THE Tablet

SUMMER 2024 | ADVOCATING FOR BRITISH COLUMBIA PHARMACY

Community pharmacy primary care clinics

We take a look at a model of care that is increasingly being adopted across Canada. PAGE 12

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†Clinical significance has not been established.

Reference: 1. HADLIMA® Product Monograph. Organon Canada Inc. December 14, 2022.

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HADLIMA® adalimumab injection

12


18


24

Contents

Member Profile

9 **MACS TRAINING** Meet Tamiz Kanji, the pharmacist behind the minor ailments and contraception services educational modules available through the University of B.C.'s Professional Development Courses page.

Cover Feature

12 **CLINICS** Primary care clinics for community pharmacies are being talked about in British Columbia. Learn more about this new model of care that has seen success in other parts of Canada.

Clinical Feature

18 **DEPRESCRIBING** Hafeez Dossa, pharmacy manager at CareRx Parksville, looks at reducing the inappropriate use of tramadol-containing medications.

Pharmacy Practice

24 **2SLGBTQ+ CARE** Tips and strategies for how community pharmacists can help reduce health care inequities by providing gender-affirming care in their practices.

Business Feature

28 **GREENWASHING** False or misleading claims about the environmental benefits of products or services are being increasingly used in advertising. Read about how to recognize greenwashing, and how pharmacies can take meaningful actions to reduce greenhouse gas emissions.

Messages

Chair's Message 4

CEO's Message 5

News Dose

International Overdose Awareness Day 6

Endnote

Ordering lab tests 30

ON THE COVER

Carolyn Cox, pharmacy manager at Brookline Pharmasave in Bedford, Nova Scotia, talks about the pharmacy clinics initiative in her province.

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Mike Huitema

A bright horizon for B.C. pharmacists

The last few years has seen our profession expand to greater heights and opportunities to practice than at any previous point in our modern history. It was not long ago that pharmacists were seen as only dispensers of medications, a role that we have been seeking to expand for decades.

It seems that for pharmacy, change comes in waves. In 2009, we saw the beginnings of significant change when government introduced adaptations as a service pharmacists could perform, with the aim of improving patient health outcomes and medication adherence. The change also introduced prescription renewals for chronic conditions, reducing the number of trips patients needed to make to doctors' clinics or emergency rooms.

The same year adaptations were introduced, the appearance of the H1N1 influenza pandemic spurred government to further enable pharmacists. Within months, injections training began, and hundreds of community pharmacists started administering H1N1 vaccines that were made available in October that year. It was also around this time, towards the end of the last pandemic, that our profession and government implemented medication review services. This service arrived in 2010 and has since continued to expand to become a core pharmacy clinical service British Columbians have come to expect.

Here we are in 2024, at the crest of another wave of changes in pharmacy and at the twilight of another pandemic. In the past two years, we have seen those adaptation powers expand to include prescription renewals for up to two years, with adaptations expanded to cover prescriptions for nearly any condition. Then came the arrival of minor ailment assessments and prescribing authority, which 90 per cent of community pharmacies offer today, and hundreds of thousands of British Columbians have now accessed. And yet more changes are coming.

By the time you read this, a further expansion to PPP-58 would have taken effect on Aug. 1 to again increase the scope for adaptations. Additionally, effective Aug. 30, 2024, pharmacists will be enabled to order lab tests for medication management. These changes mean even more options in the pharmacist's toolbox.

Even more is being explored through the concept of pharmacy clinics, an idea being tested in other places in Canada that has caught the attention of decision-makers here. These changes are colossal shifts that has changed how governments, the public and other health providers perceive our profession.

A pharmacist entering the profession today can make more out of their career than at any point in our past. As Chair of our Association and a member of the profession, I am so proud to be a part of the group working to make it happen. T

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Geraldine Vance

Election years are a time of opportunity

As you are reading this, British Columbians are getting ready to go to the polls to elect a new government on Oct. 19, 2024.

For community pharmacists, a great deal has been accomplished in this last term. Of course, it was marked with COVID-19 and all the pressures and opportunities that presented for pharmacists.

As I have said before, pharmacists showed up for their patients each and every day during the pandemic, opening their doors when access to other health-care providers was so limited. This work has helped refine the public and elected officials' understanding and perspective on the the pharmacy profession.

For those of you who attended the BCPhA Annual Conference in May and heard Health Minister Dix's remarks, you will know he and his government truly recognize the contribution pharmacists are making.

The results are there for anyone to see: whether it's COVID or flu vaccinations or diagnosing and prescribing for minor ailment and contraception, access has been significantly improved.

Since the pandemic, community pharmacists in B.C. have administered nearly 11 million COVID and flu vaccines for the public. This is a staggering number that shows the positive impact the profession has had for public health. In addition, since June 2023, more than 1,400 community pharmacies have participated in the delivery of more than 430,000 minor ailments and contraception assessments. More people are getting the care they need because of community pharmacists.

While election years can be both a time of opportunity and a time in which it seems that so many things are on pause, for pharmacy, we were pleased that the Minister was able to get Cabinet approval to enable community pharmacists to order and interpret lab tests. Meanwhile, the College has passed Standards, Limits and Conditions for lab ordering.

Still, there remain months of work ahead to develop plans on how this will be implemented. Be assured, we will press on the issue of compensation — pharmacists should never work for free. You are all essential health-care professionals who deserve to be reasonably compensated.

No one has a crystal ball in terms of what the election results will be. But what I know is, that regardless of who is elected, community pharmacists need to continue have a key and growing role in addressing access issues in the primary care system.

There is work to do: negotiating a long-overdue increase in the dispensing fee, finalizing all the elements of the long-term care and assisted living compensation package, restructuring the rural incentive program and, of course, continuing to advance scope of practice.

So, the BCPhA Board and staff team will be ready to continue to work with government and the College to enable pharmacists to provide the very best care for their patients. T

The Tablet asks our contributors:

How receptive do you think pharmacists in B.C. would be to operating pharmacy clinics?

Hafeez Dossa is the pharmacy manager at CareRx Parksville. "Pharmacy clinics would provide pharmacists the opportunity to focus on meaningful conversations with patients about their medications. From my background in LTC, and with a focus on deprescribing initiatives, I believe that this proposed environment would enable us to have structured discussions about the necessity, efficacy, and safety of all medications being taken. This would help with identifying drug therapy problems, while contributing to a more preventative and holistic approach to overall patient well-being."

Mona Kwong is a partner of Pharmasave Howe Street and Pharmacy Advisor; Pharmacist Consultant at Infinity Medical Specialists Clinic, and Director, Interdisciplinary Clinical Addiction Fellowship Program — Pharmacy Stream at the BCCSU. "Pharmacy has an integral role in each community and we all want to increase access to care within our challenged health-care system. Pharmacy clinic implementations continue to need more exploration in terms of workflow and balance of service needs within each community. A clinic setting to allow us to utilize our full scope as a health-care provider will be absolutely welcomed."

Tamiz Kanji is the Director of Continuing Pharmacy Professional Development at the University of British Columbia's Faculty of Pharmaceutical Sciences. "I believe many pharmacists in B.C. would be very receptive to this opportunity. They maintain a high standard of competency, skills, expertise, and continual professional development and learning that is conducive to this type of health care provision. Appropriate resourcing, compensation, and sustainability are imperative to the model's success."

Together, we can end overdose:
INTERNATIONAL OVERDOSE AWARENESS DAY

BC CENTRE ON SUBSTANCE USE

BY MONA KWONG, PHARMACY ADVISOR AND DIRECTOR, INTERDISCIPLINARY CLINICAL ADDICTION FELLOWSHIP PROGRAM — PHARMACY STREAM AND KEVIN HOLLETT, DIRECTOR, COMMUNICATIONS AND COMMUNITY ENGAGEMENT

International Overdose Awareness Day occurs on Aug. 31 each year and is the world's largest annual campaign to end overdose, remember without stigma those who have died and acknowledge the grief of the family and friends left behind. For pharmacists, it is a reminder of the vital role they play in helping prevent toxic drug overdoses in their communities.

The urgent need to prevent overdose deaths has also been recognized as a global issue by the United Nations. Their 2030 Agenda for Sustainable Development — a plan of action for people, planet and prosperity that all countries are expected to implement — reflects the importance of continued action to end toxic drug overdoses as part of the Sustainable Development Goal to Ensure Healthy Lives and Promote Well-Being for All which includes a target to strengthen the prevention and treatment of substance use.

Together we can is the 2024 theme for International Overdose Awareness Day and urges everyone to lean into the power that we can have when we work together. Pharmacists are leaning in, using their knowledge, skills, and abilities and working together with other health-care providers, harm reduction workers, and people who use drugs to help prevent overdose deaths. This work is impactful and needs to continue.

The overdose crisis continues to claim the lives of seven British Columbians and more than 20 Canadians every single day. Unregulated drug toxicity deaths accounts for more deaths than homicides, suicides, accidents and natural disease combined.

Stigma around substance use also contributes to the risk of overdose death through perpetuating assumptions about who is most at risk and the use of harmful language which can create barriers to accessing care.

The 2024 data from the BC Coroners Service revealed that while 71 per cent of those dying from unregulated drug toxicity were male, the death rate for females has nearly doubled since 2020, from about 13, to 23 per 100,000 in 2024. In addition, the greatest proportion of deaths (48 per cent) occurred in private residences, with 35 per cent in other inside residences including social/supportive housing, shelters, and hotels and 16 per cent outside in vehicles, sidewalks, streets or parks.

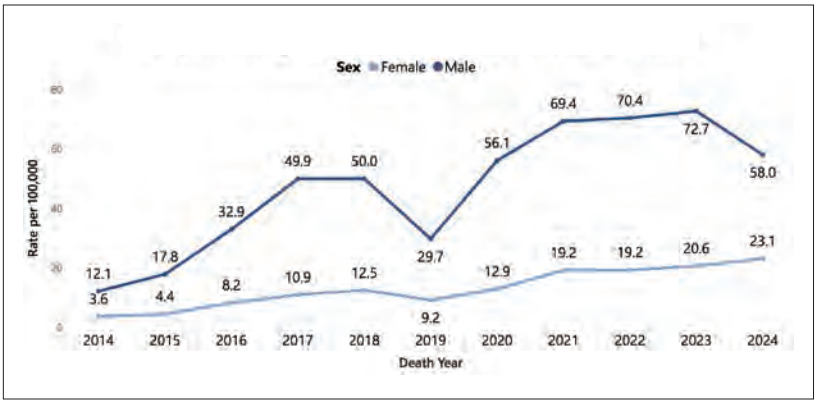
Looking Forward

While the toxic unregulated drug supply is the key driver of fatalities, challenges with accessing comprehensive, evidence-based addiction treatment and care is a major contributor to reducing substance use related harms. A whole system approach is needed to support people who use substances. Pharmacists and pharmacy teams will continue to play a vital role in preventing overdose deaths and need to ensure they are focused on providing stigma-free care and following the latest clinical guidelines.

Unregulated Drug Deaths by Place of Injury, BC 2021-2024

Year	2021		2022		2023		2024	
Place of Injury	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Private Residence	1287	55.9%	1312	54.9%	1206	47.1%	367	48.1%
Other Residence	573	24.9%	563	23.6%	713	27.9%	234	30.7%
Outside	343	14.9%	366	15.3%	485	19.0%	120	15.7%
Public Building: Other	33	1.4%	60	2.5%	67	2.6%	19	2.5%
Not available	27	1.2%	28	1.2%	31	1.2%	6	0.8%
Public Building: Washroom	13	0.6%	28	1.2%	22	0.9%	6	0.8%
Medical Facility	9	0.4%	9	0.4%	14	0.5%	6	0.8%
Occupational	9	0.4%	10	0.4%	13	0.5%	2	0.3%
Correctional Facility/Police Cell	8	0.3%	12	0.5%	7	0.3%	3	0.4%
Total	**2302**	**100.0%**	**2388**	**100.0%**	**2558**	**100.0%**	**763**	**100.0%**

Sex-Specific Unregulated Drug Death Rates per 1000,000, 2014-2024



Source: BC Coroners Service

Both the application of clinical knowledge and the trust built through pharmacist-client relationships provide valuable opportunities for overdose prevention. That's why it's important for pharmacists to be aware of the most recent updates to B.C.'s *Clinical Guideline for Treating Opioid Use Disorder* released in November 2023 and follow best practices for providing stigma-free, culturally safe care.

Pharmacists are one of the most accessible and trusted health care providers in our health care system. This provides the opportunity for pharmacists to play a key role in preventing toxic drug overdoses, working as part of the health-care team to help more people access and experience success with substance use treatment. *Together we can* means pharmacy teams are an instrumental part of the health-care team and the community in helping change the course of the overdose crisis. Together, we can help build a better and safer system for substance use care.

Using the Latest Guidance to Provide the Best Possible Care

There is now a significant amount of evidence-based information and resources available on the prevention of toxic drug overdoses and the treatment of substance use — pharmacists need to make use of these resources so they are well equipped for crucial conversations with their clients around substance use and supported in their clinical decisions.

Continued on page 8 »

Upcoming changes

On July 25, 2024, the BC Pharmacy Association, in collaboration with the Ministry of Health and the College of Pharmacists of BC, presented an informational webinar on upcoming changes to pharmacy practice.

For members who missed the presentation, the event is available in the BCPhA's eTraining Portal at **bcpharmacy.ca/etraining.**

The following are highlights summarizing what was discussed (timestamps in webinar recording):

1. **Pharmacists will be able order and interpret laboratory test results** when it is necessary for medication management, effective Aug. 30, 2024. A list of labs tests that can be ordered by pharmacies has been published and pharmacists will have access to a pharmacy-specific requisition form. (8:52)
2. **Changes to PPP-58** take effect on Aug. 1, 2024. These changes will allow further adaptations of a previously adapted prescription, allow adaptations of a valid prescription from a former practitioner, permit renewals of a prescription for a narcotic, controlled drug or substance longer than prescribed, change dosage, formulation or regimen of such prescriptions and more. (34:26)
3. **Provincial Prescription Management** (PPM) project will be expanding PharmaNet information access to other health providers, so eventually all pharmacists and prescribers will have real-time access to patients' complete medical profiles. The new PPM is currently being rolled out by pharmacy software providers, with full deployment expected in 2025. (1:07:37)
4. **OAT-Compliance and Management Program for Pharmacy** has been updated to reflect the latest opioid use disorder guidelines published in November 2023. (1:36:39)
5. **Other upcoming initiatives from the BC Ministry of Health**, including: the Opioid Treatment Access Line, a service for patients with substance use disorders; expanding networking for community and primary care pharmacists; introducing pharmacy clinics; and establishing the Pharmacists Council, an advisory group representative of pharmacists across B.C. (1:45:14)

Finding Success Through Stigma-Free Care

Pharmacists play an important role in the health-care team through frequent trust-building conversations and check-ins with clients about their health and wellbeing. As a result, the language used during conversations about substance use is crucial to earning and maintaining trust and helping clients experience success with substance use treatment.

Pharmacists need to aware of and actively work to reduce the stigma experienced by individuals with opioid use disorder, including awareness of the language they use in clinical encounters and its potential to stigmatize individuals who use opioids and other substances.

Pharmacy teams involved in substance use care should strive at all times to use "person-first" language and current medical terminology (e.g. person with an opioid use disorder) when interacting with clients, families, colleagues, and other health care professionals, and staff.

The latest Guideline for the Clinical Management of Opioid Use Disorder from the BC Centre on Substance Use *now also includes specific principles of care* related to client-centred care, social determinants of health, cultural safety and humility, anti-racist practices in substance use care, trauma-and violence-informed practice, recovery and self-defined wellness, harm reduction, integrated continuum of care, and self-defined and wellness oriented care.

The BC Centre on Substance Use (BCCSU) is a provincially networked resource with a mandate to develop, implement and evaluate evidence-three strategic areas including research and evaluation, education and training, and clinical care guidance. Both its updated *Guideline for the Clinical Management of Opioid Use Disorder* and many other resources — including a 24/7 Addiction Medicine Clinician Support Line — are valuable for pharmacists involved in providing substance use treatment.

Updated Guideline for the Clinical Management of Opioid Use Disorder

In November 2023, a second edition of the *Guideline for the Clinical Management of Opioid Use Disorder* was released by the BCCSU to ensure that health-care providers have access to updated clinical guidance aligned with the best available evidence on interventions across the continuum of opioid use disorder (OUD) care.

Opioid Agonist Treatment Compliance And Management Program For Pharmacy

OAT CAMPP training has undergone a major update to be aligned with these clinical and regulatory changes and can be found in the BCPhA eTraining Portal (**bcpharmacy.ca/etraining**). For more information, see the BCPhA OAT CAMPP registration page **bcpharmacy.ca/OAT**.

Key changes to the OUD guidelines include:

- Addition of principles of care including client-centred care, social determinants of health, cultural safety and humility, anti-racist practices, trauma-and violence-informed practice, recovery and self-defined wellness, harm reduction, integrated continuum of care, comprehensive health management, and self-defined and wellness-oriented care.
- Shifting away from first/second/third line treatments to specific client circumstance, goals and previous treatment experience. Buprenorphine/naloxone is no longer suggested as a first line treatment followed by methadone and slow-release oral morphine.
- Addition of a long-acting injectable buprenorphine option which may be offered to those stabilized on buprenorphine/naloxone
- Alignment with CRISM iOAT Guidelines with the addition of injectable OAT with diacetylmorphine or hydromorphone to be considered for those adults with severe OUD and unregulated injection opioid use who have not benefitted from or have declined oral options for OAT
- OAT dosing, titration, missed doses, dosing protocols, and take-home dosing have changed
- Addition of a Continuing Care Appendix
- Guidance on buprenorphine/naloxone initiation in emergency room departments
- Updated guidance on urine drug testing

Addiction Medicine Clinician Support Line

The 24/7 Addiction Medicine Clinician Support Line provides telephone consultation to physicians, nurse practitioners, nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment in British Columbia. The Support Line connects health care providers to an Addiction Medicine Specialist who has expertise and knowledge in addiction medicine (including emergency, acute, and community care). Consultation can include support in screening, assessment, treatment and management of substance use and substance use disorder(s). In partnership with FNHA, the line also supports Indigenous communities in B.C. to access to addiction consult phone services. **This service extends beyond clinicians and provides addiction medicine guidance to any addiction support staff calling from Indigenous communities within B.C.**, including Indigenous urban centres.

Links to resources for this article are available at: bcpharmacy.ca/tablet/summer-24/overdose-awareness-day

Enhancing pharmacist expertise in minor ailments and contraception services

BY ISHIKA JAIN
COMMUNICATIONS COORDINATOR, BCPHA

Since first becoming licensed as a pharmacist in 2000, **Tamiz Kanji** spent a decade working for an independent pharmacy. In 2005, he became a lecturer at the University of British Columbia's Faculty of Pharmaceutical Sciences and in 2016 he was granted tenure as a senior instructor. In 2018, Kanji became the Director of Continuing Pharmacy Professional Development (CPPD). In this position, he works to deliver accredited learning programs for pharmacists. In 2023, in collaboration with the Ministry of Health, the BC Pharmacy Association and College of Pharmacists of BC, he began working on and publishing educational modules for pharmacists to support the pharmacists' ability to prescribe for minor ailments and contraception services (MACS).

Tell me about your role as the Director of Continuing Pharmacy Professional Development. What do you do, and how did you get here?

In 2020, I became an associate professor of teaching, through which I currently work within our Entry-to-Practice Doctor of Pharmacy Program (E2P PharmD). In this role, I focus on teaching and supervising directed studies courses. This also includes creating admissions questions for students and assisting with clinical skills in the administration of injections courses. I also participate in various faculty committees, including the student progress committee and the academic committee, which makes decisions for our faculty and students.

In my continuing pharmacy professional development role, I build educational programs, such as independent study programs, conferences, and in-person sessions. We accredit these programs for B.C. pharmacists, essential for licence renewal. Many accredited programs are developed in-house with faculty members and also with our Office of Experiential Education (OEE), targeting preceptors and practice educators.

We also offer programs to help train pharmacist facilitators, providing learning modules focused on pedagogy, inclusive teaching practices, engagement, feedback, and assessment. Additionally, we collaborate with experts in therapeutic categories like minor ailments and organizations like the BC Center on Substance Use, offering programs on opioid use disorder and related medications.

What are the main objectives when developing courses on minor ailments and contraception services for pharmacy professionals?

When developing courses on MACS, our primary focus is to facilitate an understanding of changes to the framework and how these affect the medications and services pharmacists can provide. Each learning program has specific learning objectives, references, and goes through an accreditation process with expert reviewers. This ensures the program is transparent in its intention and includes sound content that is unbiased and current.

Can you walk us through the process of creating a course from concept to delivery?

Through yearly consultation with our program advisory committee, topics of interest for pharmacists and pharmacy practice are proposed. Expanding on the topics, we identify a subject matter expert (SME). This is ideally someone who teaches in our E2P PharmD program and specializes in the area. They also usually have further insight into current and future developments. After contracting them, SMEs draft the course's learning objectives, description, content, and assessments. This content is then provided to our Office of Educational Technology and Learning Designs (OETLD), where their team consults with the SMEs on the design of the course and builds the course on UBC's learning management system.

Left to right: Tanvi Vuradi, Karen Dahri, Gabriella Wong, Nicole Wu, Gilly Lau, Adrian Ziemczonek, Tamiz Kanji, Ali Reza Ladak, Paulo Tchen, Jocelyn Micallef and Madeleine Lee.
Missing: Jonathan Grosshuesch, Jane Xia, Jamie Yuen, Tiana Tilli and Nicole Domanski.

Formative and summative assessments, visuals, and videos are incorporated into the courses to create engaging learning experiences that reinforce the concepts being delivered. The OETLD works closely with the SME to design the courses effectively. The course then undergoes an accreditation process with expert reviewers who check for requirements such as clear learning objectives, unbiased content, generic medication names, and appropriate references. If the course isn't approved initially, we make the necessary changes and resubmit it for review. Once approved, the program is accessible through CPPD's website and typically accredited for one year with the ability to renew for subsequent years.

Why do you believe it is essential for pharmacy professionals to be well-versed in managing minor ailments and providing contraception services?

I believe it is essential so that they can practice at their full scope — pharmacists must utilize their enhanced skills, training, and knowledge. While many pharmacists are already familiar with managing minor ailments, our programs ensure all pharmacists are comfortable with these tasks. From June 1, 2023, to May 31, 2024, over 430,000 minor ailments and contraception services (MACS) were conducted in B.C., highlighting the effectiveness of pharmacists in these areas.

I believe this expanded scope allows pharmacists to provide essential services, to improve patient access to care, and to reduce the need for possible emergency department visits. I think this service increases convenience, decreases wait times, and enhances health-care system efficiency, especially in rural and smaller areas.

What innovative teaching methods or technologies have you incorporated into these courses to enhance learning and practical application?

We have incorporated several innovative teaching methods and educational technologies into our courses. For independent study programs, content is designed to be engaged with asynchronously and at the learner's own pace. These programs typically include a combination of text, voice-over presentations, graphics, customized videos, and/or animations, to best support the learning outcomes.

Utilizing tools like H5P, content is reinforced through interactivity (for example, flip cards, hotspot images, interactive presentations, formative multiple-choice questions). Having multi-faceted assessments, such as knowledge or case-based questions, enables participants to strengthen their understanding.

We also offer live webinars and virtual conferences with expert speakers presenting topics and engaging audience responses through online polling, quizzes, and visual presentations. In the fall, we will implement in-person workshops that are Observed Structured Clinical Examination (OSCE) -based where participants will be required to demonstrate specific skills, competencies, and knowledge through authentic scenarios related to MACS. These workshops will involve pharmacist facilitators and standardized patients. Participants will rotate through stations simulating real-time practice situations, receiving feedback, rubrics, and resolution tips. These workshops are fully accredited and are part of our next series on minor ailments and contraception services.

How do you ensure that the content remains current?

First, we monitor new guidelines and developments to stay updated on professional skills and knowledge. Secondly, we connect with faculty and subject matter experts who developed the courses to discuss necessary adjustments. Thirdly, we conduct an annual review of the course, making updates before the accreditation expires. For immediate changes, faculty experts adjust the content as needed, ensuring the course is up to date and renewing its accreditation for another year.

What kind of feedback have you received from participants of these courses, and how has it informed future iterations?

We collect feedback through evaluations at the end of each program, including assessing learning objectives, content appropriateness, and overall effectiveness. We also ask about how participants have applied the course material and any areas for improvement. This feedback is reviewed and shared with our program advisory committee to guide future development. While most feedback is positive, we use it to make adjustments and develop new content based on participant needs and suggestions. Participants have the opportunity to express their interest in further education by identifying topics of interest, program delivery, as well as preferred length of programming.

Their insights have helped us to tailor the upcoming Prescribing with Confidence: An Interactive OSCE-style MACS Workshop, according to the needs and concerns expressed through their surveys.

What future developments do you foresee in the areas of minor ailments and contraception services, and how are you preparing pharmacy professionals for these changes?

We anticipate that the role and scope of practice of pharmacists will continue to expand in order to meet the growing demands within the health care system. To ensure that pharmacists are ready for further changes, we need to equip them with the skills and tools to meet today's demands, such as maintaining current learning programs on MACS, opioid use disorder, etc., and prepare pharmacists for tomorrow.

Our office is currently preparing a set of courses to help educate pharmacists in ordering lab tests for medication management. We're developing clinical educational modules to support this capability, which will be very valuable in adopting the new standards set by the BC College of Pharmacists for pharmacist ordering, receiving, and interpreting of laboratory tests. We are continuously in discussion with industry leaders and decision-making authorities, to discuss the future of pharmacy practice in B.C. We have many plans to support pharmacists, and given the dynamic nature of pharmacy, we aim to be a leading educator of clinical practices. T

Carolyn Cox is pharmacy manager at Brookline Pharmasave in Nova Scotia. Her pharmacy has been operating as a primary care clinic since January 2023.

B.C. government reviewing clinic model for community pharmacies

BY MICHAEL MUI
COMMUNICATIONS MANAGER, BCPHA

B.C. government has been reviewing different models of pharmacy clinics across Canada with an interest to implementing primary care services at community pharmacies in the province.

In February 2024, the BC Pharmacy Association presented a proposal to government to bring a "clinic model" of primary care to community pharmacies to help increase access to health care in underserved communities and for unattached patients with chronic conditions. Nova Scotia was the first province to implement such a model in community pharmacies, followed by New Brunswick and Alberta.

In a presentation to attendees at BCPhA annual conference in May, Mitch Moneo, Assistant Deputy Minister of the Pharmaceutical, Laboratory and Blood Services Division of the Ministry of Health, said his division has been collaborating with the BCPhA on the clinics proposal.

"We're really interested in the implementation of the pharmacists' clinic in British Columbia," Moneo said. "It seems like the work that's being done in Nova Scotia is also showing where there's opportunities and also where there are gaps, and where those gaps can be shored up."

Moneo said one of the first areas his division is examining is the ability for pharmacists to order lab tests, which will be enabled in B.C. in late August.

"There are other regulatory changes that we have to address around the ability for pharmacists to prescribe beyond medicines for minor ailments, so we really want to provide pharmacists with the authority to prescribe, to treat conditions, particularly for people with long-time chronic conditions," he said.

In a presentation on upcoming pharmacy initiatives on July 25, Jonathan Lau, Director of Pharmaceutical Care Initiatives at the Ministry of Health, said the pharmacy clinic model is increasingly common in Canada.

"Patients seem to like it a lot and even the pharmacists providing the service say they're getting a lot of professional satisfaction," he said.

"We are trying to take the learnings from Nova Scotia and other provinces to refine our process. I think the final report when it comes to the Nova Scotia model is coming out in October, so we'll be able to learn through the experience and adopt that into B.C.'s approach."

Nova Scotia was the first to test the pharmacy primary care clinic model in 2022. Since then, 31 community pharmacies in that province offer primary care services. Each clinic has its own set of two examination rooms, dedicated pharmacist, plus an administrative staff member who are solely focused on pharmacy clinic operations separately from the dispensary.

In summer 2023, some pharmacies in Alberta began their own primary care clinics, and in September that same year, the New Brunswick College of Pharmacists and the provincial Department of Health launched their own 12-month pilot program.

Allison Bodnar, CEO of the Pharmacy Association of Nova Scotia, provided an update to pharmacy clinics in her province at the BCPhA conference in May. Services at the Nova Scotia clinics include assessments and prescribing for a range of minor ailments, medication reviews, injections and immunizations, plus chronic disease care for diabetes, lung disease, heart disease and anticoagulation management.

Like other provinces, Nova Scotia has been experiencing a lack of access to health-care services, with 15 per cent of the population without access to a family physician or nurse practitioner. Community pharmacy clinics were offered as a solution, and so far, Bodnar said, patients have embraced the new model with most pharmacy clinic locations operating at 90 per cent capacity or more.

"We often hear in pharmacy, 'fill the gaps,'" Bodnar said. "We are not here to fill gaps. We are here to redefine how we deliver health care, because the system that was designed over 60 years ago when we weren't as sick, when we didn't have technology, when we didn't have this scope, is not what we should be trying to fit into and fill gaps in."

Photos: A series of photos show the pharmacy clinics operated by pharmacists Carolyn Cox and Terry Higgins (male pharmacist, top right). Each clinic has separate consultation rooms where non-dispensing work is overseen by a dedicated pharmacist, including vaccinations, chronic disease management, prescribing, medication reviews, point-of-care testing, and more.

How a pharmacy clinic operates

The Tablet spoke with three pharmacists operating pharmacy clinics in Nova Scotia to hear about their experiences.

Carolyn Cox, pharmacy manager at Brookline Pharmasave in Bedford, N.S., said her pharmacy has been operating a clinic since January 2023. To create the additional space for a pharmacy clinic, her team leased the unit next door to their pharmacy, which itself is located inside a shopping plaza.

"The space was just renovated and we have five clinic rooms in there, there's a waiting area and a reception where we have our clinic administrator," Cox said. "We mainly use two of the clinic rooms. In one room, we do strep throat assessments — and soon to have ear and sinus assessments, too — and in the other room we have our A1C machine and lipid machine, and that's where we do our chronic disease type of appointments."

Her average clinic day is typically organized by appointments, each taking up to 30 minutes. To help split the workload, her staff team of three pharmacists share a schedule where each operate the clinic for a few days per week.

"Depending on the time of year, some of the work can be quite repetitive. For example, this year, we had a surge in strep throat appointments during the winter. There was one day where I did 28 appointments for strep throat. If I was doing that for five days a week, that would be difficult, in that it would be a lot of repetition, so we try to make sure that our team members have variety in their work," Cox said.

Cox said most patients have been very receptive to the new services, are relieved to finally have timely access to care, and are comforted by the clinic setting that reminds them of physicians' offices. For many patients, their first introduction to the clinics is hearing about them through government advertising, being referred by another pharmacy, or being referred by other health providers such as from hospitals or physician offices.

"I would say these pharmacy clinics look almost identical to a physician's office … having that private consultation room space to have someone to talk to, to have someone go over their medical history, especially for chronic disease appointments, and just having someone to listen to them is very helpful in making them comfortable," Cox said. "The public loves our services. Anyone coming in for an appointment, we ask them do a survey and the satisfaction rate is in the 90 per cent range."

Tips for implementing your own pharmacy clinic

Terry Higgins, associate owner of two Shoppers Drug Mart locations in Sydney, N.S., said he jumped at the opportunity to have one of his stores serve as a pharmacy primary care clinic when applications first opened. His store was among the first dozen selected in areas of Nova Scotia that were determined to lack access to primary care.

Apart from setting up his store to meet the physical requirements of having a clinic, Higgins and his staff also had to undergo about 40 hours of training before offering the new services, including training on ordering and interpretation of pertinent labs.

"Scope is continuing to expand and evolve, so the learning is perpetual. Before I even opened our door, I had a lunch and learn with a group of physicians and nurse practitioners in a primary care clinic for unattached patients. The purpose was to provide clarity of what we can and can not do, and to discuss how we can work together to optimize efficient delivery of care. This open discussion was invaluable to set the stage for congenial collaboration," Higgins said.

"Their clinic was extremely busy and they were not taking new patients. We forged a strong relationship with them early on, with the goal of seeking clarity on what we can offer to reduce the burden on their practice, while improving care in our community in general."

As a result of those initial discussions, the relationship between

the pharmacy clinic and the physicians' clinic has evolved into one where the pharmacy is referring complex cases, or cases where a patient's condition becomes more serious, while the physicians refer chronic conditions, minor ailments, prescription renewals and the like to the pharmacy team.

"We started as a 40-hour per week clinic and now we are operating 44 hours each week, typically at full capacity," he said.

Higgins and his team, however, had to be wary of the potential mental fatigue of complex clinical work. This led his team to start arranging appointments to have more complex cases early in the day, and to spread these appointments throughout the week so they don't all land on the same shift.

"It was a little tip from our consultant from the Association. We did a reset to allow for a mix of more complex interactions with shorter, lighter interactions, such as strep assessments and injections," Higgins said.

To help his team become acclimatized to the clinical work, Higgins created a chat group among his pharmacists so lessons from each day's clinic shift could be shared. His team also further leveraged relationships with physicians and specialists so they could ask for advice. Another important component was having a well-trained clinic administrator who can help smooth out the pharmacist's workflow.

"We call her the clinic administrator extraordinaire. Every day she comes in early and tees up the day for us. If our first appointment is a diabetes follow up, she will have the initial assessment sheet ready to go before the patient walks in through the door. I can check the notes that the previous pharmacist left, so I know right where we left off," Higgins said.

Miranda Teasdale, pharmacist-owner of Teasdale Apothecary Co. in Antigonish, N.S., signed on as a pharmacy clinic in April 2023, when the province added 14 more pharmacy locations to the existing dozen at the time.

Over the past year, her team has noticed that taking clinical work out of the dispensary has been a significant benefit.

"Where it gets tricky and what we're trying to avoid is that if you have a pharmacist in the dispensary, they should ideally be focused on dispensing, counselling and phone calls," Teasdale said. "It can get overwhelming and can become a recipe for staff burnout if you have a dispensing pharmacist also trying to help someone at the counter with a tick bite, or rash; it's just a lot better for safety and workflow to separate those two services."

Having practiced previously in Alberta, where qualified pharmacists were given prescribing authority in 2007, Teasdale said it's not surprising other provinces have began expanding their scope and implementing pharmacy clinic models.

"The health-care crisis is not going anywhere. In many places for a long time, pharmacists have not been able to practice to their full scope until very recently," she said. "The clinic-based pharmacy is the best way to utilize the profession to our full scope in the most effective and safe way for our patients. It doesn't surprise me that more provinces are jumping on board."

Currently, the vast majority of pharmacy clinic appointments are pre-booked by patients at all three pharmacies *The Tablet* spoke with. Teasdale advised that pharmacists should still strive to accept walk-in patients whenever possible.

"Because we are known as the most accessible health-care providers. But with all of these extra roles and extra scope that we are taking on, sometimes we're unable to make that expectation a reality. For example, you would never walk into your doctor's office and say I need someone to look at this immediately. You would make an appointment," she said.

"So setting that expectation with patients can be a little bit of a barrier at first. We are still accessible. What we try to do is book our appointments only two to three weeks in advance, and also reserve about 25 per cent of our appointments for same day bookings. That way we're still able to take care of someone seeking urgent, same-day service."

Pharmacy groups share thoughts on clinics for B.C.

The Tablet also reached out to several pharmacy groups operating in British Columbia to inquire about the local appetite for pharmacy clinics.

Eric Lin, District Leader with Rexall, said his company has already been operating clinics in Ontario and Alberta, where pharmacists offer services such as minor ailments prescribing, chronic disease management, immunizations, point-of-care testing and more.

"Rexall is highly committed to being part of the solution to the current challenges in our health-care system. As an industry leader in patient care, Rexall aims to enhance access to health care by opening pharmacist-led walk-in clinics in British Columbia," Lin said.

However, he pointed to several factors that should be taken into consideration to support pharmacy teams if a decision is made to implement pharmacy clinics in B.C.

These factors would include ensuring there is funding available to help pharmacies cover operational costs, such as hiring a dedicated pharmacist for the clinic, or costs involved in making structural changes to pharmacy sites to ensure pharmacy clinics have a dedicated space.

Lin said decision-makers should be open to piloting and testing new health-care services or programs within clinics.

"This may include establishing partnerships with health technology vendors or virtual care teams to enable a more holistic care model based on the needs of each specific community, as well as patient feedback," he said.

Lastly, Lin said that it would be important to have a process in place so clinic teams are able to collaborate seamlessly with other health-care providers involved in the patients' care.

"The clinic and pharmacy teams are extensions of the patient care journey," Lin said.

Along with ensuring proper reimbursement for services, the BC Pharmacy Association believes pharmacy clinics can't exist without adding additional scope of practice.

Brent Evans, General Manager, Medicine Shoppe Canada, shared lessons from his banner's experience learned in the Nova Scotia pharmacy clinic project.

"Based on our experience with the Nova Scotia Community Pharmacy Primary Care Pilot project, it is crucial to have effective administrative support, an efficient appointment booking system, and a clear distinction between core pharmacy services and clinic operations," he said. "Starting with a smaller-scale implementation allows pharmacists to gradually adapt and build confidence in the new model, especially since many are already providing similar services."

Evans said his pharmacy franchise is committed to advancing the role of pharmacist-led clinics due to the benefits this model offers for patient care and outcomes. He said many Medicine Shoppe locations are already equipped with private consultation rooms and were designed to facilitate expanded pharmacy services.

"Our existing pharmacy infrastructure, combined with a focus on providing uninterrupted access to pharmacists, makes the expansion into primary care both practical and advantageous for our locations," he said. "We couldn't be more proud or confident in our ability to deliver positive patient outcomes to Canadians, including through support for pharmacist-led clinic space."

Penny Lehoux, Manager of Pharmacy Managed Care at London Drugs, shared that their pharmacies across B.C. are planning for more expanded scope of practice roles for pharmacists.

"To best execute these services, the pharmacists need training, support, a strong pharmacy team, and more time to interact with patients, less time filling prescriptions," she said. "One way we are preparing is by adding multiple consultation rooms to our new or renovated stores. We are also utilizing advanced workflow technology and have expanded our central fill facility capacity to relieve some of the refill prescription volume."

Lehoux said London Drugs is hiring clinical pharmacists across B.C. to focus on appointment-based pharmacy services like vaccinations, MACS assessments, medication reviews, disease management, point of care tests, patient support programs, and the expansion of London Drugs Travel Clinics.

"Due to shortages across all health care professions, there is an endless supply of patients with unmet health care needs," she said. "We want to help those patients conveniently access trusted health advice and pharmacy services when they need it, so they can feel empowered to maintain and improve their health."

Pharmacists seem to love the clinic model

For those pharmacists who have worked decades in a dispensing model, being able to offer a wide range of clinical services has been exciting.

"A lot of our new graduates, they're trained for exactly this type of work. This is my 30th year as a pharmacist. When I first heard of this opportunity, I jumped at it. I love pilot projects and I try to be involved in every one that comes along. The clinical work is so rewarding and it is nice to have a mix of work between the dispensary and the clinic," said Higgins, the Shoppers Drug Mart pharmacist in Nova Scotia.

"It's been incredible," said Teasdale, owner of the independent pharmacy. "The feedback we have received is nothing but positive. We've had folks who have previously sat in the emergency room for eight hours with their young kids for what they thought was a strep throat. Now, they can book an appointment with us, get their results back within six minutes, and we send them on their way with a prescription. As a pharmacist, this is a really rewarding role."

Cox, the Pharmasave manager, echoed her colleagues.

"I love it. I really enjoy it. Especially when you see someone who has had a hard time accessing health care in the past, and now you're developing a relationship with them and seeing that what you're doing is making a difference, I get a lot of satisfaction from that.

"I never thought I would be doing this. It really opens up a world of opportunities. This was not something on my radar when I started as a pharmacist 18 years ago, or even five years ago."

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1 Dexcom G7 CGM System User Guide, 2023. 2 Puhr S, et al. J Diabetes Sci Technol. 2020;14(1):83-86.
3 Dexcom, Data on file, 2024.

Dexcom G7

count on it.

(Left to right) Pharmacists Irene Yan and Gilbert Qin, pharmacy manager Hafeez Dossa, pharmacy technicians Caitlyn Ninatti, and Maran Kokoszka.

Deprescribing tramadol in a Long-Term Care setting: A CASE STUDY.

BY HAFEEZ DOSSA, BSC | PEER REVIEWED BY DR JESSICA OTTE, MD, CCFP, FCFP

Abstract

Objective: To review the use of tramadol in a long-term care (LTC) facility setting. Based on recent literature, tramadol does not have a better safety or efficacy profile in pain management than alternative analgesics, has more problematic interactions, and comes at a higher cost. Through a pharmacist-led intervention at more than 20 LTC facilities across Vancouver Island, we aimed to re-evaluate the appropriateness of tramadol therapy across all patients.

Methods: This nine-month prospective quality improvement intervention looked at all LTC residents serviced by the pharmacy (approximately 2,000) who had a prescription for tramadol containing medications (tramadol or tramadol-acetaminophen, e.g. Tramacet). Over six months, through medication reviews, care conferences, or individual letters faxed to prescribers, recommendations were made for stopping or switching to alternative analgesic medications. Changes were processed by the pharmacy team as prescribers agreed or disagreed with our recommendations, and results were collected after the six-month mark. A follow up report was generated three months later to identify the durability of recommendations beyond cessation of the intervention (i.e. to see if patients remained off tramadol, or if tramadol was restarted). Total medication costs were also assessed for each resident who had tramadol on their medication list at the start and end of this initiative.

Results: 83 patients were identified that had a prescription for tramadol at month zero. After accounting for residents who were either discharged or passed away during the study period of nine months, 57 remained eligible for follow up. Of these 57 patients, 40 (70 per cent) were no longer using tramadol (12 completely discontinued and did not change to an alternative pain medication, while the other 28 switched to a more appropriate analgesic). 17 (30 per cent) remained on tramadol. The average monthly spend for each patient on tramadol prior to intervention was reduced by approximately $40 per month (or approximately $480 annually). Total cost savings achieved across all residents, on an estimated monthly basis, was approximately $1,550/month (or approximately $18,600 annually).

Conclusion: A pharmacist-led intervention in a long-term care setting can dramatically reduce the inappropriate use of tramadol. This allows for a reduction in unnecessary drug costs, may be associated with reduced drug interactions, reduces pharmacy dispensing, and reduces nursing administration workload, without negatively impacting pain management. Clear communication and collaborative care are factors that facilitated the reduction in inappropriate and unnecessary use of tramadol. These findings can inspire other pharmacists and health care professionals within an interdisciplinary setting to consistently re-assess the appropriateness of all medications, including tramadol.

Let's talk about tramadol.

According to data from PharmaNet in 2020, almost 150,000 British Columbians received a prescription for tramadol (any formulation). From its introduction to Canada in 2005 until very recently, tramadol was not considered a narcotic medication. But in March of 2022, tramadol was added to Schedule 1 of the *Controlled Drugs and Substances Act*.

What does this mean to me as a patient who's looking for a solution for acute or chronic pain? As health-care professionals, how do we really feel about tramadol? Let's review.

When considering medications for pain management, we typically would consider the following stepwise approach:

1. Acetaminophen (Tylenol)
2. NSAIDs (Ibuprofen/Advil, Naproxen/Aleve, Diclofenac/Voltaren)
3. ????

The "????" is based on a few factors. Does the patient have nerve-related pain, perhaps from complications associated with diabetes? Let's explore gabapentin/pregabalin. Is there a potential case to consider sciatica or lower back pain? Does the patient also have depression? Maybe duloxetine or a tricyclic antidepressant would be the answer. None of the above? Are we comfortable enough to look at cannabinoids, such as nabilone or medicinal cannabis? Might want to consider referring this to a specialist.

But the patient is looking for an answer, now. Hydromorphone or morphine? Opioids sound scary, given their abuse potential, the potential need for a triplicate prescription and the risk of overdose; not to mention the stigma associated with narcotic medications and the fentanyl crisis.

Then there's tramadol. Marketed as "not quite an opioid," but a step up from acetaminophen and NSAIDs. Tramadol is often considered a "safer" opioid based on its pharmacology and seen as a drug with not as high of an abuse potential, and risk for overdose, compared to opioids. And until 2022, in Canada, this wasn't considered a narcotic medication. Seems like the logical next step, doesn't it?

Seated (L-R): Irene Yan, Gilbert Qin, Hafeez Dossa, Ashley Kennedy.
Standing (L-R): Romil Vaya, Cindy Villarico, Maran Kokoszka, Bonnie Stafford, Jaber Khan, Saifullah Khaled, Jeesan Ul-Islam Raktim, Raj Kapadia, MihirShah and Caitlyn Ninatti.

Let's consider the following when reviewing tramadol:

- A major metabolite of tramadol (M1) does have affinity for opioid receptors. However, its potency for activity on these receptors is around 10 per cent relative to morphine, so in theory, it is not as potent of an opioid, and many would consider this to have a lower risk of abuse potential versus traditional opioids. It also doesn't sound as scary as morphine, hydromorphone, or fentanyl. Most wouldn't consider tramadol to be a narcotic medication, until recently.
- Tramadol also has activity on other neurotransmitters, including serotonin and norepinephrine. Similar to some antidepressants (e.g. venlafaxine), tramadol reduces the re-uptake of these chemicals, which may help with an overall reduction in pain and improvement in mood.

Based on the above information, tramadol sounds pretty cool! Why would someone who has not found success with other OTC and prescription pain medications not try tramadol?

Let's also consider the following:

- Tramadol is not covered by PharmaCare, is not an LTC Plan B or Palliative Plan P benefit, and is also not available for special authority. This means that unless you have a third-party plan that pays for tramadol, you'll be paying out of pocket. And tramadol isn't cheap. If taking Tramacet twice daily, our patients pay approximately $40 per month, or $480 annually. Note that opioids, such as hydromorphone and morphine, are covered by PharmaCare. For LTC residents (PharmaCare Plan B), both are fully covered and would come at no cost to the resident.
- Because of its activity on serotonin and norepinephrine, there is a risk of drug interactions. Many patients in a LTC setting take antidepressants, such as escitalopram or venlafaxine, and side effects of using both at the same time include an increased risk of falls, serotonin toxicity, and insomnia. Although opioids such as hydromorphone and morphine do have adverse effects, they do not carry with them the same risk of interactions as tramadol, as they act only on opioid receptors.
- There is evidence that suggests tramadol may increase the risk of hypoglycemia, which is especially concerning for elderly patients.
- It is debatable whether or not tramadol is as effective when compared to opioid pain medications, such as hydromorphone and morphine. Recent literature, such as a large Cochrane review on tramadol for osteoarthritis also suggests that tramadol may not even be as effective as traditional OTC pain medications such as ibuprofen.

If opioids are potentially equally or more effective, have less risk of interactions, and are cheaper, why don't we just use them in the first place? This question prompted me to see what would happen if we started this conversation with the prescribers of our patients taking tramadol.

At CareRx Parksville, we service approximately 2,000 patients who reside in LTC and Assisted Living facilities across Vancouver Island. We have the opportunity to collaborate directly with physicians and nurses through care conferences, medication reviews, and medication reconciliations during transitions into care, which enables us to engage in meaningful conversations on whether drug therapy is appropriate or not.

In November 2022, we ran a report of all patients taking tramadol containing medications (tramadol, Tramacet), and found that 83 had an active prescription. We made recommendations for each individual patient for either of the following:

- An alternative pain medication, such as hydromorphone (if pain was classified as severe and requiring opioids) or acetaminophen (if pain was classified as non-severe).
- A reduced dose, if it was determined that tramadol was an appropriate pain medication.
- Changing to a PRN dosing administration, to determine if regular dosing was necessary in the first place.
- A discontinuation of tramadol altogether, if there were no complaints of pain based on feedback from family/nursing staff.
- Continuing the previous dose of tramadol, if it was determined there was an appropriate reason.

We made these recommendations to the prescriber, following a consultation with the patient's nurse, family, and/or care aides involved in the patient's care.

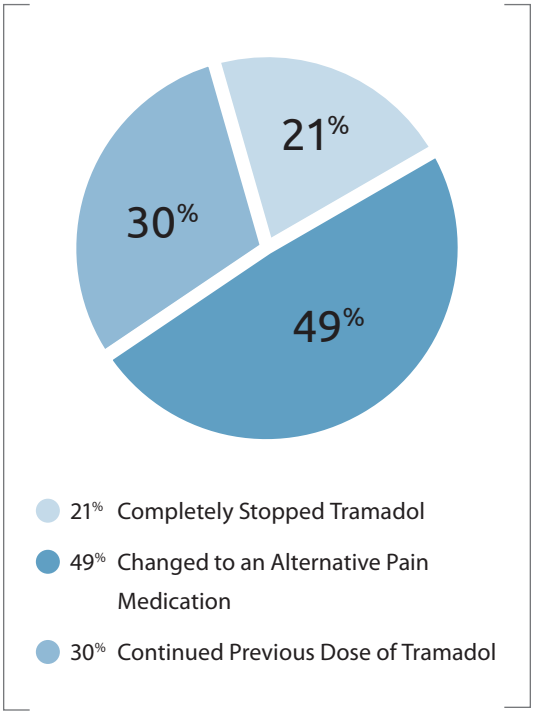
After six months, all recommendations had been made, and changes to patient's medications profile had been processed by the pharmacy. We waited another three months before compiling the final statistics, to account for any patients who may have reverted back to their previous regimen of tramadol due to an increase in pain following intervention. At the nine-month mark, in June 2023, we eliminated those who were either discharged from the facility, or passed away during the study period, which left us with 57 patients.

Here's what we found:

40 patients (70 per cent) completely stopped using tramadol.

- 12 patients (21 per cent) did not switch to an alternative pain medication (i.e. did not need medication for pain management n the first place).
- 28 patients (49 per cent) switched to an alternative pain medication, such as acetaminophen, hydromorphone, or fentanyl.

17 patients (30 per cent) remained on their previous dose.



What was the impact of this?

- For the patients who stopped taking tramadol, there were no reports of worsening pain.
- We reduced the risk of interactions associated with concurrent drug therapy with antidepressant medications, along with a reduced risk of hypoglycemia.
- In some cases, we also eased the administration of medication for nursing staff:
  - If no alternative medication was prescribed, this would reduce the need for administering a medication (which includes crushing medications in some cases).
  - If hydromorphone was selected as the alternative medication (this was the most commonly selected alternative), it is a much smaller tablet, which is much easier to swallow. As mentioned, hydromorphone is fully covered by Pharmacare Plan B for LTC residents, which means the drug is free for these residents.
- We achieved significant cost savings. The average patient taking a regular dose of tramadol, without third party coverage, saved approximately $40/month, or $480 annually. On a cumulative basis, this entire project saved the 57 total patients approximately $1,550 monthly, or $18,600 annually.

> *It is great to see that pharmacist-led efforts can help physicians and NPs revisit orders for tramadol or tramadol-acetaminophen and that it really does lead to improvements for patients. Sometimes all it takes is a little nudge to reconsider the prescription, and it seems that 'little nudge' has been very impactful.*
>
> — Dr. Jessica Otte,
> UBC Therapeutics Initiative

Let's review two cases where tramadol was successfully deprescribed:

Resident A, a 91-year-old female, was taking two tablets of Tramacet twice daily. Following a medication review, it was suggested that the patient switch to hydromorphone 1mg twice daily, as this patient did need medication for management of their pain, but there was no documented reason for Tramacet being preferred over other opioids. There was no reported change in management of pain, and this resulted in a cost savings of approximately $120 per month, or $1440 annually.

Resident B, an 86-year-old female, was taking one tablet of Tramacet twice daily, and also had an additional dose of one tablet twice daily as needed for pain. During care conference, it was suggested that this patient may benefit from more consistent around the clock pain management with a fentanyl patch, as they had challenges with taking oral medications. Special authority was granted, and this patient was changed to a fentanyl patch (12mcg strength applied every 72 hours), in addition to changing their PRN medication to hydromorphone 1mg three times daily as needed for pain. This change resulted in a cost savings of approximately $50 per month. There was no reported change in pain management, and this resulted in a cost savings of approximately $50 per month, or $600 annually.

Some examples where continuing the previous dose of tramadol was considered appropriate included the following:

- A previous history of opioid addiction with morphine, where tramadol did not have the same level of dependency for the patient.
- Drug allergy to hydromorphone.
- Intolerance to other opioid medications, where drowsiness and an increased risk of falls was cited as a concern, and tramadol did not have the same level of adverse effects for this patient.

If tramadol is not more effective than other opioid medications, is more expensive, and has a higher risk of interactions, why are people still taking it? From my experience working in LTC, there are three reasons why this happens:

1. **Prescribing inertia.** For example, a patient may have been prescribed tramadol 10+ years ago, and found that this was an effective medication to manage their pain. They weren't taking any interacting antidepressant medications at the time, and had third party coverage so there was no real harm or cost concerns for this patient to take the medication. Another patient may have been discharged from hospital with tramadol, and continued on this medication without questioning its cost and never did have a meaningful conversation with a health-care professional on the risks/benefits of continuing.
2. **Ease of access and enduring perception that tramadol is not an opioid or is safer than other opioids.** Until 2022, tramadol was not considered a narcotic medication. However, despite the recent addition to Schedule I of the *Controlled Drug and Substances Act*, tramadol still doesn't require a triplicate prescription as it is not classified as Schedule 1A. The means that a prescriber does not need to apply for a specific prescription pad to write an order for tramadol, but would require this for other opioids such as hydromorphone. For reference, the waiting time for processing an order for a new set of prescription pads is approximately two to three weeks. Although regulations have now changed with regards to tramadol's classification as a narcotic, these implications affect pharmacy inventory management processes (narcotic counts and drug-keeping records) more than accessibility to prescribers and patients.
3. **Patient perception.** There is a real fear among patients that opioid medications can lead to dependency, have serious side effects, and can cause overdose. Although these points are important to consider, when dosed appropriately and monitored by an interdisciplinary team in a controlled health-care setting such as LTC, opioids can be a safer and equally effective alternative to pain management in comparison with tramadol.

Dr. Jessica Otte, a member of the UBC Therapeutics Initiative, is a physician who does palliative care and is the family physician for some of our LTC patients. She is a strong advocate for the review of tramadol prescribing practices in all clinical settings. She had the following comments in response to the success of this initiative:

"Hafeez has once again demonstrated that combining a bit of determination with starting conversations with prescribers is a successful recipe for reassessing the appropriateness of medications, and that these small interventions have a lasting effect. Having done a Systematic Review on the safety and efficacy of tramadol in my role at the UBC Therapeutics Initia-

tive, I can say there is clearly no safety or efficacy benefit to using tramadol over other opioids and that NSAIDs — when safe for the patient — are likely more effective. The cost of tramadol is high, so if an LTC resident needs opioids, they (and insurers) appreciate deprescribing where possible or lower-cost options when opioids are indicated.

"Tramadol also complicates prescribing as LTC residents might also be prescribed SSRIs, SNRIs, anti-nauseants like metoclopramide, and then be at risk of serotonin toxicity. The fact that tramadol is associated with hypoglycaemia, especially in patients with diabetes, is really under-appreciated. Hypoglycemia can have catastrophic results especially in frail elders in LTC. Fortunately, stopping tramadol or substituting opioids that don't have these issues, like hydromorphone or morphine, are reasonable options.

"It is great to see that pharmacist-led efforts can help physicians and NPs revisit orders for tramadol or tramadol-acetaminophen and that it really does lead to improvements for patients. Sometimes all it takes is a little nudge to reconsider the prescription, and it seems that "little nudge" has been very impactful."

Gilbert Qin, pharmacist with CareRx Parksville, understands the impact pharmacists can have on patients in the long-term care sector, and the results of this project highlight the importance of our profession in optimizing medication management:

"As a pharmacist in British Columbia, I recognize our vital role in enhancing public health and ensuring medication safety. Our profession faces significant challenges, including drug shortages, staffing difficulties, and the increasing administrative burdens that can detract from patient care. We remain committed to addressing these issues, such as by reducing unnecessary medications to minimize adverse drug reactions and improve treatment efficacy."

Qin also feels that this initiative helps support advocacy efforts for the pharmacy profession.

"Additionally, there is a pressing need for increased funding and resources to support pharmacy operations, ensuring we can continue to deliver high quality care. By advocating for better support systems, we aim to fortify our practice and continue to positively impact the health and safety of our communities."

Ashleigh Wasner is an RN and Executive Director with Eden Gardens, a LTC facility located in Nanaimo. Approximately 140 residents live at Eden Gardens, and four were included in this project. She shared the following comments:

"In my role as the Executive Director at Eden Gardens, I oversee operations at the facility, which includes management of nurses and care staff, building relationships with residents and their families, and maintaining a strong sense of community within our interdisciplinary team. I have an extensive background as a registered nurse, so when patients are admitted to care at Eden Gardens, whether from community, hospital, or another care setting, there have been so many times I've questioned whether or not someone needs to be on a certain medication. We work closely with our pharmacy team to review each patient's drug profile during care conferences and medication reviews, and it's so great to see the results of this project, especially the cost savings. Many of our residents do not have the capacity to afford such high cost medications, and we appreciate the pharmacy team's efforts in advocating for our patients. This is only a snapshot of the impact pharmacists have on improving the lives of our residents through reviewing medications — we consistently see reductions in other medication classes including antipsychotics, PPI's, and antihypertensives — and we commend the initiative taken by the pharmacy team to put this project together, which showcases work that is being done on a consistent basis."

Many aren't aware of the role that pharmacists play in LTC, and there are quite a few key players involved behind-the-scenes in making a project like this possible:

- Clinical pharmacists, who are involved on-site at care facilities to engage in medication reviews and care conferences.
- Operations pharmacists, involved in medication reconciliations for patients transitioning into care and verifying the appropriateness of each prescription.
- Registered technicians, involved in final product checks
- Pharmacy assistant staff who type prescriptions, operate packaging machines, prepare medications, and manage inventory processes.

To summarize: These initiatives make a significant impact in minimizing the risk of adverse effects and reducing unnecessary drug spending. As pharmacists, we are the most accessible health care professional, and should always be thinking of whether a drug is necessary or not before dispensing to a patient. I hope that the success of this project showcases to all pharmacists, both in institutionalized settings and in community, how important our role is in the overall health care system, and that we continue to advocate for all patients to ensure safe and effective drug therapy. T

Hafeez Dossa is the pharmacy manager for CareRx Parksville, a pharmacy that services approximately 2,000 patients who live in LTC and residential care facilities across Vancouver Island. He is passionate about optimizing medication management, and this project is his second published initiative, the first being in 2020 where more than 50 per cent of patients taking PPIs were successfully deprescribed. A 2017 UBC pharmacy graduate, Hafeez also enjoys playing hockey, pickleball, participating in triathlon events, attending live music shows, and checking out local breweries.

James Morrison is Director of Pharmacy Excellence with Wholehealth Pharmacy Partners. He presented on the topic of gender-affirming care at the BC Pharmacy Association conference in May 2024.

Gender-Affirming Care: FOSTERING INCLUSIVE PHARMACY PRACTICES

BY JAMES MORRISON, BSCH, BSCPHM, RPH

There is growing evidence that people who identify as a member of the 2SLGBTQ+ (Two-Spirit, lesbian, gay, bisexual, transgender and queer) community are facing inequities when it comes to accessing health care.

According to a national transgender discrimination survey, 28 per cent of individuals in this group have postponed or avoided medical care due to discrimination, 19 per cent have been refused care due to their gender identity, and 50 per cent have found health providers lack knowledge in their care.

In British Columbia, 11 per cent of 2SLGBTQ+ individuals reported avoided emergency rooms and more than half rated their mental health as fair or poor. One in four considered suicide in the past year.

Barriers to care for 2SLGBTQ+ patients

In an attempt to understand what the experiences were in pharmacy for 2SLGBTQ+ individuals, Molly Yang and myself at Wholehealth Pharmacy Partners decided to conduct a survey among patients accessing pharmacy services at Canadian pharmacies in 2023. The survey yielded 55 responses, which give an indication of what it is like to be 2SLGBTQ+ while interacting with pharmacies.

In the survey, more than half of the respondents said they were uncomfortable or very comfortable discussing their gender identity with a pharmacist they did not know. And more than three in four said they avoided going to a pharmacy because of their gender identity. We found almost one in four patients encountered a pharmacist who refused to address them by their lived name or use their preferred pronouns while communicating. Alarmingly, more than 15 per cent of respondents said their pharmacist used hurtful or insulting language about their identity or experience.

When patients have a negative experience, it can lead to them avoiding health care altogether.

The reality is that there is a list of current barriers that 2SLGBTQ+ patients face when accessing all sorts of health care,

not just in pharmacies. These barriers include a lack of knowledge from health providers on 2SLGBTQ+ needs, or having negative attitudes towards people who are 2SLGBTQ+, in addition to potentially having less access to health care due to their ethnicity, or education and income level, immigration status, or other factors.

These barriers can result in reduced health-care outcomes. While data is scarce due to a lack of tracking of 2SLGBTQ+ health outcomes in the prior decades, there is evidence that shows trans people, for example, are less likely to be screened for cancer and have cancer detected later when compared with cis individuals.

When a 2SLGBTQ+ person attends your pharmacy, be aware that they may be guarded patients, not because of something you did, but because of previous negative experiences within the health care system. This can mean that they are reluctant to disclose their sexual orientation, or gender identity, and they may hold a perception that you and your pharmacy team are not welcoming towards 2SLGBTQ+ people until they see otherwise.

But there are also positive experiences that we heard in the survey.

One patient reported how a pharmacist began immediately using the patient's chosen name after a conversation with their doctor about a refill, and expressed how affirming the experience was.

Another patient described telling their pharmacist that they would like to pursue hormone replacement therapy, how the pharmacist said they would be happy to help in any way they can.

A third patient described how the two pharmacies they visit have at least one trans, non-binary and lesbian or gay person on their staff team.

What you can do when communicating with patients

For community pharmacists, there are steps you can take to help provide affirming care to 2SLGBTQ+ patients.

These steps can start from something as simple as using the patient's own words in your communication with them. The words your patients choose can cover anything from the patient's name, their gender identity, or to the word they use to refer to their partner. If you as their pharmacist also choose to say the same words used by the patient, this can be a form of gender-affirming care.

The language you choose is crucial, and it often starts with pronouns. Pronouns are something we use when we are talking about another person. Something I have adopted is to wear a pronoun pin and a rainbow pin on my uniform. It's not because I am trying to communicate my pronouns, or that I am a queer person, I am wearing these items to help communicate to my patients that they are safe with me. Once a patient has communicated their pronouns to you, document them for future visits and so other team members in your pharmacy will use them too.

And if you are uncertain about a patient's pronouns, or if a patient seems reluctant to communicate their pronouns, a good idea may be to avoid pronouns altogether by referring to the patient by their name. If you don't know a person's pronouns, a good default is they/them.

Inclusive language goes beyond pronouns. Recently, I was travelling and saw at the airport a "lactation pod" and I thought this was a great example of inclusive language. The word "breast" or "breastfeeding" is gendered and can cause gender dysphoria for individuals. So instead of breast, try "upper body". Instead of "penis", try "genitals" or "external genitals", and "internal genitals" instead of "vagina". For reproductive organs, try "external" or "internal" reproductive organs.

Two-Spirit

Indigenous People's term to describe a person who has both a masculine and feminine spirit. It is used by some Indigenous people of Turtle Island to describe their sexual, gender and/or spiritual identity.

Transgender

An umbrella term to describe individuals who are not cisgender, to describe individuals who feel as though their internal sense of gender does not align with their sex assigned at birth.

Non-binary

A term used by individuals who don't identify with traditional binary concepts of gender. These patients may feel that their gender falls somewhere between or outside of the binary notions of man or woman.

Gender identity

A person's internal self-awareness of being a man or woman, or something in between, or something other altogether.

Misgender

Referring to someone intentionally or unintentionally as a gender other than the one with which that person identifies.

Dead name

The name that a transgender person was given at birth and no longer uses upon transitioning.

Avoid assumptions. You can't assume a person's gender identity by looking at them or from hearing their voice. Do not assume their gender identity, their sexual orientation or their family structure. If you are unsure and the answer is relevant to the patient's care, the best thing to do is to respectfully ask.

Privacy is also extremely important. Someone's gender can be deeply personal and depending on who else is in the room, you could potentially "out" someone by accident, for example by calling across the counter about their prescription, or communicating about their gender-affirming prescription with a family member who doesn't know. Have safeguards in place to protect your patients and their privacy, and only discuss their medications with others if you have the patient's consent.

Communicating a safe space for 2SLGBTQ+ patients

As we have covered, many 2SLGBTQ+ patients have had negative experiences accessing care. Identifying yourself as a pharmacy that offers inclusive care can be a way to help 2SLGBTQ+ patients rebuild their confidence in our health-care system.

At my two pharmacies, I have created posters that identify my stores as positive spaces where lesbian, gay, bisexual, trans, Two-Spirit and queer people, along with their friends and allies, are welcomed and supported.

> *"I have created posters that identify my stores as positive spaces where lesbian, gay, bisexual, trans, Two-Spirit and queer people, along with their friends and allies, are welcomed and supported."*

Many pharmacies will have posters describing various clinical services often featuring images of families. Ask yourself whether 2SLGBTQ+ people are represented in these materials. Having 2SLGBTQ+ representation in visuals around your store help communicate, without words, that your pharmacy is in an inclusive space.

With the introduction of minor ailments, I know many pharmacies are using intake forms to fill out patient details prior to an assessment. Consider including inclusive options beyond just "male" and "female" in the intake form when inquiring about a patient's gender, and include an additional question asking for the patient's sex at birth.

Other considerations can include gender-neutral washrooms, placing your pronouns on nametags, and placing inclusive messaging on your pharmacy website. Everything helps.

Hormone therapy: a few principles

Not every trans person wants to take hormones, and not every trans person wants gender-affirming surgeries, but many do. It's important not to assume.

The most common therapy for a person undergoing transmasculine transition are testosterone intramuscular injections, which are taken to help the patient develop male secondary sex characteristics, and suppress or minimize typically-female secondary sex characteristics. Transmasculine individuals may also be treated with progestins to help with contraception and to suppress their monthly bleeding.

For transmasculine individuals taking testosterone, common side effects include acne, scalp hair loss, and internal genital dryness. If monthly bleeding continues past six months for patients receiving testosterone, the pharmacist can recommend the addition of a progestin.

Individuals undergoing a transfeminine transition will typically take oral estrogen, such as 17-beta estradiol, to develop female secondary sex characteristics and suppress or minimize typically male secondary sex characteristics. Often these individuals will also take an anti-androgen to block the effects of testosterone. Side effects can include dizziness, low libido and difficulty maintaining physical arousal.

Most changes related to hormone replacement therapy occur within the first year, with maximal effects over two to five years.

Even if you do everything right, health care is a team effort. An important part of this is helping educate your fellow colleagues so your pharmacy is offering an inclusive space even when you are absent. Many of our profession have been doing things a certain way for many years. Our patients know it is not easy to change the words we use and the way we think, but they also recognize when you take the small steps to make changes in your pharmacy to help accommodate people of diverse backgrounds.

The style I take is to make it as welcoming as possible for the learners themselves, by inviting them to see things from another perspective. It will not be easy. You can't make people want to address social inequities or inequities in health care.

Yes, there will be resistance. But as health-care workers, we are not in the profession for ourselves. We're here for our patients, and the reality is that 2SLGBTQ+ patients have always been here.

The question is whether we as a profession recognize that this is a group of patients who face health-care inequities, and whether we take steps to help this group of patients access the same level of care that everyone has a right to receive. T

James Morrison is the Director of Pharmacy Excellence with Wholehealth Pharmacy Partners where he oversees pharmacy operations for more than 200 Wholehealth pharmacies across Canada.

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Seeing through green:
CRITICAL THINKING FOR SUSTAINABLE PHARMACY PRACTICE

BY TAREK HUSSEIN, MBA, BSCPHM, RPH, C.MGR., LSSGB, DTM

While the health care sector is essential to global well-being, unfortunately, it has a significant environmental footprint. To put this into perspective, the aviation industry contributes two to three per cent of global greenhouse gas emissions. In contrast, the health care sector contributes approximately 4.4 per cent of these global net greenhouse gas (GHG) emissions, and in some high-income countries, this figure can rise to 10 per cent. Within this footprint, the supply chain accounts for about 71 per cent, highlighting the critical need for sustainable practices within the industry. Pharmaceuticals alone contribute to 25 per cent of health care GHG emissions, with metered dose inhalers and anesthetic gases accounting for 5 per cent of this share alone and the remaining 20 per cent stemming from other chemicals and medications.

Consumers — including your patients — are becoming increasingly environmentally conscious; consequently, environmental claims are increasingly used in advertising products and services. However, as the demand for greener products rises, so does the prevalence of misleading environmental claims, known as greenwashing.

Environmental Claims

Greenwashing undermines genuine sustainability efforts by making false or misleading claims about the environmental benefits of products or services. For pharmacy professionals, it is essential to contribute to environmental sustainability and critically evaluate and implement authentic green practices that lead to real reductions in emissions and waste.

Examples can include using misleading packaging, such as using specific colors to imply eco-friendliness, using particular terms such as "100 per cent natural" or "ethically sourced," or a lack of transparency about a product or service's environmental claims.

In general, there are three types of environmental claims that you should be aware of.

- Type 1 involves third-party certified eco-labels, which offer high credibility and assurance.
- Type 2 involves a company's self-declared environmental claims.
- Type 3 is an environmental declaration based on life-cycle assessment (LCA) and provides detailed information about a product's entire life cycle.

Increasingly, countries around the world are introducing safeguards to combat greenwashing. In Canada, Bill C-59 was granted royal assent in June 2024. It introduced amendments to the *Competition Act* to prohibit false or misleading representations of a product's benefits towards the environment that are not based on adequate and proper testing.

Understanding Emissions Scopes: A Brief Overview

Understanding and managing GHG emissions is critical for any organization, including pharmacies, in the fight against climate change. Emissions are categorized into three scopes to help organizations better identify and mitigate their carbon footprint.

Scope 1 Emissions: These are direct GHG emissions from sources owned or controlled by an organization. This includes emissions from company-owned vehicles, on-site fuel combustion, and industrial processes. For pharmacies, this could mean emissions from the pharmacy's heating systems or fleet vehicles used for deliveries. Direct control over these sources makes Scope 1 emissions the easiest to manage and reduce by improving energy efficiency and adopting cleaner technologies.

Scope 2 Emissions: Indirect GHG emissions from purchased electricity, steam, heating, and cooling. Even though these emissions occur at the facility where the energy is produced, they are counted in the organization's carbon footprint because of its energy use. Pharmacies can address Scope 2 emissions by investing in renewable energy sources, enhancing energy efficiency, and purchasing green energy.

Scope 3 Emissions: All other indirect emissions occurring in an organization's value chain. For pharmacies, this includes emissions from the production and transportation of purchased goods, waste disposal, business travel, employee commuting, and the use and disposal of sold products. Scope 3 emissions often represent the most significant portion of a pharmacy's carbon footprint, making them the most challenging to address. Effective strategies include engaging with suppliers to reduce emissions, optimizing logistics, promoting the proper disposal of medications, and encouraging sustainable practices among employees and customers.

By identifying and taking action across all three scopes, pharmacies can significantly reduce their environmental impact and contribute to global sustainability efforts. Understanding these scopes is essential for developing effective climate action strategies and achieving meaningful reductions in GHG emissions.

What can pharmacy professionals do?

Generally, strategies for pharmacies to confront climate change fall into two categories: mitigation and adaptation.

Mitigation aims to reduce emissions within pharmacies and, by extension, the health care system. When a pharmacy looks to reduce its emissions, there are four main areas: operations, sustainable procurement, infrastructure, and medication optimization.

In operations, pharmacy professionals could, for example, adopt paperless technology as part of the pharmacy's workflow. This might mean implementing processes such as e-prescribing platforms or providing virtual care where suitable to reduce patient and staff transportation emissions.

For sustainable procurement, many are familiar with the use, reuse, repurpose, renew, and recycle principles, which most pharmacy professionals probably practice in some form daily. This may involve monitoring one's own inventories to minimize overstocking, purposefully purchasing alternative medication bottles to reduce plastic waste, or eliminating single-use and unneeded plastic products in the pharmacy.

The concept of improving infrastructure is not restricted to the pharmacy business. Think about using energy-efficient LED lights, power-saving functions on computers, energy-efficient refrigerators, freezers, motion sensors on light switches for infrequently used rooms such as restrooms or assessment rooms, low-flow faucets, etc.

Pharmacy teams can adapt to mitigate emissions by implementing medication optimization, de-prescribing practices, improving medication adherence, and disposing of unused drugs and devices in an environmentally conscious manner.

Adaptation aims to prevent or minimize the impact of climate change on health care and create climate-resilient pharmacies or practice sites. There are three areas: disaster planning, direct health impacts, and supply chains.

We are in an era of hurricanes, tornados, wildfires, and, more recently, a nationwide heat wave. These disasters could potentially result in significant impacts on the availability of medications for patients, and the lack of this availability could affect patient health. A disaster recovery plan is critical to ensure prompt accessibility to medications and patients' information.

The pharmacist's three E's

As you start implementing your environmental strategies in your pharmacy, consider keeping a few tips in mind. I call them the pharmacist's three E's.

The first is to Explore: Get out of your comfort zone. Get out of the dispensary. Get out from behind the counter and go search for local community resources. Connect with other like-minded businesses and organizations and find what inspires you.

The second is to Evaluate: Small steps make big differences. Find where you are at. What have you already done? What assistance do you need? Listen to the experiences of others. Find your baseline and seek the necessary information and resources to grow.

The last is to Engage: Engage your team by acting as a role model. Share your experiences and motivate others in your community to follow you. T

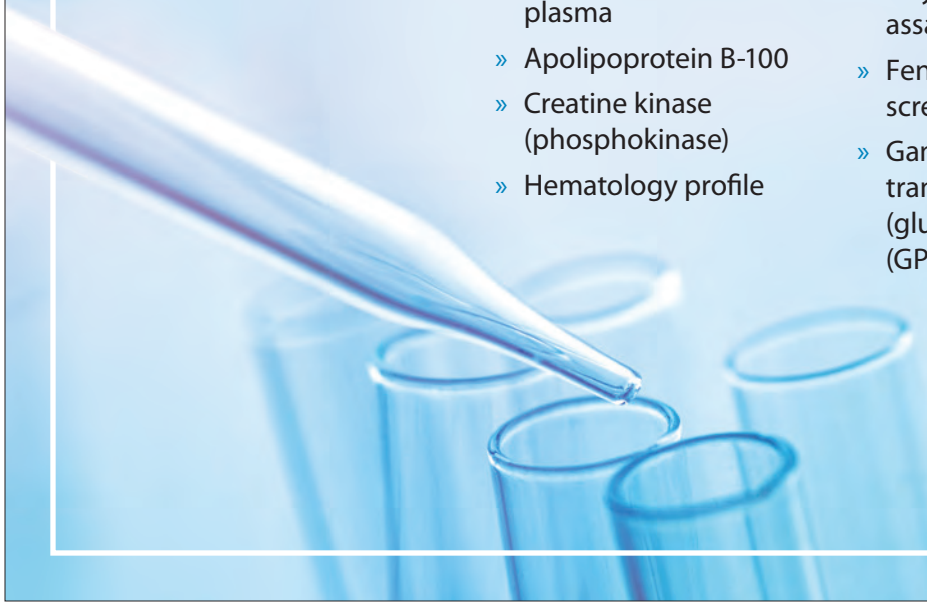
Tarek Hussein is the Adaptation Co-Lead at the Canadian Association of Pharmacy for the Environment, CAPhE, an organization devoted to the pharmacy profession's impact and response to planetary health and climate change through research, education, partnerships, and communication within the realm of climate mitigation, adaptation, operations, and supply chain management. For more information, please visit CAPhE.CA.

Lab services referring schedule

Effective Aug. 30, 2024: Pharmacists will be designated as "referring practitioners" of laboratory tests for the purpose of medication management.

List of labs that can be ordered by pharmacists in community settings:

- Urinalysis
- Sodium, potassium, chloride, magnesium, calcium, phosphates – serum/plasma
- Creatinine – serum/plasma
- Creatinine – timed urine collection
- Urea – whole blood
- Albumin creatinine ratio (ACR)
- Prothrombin time/INR
- Albumin – serum/plasma
- Aspartate aminotransferase (AST)
- Alanine aminotransferase (ALT)
- Alkaline phosphatase
- Bilirubin, total – serum/plasma
- Bilirubin, direct
- Lactate dehydrogenase – serum/plasma
- Proteins – total, serum, or plasma
- Glucose quantitative – serum/plasma
- Hemoglobin, A1C
- Thyroid-stimulating hormone (TSH) – any method
- Cholesterol, total
- High-density lipoproteins cholesterol (HDL cholesterol)
- Triglycerides – serum/plasma
- Apolipoprotein B-100
- Creatine kinase (phosphokinase)
- Hematology profile
- Vitamin B12
- Ferritin, serum
- Iron, total and binding capacity
- Transferrin
- Digoxin
- Lithium, serum/plasma
- Primidone (mysolene)
- Phenytoin, quantitative
- Valproic acid
- Clozapine
- Amphetamines
- Benzodiazepines
- Cocaine/cocaine metabolite
- Opiates
- Methadone
- Oxycodone, screening assay
- Fentanyl, urine screening immunoassay
- Gamma-glutamyl transferase (GGT) (glutamyl transpeptidase (GPT))



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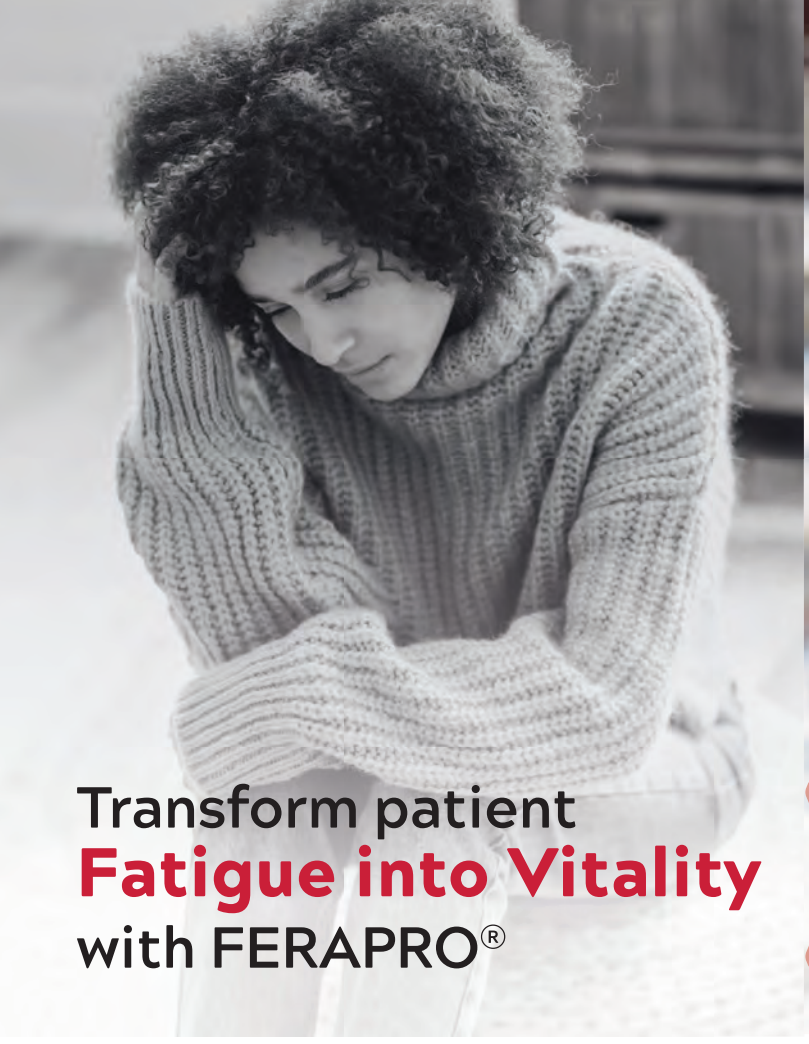

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