CANADIAN COLLABORATIVE HIV/AIDS PHARMACY NETWORK

INAUGURAL MEETING

OMNI SHOREHAM HOTEL
2500 Calvert N.W.
Washington, D.C.

JANUARY 21-22, 1997

This meeting has been made possible through collaboration from

MERCK FROSST

THE CANADIAN COLLABORATIVE HIV/AIDS PHARMACIST NETWORK
JANUARY 21-22, 1997 INAUGURAL MEETING

Omni Shoreham Hotel
2500 Calvert Street N.W.
Washington, D.C.

AGENDA
JANUARY 21, 1997

12:00 - 1:00 p.m.	*Luncheon*	*Cabinet Room*
1:00 p.m.	*Meeting Session*	*Forum Room*
1:00 - 1:30 p.m.	Introduction to meeting	M. Foisy
1:30 - 3:30 p.m.	Overview of HIV pharmacy practice (Each participant will be asked to informally present highlights of the HIV pharmacy practice of her province or institution for 10 to 15 minutes)	All members
3:30 - 3:45 p.m.	*Break*	
3:45 - 5:00 p.m.	Network discussion - Function/mission/objectives of network - Organization (ie officers, meetings) - Participants/Regional champions and partners - Election of Chairperson Elect - Next steps	All members
5:00 p.m.	Ajournement	
6:30 p.m.	Dinner at "La Maison Blanche"	

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AGENDA
JANUARY 22, 1997

8:00 a.m.	*Breakfast*	*Cabinet Room*
9:00 a.m.	*Meeting Session*	*Forum Room*
9:00 - 9:30 a.m.	Introduction to Patient Health Management (Patient Health Management Model)	M. Kader
9:30 - 10:00 a.m.	Merck Frosst Patient Health Management Initiatives (Optimal care & Pharmacy programs)	M. Kader
10:00 - 10:30 a.m.	*Break*	
10:30 - 11:30 a.m.	HIV Patient Compliance Program	M. Kader & M. Foisy
11:30 - 12:30 p.m.	Review of current situation of HIV pharmaceutical care (obstacles to optimal care)	M. Foisy & A. Tseng All will be moderated with the help of S. Burnett
12:30 - 1:30 p.m.	*Lunch*	*Cabinet Room*
1:30 - 2:30 p.m.	Proposal for improving HIV pharmaceutical care	M. Foisy & A. Tseng
2:30 - 3:30 p.m.	Discussion around the proposal	All members All will be moderated with the help of S. Burnett
3:30 - 3:45 p.m.	*Break*	
3:45 - 4:15 p.m.	Next steps and closing remarks	M. Foisy

The Canadian Collaborative HIV/AIDS Pharmacist Network Brainstorming Opportunities

January 27th, 1997

The Canadian Collaborative
HIV/AIDS Pharmacist Network
Brainstorming Opportunities

Merck Frosst, Canada Initiatives:

Merck Frosst, Canada began the second day of meetings with a presentation on Merck's involvement in the field of cardiology with respect to current health management initiatives and the success they have achieved through implementing patient health management programmes. It is the intent of Merck Frosst, Canada to reach or exceed the same success in dealing with the HIV/AIDS community in general, and with the newly formed Canadian Collaborative HIV/AIDS Pharmacy Network, in particular.

Current HIV Patient Compliance Initiatives:

The drug scheduler:

The updated and revised drug scheduler was demonstrated to the group. The following comments arose after the presentation:

- Caution must be used in ensuring that the dosage strength dispensed is the same that is used in the scheduler (Ont.);
- It might be advantageous to append a column (B.C. model) that describes what the medication is for (i.e. MAC medication);
- As well, a sample pill might be affixed to the scheduler, so that no misinterpretation is made with respect to medication required; this approach also aids caregivers who may be unfamiliar with all the various medications and/or for patients whose first language is other than English/French (B.C. model);
- Instead of a check-mark/diamond next to the day part, it may be preferable to use a visual symbol (i.e. dots) to show the number of pills that need to be taken at that point in time (B.C., N.S);
- There is a preference for fractions versus decimals when part of a med must be taken (i.e. 1/2 a pill versus .50 - N.S.)

It was generally agreed that the next step in improving the drug scheduler would be the inclusion of a comments/progress notes screen that would be built into the dispensing software. It was suggested that this would make it feasible to track interventions with respect to patient outcomes.

Patient/Health Care professional booklets:

Overall, commentary was very favourable with respect to the current Crixivan booklets. Only one remark was made by a B.C. pharmacist with respect to receiving negative feedback from patients on "glossies", given the price point of individual HIV/AIDS drugs. No other participants acknowledged receiving similar feedback from their patient base.

Medication Organizer (Pillboxes):

Merck Frosst, Canada is in the process of performing stability tests on a multi- compartment, interlocking opaque medication organizer (pillbox) designed for HIV/AIDS patients. It was explained that every effort had been made to ensure that it would be light and moisture sensitive for at least a period of 24 hours. The intent of the medication organizer (pillbox) is to provide an easy to follow means of planning all drug needs on a daily basis. It is expected that routine drug planning of this nature will inevitably lead to higher patient compliance for all HIV/AIDS drugs.

Again, response to the idea was highly positive; in particular, its portability, overall design (non-medicinal appearance) and no cost to patient benefits were cited. The following additional comments were made:

- It is important to ensure that each pill compartment can hold a larger tablet, such as ddI (P.Q.); and,
- some consideration should also be given to increasing the length of time the pills will be stable to better meet weekend away/vacation needs (Ont.)

Patient beeper:

The patient beeper (ringing versus the hoped for vibrating version) received a mixed review. It was generally agreed that the use of a beeper is an individual's choice - some patients strongly prefer the reminder, while others feel it is too intrusive a means.

The design of the patient beeper, which is small and can be attached to a neck chain or key chain was well liked; concerns were expressed with respect to potential difficulties resulting in programming, and the time it would take pharmacists to explain how to use the beeper.

Reticence aside, **all pharmacists agreed to pilot test the beepers with 20 Crixivan patients to obtain feedback.** Merck Frosst, Canada will use these results to aid in the feasibility decision of mass producing these beepers to foster increased compliance in HIV/AIDS patients.

Barriers to Optimal Pharmaceutical/Seamless Care:

Michelle Foisy & Alice Tseng subsequently presented their joint opinions on what are currently barriers to PC/SC within varying site environments: community, ambulatory practices and hospital practices. In addition to the points the authors made, the following additions were voiced by the attending pharmacists:

Community:

- Given the use of **multiple community** pharmacies, it is difficult at best to obtain a complete picture of the healthcare professionals included in any given patient's care;
- There is a necessary dependence at this juncture on patient supplied drug data, unless some standardized form of communication can be developed with treating physicians;
- Storage of paper documentation (if automated);
- If a care plan is ultimately transferred to every community pharmacist, who is ultimately responsible for monitoring patient outcomes?

- There is a large discrepancy in the knowledge base of community pharmacists; education becomes a challenge, as well as generating interest in self-education;
- There is little interest in stockpiling expensive HIV/AIDS drugs, especially for community pharmacists who serve a very small base; and,
- Many pharmacists may also be unaware of reimbursement policies, especially given the rapid changes in provincial formulary listings.

Ambulatory Practices:

- Coverage policies for main pharmacist when away from practice;
- Inconsistent transferring of patient information;
- Geographical barriers (from one place to the next); and,
- Multiple communications.

Hospital Practices:

- There is a need for hospitals to be aware of only starting in-patients on drugs that can be continued at home (because of cost/access considerations);
- If there is not a coordinated care team, there is potential for overlapping involvement;
- There is a need to monitor patients' use of different hospitals - patients may choose a different hospital for their acute versus daily needs;
- Given multiple registering for clinical trials, patients may be on a trial agent that is unrecorded by the hospital/ ambulatory care pharmacist.

Pre-supposing that all pharmacists are on-line for the delivery of seamless care, other barriers quickly became evident. Some of these included:

- Physicians' attitudes toward pharmacists;
- Community pharmacists differentiating their services to attract specific clientele;
- Reimbursement/non-reimbursement policies set by provincial governments;
- Lack of uniformity of communication forms.

A Proposal:
A Multi-centre Study of HIV Pharmacists' on Patient Outcomes:

A proposal, which could be the first joint project initiated under the newly formed Canadian Collaborative HIV/AIDS Pharmacist Network, was presented by Michelle Foisy & Alice Tseng. The main objectives of the current proposal are to:

- Formally define the role of pharmacists in the management of HIV/AIDS patients;
- Establish a model of an infrastructure that could be used by pharmacists, regardless of practice setting, in the delivery of seamless care to HIV/AIDS patients; and,
- Improve patient outcomes by consistent, positive interventions.

It was suggested that these objectives would best be met by utilizing a three phase approach:

Phase 1: Establish a baseline of pharmacy practice;
Phase 2: Develop an infrastructure for PC, then SC;
Phase 3: Measure impact of SC on specified patient and provider outcomes.

Commentary on the Proposal:

The objective of measuring a pharmacist's impact on patient outcomes was well received and considered consistent with the devised mission statement of the Network. Cautions were raised with respect to the broad approach of the proposal:

- Pharmacists' roles are very different in each site represented at the table;
- Buy-in by support staff;
- Buy-in by treating physicians (are suggested interventions accepted by doctors?);
- Specific endpoints are required;

- Difficult to isolate actual outcomes;
- May need to define baseline PC in a way that is applicable to all pharmacists;
- May need to implement a control group - match sites by those who receive SC versus those who do not to isolate impact of positive interventions on outcomes;
- May need to concretely define expectations of care for patients, nationally; and,
- May be able to adapt B.C.'s current manual form of measuring patient outcomes, if it is agreed that the current form is capturing the right information (hence, reducing the task as originally proposed).

Given the nature of the commentary, it was decided that a smaller working group be responsible for refining the original proposal to ensure the questions raised by the Network are adequately addressed. The working group includes: Michelle Foisy, Alice Tseng, Kathy Slayter and Glenda Meneilly. The revised proposal will be ready for resubmission to the group by September, 1997, when the next meeting of the Network is to be scheduled.

Next Steps:

- Piloting the patient beepers with 20 Crixivan patients and collecting written patient feedback (all); and,
- Revising the current multi-centre study proposal by September, 1997 (working group only).

Stephanie Burnett & Associates
Marketing and Research Consultancy

THE FORMATION OF THE CANADIAN COLLABORATIVE HIV/AIDS PHARMACY NETWORK: EXECUTIVE SUMMARY

January 27, 1997

97 Humberside Avenue, Toronto, Ontario, M6P 1J9
Telephone & Fax (416) 769-3213

REQUIRED ACTION

DAY 1:

In order to facilitate this inaugural meeting's desired outcomes it was agreed that **each participant** would submit provincial information to the chair **on or before March 1, 1997** with respect to:

- formulary access/reimbursement policies;
- evidence based practice guidelines;
- provincial/site clinical trials;
- provincial news/updates;
- existing forms or study results in evaluating positive pharmaceutical interventions (and the method of recording positive patient outcomes);
- specific areas of expertise (niche populations, etc.);
- continuity of care forms (seamless care)
- protocols used in prophylaxis intervention; and
- possible agenda items

Patient drug monographs, compiled by the Ontario association, will be included in the first mailing to participating network pharmacists estimated to be April, 1997.

DAY 2:

- Piloting the patient beepers with 20 Crixivan patients and collecting written patient feedback (all); and,
- Revising the current multi-centre study proposal by September, 1997 (working group only).

THE FORMATION OF THE CANADIAN COLLABORATIVE HIV/AIDS PHARMACY NETWORK: EXECUTIVE SUMMARY

Background:

Merck Frosst, Canada had agreed to fund both the inaugural and future annual meetings of a Canadian HIV/AIDS pharmacy network. The purpose of this initial meeting was to provide leading HIV/AIDS pharmacists the opportunity to establish a formal mission statement, a governing structure and direction as to the future operation of the network. Additionally, this meeting provided a forum in which pharmacists could exchange information about the similarities and differences inherent in their practice sites, which may have a direct impact on their delivery of pharmaceutical care to their HIV/AIDS patient base.

Participants:

Current membership representation in the Network encompasses both Canadian geographical diversity as well as variations in site practices: community, ambulatory and hospital-based. The following members attended the opening session:

Name	Location	Type of Practice
Kathryn Slayter	Nova Scotia	Clinical Pharmacy
Colette Bisaillon	Quebec	Community Pharmacy
Rachel Therrien	Quebec	Hospital Pharmacy
Martin Boule	Quebec	Clinical Pharmacy
Michelle Foisy	Ontario	Hospital (in pts.)
Michelle Diment	Ontario	Ambulatory Care
Alice Tseng	Ontario	Immunodeficiency Clinic
Alfred Gin	Manitoba	Clinical Pharmacist, ID
Yvonne Shevchuk	Saskatchewan	Associate Professor
Nikola Ostrop	Alberta	Clinical Pharmacy
Nese Yuksel	Alberta	Clinical Pharmacy
Glenda Meneilly	BC	Ambulatory Pharmacy
Ann Beardsell	BC	Hospital Pharmacy

Information Exchange:

Pharmacists were encouraged to discuss their provinces' and specific site's infrastructure with respect to pharmaceutical care and seamless care delivery.

Pharmaceutical care has seemed to have evolved - from an isolated activity to one which is often part and parcel of a multi-disciplinary team approach. This team may involve, in addition to a pharmacist: treating physicians, nurses, social workers, dietitians, occupational/physio therapists, chaplains and other professionals deemed to be an integral part of HIV/AIDS patients' care. While this approach is beneficial in terms of inter-site care continuity, it may not address other issues with respect to uniformity of care or seamless care.

It would appear that Ontario is the **only province** to have formally created a professional specialty group of pharmacists who have expertise in the area of HIV/AIDS that **spans the province**. The 30 Ontario members encompass all aspects of pharmaceutical care: community, ambulatory, hospital and industry. Presently, they meet on a three times a year basis, and are currently collaborating on the development of patient drug monographs.

While the idea of a provincial association holds appeal given the inherent possibility of moving toward seamless care, not to mention the benefit of information sharing, only Quebec (which has mandated a continuity of care form to be used for communication among all pharmacists who are dealing with a number of major disease states, including HIV/AIDS) and Alberta (which currently is regionalized with respect to care delivery but has a sufficient core group) envisioned the formation of a similar provincial association as a feasible possibility.

Reasons proffered for lack of applicability included the following:

- Lack of sufficient core membership within the HIV/AIDS pharmaceutical community;
- Lack of emphasis on HIV/AIDS within the infectious disease category;

- Current centralization (75%, Center of Excellence, B.C. only) of HIV/AIDS treatment through a single centre; and
- Current individual provincial (PharmaNet, B.C.) and site efforts (most) underway that are already attempting to address issues with respect to pharmaceutical care and seamless care.

The amount of time spent on consulting (assessing symptoms to determine possible drug interactions, selecting/monitoring antiretrovirals, etc.) versus dispensing antiretrovirals varied considerably among individual sites. In addition, some sites are only reimbursed on a scripts/hour basis (Alta., as well as other regions), which thereby decreases incentive for patient counseling.

Consulting within a hospital and ambulatory clinic may be designated for only a specific population of patients - for example, some pharmacists only deal with in-patients, others deal with out-patients only, and in smaller centres, a single pharmacist may be responsible for both in- patients and out-patients.

Not surprisingly, information sharing within a single centre may present a challenge for continuity of care, dependent on the number of pharmacists assigned to an individual case. It would appear that both the Wellesley Hospital and St. Paul's have dealt with potential disruption to pharmaceutical care by timely meetings/communication among attending pharmacists. It is, however, important to note that these internal meetings often do not include the community pharmacists that a patient may access for antiretrovirals and/or other ethical/OTC needs. Hence, the challenge of involving community pharmacists within an unified framework still remains despite possible internal coordination efforts (community pharmacists may only be called if patient grants permission).

When individual sites are only dispensing drugs, it becomes incumbent upon another pharmacist (who may/may not be knowledgeable in HIV/AIDS) to fill the role of counselor. In outreach areas, or among a more traditional pharmacy environment, this may pose serious problems.

A number of hospital or ambulatory pharmacies, while dispensing antiretrovirals, encourage patients to use community pharmacists for all of their non HIV/AIDS medications. In other instances, there are no restrictions on who can dispense HIV/AIDS drugs (Saskatchewan).

The issue becomes one of educating community pharmacists on HIV/AIDS drug therapies, in general and compliance, scheduling and possible drug interactions, in particular.

Current policies, while understandable within any one infrastructure, do little to aid in seamless care for the patient.

A possible solution to seamless care is being addressed in B.C. St. Paul's has started an education process which involves a timely mailing to all doctors and pharmacists on new drug therapies for HIV/AIDS patients - specifically, information with respect to drug interactions and compliance (the example given was for Nevaripine) to ensure that all professionals are on an equal footing with respect to their knowledge base on any given drug before it receives HBP approval.

The idea of B.C.'s PharmaNet was also presented. Simply put, it is an universal computer programme that would be delivered and utilized in all community drug stores. It would provide a complete profile of all ethical drugs a patient has been prescribed. While this approach would clearly educate more naïve community pharmacists by "forcing" them into understanding HIV/AIDS drug therapy, it does not address patient privacy issues.

A further caveat to health care providers' use of PharmaNet, is that each time a patient's profile is accessed, an explanation of why the file was accessed must be completed. Currently, it appears that the only feasible reason for accessing a given profile is the dispensing of additional/registered medication, versus trying to familiarize yourself with a client's current drug regime. Again, while this restriction may go a long way to addressing confidentiality concerns, it positions the pharmacist as reactive versus proactive.

Another potential approach to addressing seamless care may rest with the movement that is transpiring in Manitoba, whereby all pharmaceutical care is intended to be shifted to the community. This approach would require mass education of all community pharmacists in awareness of and familiarity with HIV/AIDS medications.

It was also noted at this juncture, that some community pharmacists are less willing to develop an expertise in HIV/AIDS drug therapy because of the number of other (more common) therapeutic areas that need to be simultaneously address.

While it is generally acknowledged that there are differing patient needs within the HIV/AIDS community, only one pharmacist who is a part of the Network appears to be presently dealing with a niche group - namely, women and children (Oaktree Clinic, B.C.).

The intravenous drug population, which often suffers from a systemic bias, does not appear to have as yet been successfully addressed by any of the attending pharmacists and/or their sites of practice.

The Mission Statement:

Despite varying access, practices and policy, the group concluded that there is a real need for a national body which represents pharmacists who have an interest and/or expertise in the treatment of HIV/AIDS patients. Common ground was ascertained on a number of levels including:

- cross-country sharing of experiences and information to improve patient care;
- the development of practical, clinical guidelines;
- cooperation on research protocols that would demonstrate positive drug related outcomes;
- continuing education, including site visits that would make information on HIV drug therapy more accessible to community, hospital and ambulatory pharmacists, as well as patients;

- the development of HIV/AIDS pharmacist mentors; and
- the promotion of the pharmacist's role in HIV therapeutics, on a national level.

To that end, the following, working "mission statement" was developed:

To bring together pharmacists with a clinical and research focus in HIV/AIDS to optimize patient outcomes and promote the profession of pharmacy through communications, education, research and clinical practice.

Michelle Foisy was unanimously elected chairperson for a 1 year term; Kathy Slayter was nominated and unanimously voted in as secretary/ chair elect.

It was then agreed that the newly formed **Canadian Collaborative HIV/AIDS Pharmacy Network** meet on a once yearly basis; in 1997 the meeting is to be scheduled around the ICAAC meeting in Toronto, in September. Future annual meetings would be held in Washington in January, in advance/following the Antiretroviral Convention.

In addition to in-person communications, it was suggested that a quarterly newsletter be published for members of the Committee that would include, but not be limited to the following sections:

- "Provincial" news;
- Reimbursement;
- Clinical Studies (outside of the Canadian Clinical Trials network);
- a Q & A column; and,
- a People column.

The idea of E-mail communication (outside of the Internet) through the development of a chat box was also considered. At this point, the exchange of e-mail addresses (and with Merck Frosst's support ensuring everyone has an available e-mail address) was considered fundamental before a potential "exchange site" is established.

It was agreed that the chair is to be responsible for the collation of the quarterly newsletter; the secretary is to take minutes of future meetings, jointly prepare meeting agendas with the chair and e-mail conference highlights attended by the chair on behalf of the Network.

Next Steps:

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