# 15th Annual HIV Pharmacy Education Day

## Strengthening allyship with key populations: The pharmacist's role

*Friday, September 29, 2023*
*The Westin Harbour Castle, 1 Harbour Square, Toronto (Regatta Meeting Room)*

## Introduction

*Linda Robinson*

The 15th annual HIV Pharmacy Education day focused on understanding the pharmacists' role in working with key populations, particularly transgender and Indigenous communities. This event was held as a stand-alone education event. The first half of the event included 2 plenary talks, followed by an afternoon of case studies. Brief summaries are provided in this report and links to the fulsome presentations are available here.

Linda opened the day with a land acknowledgment. In the spirit of Truth & Reconciliation, pins from Legacy of Hope Foundation (LHF), an Indigenous-led charity, were distributed to the attendees. LFH emphasizes voices of First Nations, Inuit, and Métis experiences by providing lesson plans for schools to discuss age-appropriate impacts of the Residential School System and Sixties Scoop, and The Ontario HIV Professional Specialty Group recognizes this level of education needs to be brought to our children and grand-children.

Linda thanked all the partners who made this day possible:

- Support: Ministry of Long-Term Care, AIDS Bureau and The Ontario HIV Treatment Network.
- Planning committee: Linda Robinson, Sue Gill, Deborah Yoong, Alice Tseng and Pierre Giguere.
- Sponsors: Gilead, Viiv Healthcare and Merck.

## Indigenous Health: The pharmacist's role

***Moderator:*** *Alice Tseng*
***Speaker:*** *Dr. Cassandra McLelland, clinical pharmacist at William Osler Health System and vice-chair of the Indigenous Pharmacy Professionals of Canada. She is a member of M'Chigeeng First Nation and belongs to the Mukwaa (Bear) Clan, who are traditionally healers. She is Ojibwe on her mom's side and mixed with French Canadian and Scottish ancestry.*

### Introduction & historical context

Natives of the land in Canada are collectively referred to as Indigenous/Aboriginal, and are divided in 3 broad categories: First Nations (only group with "status"), Métis and Inuit. They represent 5% of the Canadian population and 2.9% of the Ontario population.

Historically, Indigenous people have been limited in their movements, forbidden to practice their culture, removed from their communities, segregated from the rest of the population, abused in governmental

institutions, subjected to medical experimentations and targeted by discriminatory legislations (e.g.: The Indian Act, residential schools, sterilization, Indian hospitals, Sixties Scoop, etc.). This historical context explains the current health disparities and access to care experienced by Indigenous people.

## The present: health disparities and access to care

Socioeconomic challenges faced by Indigenous people:

- represent more than half children in foster care ("Millennial Scoop")
- active drinking water advisories in First Nations communities
- higher household overcrowding rates
- higher unemployment rate and lower average income
- fewer high school diplomas completion
- higher incarceration rates

Health disparities faced by Indigenous people:

- shorter life expectancy (mostly in young adults and adolescents) due to higher rates of suicide, infant mortality and maternal morbidity/mortality, diabetes, heart disease, asthma, arthritis, obesity, and tuberculosis
- higher HIV prevalence (2x than general population) and incidence (4x than general population), affecting mostly women and younger people, and with injection drug use being the leading exposure category. HIV positive Indigenous people also have a lower life expectancy and a lower achievement rate of the 2020 90/90/90 UNAIDS goals

| | Diagnosed | On treatment | Virally suppressed |
|---|---|---|---|
| General population | 90% | 87% | 95% |
| First Nations in Saskatchewan | - | 88% | 78% |
| People who inject drugs (PWID) | 83% | 88% | 63% |
| Indigenous PWID in AB/SK | 64% | 81% | 54% |

Barriers to healthcare access faced by Indigenous people include living in remote areas with limited access to healthcare providers and services/lack of transportation; financial instability, cost and Non-Insured Health Benefits (NIHB) policies; experiencing racism when seeking care, making them less likely to seek care again; lacking family support/childcare; language (health literacy); experiencing homelessness.
There are many real-life examples of how the healthcare system failed Indigenous people. However, Aboriginal Health Access Centres provide culturally-sensitive care and focus on giving access to traditional medicines and healers to Indigenous people.

## Medications & healing through an Indigenous lens

The Non-Insured Health Benefits (NIHB) provides coverage for prescription and over-the-counter (OTC) medications, vision and dental care, mental health counselling, and medical supplies/equipment to eligible First Nations and Inuit clients. To bill NIHB, the pharmacy must be registered with the program, drugs must be processed through private insurance and provincial drug plans first, and the pharmacist's recommendations for OTC medications must be documented.

Examples of Indigenous cultural ceremonies include smudging (most common), the burning of sacred medicines to produce healing and cleansing smoke; pipe ceremony; drumming circle; sweat lodge (not recommended if unwell), a small tent with high temperature; and sharing/healing circles.

Tips on how to address traditional medicines with an Indigenous patient:

- Ask open-ended questions in a non-judgmental manner
- Do not discourage use if there is no interaction with the treatment
- When concerned, be specific, explain the rationale and explore other traditional options
- Understand the importance of culture and storytelling in the healing process
- Refer to local organizations where they can access ceremonies and traditional healers

## Cultural safety and trauma-informed care 101


Culturally safe care:

- defined by the person receiving care, not one providing it.
- respectful, allows meaningful communication and development of trusting relationships, does not profile or discriminate, acknowledges and works to dismantle power imbalances and barriers to care, and considers historical context and how it impacts health and wellbeing.
- helps improve the patient outcomes as they are more likely to access care and access it earlier, feel empowered and more at ease, share details about their health concerns and preferences, and follow treatment plans.

Trauma-informed care:

- based on understanding that trauma can impact physical health, mental health, behaviours, and encounters with the healthcare system.
- prioritizes the patient's safety, choice, and control and aims to avoid re-traumatizing patients.
- overall approach to healthcare delivery led by:


- involves understanding triggers and being sensitive to them to help the patient develop a trusting relationship with the healthcare system.

Tips on how to incorporate these principles at the pharmacy:

- Self-reflect on your own perception and biases, and work to dismantle these stereotypes.
- Set expectations, demonstrate trustworthiness, and ensure consent is always obtained.
- Create an environment that is physically safe, inclusive, non-judgmental, and non-threatening (e.g. medicine wheel sticker up/ wear pins, ask questions, use a chair to be at the same level with a patient, remove the white coat).
- Use shared decision making to involve patients in their own treatment plans and motivational interviewing techniques to empower them. Always explain what and why you are asking.
- Understand that many Indigenous people have personal or intergenerational trauma that may impact their behaviours and respond with compassion.
- Demonstrate respect for the person in all interactions, encourage open dialogue and leave space for the patient to share their story.

## Summary & resources

Indigenous people might be seen as difficult, but it is important to understand why. Due to the direct effects of colonization, they continue to face worse health and socioeconomic outcomes compared to non-Indigenous Canadians and are disproportionally affected by HIV. Providing culturally safe and trauma-informed care is vital to improve the healthcare experience and outcomes for Indigenous patients. The pharmacy is a great place for this as it's very accessible and can be the first and/or only contact they will have with the system. Pharmacists can positively impact their care by: navigating medication access, assessing the safety of traditional medicines and facilitating access to cultural resources, creating a safe space, and empowering patients to take an active role in their health.

Resources:
Resource round-up: Indigenous Health
Pharmacy: Indigenous research and resources
Resources for Pharmacy Professionals to Support Indigenous Cultural Competency

# Allyship with Trans and Gender Diverse (TGD) Clients: The Pharmacist's Role

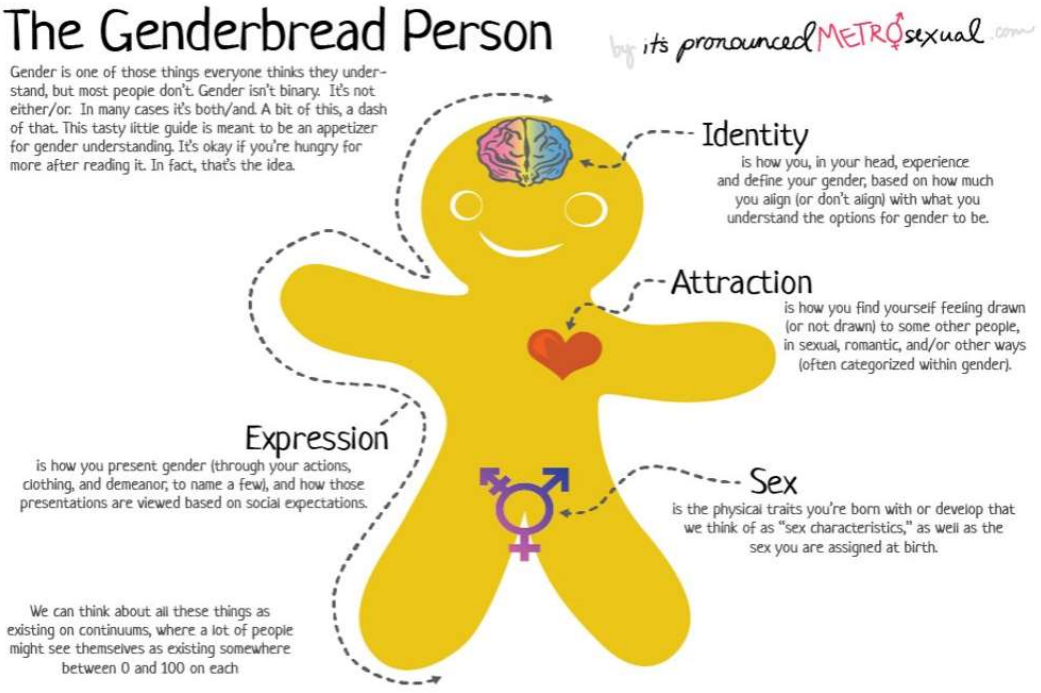
***Moderator:*** *Deborah Yoong*

***Speaker:*** *Dr. Jordan Goodridge, lecturer in the Department of Family and Community Medicine at the University of Toronto and course director at the Temerty Faculty of Medicine. Dr. Goodridge works as a Family physician with a specific focus on 2SLGBTQ+ Health and HIV primary care, with the majority of his clinical work being at the Sherbourne Health Centre.*

## Who are 2SLGBTQIA+ people?

Key takeaway #1: **2SLGBTQIA+ people represent diverse communities of gender and sexual minorities.**

Gender identity is different from sexual orientation, which is different from sexual activity/practices.



Gender identity includes cisgender and transgender. Transgender refers to individuals whose gender is different from their birth sex assignment and can be used to design a lot of different genders, such as:

- transmasculine/trans man/FTM (female to male): assigned female at birth but identifies as male
- transfeminine/trans woman/MTF (male to female): assigned male at birth but identifies as female
- gender non-binary: not exclusive to male or female
- gender fluid: can change overtime/depending on the circumstances
- gender queer: does not fit norms of society
- pangender: experiences gender along the whole spectrum

One person can use several terms in order to describe their gender identity. Some trans people identify as *transsexual*, but this should not be used to described the community or by healthcare providers. The term *Two-spirit* is used by some Indigenous people to describe a gender identity and/or sexual orientation that maybe diverse. It is usually use to describe an individual who has both a masculine and a feminine spirit, but it can be a very unique thing to that individual. **Never assume someone's pronouns**: always ask, have the conversation with everyone, and revisit it as needed.

## Health disparities experienced and why?

Key takeaway #2: **TGD people experience significant health disparities (aka, preventable differences in health outcomes) across a wide variety of domains. Inequities may be widened for people with other intersecting identities (e.g. race, Indigeneity, physical ability, etc.).**

Every TGD patient face unique difficulties based on inequities and intersectionality and can experience them in multiple health areas, including: health care access and engagement; mental health; safety (e.g. intimate partner violence and abuse); substance use; cardiovascular disease; sexual health & STIs; and preventive care and screening.

Why these inequities/disparities?

- Oppressive systems and institutions: Canadian laws only recognized gender identity and expression in 2012 and added to the *Canadian Human Rights Act* and *Criminal Code* in 2017.
- Minority stress: stigma and discrimination faced by sexual minorities that lead to increased stress.
- Microaggressions: brief and commonplace daily verbal, behavioral, or environmental indignities that communicate hostile, derogatory, or negative slights and insults.

Studies on barriers experienced by TGD patients:

- trans women living with HIV interacting with healthcare providers or staff: discrimination; denial of services; lack of training and literature; and agencies not perceived as welcoming*.
- trans women living with HIV navigating the health system: lack of trans-specific services; disjointed healthcare delivery models; siloed care; discrimination in social services; and geographic barriers*.
- transgender patients with their family physicians: discomfort discussing trans health issues (50%) and at least one trans-specific negative health care experience (>30%).
- social determinants of health: trans people are overeducated and underemployed.

* from the Trans PULSE project, a community-based research project that investigated the impact of social exclusion and discrimination on the health of 433 trans people in Ontario, Canada.

## How to address these health inequities?

Key takeaway #3: **Addressing health inequities faced by TGD people requires individual actions & inclusive (health care and other) environments.**

Overcoming barriers to care relies on five key principles: create safe, inclusive, non-judgmental spaces; trust/make sure the patient feels trusted; respect for privacy & confidentiality; culturally competent and culturally safe care; and anti-discrimination policies & staff training.

Tips for health care providers:

- Assess your space: positive space, non-discrimination policy, positive space sticker/sign, pronouns on slides/name tag.
- Know your patients: gender identity, correct name and pronouns, gender-affirming language.
- Avoid assumptions and ask open-ended questions.
- Don't ask sensitive questions that are unnecessary/curiosity-led and focus on the part of their medical history related to their current care.
- Apologize if you make a mistake!

## Hormone therapy

Hormone therapy (HT) and surgery can be important for many TGD patients but might not feel necessary for all. The pharmacist's role is to ensure proper dosing, monitoring of side effects, and adherence counseling for HT. **All gender-affirming hormone therapy is off label.** The effects of HT can take months to be noticed, years to be in full effect, and are variable based on genetics and body characteristics. Most changes are partially reversable when discontinuing medications. Full information available at the Sherbourne Health Guidelines.

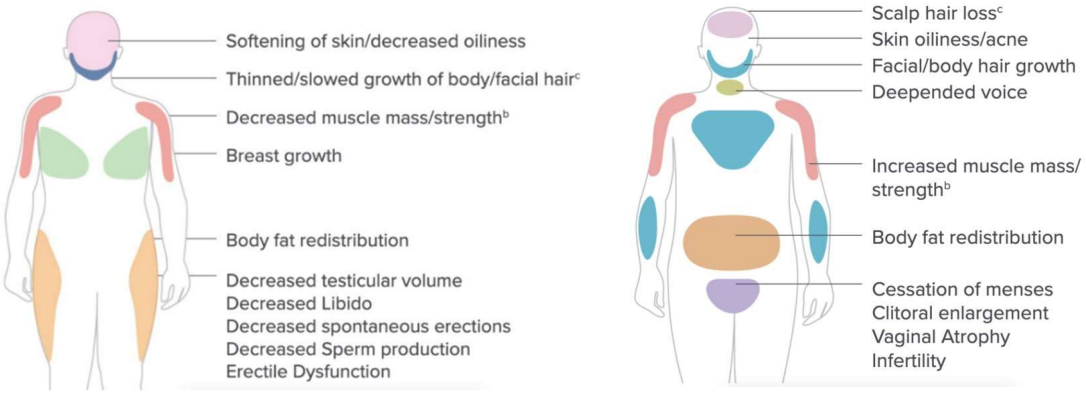
Transitioning is a long and stressful process. The Trans PULSE project showed a higher rate of suicide in patients planning their medical transition but not starting it yet compared to those engaged in the process, as well as a great reduction of attempted suicide once patients have completed transition. This could be linked to long waiting lists to access an assessment and/or counselling, encountering health care providers who are not trained or comfortable with transition, etc.

<u>Feminizing HT</u>

- Drugs:
  - **Anti-Androgens:** hormone blockers preventing testosterone from having an effect on tissues. Can act as "puberty blocker" to put a brake on puberty changes in teens.
    Spironolactone and Cyproterone: most used
    Leuprolide Acetate and Buserelin: less common - injectable and expensive
  - **Estrogens:** can be combined with anti-androgens.
    Oral pill (17β-Estradiol): most prescribed, ODB-covered
    Transdermal Estradiol: patch, not ODB covered, reduced venous thromboembolism risk but increased hypertriglyceridemia risk compared to oral option
    Injectable estradiol valerate: compound, same venous thromboembolism risk as oral option
- Effects: breast growth is irreversible, no effect on voice (vocal training might be considered)
- Risks: venous thromboembolism (route and drug dependent), hypertriglyceridemia, weight gain.

Masculinizing HT

- Drugs:
  - **Testosterone**
    Injectable (testosterone enanthate or cypionate): ODB covered, preferred choice
    Transdermal (gel): not as common - steadier testosterone level but risk of transfer
    Oral: typically avoided due to hepatotoxicity concerns
- Effects: voice changes and clitoral growth are irreversible
- Risks: weight gain, increased LDLc and lower HDLc, sleep apnea, hypertension.




Starting dose of HT is based on the patient's individual gender goals and monitoring should be based more on clinical effects rather than lab work. After the first year, bloodwork it is done according to guidelines for cis patients.

Anatomy & tips on terminology use:

| Consider Avoiding | Consider Using |
|---|---|
| Vagina | Inside the genitals / front hole |
| Vulva | Outside of the genitals |
| Clitoris | Erogenous tissue / erectile tissue |
| Period / Menses | Monthly bleeding |
| Bacterial vaginosis | Bacterial overgrowth in the genitals |
| Atrophic vaginitis | Thinning of the internal genital tissue |
| Breasts | Chest |
| Penis | External genitals / erectile tissue |
| Testes | External genitals / gonads |

## TGD HIV Care

TGD populations are disproportionately affected by HIV, which might affect their safety even more. Receiving appropriate gender-affirming care can have positive implications on their HIV care (and vice-versa). HIV prevalence is 66 times higher in transfeminine individuals and 6.8 times in transmasculine individuals (although less researched – most identifying as GBMSM) than in the general population worldwide. And while trans women are disproportionately affected by HIV, they access HIV care and achieve virologic suppression at lower rates than other populations.

TGD patients living with HIV tend to prioritize gender-affirming care and HT over ART: concern about drug-drug interactions can lead them not taking ART or HT as prescribed, but only a few discuss it with their provider. It is important to have a conversation with the patient to understand their goals, keep them engaged, and reassure them of the safety of using these therapies together.

- Anti-androgens + ART: No studies conducted but some interactions expected based on inhibition/activation of CYP3A4
  Spironolactone: not expected to interact with PIs, NNRTIs, INSTIs, NRTIs, CCR5i
  Cyproterone: levels may be increased by cobicistat and ritonavir, may be decreased by EFV, NVP, ETR, but no expected effect from NRTIs, INSTIs, CCR5i
- Estrogen + PrEP: no significant effect on estradiol levels but decreased TDF levels. Clinical significance remains unknown but daily PrEP should be recommended as this result questions the efficacy of PrEP on-demand
- Estrogen + ART: decreased EFV and TDF levels but 90% of participants were virally suppressed at 12 weeks. Decreased estradiol level when co-administered with EFV but not with INSTI
- Testosterone + ART/PrEP: no studies conducted

## Clinical Case #1: Cabenuva after bariatric surgery

***Speakers:*** *Suzanne Gill & Alice Tseng*

### Case

A 33-year-old female diagnosed with HIV in 2008:

- virologically suppressed on rilpivirine/tenofovir + DF/emtricitabine since diagnosis
- clinic attendance inconsistent but good adherence to ARVs
- most recent CD4 1177 cells/mm3 and viral load < 20 cells/mL (Sept 2022)

Admitted to hospital for Roux-en-Y-gastric bypass surgery (BMI = 63 kg/m$^2$) . ID physician wondered if a **switch to long-acting cabotegravir/rilpivirine could avoid absorption and drug-drug interaction concerns post-surgery?**

### Context

There are increasing rates of obesity in people with HIV and while bariatric surgery helps with weight loss and comorbidities, antiretroviral PK can be influenced by **both** weight & surgery. Studies showed that:

- as BMI increases, the concentration of ARVs decreases (etravirine more affected - doravirine less affected) and less people reach their Cτ target (etravirine and rilpivirine with highest risk).
- surgery decreases gastric motility and volume, increases pH levels and possibly decreases first pass effect, which can result in delayed Tmax and issues with pH-dependent absorption. Mostly in the first 2 months and can normalize at 6m so consider TDM/close monitoring and/or increasing in ARV dosing for the first couple of months.
  - PrEP (TDF/F): consider doubling the dose for the first month and use daily PrEP rather than on-demand.
  - Rilpivirine, PIs: limited food intake makes it harder to make the food requirement
  - Atazanavir, rilpivirine: avoid as gastric acid reducing agents can have drug interactions
  - INSTIs: interact with cations and supplements
  - All: limited data are available on safely crushing ARVs and pediatric formulas cannot always be used for adult dosing
  - bictegravir/tenofovir alafenamide/emtricitabine: case studies remained virologically suppressed

Given these concerns, what about cabotegravir/rilpivirine (ART) or cabotegravir alone (PrEP) injection? Note: skip oral lead-in to avoid any DDIs post-surgery

| Benefits | Potential drawbacks |
|---|---|
| – bypasses GI tract so no DDIs with oral medications or food requirements<br>– not reliant on the gut for absorption<br>– no formulation manipulation<br>– dosed bi-monthly<br>– decreased stigma and pill fatigue | – only clinical trials in BMI=30-54 kg/m$^2$<br>– high BMI identified as risk factor for virologic failure<br>– longer needles difficult to source<br>– limited window for injection so reliable clinic appointment attendance needed |

Studies identified predictors of virologic failure to long-acting cabotegravir/rilpivirine in participants with at least 2 of these risk factors: RPV resistance-associated mutations, HIV-1 subtype A6/A1, and BMI ≥30 kg/m$^2$. BMI alone does not predict confirmed virologic failure: Cτ initially drop then normalized.

### Case follow-up

Hesitation to put the patient on CAB/RPV due to:

- missed appointments in the past and more frequent appointment needed with this treatment
- supplements and pantoprazole needed after surgery
- current BMI>BMI in clinical trials
- delayed delivery for 2inch needles

After discussion, the patient was switched to BIC/TAF/FTC and decided to wait 6 months and re-evaluate for CAB/RPV with the hope that she will have lost weight by then. However, this regimen needs to be spaced out with food and supplements. Good decision as the patient has not made it to any clinic appointments since the end of January but her viral load remains suppressed.

Note: Patient on CAB/RPV can take a few months to be virally suppressed and those with higher BMI have lower Cτ so can consider Cτ at week 4 and 8 to predict virologic breakthrough, and overlapping injection and pill for the first month post-surgery before going to Q2.

## Clinical Case #2: Paxlovid & the community pharmacist

***Speakers:*** *Kristen Watt & Pierre Giguere*

### Context

In the “post pandemic” era COVID is becoming a seasonal respiratory virus and its management is focusing on the reduction of severe illness with Paxlovid (nirmatrelvir/ritonavir), which reduces the likelihood of patients getting into the inflammatory response of the viral illness when taken in the first 5 days. Studies showed Paxlovid benefits in mortality rate, polymerase chain reaction negative conversion time and hospitalization/death rate, but not in COVID-19 rebound, emergency department visit, intensive care unit admission and adverse events.

In Ontario, all patients 60 and older are eligible for Paxlovid prescription. Patients 18-59 years old must be immunocompromised or have one or more comorbidities that put them at higher risk of severe COVID-19, or be unvaccinated/have an incomplete primary series/have completed the primary series AND their last COVID-19 vaccine dose was more than 6 months ago AND their last SARS-CoV-2 infection was more than 6 months ago.

## Case

A 88 years-old and an active well elderly man with atrial fibrillation, cataracts, benign prostatic hyperplasia and hypertension has tested + for COVID and prescribed Paxlovid three times in less than a year, all managed differently:

**April 2022**

Pharmacist recommended Paxlovid
MD prescribed Paxlovid
both collaborated on changes

| Medication | Paxlovid Action Plan |
|---|---|
| Tamsulosin 0.4mg | HELD x 7 days |
| Xarelto 20mg | HALF DOSE x 7 days |
| Metoprolol 25mg BID | No change |
| Lansoprazole 30mg | No change |
| Candesartan 8mg | No change |
| MgOx 420mg | No change |

**October 2022**

MD prescribed Paxlovid
MD managed all DDIs alone

| Medication | Paxlovid Action Plan |
|---|---|
| Tamsulosin 0.4mg | HELD x 7 days |
| Xarelto 20mg | HELD x 7 days |
| Edoxaban 30mg | STARTED x 7 days |
| Metoprolol 25mg BID | No change |
| Candesartan 8mg | No change |
| MgOx 420mg | No change |

**August 2023**

Pharmacist prescribed Paxlovid
Pharmacist managed all DDIs alone

| Medication | Paxlovid Action Plan |
|---|---|
| Tamsulosin 0.4mg | HELD x 7 days |
| Xarelto 20mg | HALF DOSE x 7 days |
| Diltiazem 180mg | Changed to Q2D x 7 days |
| Metoprolol 100mg BID | No change |
| Candesartan 4mg | No change |
| MgOx 500mg | No change |
| Lansoprazole 30mg | No change |

Xarelto should not be co-administered with Paxlovid due to the risk of significant increase in drug concentration levels. The recommendation is to hold Xarelto and restart two days after completing Paxlovid due to the risk of bleeding. However, there is a risk of stroke associated with holding Xarelto, which is why the pharmacist decided to go for a half-dose, as the patient was worried. This case is a good illustration of how to leverage community pharmacist skills by conducting a comprehensive medication list; managing drug-drug interactions; adapting, adjusting and managing where needed; and following up.

## Editorial comments: Calcium Channel Blockers

Several case reports of serious toxicity with Paxlovid, e.g. acute kidney injury and multi organ failure leading to death when interacting with nifedipine; low blood pressure when interacting with verapamil.

Dosage recommendations on dosage adjustments vary depending on the source:

- **Health Canada (PM):** Drugs plasma concentrations expected to increase by co-administration with ritonavir: use with caution and reduce dose if needed.
- **NIH:** Closely monitor blood pressure and if hypotension: reduce calcium channel blocker dose by 50% while taking Paxlovid and for 3 days after.
- **FDA:** Caution and clinical monitoring of patients is recommended: dose decrease may be needed.

In the context of direct oral anticoagulants, the Ontario COVID-19 Science Advisory Table (OST) algorithm presents recommendations by agents and by indication.

## Pharmacist expanded role and prescribing in the context of HIV: Sharing Successes and Challenges

***Moderator:*** *Linda Robinson*
***Panelists:*** *Harvinder Dhunna, Kristen Watt, Mikaela Klie & Sheri-Lynne Livingston*

The panelists have very different experiences as they worked in different settings.

Harvinder Dhunna is the designated pharmacy manager and an accredited HIV pharmacist, who has worked at Church Wellesley Health Pharmacy since 2012. He also has a consulting practice and has helped set-up and operate HIV-specialized pharmacies in Niagara and Durham regions. Harvinder is an invited speaker, presenter, panelist, published author, and mentor for pharmacists looking to obtain their credentials through the American Academy of HIV Medicine. Because he works in a clinic, Harvinder is closely tied to primary care physicians, which gives him the opportunity to go over to the prescriber to talk about clinical cases and review prescriptions as needed. He is steadily increasing his scope of practice, but it is easier to coordinate with the primary care team for now.

Kristen Watt, owner of Kristen's Pharmacy in Southampton Ontario, practices innovative Community Pharmacy by moving the Pharmacist out of the dispensary, into an office to maximize patient care. A graduate of the UofT, Kristen opened her own independent Pharmacy, in 2017, with a clinical focus. Kristen works closely with her community to improve the health of her patients – from HRT and mental health to the newly minted minor ailments and all things COVID. Kristen believes Pharmacists should be working to their full scope as clinicians in all settings and looks forward to a bright future in Community Pharmacy. In addition to her Community Pharmacy, Kristen works with the University of Waterloo as a Regional Clinical Coordinator and sits on the Boards of Directors for PharmaChoice Canada, the Ontario Pharmacists Association and the Grey Bruce Hospice. She recognizes the importance of technicians; she has two who work offsite for data entry and two who work in the dispensary. The pharmacist (herself) and the two students have offices and run appointments. She uses a patient-facing website for intake and appointment booking. Their model is not a walk-in clinic as this does not work for their time: her team works by appointment only, prescribe what they can under the list, and contact the prescriber when needed.

Mikaela Klie works in Prime Care Pharmacy at Guelph with six other pharmacists. They handle geriatric care, hospice care, and work closely with clinics. The pharmacy uses the MAPflow software to help with what they can and cannot prescribe and which documentation is required. Because they work on a no appointment needed model, things can get challenging as they never know what kind of conversation they will walk into when called.

Sheri-Lynne Livingston is the HIV pharmacist at Windsor Regional Hospital's Tecumseh Byng Program, in Windsor, ON, where she was born and raised and still lives. Sheri specializes in HIV treatment, Pre-exposure and Post exposure Prophylaxis. She completed her PharmD degree at Wayne State University, Eugene Applebaum College of Pharmacy and trained in Michigan at Harper Hospital and Children's Hospital of Michigan before working in community pharmacy in Essex County. Sheri is a member of CHAP and loves working with HIV population to help empower them with tools and education to improve their own health.

Sheri works in an HIV clinic, which includes dispensary and clinical activities. She does PrEP care every three months in collaboration with the nurses (prescribers see the patient only once a year), as well as minor illness assessment, vaccination, and smoking cessation. She also fills in at at another pharmacy, where she sees the patients by appointment only.

The discussion highlighted a few key points that seems to matter deeply for the panelists and the attendees:

- The importance of registering technicians so that they can have more responsibilities and not be considered as assistants only.
- The MAPflow software is useful for consultations, as it highlights the clinical pathway to follow and red flags to look for when prescribing in a retail pharmacy. It can be particularly useful in the context of HIV to help identify potential new infections.
  While MAPflow itself is prescriber facing only, when used in combination with a compatible interface, it can allow the patient to complete the assessment ahead of the appointment.
- Minor illness assessment does not have to result in a prescription, the pharmacist will be paid for the assessment anyway. However, there is a limit in the number of consultations that can be billed per year by patient.
- The pharmacists used to do the triage for primacy care, but the new responsibilities allow them to expand their scope and to become specialized. Not everyone will master all new responsibilities and it can be the opportunity to reach out to colleagues who are specialized in a therapeutic area you are not.
- Prescribing Paxlovid can be stressful as ODB auditors can flag high prescription rates, even when it is justified in the context of older communities. This induces a fear response for the pharmacists who can become hesitant in prescribing it. The OPA can help protect pharmacists and advocate for them.
- MedsCheck can take a very long time and require a lot of documentation to complete for only $60.
- There is a real need for open prescribing so that the pharmacist can focus on the patient and asking questions, rather than the answers to pick one drug from the list. And while some doctors have been resistant to changes and think pharmacists have no place in diagnostics, some are very supportive!
- The vaccination of COVID-19 on babies (6m+). The recommendation is to go ahead if you feel comfortable, but additional training can be accessed if needed.
- The ClinicalConnect tool is available for all pharmacies in Ontario. However, patients can block some information if they decide to. The fear of disclosure can complexify patient care: not all patients are comfortable disclosing their HIV medications or PrEP, which can pause interaction issues, especially if the patient is from a small town but goes to the city for their HIV care. It is important to educate them on the fact that pharmacists have to protect their privacy!
- These new responsibilities can feel like a lot, so start slowly and adapt to your comfort level! If you are registered with the OPA, liability insurance will cover automatically any new scope activities.