Canadian HIV and Viral Hepatitis Pharmacists Network (CHAP)

Réseau Canadien des Pharmaciens en VIH et hépatites virales

CHAP ANNUAL GENERAL MEETING (Virtual)

Wednesday, May 25, 2022; 11:00am to 9pm EDT (all times EDT)

10:45-11:00	**Welcome: Linda Robinson** Land acknowledgement Thank you to all of our generous sponsors of this event Gilead, Viiv, Merck, and Abbvie. Videos from the pharmaceutical companies were played and several congratulations on CHAP's 25th Anniversary were offered. A virtual conference bag will be distributed to CHAP members. **In Attendance (for all or part of the meeting):** Linda Robinson, Jenn Hawkes, Alice Tseng, Deborah Yoong, Carley Pozniak, Gary Bloch, Benoit Lemire, Brenda Rosenthal, Debbie Kelly, Genevieve Olson, Karen Tulloch, Katherine Lepik, Linda Akagi, Lucas Thorne-Humphrey, Michelle Foisy, Pierre Giguerre, Rachel Therrien, Shanna Chan, Shayna Campbell, Stacey Tkachuk, Stephanie Gysel, Sue Gill, Tasha Ramsey, Tracy Janzen Cheney, Christine Hughes, Marlene Shehata, Sheri Livingston, Jinell Mah Ming
11:00-12:00	**Opening Plenary:** *Treating Social Risks to Health*: Taking Action on the Front Lines of Care **Guest Speaker: Dr. Gary Bloch; Unity Health, Toronto, ON** Dr. Bloch provided an excellent presentation with some takeaways that all of us can apply to our practice. A summary of important points from Dr. Bloch's presentation are listed below: We have to address the social factors before we can be successful with treatment no matter what we do as healthcare professionals. He provided case examples to demonstrate his learning points. There are social issues that push themselves to the top of the list of what needs to be done. His medical training didn't prepare him for these situations. We have to deal with the social circumstances first to improve health. Even if changing socioeconomic status later on, people still suffer the effects of growing up in poverty. People living with HIV and in poverty have issues that are compounded further. Covid has highlighted the inequities in our society. Interventions-what can we do as individual healthcare providers in our practice? He shared a clinical tool on poverty. One of the questions to ask was, do you ever have trouble making ends meet? See his slides for other steps he mentioned with this tool. Make time to listen to people's stories.

	Benefits Wayfinder…a tool they use to maximize and simplify access to benefits that a patient is entitled to. He mentioned increasing community engagement with people who have lived experience, closer to the center of decision making processes. Gave a taste of how they implement a variety of social interventions in a primary care clinic. He asked about barriers to implementing interventions within your own team. Sparks study. HEIA tools that are out there (ON ministry of health HEIA, search) for tools for evaluating health through an equity lens. His team has re-allocated time spent on other activities to the social aspect of a patient's care and have found that this pays off. Pharmacists are often involved in income related questions so we can get help for the patient to afford their medications. Contact Dr. Bloch if wanting more information or if you have questions on what was presented, gary.bloch@utoronto.ca
12:00-13:00	**AGM BUSINESS** • **Executive Report – Linda Robinson** *Minutes* were approved by 15 of 19 WG members, unanimously approved. Link to access the minutes: https://hivclinic.ca/chap/downloads/minutes/minutes_2021.pdf Thanks to executive team for their work throughout the year (Linda Robinson, Jenn Hawkes, Alice Tseng, Deb Yoong, Carley Pozniak) We met 8-9 times throughout this year. AGM was supposed to be in person Apr. 27th, we found out in January the meeting switched to virtual, had to re-jig request letters. CAHR decided to start the meeting on our AGM date thus the switch in our meeting date to today. *TOR changes* 5.5.2-Working group applications needed updating (nominated or self-request membership) only no was a qualifier in wording. Some people may want to stay in the working group but they may have been on a LOA, sabbatical etc. so can ask for a LOA from WG up to 2 years before having to re-apply. 4.4.1 and 4.4.2-*New-addition of Lifetime CHAP Emeritus status granted to individuals who served on the CHAP executive for at least one 3 year term. Can attend AGM, social and apply for travel grant to attend. 18 were in favor, 1 had a particular request about the travel grants for the AGM, took that into consideration in the statements. Working group members will get preference for travel grants.

	CHAP Collaborations PrEP/PEP guidelines endorsement, CPARG infant feeding guidelines endorsement, LA-ART Consensus Statement endorsement, International PK Workshop endorsement, Paxlovid (drug interaction table in ON), ARV Tool Updated (Alice and Linda), now includes a page on PrEP, look for under tools and resources. *CHAP Chats* Secured funding for 4 chap chats this year, have done 3 so far (Covid: Vaccines and Variants, Dr. Sharkawy, ART Resistance: Complex Cases, Dr. Shafran, DDI: Focus on Covid Treatments, Dr. Alice Tseng) 4th one is coming June 24th-Navigating Barriers with HCV and Substance Use, presentation by Jenn Hawkes and colleagues. Action item-Carley to send poll whether we continue with CHAP chats next year (to WG). Consider that it's very likely we'll have an in person meeting in Quebec City next year. Involves extra time on requests and organizing. How useful are they, should they continue, any other ways we should use the time? Get together in other ways, mini meetings, journal club. Feedback from group: -Tasha, planning for a rough fall in NS Covid and other resp viruses, may be worth planning CHAP chats over the next year. Perhaps conference reviews from folks attending. -Pierre, he appreciated CHAP chats, how many should we have? May conflict with topics at AGM. Maybe have fewer chats. -Shanna, for a live AGM will there be a hybrid option to participate? In person and virtual. Ask this question in a survey. Could this affect funding? Linda responded what we ask for is usually given. They are quick to adjust if we go virtual. Travel will get more expensive due to gas, food, airplane travel. Post covid inflation everywhere. Something to think on. *CHAP Acronym* 47.37% yes in favor of changing acronym, 42.11% no. 10.53% said yes but see my suggestion for definition of acronym. Numbers of companies not going up that can fund initiatives, costs are going up. Flip side, all the pharmacists involved in COVID etc. join and not as specialized in just HIV/HCV? -Jeff Kapler shared an e-mail with his thoughts. His preference is to keep COVID out of this realm. Fits more with general ID (COVID), not core to our work. If COVID became part of the mandate, we'd have to become experts in this as well. COVID may become like influenza in a few years anyhow. Is it worth asking again as an official vote, or leave CHAP acronym as is? Vote today or people send further comments in CHAP Google group.

-Debbie Kelly-she agrees with Jeff, covid very reactionary, hoping things will settle down. Not sure another vote will change things. Either drop it or shelve and re-evaluate at this time next year. Slight majority in favour.
-Pierre likes Jeff and Deb's comments. If we're talking about covid we can still approach those companies. The main focus should remain HIV, risk of diluting expertise. To change the acronym needs the majority to approve changing this, more like 75%. For now his vote would be keep on for further discussion but not a must.
-Brenda-would we have been involved in covid treatments if ritonavir wasn't part of it?
-Linda-In small communities if it's anything to do with viruses you get asked. We could consider approaching generic companies for funding as well. Are other viral conferences successful in asking generic companies for funding? Pierre asking, Alice not sure if they're worried about alienating the brand companies.
-Tasha-50 HIV/50 General ID is her role, COVID has turned into the loudest problem child, if we took on covid as well, a lot of groups constantly meeting. Might be pulled too much in the COVID direction. Likes revisiting things in a year to see where we're at. Agree we won't vote at this time. Table this for next year's AGM.

Last comments and to do's

-Linda will send out WG affirmation, perhaps in a google form.
-Call for new members or change in membership status. 2 new requests for WG membership already without even asking.
-Spring newsletter with minutes from this meeting (Carley)
-Virtual delegate bag will be sent out (from Linda), each company name will be listed, links to MSL's, tools etc.
-Exciting opportunities for registration discounts or a lottery for the PK conference in Barcelona, September

- **Treasurer's report – Deb Yoong and Alice Tseng**

Deb

2021 CHAP AGM May 4th (virtual)
-we had 37 virtual attendees, 18 WG and 19 non- WG members, 0 AGM grants distributed

Grants for 2021 meeting-$2500 from Gilead, Viiv, Merck, and Abbvie, a total of $10,000.

Total Expenses-$9825.99
Chair grant $2000
5 chap chats @ 1500 each, 7500 total
Zoom account $180
Misc (gift & courier costs) $145.99

	Net balance from 2021 meeting was $174.01 Amount carried forward to 2021-$70,667.58 Amount carried forward for 2022-$63, 157.59 Grants for 2021-22-$11,000 (3x $3000 Gilead, Merck, Abbvie, 1x $2000 Viiv) Expenses-$5,651 (Chair grant $2000, AGM Speaker Dr. Bloch $2000, Meal vouchers 19 x $75, $1425, Zoom account $226) CHAP chats for 2021-22-$10,000-$6,000 -Grants 4 x $2500 (Gilead, Viiv, Merck, Abbvie) -CHAP chat speakers 3 x $2000 Amount carrying forward for 2021-22: $63,157.59 Current balance: $72, 506.59 Aim to keep enough money to run 2 meetings if no money is received from sponsors. Usually costs $40-50,000 to run an in person meeting. Mostly the food. We quoted a $40,000 budget until we found out this year's meeting would be virtual. The big 3 have the CHAP AGM on their annual budget. Will have to increase the budget for next year's meeting in Quebec City. • **Election of a new secretary** -2 nominations put out, 1 was accepted and 1 was not. Asked if any others put forward as well? Tasha accepted. Three year commitment-Secretary does minutes for exec meetings, newsletters, AGM minutes. Chair-secures funding, plans AGM, plans educational events. Past chair-WG affirmations, mentors Chair. Alice and Deb are always on the exec as treasurers and webmasters.
13:00-13:15	Break-back at 1325
13:15-15:00	**PRACTICE-RELATED HOT TOPICS AND ROUNDTABLE DISCUSSION** (15 minutes each) 1. ADR's: Brand to Generic Transition : Kathy Lepik -In BC, generic equivalent is to be prescribed if there's one available. If someone has an adverse event they can apply for a different arv. They looked at Brand to Generic switches, then Generic 1 to 2 switches. Adults 19 yrs and older. Data from BCCfE database. June 2017 to June 2021, over 5,000 ppl who rec'd the study generic products (either 1st or 2nd rollouts) 93 product substitution incident reports were collected. ABC/3TC example in 2017. Typically 2-3 months before they get an incident report. 1st rollout of generic, only 7% had used a generic before, by 2022, 72% had used a generic. Familiarity with generics started to increase. Little less than 1% experienced a product substitution issue. Transitions were well tolerated, GI upset was a big one, reasons were I don't feel good/don't like it, CNS sx's HA, dizziness

	particularly with EFV containing product. Little bit of skin issues. Generally a positive story but we do need alternate options for those that don't tolerate a generic product. Some people do have a strong psychological opposition that can manifest as physical symptoms due to aversion to certain products. Limitations with voluntary reporting. Requirement to report the adverse event to get access to alternatives so may influence PSI reporting. Patient/Care provider has to identify a suspected PSI. Are we maybe missing some PSI with generics? Next steps, likely will see there's no difference at all. Contact Kathy for more info. 2. Suboxone Micro-induction: Jennifer Hawkes -Cross titration to a full opiod agonist to a partial opioid agonist, appeal is that it's without withdrawal symptoms. Start on Suboxone immediately without needing a washout. Most reports are case studies (total N was 63 pts) 18 studies reviewed. 0.2-0.5 mg cross titrated over usually 4-8 days up to 8-16 mg. Illicit drug supply is very potent however. We don't know how much fentanyl people are actually getting from the illicit supply. Most UDS screens are +ve for polysubstances. Showed different potencies, Suboxone only partially fills the opioid receptor so less of a high, more ceiling effect. Micro dosing gradually fills the receptors, micro displacement. The microinduction is an overlap, need to still give full agonists. Kadian as overlap to get them up to their Methadone dose. Combination of methadone and Kadian may be more effective during titration phase for people who have high opioid tolerance. Titrate to 70-80 mg methadone as quickly as possible, protective against overdose. Suboxone microdosing effective. Huge trauma with withdrawals. Rituals that go along with drug use, people miss them. Consult Jenn for further details. 3. Contraception Practice in BC Clinic: Karen Tulloch -Higher rate of unintended pregnancies in women living with HIV. 56% v.s. 27%. WLHIV have a faster return to fertility due to avoiding breastfeeding. Contraception counselling linked to contraception uptake. Most studies conducted in Africa on contraception in WLHIV. Primary outcome, proportion of WLHIV using any method of contraception within 3 months of PP, secondary endpoints, proportion of different contraceptive methods used by WLHIV within 3 months PP, proportion of intended contraception plans that were implemented within 3, 6, 12 months PP, association between receiving contraception counselling anytime during pregnancy & up to 3 months PP. Retrospective cohort study. 90% uptake of contraception occurred in the first 3 months, so the earlier it's implemented, the better. One of the limiting factors was the 3rd agent used in an arv regimen. As a clinic they try to avoid the COC pills with different options that are available. Contraception counselling did result in uptake of contraception. Incorporate contraception counselling during pregnancy visits. Optimal window is within the first 3

	months postpartum. IUD’s and Depot Provera are their go to at the clinic. They’ve started using Dolutegravir again, not using BIC, using some RAL, not EVG. Opting for longer term options. Main thing is talking about a plan for contraception prior to the 6 week point/delivery of baby. Considerations, earlier return to fertility etc with WLHIV. Consult Karen for more details if desired. 4. Integrase Inhibitors and A1C: Genevieve Olsen -2017 reports started coming out. Retrospective trials were contradictory in their results in North American study (22% higher risk of new onset DM INSTI and PI v.s. NNRTI). European study said no increased DM risk with INSTI v.s. NNRTI, a1c of greater than 7.5%. Neither study included already diagnosed diabetic pts. They were only looking at new onset patients. Her study, retrospective cohort study, PWH started on INSTI, PI, NNRTI between 2010-2020. Assessed change in a1c pre and post start. More likely to be arv naïve if a1c was less than 8.5%. Had to take PI’s out of analysis as there were only 4 pts on PI’s. Figure 3, INSTI’s had increases in A1C, none of the p values were statistically significant when calculations were done, but may still be clinically relevant. More research needed on new onset diabetes and insulin resistance after INSTI start (non-diabetic). In diabetics, further studies with sufficient follow ups of diabetic plwhiv on insti to gain clarity into short and long term glycemic implications assocated with insti use. Changes in medicine, diet, exercise, could have had antiglycemics added on. Less likely if they had an a1c under 8.5 less likely for more meds to be added on. Lack of increase in a1c (family physicians adding meds in) Would be a nice to have a larger patient cohort to get significant numbers. Contact Genevieve if more information is needed. 5. Viral Blip after COVID-19 Vaccine: Sharan Lail (unable to attend and present)
15:00-15:30	**Refreshment Break**
15:30-17:00	**CHAP PROJECTS AND INITIATIVES** **Ongoing:** 1. Role of Pharmacist Position Paper – Stacey Tkachuck/Erin Ready (BC) -Stacey Tkachuk presenting update. Update on this paper from 2012. They were talking about CJHP publishing as before but ran into issues with word count. CJHP had a really low count whereas Canadian Pharmacists Journal has a 6000 word count limit, good compliment to shift in care being done in community v.s. hospitals. May do a short article in CJHP to reach hospital pharmacists. Cascade of care model for the paper. Leads on each sections. At the editing stage right now. Targeting submission date for September 2022. Completed writing in March 2022. Word count is well over what we’re

	allowed. Working on getting the numbers of words down at the moment. At 9000 words, need to get down to 6000 words. 2. CHAP Observership Program – Alice Tseng -Has been on hold last couple of years due to COVID. Opportunity to enhance practice knowledge, professional collaboration, increase awareness of different practice sites. Applicants can be new to the area or existing practitioners looking to expand practice area. 2-4 days in length. In 2020 one was scheduled but later withdrawn due to covid/schedules. Feedback has been excellent on this program. One was later a preceptor in the program. For 2022/23 return to in person or hybrid combination for observerships. Grant 2-3 observerships per year. Looking for new members to join the observership working group. Update TOR, review applications, potentially offer observerships. New observership sites? Hybrid-onsite clinical/shadowing, also sitting down, working through cases/discussions on certain areas, opportunity to have deeper discussions. Some of that could be virtual. Might open up exposure to different areas, drug intearctions, covid clinic in Ottawa with Pierre, Debbie's POC testing. Debby interested in observership program (her clinic is only 1 day a week, but are there research opportunities ppl would be interested in? medication management clinic, resistance, drug interactions) see how people work in other environments might be interesting as well (Pierre). Alice will send out a recruitment call in coming weeks. 3. Dual Therapy – Christine Hughes (AB), Pierre Giguere (ON), Tasha Ramsey (NS), Shayna Campbell (AB) -Shayna is the lead. Met last year and came up with ideas to work on. Survey project, similar to Pierre's Metformin project a few years ago. Ideas to share with wider community pharmacy group. Continuing education unit in pharmacy practice. Currently the article is available online as a continuing education resource. Magazine editors, accreditation editors, CHAP members edit. By the time each round of edits was done, it became very long. Still hope it will be published in the print version. Switches to Dovato, DTG/RPV, starting dual therapy, touch on long acting dual therapy as well IM. So community pharmacists can have exposure to this. Included a case to show off the drug interaction checking app. Confusion on PEP/PrEP so included details on this. It may be too long for print. Link to this course: https://www.ecortex.ca/course/view.php?id=1349. Anything from the CHAP perspective? Alice-extra amount of work to get it published may be best to keep it as is. Great resource as it stands now. CHAP is already listed on it. Put it on the CHAP website. Share the paper.

	New Possibilities: 1. Guidelines for the Management of HIV Exposed Pre-term Neonates. Carley Pozniak (SK); Karen Tulloch (BC) Background-Not a lot of data out there around guiding preterm dosing of arv's. CHEO document that Natalie worked on has some guidance. We're challenged on where we're located to get TDM done in a timely way to help guide dosing despite Quebec program being fantastic about prioritizing our samples once they're received. Would like to get a few sites in on this. Thinking a case based series perhaps. We tend to have a fair number of preterm births. Stacey Tkachuk-interested to join, guideline document v.s. case series. Ped pharmacist involvement, tools at the neonates bedside, specialists working group involved, treaters are getting help/advice on this, cheat sheet on tdm, monitoring. Stacey, Karen, Carley are all interested. Discussion turned towards what makes something a CHAP initiative? 2 or 3 members, why or why not a CHAP project…publication fees could be a role. Funding to help support that. Endorser/reviewer role? Ask Jason Brophy if other people are looking at this, see how this evolves, who is going to be part of it, could be a CHAP project if only CHAP members involved. Could support with the CHAP zoom account if members need or help with fees to publish. 2. "Back to Basics" Educational Series Proposal – Linda Robinson Background-on the CHAP website-drug-drug interactions with arv's, induction v.s. inhibition, mechanism of action on antiretrovirals, include basics and fundamentals that don't change much over time. Fundamentals on resistance, research protocols, HIV testing, mother to child transmission. Helpful for new pharmacists, students, residents. Bone issues (Michelle Foisy), Linda and Christine with resistance, Alice with drug-drug interactions. We're the right group to be doing this. Working group could work on this initiative. What are the basics that we would include…basics on HCV, transmission, treatment modalities. Legacy on the website. Standing working group to keep this up to date? Linda's thinking of including basics that don't change. Alice commented important not to re-invent the wheel, there's the residents package in Toronto, National HIV Curriculum. Leave this as a possibility, reach out to see who is interested in participating after this meeting. Compile what's already out there and then see what's missing next year. Call out for taskforce.

19:30-21:00	**Annual CHAP Dinner, Slideshow, and Virtual Social (separate Zoom link)**