why Hypertension Canada says we should have pharmacists do this. Again, it's because you're combining accessibility - patients are in pharmacies up to 24 times a year - and the medication management. That's the key here to success, and you can see that in hypertension. We see it play out in diabetes.

We did a pilot program last year that was called the Collaborative Care Demonstration Project in which pharmacists and physicians worked together to identify patients who would benefit. These were multiple co-morbidity patients that had to have at least two chronic diseases or a single chronic disease with multiple contributing factors like obesity, smoking, or documented non-adherence to their medications. They worked together to identify this.

Pharmacists worked with the patient to identify a care plan and then they executed that plan over the following 12 months. We saw statistically significant improvements in all of the clinical areas including reduction in smoking, weight loss and lifestyle goals, and better eating. On the clinical side, improvements in all of the clinical outcomes as well.

Again, it's about patients' convenience. It's about the trust they have in pharmacists. Every year, pharmacists rank as one of the top trusted professions in Canada year over year. We're in a unique position, and I think we need to capitalize on that role of being that health coach, for lack of a better word, with the expertise of medication to really help patients achieve their goals.

COLTON LEBLANC: Thank you very much for your time this afternoon, and I agree wholeheartedly that this is about patients. I am thankful that patients in Nova Scotia, whether they have a family doctor, or they don't, are going to have increased access to care. Hopefully it will be in the right direction, especially when it comes to managing chronic conditions.

This expanding scope, or availability to do more in their practice, for pharmacists, is this going to create an opportunity to have more pharmacists' jobs in Nova Scotia?

ALLISON BODNAR: We hope so. Up to yesterday, this has been a period of nine consecutive years with cuts to pharmacy. Not just little cuts; really significant financial cuts to pharmacy.

THE CHAIR: Order. Time has lapsed for the PC caucus. We'll turn it over to the NDP caucus for 20 minutes. Ms. Leblanc.

SUSAN LEBLANC: I'm going to get to those cuts in just a second, but I wanted to know in terms of the announcement that was made yesterday, can you clarify what the province used to fund pharmacists to do before and what is being funded now?

If you could talk a little bit about what else you were looking for in the negotiations, and it would be great if you could talk about what you just mentioned a few minutes ago about the give and take and that there were cuts made. If you could sort of expand on all of what went into the announcement yesterday.

ALLISON BODNAR: It's a long process, and as with any negotiation, there's give and take. To give you a picture of where we were, so prior to yesterday, with the exception of flu shots and Naloxone training which are province-wide, anything else pharmacy was funded to do was for Pharmacare beneficiaries only - the 200,000 people in this province, either Seniors' or Family Pharmacare. We weren't able to provide services to anyone else.

Yesterday's announcement included a whole separate agreement, so we continue to have an agreement just for Pharmacare services, but we now have a separate agreement where any services that are province-wide will now reside. They're not to Pharmacare; they are to the health system in general. That's a great step. It's something that we've actually wanted for 10 years. We've been wanting a separate agreement outside of Pharmacare since I've been at the association for 10 years. For us, this is kind of a massive first step in actually integrating into primary care and not just being viewed as the distributors for medication.

That being said, as the distributors for medication, our funding model, with the exception of services, is predicated on the price of drugs. We receive a fixed dispensing fee, but we have a markup, which is a function of the drug price. Since 2011, drug prices, to the benefit of everyone in this country, have been reduced, and they've been reduced significantly. They've been reduced from about on average - if you compared a brand drug to a generic drug in 2011 when we started this, they were probably 57 cents on the dollar for generic. They're now down in the low 20 cents. We have some as low as 15 cents. The most common are at 15 cents or 18 cents, and then they go up to 25 cents. New entries are significantly higher until there are three manufacturers.

Because of that funding model, and that model has been in place for decades, when the price drops, so has the compensation to pharmacy, and for nine consecutive years - and that's outside of our contract, the price of drugs. It has nothing to do with our contract. It just happens to be that our markup is a percentage of the MLP. As that has been reducing year after year, at first independently by governments putting legislation in place and then when the pan-Canadian Pricing Alliance came into effect about five years ago, they started negotiating directly with generic manufacturers. They now have an agreement in place for the pricing of not just generic drugs, but other molecules as well.

That has been a huge hit to pharmacies. I'm sure all of you have heard from pharmacy owners and pharmacists about cuts to services, cuts to hours, cuts to jobs. That has been a steady model over the last few years. Now that we have this type of investment into pharmacist services, it is my hope and my expectation that we're at the bottom and we're on our way back up. Now we'll start investing in more hours, more overlap of pharmacists, more availability to do this because there are a lot of pharmacists around to do it. We have the manpower to do it, and they're looking to get more hours. They're looking to do more.

I think this new model is that first step in some stable funding. I think you all are as aware as I am that patients don't want to pay out of pocket. Although we've had most of this scope since 2011, it's really hard to base a business model on getting patients to pay for health care. That has been a real challenge over the last nine years.

THE CHAIR: Ms. Leblanc, did all your questions get answered?

SUSAN LEBLANC: Sort of. The one thing that I didn't hear was, did you get everything that you were looking for in this round of negotiations; what is still on the table for the next round? What would you be going after?

ALLISON BODNAR: Of course, we didn't get everything. We submitted a proposal where I think we took a very open approach. We took our whole scope of practice and said, this is why this service would be of value to you. Chronic disease management - this would be of service to you and we would like to do this - opioid management, all minor ailments, all that type of stuff.

We laid out our scope and we said, what is of most value; what can we work on together and what's a good first step? This is where we landed. We landed here with good reason. UTIs are the fifth most common reason for an ER visit. We have documentation that there are access issues to contraception. Young women in particular cannot access contraception in the way they want. Shingles is a time issue. If you have shingles, you need to start on medication very quickly. So there are very strategic reasons why we settled on these ones as a starting point.

Where do I want to go and what's still on the table? We have chronic disease management. We have a pilot program that's in its final stages of evaluation on the anticoagulation. We absolutely want that expanded. We have a pilot that's in smoking cessation right now and are hopeful that the results will be what we think they will be; we want that funded. We would like to see us fully integrated as another access point into health care, and we're working towards that.

SUSAN LEBLANC: When you were talking about the lab test issue, the fax file and the electronic file, that's quite unbelievable. The number one thing that was announced yesterday, that patients who need to have a prescription renewed will be able to get up to a six-month renewal. Does the lab test issue that you were just talking about - sometimes people want a renewal and they need to get blood work done first - is that going to affect that ability in particular?

ALLISON BODNAR: It will, absolutely, but there are a couple things in place. One is they may have had it and we simply don't have the records. We do have access to SHARE, the health portal where lab results reside if they've been ordered and if blood was taken by the public phlebotomist. If it was done in a private facility those results do not reside in SHARE, so it's not a complete record of their lab results. So, number one, we can access SHARE.

Number two, if they have a physician, you can make that call. Yes, if in fact you get to the point where you haven't had your tests done and you're six months overdue, then it's going to be an issue because we can't order the lab tests. What we can do is say we're not comfortable giving you a six-month supply, but we will do a renewal for 30 days and in that 30 days, you must find a walk-in and get the lab tests and then we can do it. Yes, it's an unnecessary hurdle to their care.

SUSAN LEBLANC: I just want to ask a little bit about point-of-care testing. We know that new medical technologies are giving us a number of point-of-care tests for a variety of ailments, for a litany of different issues from syphilis to malaria to cardiac issues to HIV.

You did mention point-of-care tests for one thing, but I'm wondering if there's any interest in the pharmacy community providing more of that kind of testing. Are pharmacists trained to administer those sorts of tests and, if not, is that part of the training that is available?

ALLISON BODNAR: Point-of-care testing technology has made leaps and bounds from where it was previously. I mentioned our anticoagulation management project; that is a point-of-care test. It is, in fact, the same point-of-care test they use on the floor in the hospital and it has very good results. Again, from a convenience perspective, reducing the burden on the lab system, reducing wait times in lab, point-of-care testing is something that we need to seriously consider.

As part of our agreements with government, we have a $2 million project fund. It has been in our agreement in the past and it continues in this agreement. One of the things we're talking about for the next one is a diabetes management program; in that, we're recommending the utilization of point-of-care testing to make it easier for patients to manage their health.

There's a lot of things that we could do in the pharmacy with point-of-care tests: A1C, lipid panels, things like that right in the pharmacy. There would be some that would have to be ordered in a lab, and if we had our lab ordering authority, we could make it a complete and seamless package.

In point-of-care technology, HIV is a great one. I've had some contact with Capital Health and NSHA about potentially rolling HIV testing out in a pharmacy, as well. That hasn't continued in the past few months, but I'm hopeful. Pharmacy is the place to do this type of stuff. It's private. It's inconspicuous. When you go into these, no one knows what you're going into the pharmacy for, so it's a great place to do that kind of testing whether it's the STI test or HIV. There are all sorts of opportunities to utilize the point-of-care systems.

Point-of-care testing is relatively simple in the sense of the activity of testing. Anything we do in pharmacy is a lancet, so it's a finger probe. We don't do a blood draw from a venous blood draw, so it's a lancet which is something that patients do themselves. It's not a tricky technique, and once you understand the test, then it's a question of understanding how to read the results. We do provide training when we introduce a new point of care. We also maintain a procedures manual at PANS that we provide to pharmacies in different point-of-care devices that we envision they might want to use. I do see point-of-care testing as a huge part of our system in general moving forward.

SUSAN LEBLANC: What kind of funding commitment from the province would be required to provide, for instance, a rapid point-of-care test for HIV?

ALLISON BODNAR: You would have to cover two things. One is the cost of the test, and point-of-care testing is more expensive per test than lab testing, but it's not often much more than you think. It really isn't, but absolutely it is more expensive than if you go make someone wait and get a blood draw, just because of the volumes and the machines that they're using in the public labs.

There's that cost and then you would have to compensate pharmacy for just the administration of the test plus whatever disease management process that you're doing. That would vary by the test and by the disease state, so it would be something you'd have to work out each time.

[1:45 p.m.]

SUSAN LEBLANC: Another interesting point-of-care testing is around Lyme disease and I understand that that research isn't totally finished, but we know that the faster an infection from a tick bite gets addressed, the better your outcomes for not getting Lyme disease or chronic Lyme disease. It's still in development, but would it be possible for pharmacists, in the meantime, to prescribe antibiotics for tick bites in the same way that they're now allowed to prescribe antibiotics for a UTI or another simple specific type of infection?

ALLISON BODNAR: At the moment, that is not within the scope of practice. We have had lots of discussions about it with our regulator who is open to the idea, but there's still a lot of controversy right now over Lyme disease, whether or not it is Lyme disease or whether we're overtreating.

I had a call just in the last day or two from somebody saying something like 20 per cent of visits now to an ER - this is a resident telling me this - are now related to Lyme disease. I don't know if that's true or not true. It's certainly more prevalent than it ever has been, but there's still some hesitancy by some groups within the medical community as to what should be done for the majority of patients.

I think once there is less debate and a clearer process that we certainly would be able to add that into the scope of practice, and it's something that pharmacists would be able to handle very easily.

THE CHAIR: Dr. Chafe, did you have something you wanted to add to that?

DR. CURTIS CHAFE: No, thank you.

SUSAN LEBLANC: I just want to change course again. I have a few general questions about the state of drug compliance in Nova Scotia. You did mention it a little bit in your comments, but we know that many people aren't able to comply with the correct course of their medication because of the cost. It's not just people who are living in real poverty who are facing this. There's lots of people that we've spoken to who have private insurance but that insurance maxes out and then they're left to have to pay for their insulin and test strips out of their own pocket, for instance, and they're spending thousands of dollars a year to do that.

We know that people do things like ration their medication when money is tight. I have a number of constituents who have come into my office who've told me they do this. I'm wondering if you can tell the committee, from a clinical perspective, what happens when a person is only able to take their medication, for instance, every other day, or what happens when they cut their dose in half or if they don't test their blood sugar as much as they're supposed to?

ALLISON BODNAR: If you don't mind, I'm going to let Dr. Chafe answer the clinical response to that.

CURTIS CHAFE: Honestly, it's what you would think. If somebody's not on an appropriate dose, then whichever condition that treatment is supposed to be treating is going to be substandard.

In the case of a diabetic, if they're halving their insulin or they're cutting it back, sometimes they may not be within that 4 to 7 and they think maybe it's okay to run in the 9 to 10s; they don't feel so bad and the insulin lasts a little longer. Same thing with blood pressure medications. Some people are very good at monitoring their own blood pressure. It's one of those silent conditions, you don't know until you measure and if they run a little high, then they think it's not so bad.

The unfortunate thing, though, is that when things don't go within established treatment protocols and we follow guidelines, what you're going to end up having - in diabetics in particular - are more heart attacks, more strokes, more infections and amputations, more retinopathy and blindness, and all those associated conditions because they're not controlled under their condition.

Same thing for people with cardiac disease. If they're not taking enough cardiac pills or they're letting their blood pressure run high or they're not taking control of their cholesterol, those are all risk factors. It's not the blood pressure that gets you, it's the heart attacks and the strokes. What you end up seeing is that those people are not going to live as long and they're actually going to have a lot more morbidity because they are going to have those hard outcomes a lot sooner.

SUSAN LEBLANC: Given that, can you talk a little bit about the cost to the health care system for people who are in non-compliance of their drug protocols? I'm talking about financial costs, but I'm also talking about human cost, suffering.

ALLISON BODNAR: We don't have specific costing data. We know that as part of the national Pharmacare debate, there have been some estimates around those numbers. I can provide you some of the Pharmacare documentation if you haven't seen it, but it is a significant cost, and it's one of the drivers as to why groups are looking to a national Pharmacare program - because of what we like to call our catastrophic drug coverage.

The very definition of catastrophic is very different across the country, and how it's implemented is very different across the country. While one province might say we think it's acceptable to have to spend 5 per cent of your income to manage your condition, other provinces might say they think it's acceptable to only spend 1 per cent or 2 per cent. That's part of this debate: what should people be expected to contribute to their health care, if any, and how do we ensure a level of equality of health care across the country?

That's the debate. It's not about whether we should have access to drugs for all people in the country. It's about how you implement that in a fair way, recognizing that some provinces already have very strong systems. As an example, Quebec has a Pharmacare system. They have over 5,000 DINs on their formulary, compared to about 3,500 in this province. They have a very strong system. They have no interest in going backwards. Are we going to bring our entire national system up to that level? What is it? Are we going to have an essential medicines list? How we get to national Pharmacare is the real crux.

People recognize that it's not just the people who have no insurance coverage that we're talking about here. There is a whole group of people who have very limited insurance coverage or they have coverage that they can't afford because that percentage - 3 per cent, 4 per cent, 5 per cent, or whatever it is - is too much for them because of their circumstances, so they start rationing and trying to make things last longer for them.

This debate on national Pharmacare is huge, and one that I think we need to pay attention to as a province on where we stand on that and how we think it should be implemented. Do we scrap the entire provincial programs and go with a national one, or do we fill in the gaps? Do we find a better way to provide catastrophic coverage? That's a debate that's worth having into the future.

SUSAN LEBLANC: Does the Pharmacy Association of Nova Scotia have a position on that?

THE CHAIR: Order. Time has elapsed for the NDP. We'll move to the Liberal caucus for 20 minutes. Ms. DiCostanzo.

RAFAH DICOSTANZO: I am so excited and proud, truly, of our government for the announcement yesterday. I have been waiting for it for at least a year and a half, hoping. I knew there were negotiations, but what the negotiations were leading to, I wasn't sure. When I saw four different items, I was truly excited. It is a combination solution for so many things that our system needs to do. Everything is concentrated on the family doctor. As you said in your speech at the beginning, we have to expand the scopes of all our health care.

The pharmacists are well trained for so many different things that are not being used. This is a real example of what we are allowing the pharmacists who have been trained to do. My daughter is a pharmacist, and she says, Mom, it breaks my heart, the number of patients who I have to say no to. I say to them, this has a cost, and they leave the pharmacy. I know I can help them, and I don't know how long before they can get to see their doctor. A lot of the pharmacists I know will be so excited to be able to help those patients who are showing up at their door. I'm more than excited for you and for our government for taking this amazing step.

I just wanted to ask something about the access to birth control. To me that was something amazing. Maybe you can tell me in numbers what that would mean. How will that help the youth or the younger girls to come to a pharmacist? Would that be much easier for them than to go to their family doctor? How do we track access to giving birth control within pharmacies compared to doctors? How do we track the number of visits to the doctor that we will be saving? How do you plan to do that?

ALLISON BODNAR: As I mentioned earlier, we have built right into our agreement an evaluation of these new services so that we can do just that - so we can track who is using pharmacy for these services, what the profile looks like, and how it compares to physicians.

Also looking at - and this is important as a government and I think we need to think about this - are these patients double-dipping? Are they going to a pharmacist and then just waiting until they get that doctor's appointment and then going in and double-checking with the physician? So we have a bit of history. We did a minor ailments project a few years ago and maybe it was really early in the awareness level, but we did find that although the majority of patients did not do this, there was still a sizeable group that within 7 to 14 days were visiting their family physician again. What we don't know is why. That evaluation did not ask why they were there. They could have legitimately been there for something completely different. That's the limitation of the research that we had at the time.

We are going to look at that because it's important that the messaging come from government that this is what we want patients to do - that this is not a substandard, only go if you can't possibly get somewhere else, because patients will heed that. They will go, okay, I'll just go if I have to. If we really want to change the system and we really want to move less difficult, less complex things to other providers, then we need to encourage patients to do that. We need to promote these services from government to say, this is the right thing for you to do; we did this because we want you to utilize the service. Otherwise, we risk creating a perception that this isn't as good as something else. I think this is something that we're concerned about and something we want to work with government on in terms of communication - simple things.

As an example, in New Brunswick in their emergency rooms they have a sign up in the older emergency rooms that says, "Are you here for a UTI? Don't wait for five hours - go to your pharmacy." That type of communication from the system tells the patient that this is the right thing to do and we want you to do it. I think we have to work collaboratively on communicating to patients that this is a shift in health care so that you all do have access to a family physician when you need the family physician and you have access to other providers all the time for everything else. I think that's a change in the messaging and something we need to work on collaboratively to spread that message.

RAFAH DICOSTANZO: That's a really good point. I didn't know that patients were double-dipping, but I can see why because they would think, I'll just check to make sure that the pharmacist knows as much as a doctor, because they're just not used to it. Just as with vaccines now, people just go to a pharmacist. They've become accustomed. Why do we need to wait an hour to meet your doctor to get your vaccine? It's much easier, so I'm hoping that we will.

We as MLAs are very excited to put up posts and tell people so that they can go to their pharmacist. It just makes sense. There are 1,300 pharmacists and 300 pharmacies that are open - at night, you can go anytime. The access point is going to be so much better for the public. I can't see it but helping.

The other question that I really wanted to ask about is the impact of this agreement for the next five years and how you compare it to other provinces. Where will it put Nova Scotia on the map in comparison to other provinces with this amount of spending that we've done? After five years, will we be one of the best provinces in utilizing our pharmacist scope of practice? How do you see it?

ALLISON BODNAR: I think in terms of services, this certainly moves us from one of the least funded services to one of the better - I wouldn't say the best, there are still others that fund more services, but it certainly moves us well up there in terms of services. To me, it's a very exciting opportunity - even compared to Alberta, which some would argue has the broadest scope. That's a two-tiered system so in order for pharmacists to be able to utilize that expanded scope, you have to complete a certification. You become a different level of pharmacist.

[2:00 p.m.]

It's not more training. It's just an application process that you've worked in this disease state for a long time. You have other clinicians that can vouch for that. It's a different process, so I don't compare us to Alberta very often, even though everybody will say to me, they've got all those green checkmarks. Yes, they certainly do, but those green checkmarks relate to those who are prescribing pharmacists and not those who haven't done that.

We have a very different model that's developed in Nova Scotia. I think the regulator here has done a really great job. It truly encourages collaboration with other providers, as much as they might not like our faxes. They will always tell you they'd rather the fax than nothing. It encourages communication. It encourages a collaborative approach to patient care.

I think this model, this agreement, starts us down that path, and hopefully other provinces that are now behind us will take notice and start to move down that road. I know my colleague in New Brunswick was in the media yesterday wishing that his government would take a similar approach to what we've done here. It certainly leapfrogs us from where we were, and I think more importantly, it opens the door to fully integrating pharmacists into primary care, which we can't do overnight. I hope the next round of agreements takes us to that next step into full integration.

RAFAH DICOSTANZO: I was very excited to hear about the UTI and the infections because we just had an incident with my father; he ended up at emergency in an ambulance and we didn't even know. We just thought he had a stroke. We were so afraid, and it turned out to be a UTI - and the cost of this. He was waiting to see his doctor, and nobody knew that this had progressed so much.

The cost to the system, the family and everybody, and it had gotten so much worse. If he had the access at the pharmacy, I wonder how different that would have been. Can you give us some idea on the savings just for UTIs that you're hoping to see per year?

ALLISON BODNAR: A couple of things - I just want to make sure we're very clear on these scope-free UTIs. I don't want there to be any misconceptions. Scope-free UTIs is uncomplicated urinary tract infections. By definition, that excludes males. If it is a male, by definition it is a complicated urinary tract infection and it, in fact, cannot be treated in pharmacy - at this time. Let's be clear. This is the first step into this and so things may change, just like our scope in 2011 was much more restrictive and very prescriptive, so changes have happened. I think in years time we may see changes here, but for now, that's where that is.

But if we come back to uncomplicated UTIs and the burden on the health care system - the thing about UTIs is that women know when they have them and they know they need to have them treated quickly. By and large they end up at an emergency room. We know that it is the fifth most common - about 8 per cent. I had a physician tell me yesterday that when he is on call in his community, 10 per cent of the visits he gets on call are UTIs.

What we're talking about here is taking people out of emergency rooms and the cost of an emergency room visit or into walk-in and after-hours care costs. We're talking reducing the fee from well over hundreds of dollars per visit down to a pharmacist fee of $20 for the visit. The savings are huge. When we know, given the volume of patients who are visiting ERs and the potential here, this is a huge cost savings as well.

RAFAH DICOSTANZO: When it comes to the female UTI, I know to go to my doctor, they have a bathroom and they give you the bottle, how are you going to provide that at the pharmacy? How is that being set up?

ALLISON BODNAR: I'm going to let Curtis give you the clinical flow of how this will happen in his pharmacy.

CURTIS CHAFE: When you look at the Health Authority guidelines for diagnosing an uncomplicated urinary tract infection, catching the urine is not necessarily required because it can put in a false negative for just asymptomatic bacteria. We have bacteria in our urine, our urine's not sterile, so you can get a lot of false positives for that. While that was something in the past, that's not something that you would look at right now.

The other thing, too, I do have patients who look for urinary dipsticks; you pee in a little cup and they stick the stick in, and depending on what colour it is, it will show bacteria or not or certain things that are associated with bacteria. They have a lot of false positives with them. Interview and assessment through the patient without any kind of sample taking is what is the gold standard at this point, and it's been run successfully in New Brunswick at pharmacies for the past three years.

When a patient will present to my pharmacy and through talking, it seems they might have a urinary tract infection: come into the room and let's discuss this a little further. In order to have a very good stance or to be confident that what they have is an uncomplicated urinary tract infection doesn't necessarily need anybody to provide a sample anymore. It's actually that good.

RAFAH DICOSTANZO: Thank you. I did not know that you can do that. That's great, but the symptoms are there and very obvious. I guess there's no other diseases that have similar symptoms that we can confuse them with - anyway, it's unusual. We've been using this method for the last 30 or 40 years that I know of. I'm surprised to see that but lovely to understand that.

The other question I had here was about the prescription renewal. To me that is an amazing thing because there's so many of us on medication for 10 years and for us to have to go to the doctor every month or two months - now, if you're on a medication for a long time, is it every six months you need to see your doctor? Is that how it's going to be? If you could elaborate on that as well.

ALLISON BODNAR: The pharmacist has the ability to renew for up to six months. They can do that in shorter periods. They can do a month, plus another, then plus another, but after six months they will have to have another prescription.

We're not replacing visits to family physicians. It's still important that people get to a physician on a periodic basis. What we're saying is they don't maybe have to go as often, and more particularly, for those who can't get there, there is another option for six months. Other provinces allow for up to 12 months. We were at 90 days until last February when our standards were amended to 180 days. Maybe if this is very successful, we'll see another change in a few years.

Again, that's going to depend on how this is run and rolled out and the demand for longer periods of time. That goes hand in hand with lab tests, and being comfortable in writing a prescription for that length of time requires you to have all of that information on hand.

RAFAH DICOSTANZO: I think I'm done with my questions, if my colleague would like to take it.

THE CHAIR: Mr. Jessome.

BEN JESSOME: Madam Chair, how much time do I have?

THE CHAIR: You have about four minutes.

BEN JESSOME: I'll start off with a couple of quicker ones, I guess. To clarify, when we were talking about communicating, that the first line of defence can be, or should be, entry to see a pharmacist, you referenced a couple of different things that people go into the emergency for and you say that they can just go there. Is that something that the triage nurse can communicate, or is there an issue that I'm not clear on that would prevent that triage nurse from indicating that this is an option for that patient?

ALLISON BODNAR: I can't speak specifically to the triage process in the ER, but certainly it could be built into that. I can speak to 811 for a second. We think it's critically important that pharmacies be added to the protocols for these areas when people are calling and looking for an option. With 811, it's a process. These protocols take time. It's a committee that developed them: physicians, nurses, and pharmacists. That's a process that we hope we can get started really soon, that the government will help us move that forward. Again, if we want people to use them and you want them to feel that it's not substandard care, then it needs to be part of those processes where people are triaged and then sent to the appropriate place.

Certainly with 811, we are aware of how those protocols need to be changed. I'm not aware of how the triage protocol works in an ER. Certainly once we are aware of that, I would think for the same reason that we know how to do 811, we could be able to change that process as well.

BEN JESSOME: Further along those lines, communicating entry points to the health care system and people who have experienced the health care system in such a fashion, and I think of senior citizens who are in the habit of - I shouldn't say senior citizens. I should say anybody who has made a habit of injecting themselves into the health care system, seeing their GP as their first point of contact. Do you perceive or anticipate any complications in trying to get patients to come in a different way than they may have traditionally done so?

ALLISON BODNAR: I think that particular group is likely the most challenging group to change behaviour. I don't care if it's behaviour in the health care system or otherwise; as we get older, we get more set in our ways. The system has worked this way for their entire lives, and now we want them to do something different. That's going to have to come with direction from government, from physicians, from all of us that this is the way it should be done.

With contraception and UTIs, you're looking at a very different population, obviously, a population that we know values services coming to them quickly and efficiently: I don't want to spend any time waiting in an office or an ER, I just want it now. These services are going to be, I would think, very popular to young women in particular for UTIs and birth control. They're going to be able to do this very quickly, on their time, when it's convenient for them. I think we will see very little difficulty communicating to that group of patients. With the older patients, where maybe herpes zoster or renewals in some cases . . .

THE CHAIR: Order, the time has elapsed. We will move over to the PC caucus - Ms. Adams, 11 minutes.

BARBARA ADAMS: I was reading a study that we were sent in preparation for today, a report from PANS that states "Access to Healthcare Concerns are Rising in Nova Scotia," and it said: "A new Study by Abacus Data has found that Nova Scotians' concerns about access to healthcare in the province has increased 16 points since 2018. Of Nova Scotians surveyed, 86 percent expressed concerns about being able to access healthcare. One-third of those surveyed said they were extremely concerned." It went on to say that in a national study, they found that "Nova Scotians were more concerned than the National Average (by eight percent) . . ."

I think that's a really important statistic because you said to us that this was a first step. To me, it's a very small step. What you said earlier was that there have been almost 10 years of cuts to pharmacy, and now we're getting $1.8 million to make up for the fact that you were underfunded for nearly 10 years. It's a similar thing that happened to long-term care. They cut funding two years straight, then they've given a small amount of money based on the long-term care report. We also had cuts to other departments and then they give a little bit of money back.

My question for you is: $1.8 million per year is not a lot of money when you consider how many pharmacists you're talking about and how many potential patients are going to a pharmacist. Do you have a number that you're allowed to bill for that visit and how much is it? I know that pharmacies were charging somewhere between $15 and $22 when the patient was paying out of pocket. How much are you going to be funded by the Department of Health and Wellness to do this?

[2:15 p.m.]

ALLISON BODNAR: It depends on which of the services we're referring to, so I can lay it out for each of them. That's no problem.

For herpes zoster and UTIs, it will be $20 per assessment. For contraception management, there's sort of a tiered approach to that, so an initial assessment would be $20 and then a subsequent assessment, depending on whether there was a change in therapy or no change in therapy, would either be $20 or $12. Renewals are a similar tiered model. If three or fewer prescriptions are being renewed at one time, it's $12; if it's four or more, then it's $20.

In terms of caps and limitations, I just want to keep coming back to the $1.8 million. There are no caps on billing, so if we use $1.8 million, we're not done. That's just an estimate of growth and it's not flat each year. We've estimated an upwards growth each year, but there are no caps. If we are successful and patients want this, then it will be a bigger investment into those four services.

There are caps on the number of services we can provide to any given patient in these areas. As an example, for herpes zoster, we can't do more than two in a year. For UTIs, we can't do more than two in a year. Some of the reason for that gets to the definition of what is an uncomplicated issue versus a complicated issue. It becomes complicated if they have more than two in a year. Again, it comes to the definitions of some of these services and best practices.

BARBARA ADAMS: We understand that we have over 50,000 Nova Scotians without a family doctor. We now know that there are four long-term care facilities in the province - one in Debert and one in Truro - that have lost their physician and we have others in Riverview, and Ocean View Manor in Eastern Passage.

In the negotiations for this, did the Department of Health and Wellness come to you to talk about what role pharmacists have in long-term care, especially now that we're seeing an escalating number of long-term care facilities losing their family physicians?

ALLISON BODNAR: Generally speaking, long-term care discussions don't happen as part of our negotiations. They're typically negotiated directly with the providers of the contracts for those facilities, so it's not part of our overall agreement.

That being said, there are some discussions right now about whether or not these services that we've just announced may be or may become available in long-term care facilities because of some of the issues that you've mentioned. I think that's a discussion that's still happening behind the scenes. Typically, our agreements do not allow for the services to be provided in long-term care, but they're having some discussions around that right now.

BARBARA ADAMS: One of the serious issues is that in the Truro facilities, if someone leaves the long-term care facility to go to the emergency, they're not going to be allowed back. If someone leaves the facility out on a day pass with a family member and they go to your pharmacy, are you going to be able to assess and prescribe their medications and have that translated back into care at the long-term care facility?

ALLISON BODNAR: I'm not in a position to answer that today because the policies around this agreement have not been developed yet. Once they decide about whether long-term care residents are eligible for these services, then that will dictate when and how we can bill and get that information back into the long-term care facility.

Typically, our services have been excluded from LTC and residents of those facilities, regardless of where they obtain the service. That is something that we're trying to work through. Because this is new and province-wide, we haven't even seen a first draft of policy yet.

BARBARA ADAMS: I would hope that those policies are in place really soon because those facilities are without physician coverage. I can see what's going to happen if we continue to lose physicians there.

I have a question about if someone comes in and you decide you're going to prescribe a certain medication, but you're concerned, and you need to call the family doctor. In the negotiations, if you call the family doctor to discuss this with them, it's my understanding that the physician is not paid for that phone call. I'm just wondering, with this new policy, is the physician going to be paid to be a consultant for you?

ALLISON BODNAR: There's nothing in the pharmacy agreement that provides funding for physicians. What physicians have in their agreement is a matter of negotiations. They have just concluded theirs. They have different funding models depending on the collaboration they have with other providers. Pharmacists aren't paid to take physicians' calls either. Neither party, at this time, is paid to have those calls.

Pharmacies take dozens of calls a day from physicians asking about which medications should be prescribed, what's short, what they should do. Neither party is funded to take those calls. It's just something that has been done. It's one of those things in the model. We have some underlying infrastructure problems in terms of promoting collaboration. The way we're each funded to collaborate with each other and communicate with each other would be another one of those issues on the list of things that need to be addressed.

BARBARA ADAMS: That's a really good point because if you already get a lot of calls every day from physicians, and if they're not funded to speak to you, and you're not funded to speak to them, I can anticipate because of the way phone calls go and when you're actually free to take a call that if an increasing number of patients are going to be coming to you, the number of calls potentially is going to go up. If a physician is making a call, and the patient is in the room with them, then they can bill for it. If the patient's not there, and they're making the call to you, they're not going to be able to bill for it. If it's a Thursday, the client was in to see you on Tuesday, and you get a phone call, are you going to be able to bill for the phone call to consult with the physician?

ALLISON BODNAR: No, we have no mechanism for getting funded to consult with other providers.

To be fair, in our modelling in terms of this, we aren't anticipating increases in communication in terms of asking questions because of these services. This is fully within the scope of pharmacists. If they have someone in front of them for renewals, they have a patient file, they should have a full history. They have access to SHARE for lab results. I would think they would have the bulk of the information. Yes, there will be circumstances if the portal is missing labs and the patient insists that they had their labs done, they're going to reach out to the physician. The whole point here is for pharmacists to exercise their professional judgment and to perform that service.

BARBARA ADAMS: Are you concerned about the inability to order tests or to read some tests that you may have incomplete information to make the safest prescription recommendation?

ALLISON BODNAR: This is the issue that I have raised throughout, the SHARE being incomplete, number one. We know that privately drawn blood tests don't show up into SHARE. That is an issue. Not being able to remedy that problem by ordering a test because we don't have the operational authority will drive pharmacists to say, I am not in a position to do this, and to have to refer back to a physician or in cases where there is no physician, tide them over with enough medication with a short renewal and ask them to get into another . . .

THE CHAIR: Order. Time has elapsed. We'll turn it over to the NDP caucus for 11 minutes. Ms. Chender.

CLAUDIA CHENDER: I'm going to just jump right back in and let you answer that question. I'll just say the specific piece of that that I'm interested in is where the barrier is. You mentioned that you have the legal authority but not the operational authority. On this checkmark sheet that we have, it also says pending legislation, regulation, or policy. In your view, what is pending in this case? Is this an issue with the college? Is this an issue with the government? What fixes this?

ALLISON BODNAR: I don't think it's a regulatory issue. We don't need a legislative, we don't need a regulatory, and we don't need a standards change. This is fully within the scope of the government and the Health Authority to implement. There are procedures that need to be developed. We operate differently than a family physician. We operate more in a team environment. There are new things but it's not new to Canada. Alberta has had lab-ordering authority for 10 years, so I think we can get there.

I think one of the issues that's come up in the last couple of years is workload and work changes within the authority. Obviously with the amalgamation and now with OPOR happening in the authority first in the amalgamation of the three lab systems, that creates a whole different set of workloads and priorities. Pharmacy just hasn't been in that top priority of things to do.

We are hoping that we'll be able to actually start some small work in this area in the very near future. Have a few pharmacies connected to one of the three systems and start to work through those operational issues that we talked about: how do we do this in the best way, what needs to happen, how will the reporting happen - work through some of those bumps and bruises to develop the policies we need. Then hopefully expand and be part of amalgamating those three systems province-wide so that we can be part of the solution rather than an afterthought years down the road once the three are amalgamated and implemented and then we have to figure it out.

CLAUDIA CHENDER: Would there be a cost associated with operationalizing that lab-testing piece for pharmacies?

ALLISON BODNAR: In terms of a cost to pharmacy, there would be some training costs involved - learning the rules of the labs and that type of thing. I don't think there's much in terms of other capital costs that are required. Certainly, we'd have to look into building that into the pricing model of services when we're talking about labs, but it's really early days in any of that. Right now we're just trying to get it going.

CLAUDIA CHENDER: Just so I know that I understand this appropriately, when you talk about the kind of cuts over the last decade, I heard you explain it as the fact that pharmacy funding is tied to drug costs. We have kind of successfully and rapidly and for the good of patients, reduced those drug costs partly with the pCPA so that reduced cost of generics equals reduced funding for pharmacies.

If I have that right, I guess my follow-up question is that seems like a weird system. That's not really a question, that's a statement, so I will add a question. Is there a better system? If we hope, which I think we ought to, that drug prices will continue to fall and be more accessible, you're going to be in professional conflict hoping that. Is there a better way that pharmacies could be funded?

ALLISON BODNAR: Yes, I do think there's a better way in which pharmacy can be funded. It's certainly a piece of work that my counterparts in Pharmacare, when we talked through this negotiation, we all agree, like lots of other parts of health care, that it's a really antiquated system and we should look for an alternative solution where we're paid for the services we provide, regardless of the price of an external product that we have absolutely zero control over.

We all agree with that. Then the question is, what is that better model? I can tell you that Quebec has been working on this particular issue, this file, for at least three years now and trying to figure out what that solution is. They continue to work with government to define it, so they will hopefully be a leader in this area. They've certainly made some progress, but they haven't landed on anything.

We are committed to working, before the next agreement, to see if we can come up with a model that sort of removes that aspect of pharmacy away from something that we have absolutely no control over. We set an agreement today based on what we know today and, if it's like the past, we'll have three different things happen to us over the course of our agreement that impact our funding that came out of the blue to us but are in the contract, so we have no control.

We are hoping to find a better model and I think we can get there. I think there are options out there. We have other providers that aren't tied to a product, so we should be able to remove pharmacists from that product as well.

[2:30 p.m.]

CLAUDIA CHENDER: I'm curious if there have been discussions at the college or with you guys around the prescribing of birth control. As you mentioned in your opening, the hope would be that this would reduce the barrier to access. I know myself as a teenager, that was not a conversation I wanted to have with my doctor. I suspect that will be the same for my daughters. For all the reasons that you say pharmacies are a good place for these conversations, I agree with you.

We know that today in Nova Scotia there are doctors who will not prescribe birth control, and in small communities, particularly maybe some of the places where already there is an issue with accessing a physician. Is there any assurance either in the way that pharmacists are trained or in the way that you kind of roll out, not the expanded scope but the expanded access that will take place - that you're sort of actively working to mitigate against a young woman finding herself speaking to a pharmacist and then being denied access to a prescription?

ALLISON BODNAR: Like with all health care providers, pharmacists also have the right to refuse based on ethical and moral reasons. However, they also have an obligation to ensure that patient is cared for. That's first and I think it's important.

The second piece, as I already mentioned, is that we operate more in a team environment. Because we are a facility that employs multiple providers, I would think it is highly unlikely, if not impossible, to be in a pharmacy that all of the pharmacists would refuse this issue on moral grounds.

The other point - and I think a lot of people aren't aware of it and I certainly wasn't aware of it three years ago when we started advocating to get this authority - birth control is over the counter in about half the world. It's only in North America and Europe that we require a prescription. I think we overthink this way more than we need to. I think the easier we make this - and I know that the society of gynecologists in the U.S. has recommended that this become open access.

There is a lot of effort to move this to make this simple and easy for people. I think we will be able to do that. I think those who are refused on ethical reasons will be a very small number, and the pharmacy owners are going to be aware of this and will structure their business accordingly to ensure that access is there.

CLAUDIA CHENDER: Thank you, I'm really glad to hear that. There is always still a fear for me because if you sort of operationalize what you just described and you think of a young woman walking into a pharmacy and then one provider saying, I can't do that for you - and if they're willing to stick around and if that provider is willing to share the burden with someone else, then they're sitting there waiting, maybe feeling shame because they asked and were denied.

I'm sure there's probably nothing else you can say about it, but I would just flag that issue. I'm sure it's not something you haven't thought of, but it's certainly something that we'll be watching and seeing how that goes.

To shift a little bit, you've been talking a fair amount about pharmacists' role in the community - this community practice. We've been doing a bit of research about how pharmacists might be better integrated into primary care generally. The U.K. has some interesting examples of that. I'm wondering what kinds of options there are for pharmacists

to work in the public system right now, and is that mainly hospital-based practice or are there other ways in which pharmacists are integrated?

ALLISON BODNAR: We have a few hundred pharmacists that work in our hospital system here and in ways that I think many people don't even recognize. We have very skilled pharmacists that work on the floors directly with patients in hospitals in all of the various departments. If you aren't aware of everything they do in a hospital, I do recommend that you take a look. They're in the cancer wards, the heart wards, and they meet with patients in pre-op, post-op, and on discharge. They are an integral part of the team in hospital. There is certainly an opportunity to expand that role in hospital, as well as in community. Certainly that's one option.

The other option, where they are being utilized a little bit is . . .

THE CHAIR: Order, the time has elapsed. We'll turn it over to the Liberal caucus. Mr. Jessome.

BEN JESSOME: If you would like to wrap up your answer, feel free to go ahead please.

ALLISON BODNAR: The other area is in some of the physicians' offices. There are some physicians who are having pharmacists come in to do medication reviews. We are funded to do medication reviews. They're looking for some opportunities where there's some funding to bring them in - they do that a little bit. I think for certain services, that works really well. For other services, I think it works better to have them back in the community pharmacy for convenience's sake.

There are a multitude of entry points, and I think we can utilize pharmacists in hospital better. I think we can utilize them in collaborative care centres better. We absolutely can utilize the community pharmacy way better than we have been.

BEN JESSOME: I would like to ask a final question around supply management of drugs. I was made aware of an issue in the not-too-distant past around a shortage for a particular drug and kind of an "aw" moment that took place when this particular individual went in and found out that they were going to be limited in how much of the prescription they could fill.

We have an opioid-tracking system, and as I understand it, it's kind of overarching. We have the ability to know how much is coming and going. I'm just curious what the difference is between the general tracking supply management stream and how we do opioids. I guess the goal would be to avoid the scenario whereby someone walked in and found out that there was a lack in supply of a particular medication - to try to avoid that scenario or that shock when you walk through the door.

ALLISON BODNAR: That's a really big question. I just want to distinguish between the systems. The Prescription Monitoring Program that we have is not really to deal with shortages per se. It's to ensure that patients are getting controlled substances in the manner that they are intended to be given - there's not double doctoring, there's not early fills. That gets monitored in the Prescription Monitoring Program.

Now that we have a DIS - a province-wide drug information system - pharmacies now have a view into all medications and where they have been dispensed. There's a much more open view to pharmacies, whereas before the DIS, you only knew what the patient had if they had gotten it in your pharmacy. You didn't know what they had anywhere else, except for those under the Prescription Monitoring Program, you would get a notification. That's a different issue.

The drug shortage issue in supply is hugely complicated and something that pharmacy has been working on for a while to make more transparent. The national drug shortages database has only been in effect for the last two or three years - all the dates run together for me. That was after a lot of advocacy so that pharmacy would get a heads-up so that we would have some knowledge that shortages were coming. It's still not great. Sometimes we get the notification on that day, and that's a problem.

The reason for the shortages is also a problem. That's where people who are in positions of making policy really need to understand how this happens. As an example, if you reduce the prices so much on a drug that all manufacturers get out of the business of making that drug except for one, then you have just put yourself at risk for manufacturing problems at one facility. We've done that. Over the last nine years, we've reduced the number of manufacturers and the number of facilities where this is available.

That is not the only cause, let's be clear. If there was an easy answer to drug shortages, I'm sure Health Canada would have made some progress in this area. You have single manufacturing facilities. You have where raw ingredients are coming from. We have raw ingredients coming from all over the world, from facilities all over the world with different standards. That's causing some issues that I'm sure you're all aware of in raw ingredients. We know we've had some carcinogens in blood pressure medications. Health Canada is now investigating that in some diabetes medications, that was just announced this week.

We have problems and it's complicated, but it's becoming a huge issue. As I said earlier, there are 2,000 shortages on the database already with five coming in every day. Pharmacists have been surveyed. They are trying to deal with this multiple times a day with no compensation. It's a problem and one that pharmacists can help a little bit with.

If we were funded to do therapeutic substitutions, broadly speaking, we would be able to find the best alternative drug within certain criteria to help those patients more quickly. What happens now is that there's another drug we could substitute, but there's no compensation; I have to go through an assessment and the documentation that I have to do

for therapeutic substitution, so I'm going to have to refer you back to the doctor. They go back to the doctor, and the doctor picks up the phone and asks what the available medication is.

They don't like that situation any more than we like that situation, so that's an area that we could help resolve a little bit. The drug shortage problem is incredibly complicated. Our national advocacy body is begging Health Canada to work on this issue, to set it as a priority and to think about it when they're making decisions because when you play with pricing, it impacts on manufacturers' business decisions. That is having an impact.

THE CHAIR: We'll turn it over to Ms. Miller.

HON. MARGARET MILLER: Thank you so much for being here. It's certainly a great time to be involved with government when you see things moving forward like this that you know are going to have a positive impact on the health of Nova Scotians. Certainly because of doctor shortages, I think we're looking for all different ways, and this is one way that is going to have an impact as well as helping your industry.

Just before I came here, I talked to someone that was representing one of the local pharmacies and medical clinics, and they're going to be working together to see which patients who have lost doctors recently will be able to be served at the medical centre and which ones will be able to be served at the pharmacy. I think that you're going to see more of those collaborations going on around the province, and it's very positive to see that it has become an issue that we're all embracing and seeing how it can be best handled.

You talked a little bit about how you were afraid that some of the patients didn't treat pharmacists with the same level of - I won't say respect - knowledge that the doctors had. I think you're absolutely on the mark, but for me I know if we have an issue about a drug that maybe our doctor has prescribed, we'll talk to the pharmacist. I have actually gone in to get refills filled and the pharmacist says they can't, they have to talk to the doctor because this isn't going to work, or this counteracts with something. I'm hearing conversations between the doctor and the pharmacist debating over which are the best drugs to prescribe. It gives me a real sense that I'm being cared for, that my family's being cared for. I certainly do appreciate that.

I think it's wonderful that pharmacists are taking that role, and I was actually surprised to hear you say that pharmacists have the final say. If they're not agreeing with what the doctor has prescribed, they can actually refuse it if they think there's going to be a negative impact on the patient. Having that extra set of eyes is a fail-safe, and I certainly do appreciate that as well.

I was thinking of a couple of things as we were going through all of this . . .

THE CHAIR: You have two minutes.

MARGARET MILLER: . . . and also, 811. I know a lot of people call 811 for medical advice when issues are going. Do you expect that 811, with the range of options that they have for patients, will be able to also recommend the pharmacist?

ALLISON BODNAR: As I mentioned earlier, 811 is a critical piece of the communication around this and they have established protocols. If you called 811 on January 1st, we're not going to be in that protocol. What we have to do, and what we've started the ball rolling on, is we've made initial contact with 811, but it's going to require government as well as the 811 provider as well as us to work together to get those protocols changed as quickly as possible so that when the nurses work through their decision trees, we are one of the options at the end of it.

[2:45 p.m.]

MARGARET MILLER: Thank you for that. I recently had blood work done. The results go to my family physician. Can I actually request that so next time if I need to have a refill and want to go just to the pharmacist and want to confirm with the lab results, can I actually request that information to be able to keep it myself and use it as a reference?

ALLISON BODNAR: For an individual patient to get a copy of your blood work, I think the process that exists today, if I'm not mistaken - and I know there's a bit of a hold on it. There is the portal that your physician and you can sign up for, but there is a change of provider that is happening, so there are no new applications being accepted to that. I understand as a patient . . .

THE CHAIR: Order. The time has elapsed. I'll ask for closing remarks from our witnesses or one of you. Ms. Bodnar, would you like to do that?

ALLISON BODNAR: Just very quickly, I really do appreciate the opportunity to speak to you today to answer your questions. I think this is a fantastic first step, and I do applaud the government for that. I also think there are much bigger steps yet to come. We're here to help pharmacies live up to the trust that has been placed in us and to ensure that we can meet the expectations of patients and to work collaboratively with providers.

We work very closely with our partners at Doctors Nova Scotia, and we intend to keep doing so because it is the patient at the centre of this. We hope to be able to help to remove those access barriers in this province and really start to tackle the issues that this system in this province of aging population and chronic disease - that we can really help shift the direction of this province and start to get a healthier population.

THE CHAIR: Thank you, Ms. Bodnar and Dr. Chafe, for being here. You made a couple of references, so you may wish to table some documents with our clerk, Ms. Kavanagh, before you leave.

We'll take a short recess to let our witnesses leave the Chamber, and we'll have a short business meeting following that. I'm sure the media will be gathering with you shortly.

[2:47 p.m. The committee recessed.]

[2:50 p.m. The committee reconvened.]

THE CHAIR: Order. We will resume our committee meeting and our committee business. Witnesses for January 14, 2020 - believe it or not, the next time we meet will be in the new year - is on children's oral health, with witnesses from the College of Dental Hygienists and the Department of Health and Wellness. There are two approved witnesses from the Department of Health and Wellness: the deputy minister and Angela Purcell, the Executive Director of Pharmaceutical Services and Extended Health Benefits.

The department is in the process of recruiting and hiring a new deputy minister, and there may not be anyone in that role by January 14th. The associate deputy minister is filling in. The department says that Angela Purcell is the most senior executive in the department who would be able to speak, instead of the deputy, with specific knowledge on this topic.

The department has asked whether Angela Purcell can represent them without the deputy minister. She would bring along appropriate staff with her. If not, this meeting would have to be rescheduled for later in the year.

Is there any discussion? Ms. Adams.

BARBARA ADAMS: This was a topic suggested by the NDP, so I think it would be important for them to let us know.

SUSAN LEBLANC: We're fine with that substitution.

THE CHAIR: Is everyone in agreement? Okay, I will direct the clerk to make those arrangements or confirm them.

Also in your correspondence, you should have a letter from the Veterans Affairs Committee. It has referred a potential agenda topic to the Health Committee. Ms. DiCostanzo.

RAFAH DICOSTANZO: As the Chair of the Standing Committee on Veterans Affairs, the committee had passed a motion at our November 19th meeting regarding the NDP topic: using physician assistants to address health human resource shortages in primary care and emergency care. We felt that this was more appropriate to have at this committee, the Health Committee. We would like to defer this to the agenda-setting committee.

THE CHAIR: Is there any other discussion? Ms. Leblanc.

SUSAN LEBLANC: Madam Chair, can you clarify when that agenda-setting meeting is? Where are we in our agenda in terms of topics?

JUDY KAVANAGH (Legislative Committee Clerk): We should be ready for one in March.

SUSAN LEBLANC: Given that this was the one topic that we brought to the Veterans Affairs Committee, and it was sent over here to be added to the agenda, we feel like it should be simply approved by this committee so that we can add it to the current agenda. It's a matter of great importance to the province, and it feels like there may be a bit of football being played with our topic. I would make a motion that we actually just put it on the list now without sending it back to agenda setting.

THE CHAIR: Is our schedule filled until then?

JUDY KAVANAGH: If we go through our current roster of topics, that will take us up to and including March, assuming Doctors Nova Scotia is available in March. I haven't spoken to them yet. The next available slot would be April anyway.

BARBARA ADAMS: A number of us here now were at that meeting. We were all in agreement that it be referred to this committee. I think a topic that's referred from another committee doesn't automatically make it on the agenda, and since we reach the agenda-setting time anyway, it would simply go on the list of the recommended agenda items from the NDP.

SUSAN LEBLANC: It's just that my concern is if we wait until an agenda-setting meeting, which would be in March, at the end of March - I guess at the meeting for March, then this topic could potentially not see a committee until sometime next Fall.

THE CHAIR: If you had listened to what Ms. Adams just said, and it has happened at other committees, things that have been referred haven't necessarily been accepted as part of the agenda setting.

SUSAN LEBLANC: I have a motion that we should not wait for the agenda- setting meeting, that we should add it to the list - I guess it would be the April meeting, that we would make this topic the April meeting of the Health Committee.

THE CHAIR: There's a motion on the floor. Ms. Adams, do you want to speak to that motion?

BARBARA ADAMS: Just for my clarification, does that mean that when we do the agenda-setting meeting, you would forgo another topic for the agenda, or are you asking for an extra agenda item?

SUSAN LEBLANC: I guess I'm asking for an extra agenda item because this one's our agenda item for the Veterans Affairs Committee, and it was denied and told to come to this committee - yes, extra item, please.

BEN JESSOME: I would just like to state for the record that there was a movement to put this topic before the Health Committee, but that did not dismiss an opportunity for the NDP to submit a topic. We deferred until a later date the ability for them to submit a topic in keeping with the practices of all of our committees.

Can I clarify, did Ms. DiCostanzo have a motion on the floor prior?

THE CHAIR: Did you make it as a motion? No.

I would just like to clarify. Ms. Leblanc, because something is referred to the committee, it does not automatically go on our schedule. You're asking us to not have the subcommittee meeting and put it on the agenda for April and then have a subcommittee meeting in April? Oh, an agenda-setting meeting.

SUSAN LEBLANC: That is what I was asking, Madam Chair. I also don't know for sure if we have - I guess this question is for the clerk. Do we have rules and regulations and a way of working? This committee is quite new. A member has just said we don't do that, but I don't even know if that's written down anywhere. It might be good to define the terms and references of how the committee works. There might be somewhere that we know that.

That is my motion. I understand it's going to get voted down. I'm happy to go to the question on it.

THE CHAIR: We have a motion on the floor. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is defeated.

Ms. DiCostanzo.

RAFAH DICOSTANZO: I would like to make a motion to defer this to the agenda-setting meeting before the time runs out or we need to extend the time.

THE CHAIR: The motion is to defer this to the agenda-setting meeting in March. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Our next meeting will be Tuesday, January 14, 2020, from 1:00 p.m. to 3:00 p.m. The topic will be children's oral health.

This meeting is adjourned.

[The committee adjourned at 2:59 p.m.]