The HIV Care Cascade: Identifying Gaps and the Role of the Pharmacist

Tenth Annual HIV Pharmacy Education Day – December 7, 2018

Introduction

The tenth annual HIV Pharmacy Education Day was an opportunity for Ontario pharmacists from community and hospital settings to share experience, look at models of care from outside the province, and talk about ways to enhance the pharmacist's role in Ontario in ways that enhance the lives and health of people living with HIV. This year's event was held in conjunction with the *OHTN Endgame 3: Breakthrough Initiatives Conference*, allowing pharmacy participants to attend plenary sessions from the main conference. Brief summaries of plenary content and recommended resources are provided here in text boxes. More fulsome coverage of plenary sessions will be available at www.ohtn.on.ca in the near future.

Loneliness in Older Adults

Meredith Greene, University of California San Francisco

This conference plenary explored the growing understanding of loneliness as a factor impacting the health and wellbeing of people living with HIV. Dr. Greene defined loneliness as the "distress individuals experience due to the gap between their actual relationships and their desired levels of relationship and connection." There is now strong evidence that loneliness impacts the wellbeing of older adults in both Canada and the US and that risk factors, including low income, mobility challenges and LGBT identity, amplify this impact. Loneliness predicts depression, cognitive and physical decline and death. With the aging population of people now living with HIV, similar trends are becoming evident in communities of HIV-positive people. Dr. Greene briefly reviewed major studies of loneliness in people living with HIV including the Research on Older Adults with HIV (ROAH) in New York City, and ROAH 2.0 in San Francisco, as well as the recently reported Positive Brain Health Now, a Canadian study. Dr. Greene recommended resources from the Campaign to End Loneliness in the UK to begin thinking about how to talk to patients about loneliness and to provide links to support. The Loneliness Project, created by Canadians, is a digital archive which highlights that loneliness is not only a challenge for older adults.

Opiates and Pain Management

Lisa Bromely, University of Ottawa Health Services

Dr. Bromely provided an overview of principles for safe, effective opioid prescribing following the recommendations of the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain. In these guidelines, recommendations 1-7 largely deal with opioid-naïve patients. They stress maximizing non-opioid options, and keeping dosages low, noting the most of the benefits of opioids come from lower dose prescribing. Recommendations 8-9 address legacy patients and suggest rotating the opioids used and offering a taper, prioritizing patients taking ≥90 mg MED/day. Do not destabilize people; if people experience significant increases in pain or decreases in function, be prepared to pause or abandon the taper. Dr. Bromley noted that there are also two great guidance documents for managing opioid use disorders, the Canadian Research Initiative in Substance Misuse guidelines and A Guideline for the Clinical Management of Opioid Use Disorder from British Columbia. She strongly recommends that providers treating these patients become familiar with the use of buprenorphine.

Opiates and Pain Management, continue

Laura Murphy, University Health Network

Dr. Murphy discussed the use of medical cannabis for pain management. She stressed respecting the patient experience and offering support for patient questions. There have been five meta-analyses of cannabis for pain management. These include reviews which suggest some benefit but also a Cochrane review, which concluded that the potential benefits might be outweighed by the potential harms. Her summary: cannabis has a lot of promise, and may be beneficial for some individuals for reducing their pain, but we do not know yet whether it helps people improve their function. Monitoring for adverse effects is essential. More detail and protocols are needed to address challenges we are likely to see more of such as cannabis withdrawal syndrome. Providers considering medical authorization of cannabis use, should review the guidance Health Canada has created. The cost is currently quite high for chronic pain patients compared to other treatments patients may have access to. Start low and go slow for dosing. The route of use matters (smoked/vaping versus oils/ingestion) and people need education about the slower effects of oils and the duration of effects. There have been case reports of pharmacokinetic interactions between cannabis and other drugs, and there are theoretical interactions but little data. There is some hope around an opioid-sparing role for cannabis, but also possible risk around increased abuse liability.

De-prescribing and Chronic Pain (Tips for Opioid Tapering)

Laura Murphy; University Health Network

In 2017 in Ontario, 1/3 of opioid related deaths and 1/2 of hospitalizations were among people being treated with a prescription opioid (Gomes, 2018) Many would have visited a pharmacist in the last 30 days. Laura Murphy talked about practical considerations for creating an opioid tapering plan and motivating the patient.

When talking to patients about opioid use, "what the drugs are doing to them versus what the drugs are doing for them" is the key issue, not abstract ideas about an opioid crisis or the amount of drug they "should" take.

Benefits for chronic pain patients are modest - Even low doses of opioids increase the mortality risk, while the benefits for chronic pain patients are muted. Pain is decreased by 10-20%. The functional gains are even smaller. In fact, there is no good evidence of improved functional outcomes with long-term use. Ask, "are your opioids helping you do more of the things you want?"

Complications for chronic pain patients can be severe – People often don't register these as drug complications. Opioid-induced hyperalgesia is probably the most significant to patients. The idea that the drug can be causing greater sensitivity to pain and more widespread pain, challenges the idea that they will not be able to handle their pain without the opioid. It is helpful to show them how their pain map has evolved over time. When they begin the taper, you can often map a reduction in the areas where they feel pain, helping to motivate effort. For other complications, particular those like reduced sex drive or bowel problems that might be embarrassing, it is helpful to talk about what we observe in other people, as a way to begin the conversation. Other long-term complications worth noting: myocardial infarction, fractures, sleep apnea (opioids cause apnea and make it worse), immune suppression, and depression.

The *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* provide guidance for tapering people, particular those taking ≥90 mg MED/day. They suggest a target of 5-10% reduction of MED every two-four weeks. In her practice, Laura Murphy says four or even six or eight weeks is most effective for most patients. Unless people are coming to you because they are motivated to get off, it is important to go slow. People may also need to take breaks to succeed in the taper. Rapid dose decreases are not recommended. Where people are really struggling, multidisciplinary collaboration is especially helpful.

Motivating change is about communication. If people don't want to reduce the drug, "I am doing fine, just leave me alone," you can't start there. Resources on providing motivation and generating dialogue are listed in the resources below. In general:

1. Begin with getting to know them and what is important to them
2. Elicit from them the upsides and downsides of their experiences with the drug. These patients are beginning to talk more about the stigma of being on opioids.
3. Reflect their responses. You may not agree, but don't deflect or justify the behaviour of colleagues.
4. Link together the pros and cons. "On the one hand you are getting some benefit but you still can't do the things you want and you are tied to your opioids. You feel afraid of what happens if you try and make a change." Live with the silence and let them think about it. Often reflection is all that can be achieved in early conversations. Leave the door open.
5. Ask permission to provide information. Does it feel like they are ready to know more? Don't force it.

Multi-opioid regimens - Your eventual goal is usually to consolidate to one extended release opioid (e.g. KADIAN®). There is no right way to start, ask the patient about their preferences. What would be the easiest to give up? Short-acting drugs sometimes give patients a sense of controlling the process.

What if I can't take the pain? - Reassure patients that pain increases are temporary, you have been able to manage it for other patients in the past. If the pain hasn't gone down by the next scheduled taper, pause so people feel stabilized. Work to optimize sleep, relaxation, and supports (certifying pets as service animals can help!) Acetaminophen can be used for body aches.

High-dose fentanyl patches – Some people have a concern about converting these patients to other therapies because it is hard to know how much drug is being absorbed. At high doses, start by tapering the dosage of patches, and don't switch to oral until they are at 100 mcg fentanyl or lower. The first time you switch to oral, wait 12 hours and then take half a dose. Call and support regularly and have naloxone on hand.

In the Q&A:

How to start the conversation in the context of HIV: 60% of people living with HIV, live with pain, so you will see opioids. Ask about how people are managing their pain, and focus on what they are doing that works for them, before talking about specific drugs or switching. Mention new guidelines and suggest discussion.

What are the most challenging patients: There is a high-comorbidity between personality disorders and chronic pain. Conditions like fibromyalgia and immune conditions also complicated. Start with brief pain inventory and track over time to individualize the approach. Look for small wins. Consider antidepressants or talk therapy and let that get established before pain med changes.

What is the best discussion to have with people receiving opioids for painful neuropathy? Once again pain diagrams are very helpful to consider how pain might have been spreading over time. Let them know that there are now medications designed specifically for neuropathic pain, and maybe start some before reducing opioid.

Do a universal risk assessment for possible misuse with every patient using opioids, before starting treatment change. For those with issues, have them sign an agreement about not getting drug from outside sources, but don't stop treatment if they do so.

Resources

- 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain
- Tapering opioids using motivational interviewing Co-authored by Laura Murphy in the *Canadian Family Physician* 2018 (includes a list of useful questions).
- Guidance on opioid tapering in the context of chronic pain: Evidence, practical advice and frequently asked questions. Co-authored by Laura Murphy in the *Canadian Pharmacists J* 2018

Antiretroviral Therapy: New Drugs, New Strategies

Dr. Roy Gulick, Weill Medical College, Cornell

Dr. Gulick discussed the evolution of antiretroviral therapy (ART) and the emerging treatment opportunities. There are now 32 approved drugs with which to construct ART regimens in five mechanistic classes: nukes (NRTI), non-nukes (NNRTI), protease inhibitors (PI), integrase inhibitors (INSTI) and entry inhibitors (EI). All jurisdictions world-wide are agreed to start ART at all CD4+ counts, although the World Health Organization retains a priority status for those with CD4+ counts <350, a recognition of cost issues in lower-income settings. The same basic treatment strategy of two nukes plus something else (an NNRTI or increasingly an INSTI) is also used around the world, but there is little consistency between jurisdictions about first-line therapy; seven different regimens are recommended worldwide. Efavirenz (EFV) is now usually included as an alternate therapy, and more PIs are disappearing from recommended lists due to toxicity concerns.

ART regimens are chosen based on four properties: antiviral activity, safety and tolerability, convenience and extending life expectancy. We know that life expectancy has now reached near normal outcomes for people living with HIV. Dr. Gulick used data from a systematic review on the success and failure of initial ART in adults presented by Andrew Carr at the recent Glasgow HIV conference to explore other properties:

Virologic Response – Advances are not just in controlled studies, 88% of people in care in New York are virally suppressed (Note: In Ontario, 80% of diagnosed people and 94% of those receiving ART are virally suppressed). Dr. Gulick also highlighted new developments in entry inhibitors (EI) which now make it possible to interrupt the binding of HIV to immune cells at all three steps in the process. This class is an opportunity for suppression for drug experienced patients. One new drug, Ibalizumab (IBA) is a monoclonal antibody (injectable) that modifies the host cell not the virus. Early studies (Emu et al, NEJM, 2018) support use in cases of multiple drug resistance. Fostemsavir, (FTR) an oral EI, has similar utility. These drugs are now being approved by the FDA in a new way as breakthrough drugs based on very small phase three studies in experienced patients with short study duration. Two other classes of ART drugs, HIV maturation inhibitors and HIV capside inhibitors are in the pipeline, but not yet in clinical trials.

Carr data	Emerging studies
Analysis of 354 studies from 1994-2017: On average 45% of people were undetectable after 48 weeks in 1994 compared to 77% in 2017	In recent studies many drug combos are over 90% at 48 weeks including TAF/FTC +DTG, ABC/3TC/DTG even a two drug combo (DTG+3TC) all reporting 93% supressed

Safety and Tolerability – Research is exploring the possiblities of lower doses, such as the ENCORE 1 study which showed that a 400 mg dose of efavirenz (EFV) is non-inferior to the standard 600 mg dose, as well as switches to less demanding drug regimens: e.g. once daily darunavir/ritonavir is non-inferior to twice daily lopinavir/ritonavir and significantly cheaper! Drugs are also being modified to reduce toxicity e.g. TAF to TDF has similar virological activity but improved renal and bone markers. Multiple studies are exploring two drug regimens: PI/r+3TC, PI/r+INSTI, NNRTI+INSTI. Most notably the SWORD study of RPV/DTG and DTG+3TC, which the ACTG 5353 trial showed had 90% viral suppression at week 24. This may be the future, but the world is not ready to begin switching everyone to 2 drug combos without longer term data.

Carr data	Emerging studies
Analysis of 354 studies from 1994-2017: On average 10% of people drop out of studies due to toxicity in 1994 compared to 4% in 2017	In recent studies, discontinuation for adverse events are very low e.g. 2NRTI+RAL (<1%), TAF/FTC/ BIC (0%) TAF/ETC/EVG/c (1%)

Convenience – There has been an explosion of once daily dosage options (nine not including generics). This was once the holy grail, but now we are beginning to consider even less frequent dosing and injectable formats. The LATTE-2 study put two injectables together (IM CAB + IM RPV) and compared q4 and q8 dosing schedules with good outcomes. This combo is now being evaluated in phase III studies. MK-8591 is a new oral drug that could be dosed once a week if suitable partners were available. Subdermal implants containing TAF or of MK-8591 (potentially for PrEP) are now in animal studies.

In the Q&A:

- What are Dr. Gulick's impressions of darunavir (DRV) + dolutegravir (DTG), a combination now being studied? This double D combo has proven helpful at UHN when working with very drug experienced patients. The data is incomplete but there is excitement about the potential.
- Is targeting human immune cells rather than the virus itself with new drugs like Ibalizumab a way to get around drug resistance? You would think so, but the virus has managed to get around this in the past. Some resistance has occurred with maraviroc, another host-targetted drug. We have to plan for resistance, no matter what.
- Can we combine IBA+FVR? This seems theoretically appropriate because they target two elements of the same cell entry step, and the phase III FVR study allowed people to use IBA as a second drug. People did well BUT… the cost is immense.
- We have seen some integrase resistance in Toronto. How do we use DTG first line in this environment? Can we? In the US, 17% of people are infected with virus resistant to some drug, primarily nuke and non-nuke. Integrase resistance is very rare. We don't screen for it before starting, except, for example, if the partner is poz and being treated with it. DTG and BIC have a high barrier to resistance and require more than one mutation for resistance and are generally preferred. RAL less so, but there is more experience in pregnancy.

Trauma-Informed Care: The Role of the Pharmacist

Jay MacGillivray, midwife, St. Michael's Hospital

Jay MacGillivray works in the positive pregnancy program (P3) at St. Mikes. She works with women living with HIV, HCV, and other at risk women including those with mental health challenges, addiction and involved in non-autonomous sex work. In all of this work U-TAP, universal trauma aware practice, is crucial.

Universal trauma aware practice is about reducing the power imbalance that a client experiences when they interact with you and the system. It is about not doing harm to the client's social and emotional wellbeing. It is emphatically not about pity – pity undermines people's strength. U-TAP "recognizes that trauma runs through HIV like a bass note." For many clients, HIV or taking meds is not the biggest priority.

U-TAP is about working to understand client experiences as much as possible and recognizing that our own privileges are barriers to effective practice. If you work with Indigenous clients, or even if you don't, read and become familiar with the Truth and Reconciliation Calls to Action. Be aware of the power imbalances associated with some identities: 66% of women living with HIV, and 28% of men living with HIV are part of Black or First Nations communities. Eighty percent of women living with HIV in Canada have experienced violence in adulthood. Fifty per cent of all Canadian women have experienced an attempted sexual assault, so it is completely appropriate to treat all clients as if this is their reality. HIV stigma is about control and punishing people's behaviours.

(Re)-consider the following behaviours:

- **Read the chart.** Some painful or stigmatizing information might be relevant to a person's care, but they don't need to repeat it over and over again to different people.

- **What information do you need to solicit and retain?** What purpose does it serve to put "chlamydia 2006" on the chart if it was treated and cured? How is it relevant now, except to stigmatize the client? Never ask about how a person became positive, it is not clinically relevant.
- **Make sure the room is empty**. Words matter. Don't inadvertently "out" people's HIV status or other personal information to others in their lives.
- **Sit down and take off the white coat.** Talk to people human to human, don't hide behind your privilege. You are working with people who are facing daunting challenges, not providing care from on high. Ask for permission to talk about potentially difficult subjects.
- **Provide peer support, when desired.** Peers can help people work through complex experiences as equals, but some people also fear being exposed through interactions with peers.
- **Use words that recognize people's strengths, instead of emphasizing your own power.** "It would help me to know…" or "Welcome back. It is so good to see you" after an absence from care.

Working with people in a trauma aware way is part of our roles. In people with HIV, death rates are increased two-fold and people are unable to take ART four times more often, when they have experienced trauma. U-TAP is about safety, trustworthiness, choice and collaboration. We must work to present ourselves as partners, empowering people's choices and respecting autonomy. So much is solved by humility.

HIV and Cancer: Treatment Challenges and Strategies

Dr. Irving Salit, Alice Tseng, University Health Network

Dr. Salit described the three types of cancer seen in HIV: 1) AIDS-defining cancers such as lymphoma and Kaposi sarcoma, which are rare now with modern treatment; 2) non-AIDS-defining cancers that are more common in people living with HIV but not evidence of AIDS such as lung and anal cancers; and 3) non-HIV, common cancers often associated with aging that we are now seeing more often in people living with HIV such as breast and colon cancer. The middle category, non-AIDS defining cancers is the most common, and are now the leading cause of death (19%). Most commonly, these are lung and anal cancer, as well as liver cancer and Hodgkin disease. This is largely related to the increased frequency of risk factors such as smoking and HPV exposure in those with HIV. Anal cancer is 100x more common, in those with HIV than in the general population. Dr. Salit described the screening tools used for anal cancer.

Alice Tseng began her talk with a recent US study which showed that people living with HIV are still less likely to receive cancer treatment than the general population (Suneja G et al, 2016). In the past, it was common to suspend or delay ART during chemotherapy. Recent NCCN guidelines recommend that most people with HIV who have cancer should be offered the same cancer therapies as HIV-negative individuals. These recent guidelines also provide tables of systemic cancer therapy-ART interactions by ART drug class. In cases where interactions between proposed chemotherapy and existing ART occur, the guidelines suggest the following step-wise approach.

1. Substitute different ART drugs with less potential to interact.
2. Select alternative cancer therapy with less potential to interact.
3. Temporarily discontinue ART – only in consultation with an HIV specialist and only if a cure for the malignancy is the intent and the duration of the chemotherapy will be short OR the malignancy has a poor prognosis and the goal is palliation.

Generally, the use of non-interacting ART is preferred such as unboosted INSTI (BIC, DTG, RAL) and non-inducing NNRTIs (RPV, DOR). These drugs are most useful for those being treated with chemotherapy.

HIV and Cancer, continue

Resources

- Cancer in People Living with HIV, NCCN 2018
- Antiretroviral Interactions with Chemotherapy Regimens
- 2014 HIV Oncology Handbook
- HIV/HCV Drug Therapy Guide (also download from Google or Apple Stores)

Pharmacy Delivered Point of Care Testing (HIV, HCV) and PrEP Delivery

Deborah Kelly, Memorial University Newfoundland; Sugi Thivakaran, Pharmacy.ca, Toronto; Mike Stuber, Saskatchewan Health Authority, Regina

HIV Testing at the Pharmacy: The Approach Study

Deborah Kelly described a study done in two Newfoundland and two Alberta pharmacies (one urban, one rural in each province) to offer HIV testing using the INSTI HIV point-of-care testing kits. The test itself is simple, the more challenging part is to think about providing results and supporting people to link to care. The project required a lot of leg work and homework in the following areas:

Regulations and Scope of Practice – This varies by province. It was important for the study to get an opinion from the provincial colleges that this fell within the scope of practice, in order to assure liability coverage. In Newfoundland there was an absence of legislation in this area.

Linkage to care – The intervention requires simple, direct strategies to link people to care resources, if they test positive. Provincial advisory committees were established including public health people and care providers. In both provinces, a nurse practitioner from the province's HIV program was signator for the confirmatory testing requisition, thus test results came back to a major treatment centre.

Training of Pharmacists – The study did a full-day of training for the pharmacists participating including how to do the test (easy), counselling people about testing and a positive result. They used a role-playing approach on this counseling and providing information about related services in the communities involved such as STI testing and PrEP.

Promotion of Testing – The study used both social and mainstream media to promote the service and worked with local ASOs. Despite choosing pharmacies that might be easily accessible to people using drugs or involved in sex work, the people coming for testing did not reflect these populations.

In the two provinces, the four pharmacies (really three one Alberta pharmacy was lost early in the study due to staff turnover) tested 123 people. Of these people, 75% were moderate to high risk for HIV infection, thus an appropriate testing population; 28% were first time testers. Clients were enthusiastic about the location, said it was less intimidating than a doctor's office or clinic. Clients said they would have been willing to pay up to $20 (although this would not be sufficient for a sustainable service outside the study). The pharmacists felt prepared for their role and proud to be offering service, but apprehensive about delivering positive results.

Although the study showed that testing was feasible and successful, it is not clear that it is viable. Ongoing remuneration issues outside the study have not been worked out, and the testing hours required double pharmacy coverage. If the service was ongoing, there would also be costs for tests and supplies (the kits were donated for the study) and ongoing promotion needs. Engaging other pharmacy staff to direct people appropriately (including front staff) is also important to creating low-barrier and not stigmatizing access.

Ideally the service would expand to provide other types of STI testing, but that would encounter additional logistic and regulatory issues.

Hepatitis C Outreach and HIV Supports

Pharmacy.ca is a full service community pharmacy on Sherbourne Street. It serves large numbers of people who use drugs and men who have sex with men and is affiliated with the Sherbourne Health Centre (SHC) next door.

Much of the population served is very transient and needed better linkage to HCV testing and care. The HCV rapid test (approved in Jan 2017) takes about 20 minutes and uses finger stick blood. Because of the wait between the blood collection and the results, it was important to gather as much contact information as possible, including information about shelter use. The wait was also an opportunity for counselling people and linking them to resources, including potential primary care at SHC.

The process for testing included: 1) Approach and risk assessment (screen for risk factors and antibody test); 2) Talk about consent to testing and make sure that they understood that if they tested positive they would be referred to SHC; 3) Pre-test counselling which built on a scripted dialogue developed by the CDC; 4) The test itself and appropriate record keeping; 5) 20 minute wait where much of the post test counseling could be done and patient's questions answered; 6) Results and post-test counselling. One complication encountered: It was not clear whether or not pharmacists had the same duty to report to public health as a physician or how they should do so; in the end they used the same form as physicians.

In addition to the pharmacy based program, the pharmacist was also involved in outreach testing programs, such as a screening initiative at Seaton House (the largest homeless shelter in Toronto). This involved a multidisciplinary team including a hep C nurse, community support worker, physician and inner city health nurse, and social worker as well as the pharmacist. It happened in a concentrated way over two days, screening 70 men, and identifying seven individuals positive for HCV. It was chaotic and difficult to engage people in large groups, but bringing testing to the shelter simplified tracking for follow-up care. The pharmacist also does monthly HCV testing at the PWA Foundation. It works well to link services together, and people being tested can visit the food back while they wait for results.

In addition, pharmacy.ca collaborates with SHC on a variety of HIV treatment and prevention supports including the development of HIV Primary Care Guidelines, and on adherence programs for HIV meds. The pharmacists also help navigate compassionate access to HIV drugs, and accept the risk of waiving drug costs. They support the BePrEPd program, to offer confidential delivery of PrEP medications across Ontario.

Pharmacy Driven PrEP Clinic, Saskatchewan

The PrEP program in Regina was driven by demand for service from men who have sex with men. Its objective is to deliver low barrier PrEP care through the publicly funded system with minimal use of healthcare resources. Since PrEP is now fully funded in Saskatchewan, the primary barriers in Regina for PrEP care have to do with limited access to supportive physicians. There are only three ID docs in the city, and the hospital is not inviting. The PrEP clinic is a partnership between a sexual health nurse at a local full-service STBBI clinic already being used by the target population and the pharmacist.

- The **nurse** does STBBI testing, arranges lab results, schedules visits and calls patients as needed.
- The **pharmacist** reviews lab results, does initial patient interviews and counselling, writes prescriptions (and helped arrange drug coverage, prior to funding). He leads the patient follow-up including reviewing labs and checking adherence.

Prescribing is possible through a collaborative pharmacist/physician Rx agreement and is approved by the Saskatchewan College of Pharmacists and Sask Health Authority. The pharmacist can prescribe drug under

his own name, but lab tests are ordered under the physician's name. The pharmacist has access to the ID physician for consultation as needed (rarely).

This monthly clinic has started 90 MSM on PrEP. They have learned that patient follow-up is the most demanding part (chase down lab results, scheduling), and that more days are needed at the clinic as appointment time is increasingly consumed by follow-up appointments. Initial planning and protocols as well as good use of EMR are essential. Complications around drug supply are also common. With universal coverage there is minimal extra cost to the system, as no additional physician time is required. The demands of PrEP follow-up may be greater than physicians would find economically feasible. Neither the pharmacist or nurse are paid based on fees for service and the time demands are large. The program has increased HIV and STBBI testing, and sexual health awareness, as well as reducing HIV stigma.

The team is currently in discussion to expand the program to an opioid substitution therapy setting for injection drug users and hopes to roll-out collaborative prescribing on reserve and in remote settings.

Discussion

In the discussion about these practice models several common themes emerged:

1) These activities are well within the capacity of pharmacists and are a rewarding form of practice
2) Remuneration remains the key challenge. Many of these activities are time consuming, requiring extra staffing and significant time spent with patients. There is no clear pathway to remunerate this extra work, particularly in community settings, and without this it will not be economically viable for most.
3) Partnership is essential to all of these projects – creating multidisciplinary teams that can offer the integrated services that make these projects succeed.
4) Other pharmacy staff are an important part of the care model. Need to think more about what additional roles pharmacy technicians might take on to enable this work.
5) It is important to have the provincial Colleges onboard to support these expanded practice models. This is important to help limit pharmacist liability but also to avoid public spats as recently occurred around strep testing in Nova Scotia.

Expanded Role of the Pharmacist: Implications and Opportunities

Judy Chong, Manager of Hospital Practice, Ontario College of Pharmacists

The scope of practice for pharmacists in Ontario expanded in 2012, in ways that might enable many of the projects discussed this afternoon. Judy Chong was invited to review these scope of practice possibilities and to talk about how pharmacists in Ontario have been doing at expanding their scope since the program rolled-out.

Ms. Chong emphasized that discussions of scope include all pharmacy professionals - pharmacists, students and technicians. She quickly reviewed the things that pharmacists have always done, and also newer responsibilities, noting that the expansion was a balance act between what pharmacists could do, and what they have the time to do. Newer possibilities include:

- Prescribing specific drugs for smoking cessation
- Reviewing and adapting prescriptions
- Performing a procedure on tissue below-dermis
- Administer a substance by injection or inhalation for the purpose of education or demonstration
- Administer or authorize vaccine to patients older than 5

These responsibilities are evolving across Canada, and are different in different provinces. Right now Alberta and New Brunswick have the fullest scope of practice, particularly in terms of prescribing and instigating laboratory testing. Many regulatory acts involved, particularly challenges around the lab act.

Research in 2014, looked at the facilitators and barriers to expanded practice and what was actually happening in Ontario with regarded to the new scope of practice. Work by Zubin Austin found that pharmacists often hold back, and are concerned about physician acceptance of their broader role. The Ontario Prescribing Pharmacist's Survey found that the primary barriers for expanding the scope of practice for community pharmacists were: documentation required, access to patient information, and pharmacy workflow, while physician relationships and patient expectations were primary facilitators.

OCP has developed a practice assessment program that will work with people in their own practice environments. (See the website for details.) The new program will see practitioners every 4-6 years, and take a quality improvement and coaching approach in four domains:

- Patient Assessment
- Decision Making
- Documentation
- Communication / Education

Community practice advisors observe processes and practices within the pharmacy, and review prescriptions. Thirteen performance indicators are used, so if someone was practicing to full scope they would be doing all of these things. Results from the first two years of the program (2016-2017: 2000-3000 pharmacies reviewed per year) shown that 8% of practitioners are providing optimal services in all performance areas (full scope), while challenges were found with 2-3% of practitioners. However, the vast majority, 88-89%, are providing satisfactory service but not practicing to their full capacity (all performance indicators). Pharmacists do well in the domain of communication and education but there are many opportunities for improvement in documentation, and some around decision-making (wanting others to make the final decision) and patient assessment.

The College is focused on how to optimize practice and make pharmacy an integral part of the health care system. It is about building relationships across the health care system to create more patient-focused care. A summary of the Optimizing Practice Strategy was published in *Pharmacy Connection*, summer 2017. The College has been holding focus groups to understand what is happening and to identify some of the best practice models that will help pharmacists and pharmacy technicians work to full scope with partners across the system. Data shows that most pharmacists (~80%) are doing adaptations of prescriptions, but other services such as smoking cessation are much less commonly offered (25%). In total <20% of pharmacies utilize pharmacy technicians to full scope and only 2% of pharmacies provide all expanded scope activities. We also need a greater emphasis on positive intra-professional relationships to expand the scope of practice and this relies on build professional identity and confidence among pharmacists.

We continue to need data on how pharmacy practice improves patient outcomes so that our practice is truly based on evidence. The most recent *Pharmacy Connection* included a discussion of Quality Indicators for Pharmacy and this is an area where the College will continue to work.

Ms. Chong also highlighted the OCP Opioid Strategy. She also spoke briefly about ONE ID, a new electronic system intended to give all pharmacist practitioners greater access to patient clinical information, enabling them to make better informed decisions. This is an ongoing project with eHealth Ontario.

In the Q&A:

There was discussion about the challenges of the systems used to access patient information. What ONE ID provides is currently limited to emergency room records, but this will change over the next year, so that pharmacists will be able to see labs and specialist visits.

MedsCheck was an important tool to allow pharmacists to contribute to patient care, to improve documentation (one of the challenge areas) and to get paid for it. However, Ministry requirements have mandated a huge increase in the information needed by MedCheck and the workflow impact means that it is really too onerous for many pharmacies and pharmacists to complete. Is there a way to advocate for change? Although advocacy is not the role of the OCP, they certainly can identify some of these issues. Advocacy issues would need to be led by professional associations, but OCP would support.

OCP has been working to better educate people about their role – as a regulator for the pharmacy profession in Ontario. They can not advocate for change as this would be a conflict. This led to discussion about inviting representatives of some of the professional bodies next year. There was also discussion about the disconnect between working to scope and getting paid to work to scope, and the role that OCP could play in highlighting these challenges (without advocacy).

The HIV pharmacist group is piloting a SLACK group for Ontario HIV pharmacists to communicate. Please contact Alice if interested at alice.tseng@uhn.ca. You are also encouraged to join the Canadian HIV and Viral Hepatitis Pharmacists Network (CHAP), which also has a networking email group.

Structural Racism and Stigma in Health Care

Arjumand Siddiqi, University of Toronto

Dr. Siddiqi's presentation aimed to challenge three emerging narratives about race and racism:

1) Race is biological thing; Canada has been ignoring it.
2) Racism is an American problem
3) Racism is injustice that we can address by eliminating unconscious bias

1) Race is not dictated by biology; it is a social category. Social experiences, like stress, can manifest biologically and these have health impacts and may trigger behaviour responses. This does not mean that health differences are due to race. So for example to say that norms for blood pressure are based on studies of white people and that is why many racialized people don't meet them is wrong. It is not about race, although it may be about socioeconomic factors that lead to better outcomes for white people.

2) Yes, there are large racial disparities in the US, but systemic differences in health outcomes for Black and Indigenous are also evident in Canada.

3) Unconscious bias is a popular way to frame discussions of racism these days, and to suggest that negative outcomes in service environments are the result of provider's unconscious biases. However, research has shown that bias training is not a very effective way to improve outcomes and experiences. Dr. Siddiqi contents that racism is actually a function of systemic action on a group level that leads people to protect the economic and social power of their group. This is exemplified by the Trump election, and many other examples. The only way to address racism is to act boldly to change power and resource structures. Community-based programs operating in this structural environment may do good work but still be unsuccessful due to this systemic challenge. Successful change will not be small, incremental change.