THE Tablet

SUMMER 2022 | ADVOCATING FOR BRIT RMACY

Practicing cultural safety and humility

New standard published for B.C. health organizations

PAGE 13

British Columbia
Pharmacy Association
bcpharmacy.ca

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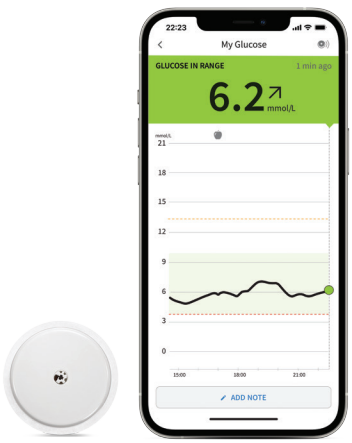
ANYTIME,* ANYWHERE†

FreeStyle Libre 2
FLASH GLUCOSE MONITORING SYSTEM



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HCP, healthcare provider.
* 60-minute warm-up required when applying the sensor.
† Sensor is water-resistant in up to 1 metre (3 feet) of water. Do not immerse longer than 30 minutes. Not to be used above 10,000 feet.

ADC-55172

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ON THE COVER

A new Standard intends to help guide British Columbia's health organizations to achieve cultural safety and humility in working with First Nations.

Check out all the latest news at **bcpharmacy.ca** | Got a story to share? Tell us at editor@bcpharmacy.ca

Jamie Wigston

Challenging autumn likely on horizon

As much as I would like to not write another article about COVID, unfortunately it is still very much a part of all of our lives. We are currently experiencing a surge in cases and hospitalizations as a result of the BA.5 variant, and because of this we will all be seeing an increased number of patients dealing with symptoms. This will be especially difficult because of shortages of certain 'cough and cold' products, as well as having patients with symptoms coming in because they believe it's 'just a cold'.

This is going to continue to be a frustrating time for all of us, but we need to make sure we keep trying to be patient with our patients (to an extent). We need to make sure we are doing as much as possible to keep ourselves safe, by either continuing to wear a mask at work, or thinking about re-implementing masking in our workplaces.

In addition to this, now is the time to start thinking about preparing for the fall flu/COVID shot campaigns. With the recent announcement from the ministry that everyone will be eligible for a second booster in the fall, we all know how hectic things will get when that time finally rolls around. It is very important to make sure we are all prepared well ahead of time, and that we are stocked up with all the required products.

One of the things I'm sure everyone has been hearing more and more about is cultural humility and sensitivity, and what it might mean for health care, and pharmacy, specifically.

When approached with the idea that we, as health care professionals, have things to work on when it comes to cultural sensitivity, it is easy to become defensive. However, it is certainly not something to be defensive about. Cultural and racial insensitivity has long been institutionalized. It can be something that is hard to pinpoint in our everyday lives without knowing what to look for, and the association is going to be working on developing helpful material for this in the future.

We all have a great deal to learn on the subject. We as people and professionals can better ourselves by taking the time to reflect and learn. Doing this will certainly not happen over night, and will take time and effort on all of our parts, but the result will be that everyone will feel much more included and comfortable when working with their health care professionals. This will undoubtedly lead to better care and better outcomes.

With all of this being said, I really hope that everyone manages to find some time this summer to take some well needed vacation, and recharge themselves for what will most likely be a hectic fall. T

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Geraldine Vance

Collaboration is key to moving forward

Many years ago when I worked in communications consulting, my boss had a saying: "Look after the relationship and the business will look after itself". This mantra is something I have reminded myself of more than few times in my career.

In recent months, I have thought about the strength that can come from collaboration, and what real leadership is all about. In January 2022, the College of Pharmacists of BC welcomed new Registrar Suzanne Solven. Suzanne returned to the College to lead the organization and from the beginning has reached out to build strong working relationships.

Less than two weeks on the job, Suzanne joined the BCPhA as a guest on one of our regular member town hall sessions. It was a great opportunity for pharmacists across the province to meet her and learn about the College's priorities, and how it plans to move ahead on key issues. Since that first meeting with Suzanne, we have shared information about a number of pressing matters: the role of pharmacists in the response to COVID-19, how pharmacists can better understand and support patients with Opioid Use Disorder, what role pharmacists can and should play in responding to the deadly toxic street drug supply, and how to ensure pharmacists and their Association deliver culturally safe and appropriate care to Indigenous People.

The College of Pharmacists, along with the College of Physicians and Surgeons of BC (CPSBC), the College of Dental Surgeons of BC (CDSBC) and the BC College of Nurses and Midwives (BCCNM), and the First Nations Health Authority have shown great leadership in addressing the shortfalls in care provided to B.C.'s Indigenous patients. The December 2020 report *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care* made clear that fundamental changes are needed in the delivery of health care in B.C.

Since that report was released, the College of Pharmacists and other regulators have taken on the challenge to understand and address systemic racism that negatively impacts the care Indigenous patients receive. In May 2021, the College of Pharmacists alongside the CPSBC, the CDSBC and the BCCNM issued an apology to the Indigenous Peoples and communities. "As part of the apology, the Colleges pledged to take action within their organizations and as partners in the broader community to dismantle the Indigenous-specific racism that exists within our health care system."

Under Suzanne's leadership, the College is taking this commitment seriously. The BCPhA is in the process of developing its next three-year strategic plan and we know we will be calling on the College of Pharmacists to share their learnings and understanding of this critical issue. I am confident that the collaborative approach our new Registrar has demonstrated will help us move forward to meet our obligations in ensuring pharmacists have the knowledge and training to provide safe and culturally appropriate care for the many Indigenous patients across the province.

The Tablet asks our contributors:

How do you think the BC Cultural Safety and Humility Standard for health organizations will impact the way pharmacists work with Indigenous Peoples?

Ayah Kapani is a recent University of B.C. PharmD graduate and recipient of the 2022 BCPhA Scholarship. "Establishing a set standard of care will ensure that all Indigenous People are treated with appropriate respect and increase their access to different health and wellness services. As a pharmacist, creating a culturally safe environment can result in an increase in positive health outcomes for the Indigenous People."

Javed Jokhoo is pharmacy manager at Seabird Remedys Pharmacy and has spent the last four years working almost exclusively with First Nations clients. "We have to understand what they have been through, especially the older generation, and how we can make it better. There is generational trauma and it is up to us to address that and make them feel reintegrated into the health system."

Parm Johal is a community pharmacy leader with 35 years of experience, who currently heads the Wilson-Davies Group. "The Standard allows us as professionals an opportunity to be better equipped with the knowledge and understanding of B.C.'s Indigenous People. Henceforth we can formulate more cohesive relationships and treat them with the respect and dignity deserved. This process is long overdue to address racism and inequities towards the Indigenous People. It is also in alignment with the values of the culture mosaic of our great nation."

Don Davies, Member of Parliament for Vancouver-Kingsway, attended a tour of Pharmasave - Kingsway & Commercial at 1808 Kingsway, Vancouver, to understand the work of community pharmacists in helping patients get the medications they need. Davies also received his flu shot from pharmacist owner Balhar Shergill.

Your questions about national pharmacare answered

MP Don Davies serves as Health Critic for the federal NDP. He took part in an in-depth discussion with BC Pharmacy Association Members on the May 24, 2022 all-member telephone town hall.

As national pharmacare is slated to become legislation by the end of 2023 with a national formulary of medicines to follow, it remains to be seen how Canadian drug coverage will be impacted with the changes.

On May 24, Don Davies, Member of Parliament for Vancouver Kingsway, made a presentation to the BC Pharmacy Association where he spoke at length about the potential impacts of a national pharmacare program to pharmacists across the country. In the hour-long town hall, Davies answered a range of members' questions to reveal some of the insights and ideas behind the federal Liberal and NDP's initiative, as part of a supply and confidence agreement, to implement universal drug coverage Canada-wide.

"It'll save individuals, employers and the public system money if it's done properly," Davies told pharmacists. "And it'll build on the best traditions of medicare, which is that everybody will have access regardless of their ability to pay."

Davies said his intention would be to develop clear policy to operationalize a federal drug coverage program, and part of that progress involves obtaining the input of pharmacists for consideration over the next two to three years.

In the wide-ranging conversation, here are some of the questions asked by members during the evening and the answers provided:

What would you envisage as a way in which pharmacies can begin to be compensated for the work that they do? Is it through clinical services? Is it through some kind of subsidy through dispensing fees?

Davies: We need to deep dive into right into the mechanics of how the present pharmaceutical delivery system works in this country. Because to be frank, that hasn't been explored enough, and I think we have to really understand from A to Z the entire business of pharmaceuticals, from how they're purchased to how they're ultimately dispensed, and the economics, so that we can complete the picture.

The core principles, throughout the entire study, every policy-maker, and I was there for the whole entire two year study at the House of Commons, understands the pivotal core importance of the pharmacist in this and one of the core principles has to be to maintain the remuneration of pharmacists.

We recognize pharmacists as "the" key health care professional, that is the gatekeeper and the professional at the at the prescription, dispensing and advice level.

In all honesty, I don't think that's received the attention it deserves, but nobody is talking about getting system savings out of the pockets of pharmacists.

I think that what we are talking about is the system-wide savings in some of the bulk buying and some of the streamlined administration, for instance.

I still can't get over this figure, but Eric Hoskins, in his report, said that there's over 100,000 extended benefit plans in Canada. Now, if you think about processing claims through, as an example, each province's medical services plan, you could reduce that to 13 different plans. So, streamlined administration is a cost saver.

Cost related non-adherence is a major, I think that was estimated to save about $1.1 billion a year. In other words, people who don't otherwise get sicker or go to the hospital because we can get them their medicine in a timely manner.

Of course, bulk buying. The figures I've seen, either from the U.S. Veterans Association or from New Zealand, or in the Scandinavian countries, we can save an average of 40% on prescription medication by buying in bulk now. I know we're doing that now, so that's not new savings. I think that there's certain provinces we are already realizing those savings.

But the bottom line is, we have to understand the pharmacists, and the pharmacy business, to make sure that those professionals are well remunerated for the services, and we have not worked out what system that would be. Obviously, dispensing fees and advice is one thing.

The other part of the equation, I think we need to always keep in mind, is we're also talking about a significant injection of new business into the pharmacist's world. If it's true that 20% of people don't have any insurance and even more than that don't fill their prescriptions, you're talking about injecting into the system millions of potential customers and patients into pharmacies that are not doing that now.

Where I will conclude on this is, Canada is the only wealthy country in the world with universal health care that does not have some form of universal prescription coverage. We also happen to pay, depending on who you believe, either the third or the fourth highest prices in the world. It's like a perfect bad-policy storm.

We have many other models to look at. We can look at the U.S. veterans who do provide universal single payer coverage for all U.S. veterans; we can look at New Zealand; we can look at U.K.; we can look at Germany; we can look at the different countries, and we have.

I think we need a made-in-Canada approach ultimately, but we can be informed by the best of what's working in those countries.

To me, the core is, I want pharmacists. Frankly, I believe in expanded scope of practice for pharmacists, and I also believe that their financial situation has to be completely protected, if not enhanced through this process, and I think it can be if we do it properly.

What are your thoughts on preserving the current role of insurers? From a pharmacy perspective, public payers make up only 40% of the amount paid.

Davies: There is no question that delivering this medical service through a single-payer system is the most efficient, the fairest and the most cost effective way to do it. We do think that we should be going through the public system in the same way that we deliver other medically necessary services.

There's no question we have unanimity on the health need. Pharmacists are, first and foremost, health care professionals, that's why they went into pharmacy. So we all we all share the same goal of making sure that everybody gets the medication that they need, and pharmacists are properly monitoring that and are at the point of contact with patients of, so critical to the system.

But the other two parts really are, how do you deliver it from an administrative point of view and the economics of it. Fusing these two things, the system that makes most sense is the single-payer system.

Quoting from a paper that was done, it says, here's the differences: arguments integrate the present patchwork of public and private schemes, and fortunately, often proved to be euphemisms for arrangements where profitable enrollees stream to the private sector, while the needs of high risk patients are left to public drug programs. That fill-the-gaps or plug-the-holes approach would result in a high cost, inefficient system.

To say, keep the current system you have now and just have a public system for those that aren't covered, which is called the patchwork system, have proved time and time again to be inefficient and the most expensive.

That's Quebec system now, and they pay the highest per-capita costs for drugs in the country because of that. So that's only one

of many reasons why we think it should be through the single payer system. Insurance companies would not be part of the system that we envision.

Can there be a case made for reducing healthcare costs, by allowing pharmacists, for example, to prescribe for minor ailments?

Davies: Pharmacists I believe are our experts on prescription medications and often know at least as much if not more than a lot of physicians.

I say that with great respect to physicians, but this is how we train our pharmacists, and in my opinion, we're not utilizing them to the full extent of their knowledge.

With a healthcare system under enormous strain, if not a crisis, I think this is an opportunity for us to rejig the system and get the professionals doing more of what they're trained for, and that includes pharmacists.

I'll tell you an example, it just happened yesterday. I phoned my doctor for renewal of a prescription I've been on for 20 years. Why do I need for my doctor for that? I think pharmacists should be able to do renewals of medication that that the patient is going to be on for a long period of time.

The ability to prescribe for recurring, easily diagnoseable, things like UTIs, maybe pinkeye, again, I don't want to take away from other professionals, because sometimes pinkeye isn't pinkeye — sometimes it's something else — but surely, we can be getting more value out of pharmacists and using their talents and their skills in a more efficient way…we started off talking about how can we get prescription medicine into every Canadian's medicine cabinet when they need it.

That's the simple question we started with. As we get further and further into this, we realize there's real opportunities here for us to get more effective, more efficient, in everything from how we prescribe, to who's doing the prescribing, to who's monitoring the medication, to how we're paying for it.

That's where the voice of pharmacists, I think, we really need to blow a hole into this discussion and get pharmacists right at the table, with a big seat at the table, helping to develop that, because we don't have all the answers.

In B.C., it can be argued that we already have universal PharmaCare program in that every patient is eligible for Fair PharmaCare, which is an income based system where people's deductible is based on a percentage of their income. Would you see the national PharmaCare program mimicking what we have in B.C. already?

Davies: I think B.C. is almost leading the country in making pharmaceuticals available to its population, but it's not quite the model that we have in mind, for two reasons.

I would argue it's not universal, because it has a significant deductible. To make to make a very, very crude analogy, it's like saying everybody's covered for pharmaceuticals but you got to pay the first $2,000. You could say that's universal but because the deductible is so significant, it's not truly universally accessible.

That's kind of the barrier I see with the B.C. system, although as a percentage of income is about the fairest you can get if you're going to have a deductible of any type at all… our view is that, to have a truly accessible program, respecting the principles of the *Canada Health Act*, then that means there's no deductible at all. It means that it has to be truly universal coverage without any barriers.

How does National PharmaCare affect First Nation coverage? Will it be applied to First Nations as well?

Davies: Right now, First Nations are covered by a plan called the non-insured health benefits plan, which provides extended health benefits to Indigenous Canadians. I think that the best thing to do is, and frankly, the constitutional thing to do, would be to sit down with Indigenous Peoples and negotiate the proper plan that they would like.

What medications will be on the national formulary? As good as PharmaCare is there's a lot of medications that either require special authority because they're only indicated for certain conditions, or they're just not on formulary at all. What will happen to access to medications like that?

Davies: The truth is that we can have as broad and as generous a formulary as we're prepared to pay for. My view has always been: I want a wide and generous formulary.

It still should be evidence-based. With expensive biologics coming and of course, we haven't even touched on drugs for rare diseases, there's some very important subsets that we have to address.

Our vision is one where the Canadian Drug Agency sets a very wide and generous formulary. Decisions have to be based on clinical evidence and value for money.

There should be a process where patients will be able to appeal any priority-setting decisions to ensure that their voices are heard. We also think that, to maintain transparency and accountability, that the formulary decisions of the body are subject to regular reports or audits.

We also still think that there may be a role for private insurance as well, that people could pay for if they wanted to, to pick up additional coverage that perhaps the public system didn't have is also an option that people are looking at.

Bottom line is we want patients to be able to get the medication that they need and that their doctors prescribed. T

To see all of the Association's previous town halls, including accessing recordings of the town halls, please visit bcpharmacy.ca/town-halls. Member log-in is required.

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Pharmacists need guidelines for dispensing safer supply: BCPhA

FROM BCPHA SUBMISSION TO B.C.'S SELECT STANDING COMMITTEE ON HEALTH

In early July, the BC Pharmacy Association provided a written submission to B.C. government's Select Standing Committee on Health on the topic of B.C.'s safer supply pilot projects. Safer supply is part of the provincial government's work to reduce harm associated with using illicit drugs.

The Select Standing Committee, which received the submission, is one of nine permanent all-party committees of the Legislative Assembly of British Columbia. It works to identify potential strategies to maintain a sustainable health care system for British Columbians; and consider health capital funding options.

As part of Budget 2021, the provincial government directed funding of up to $22.6 million to support the planning, phased implementation, monitoring and evaluation of prescribed safer supply services. Once implemented, it is expected that people at high risk of dying from the toxic illicit drug crisis will be able to access alternatives covered by Pharmacare, including a range of opioids and stimulants.

The Association, in its written submission to the Committee, communicated its belief that considerable work needs to be done to create a treatment protocol and clinical guidelines that can be understood and implemented by prescribers and pharmacists and their patients. Regulatory bodies and organizations representing practitioners must be involved.

The BCPhA's position is that current guidelines for dispensing safer supply are inadequate and leave pharmacists in a position where they are vulnerable to regulatory and PharmaCare audit exposure. While the development of guidelines needs to be done immediately, there also must be plans for proper evaluation on safer supply. Clear evaluation methods should be developed that include proper clinical support, which include assessments and follow-ups, not simply a witnessed ingestion or a dispense of this medication from pharmacists. We understand the launch of B.C.'s safer supply pilot projects were predicated on an evaluation process that would provide important learnings about the role risk mitigation strategies like safer supply can and should play in the battle against opioid deaths.

We believe a wraparound approach is key when delivering safer supply. What will be key is addressing the challenge of consistency in access to prescriptions for safer supply. Not all practitioners will prescribe for this. In fact, we have seen not enough clinicians prescribing for opioid agonist treatment throughout the province. It is imperative that individuals understand that without a prescription, pharmacists can't dispense, regardless of their interest in doing so.

Pharmacists as health care practitioners will never abandon their duty to care. While there is an understanding that safe supply is harm reduction, not clinical treatment, it must be understood that health care providers will always need to ensure that nothing they do will cause harm to a patient.

In the submission, the BC Pharmacy Association asks that we are part of the discussion and planning of well-developed clinical guidelines and evaluations to ensure that all issues are being considered when delivering important care to patients. We want to be at the table when discussions begin to bring our experience and expertise in delivering care for patients with opioid use disorder. T

The full submission to B.C. government can be found at bcpharmacy.ca/advocacy/submissions

Ayah Kapani is a 2022 University of British Columbia Doctor of Pharmacy graduate and recipient of this year's BC Pharmacy Association Scholarship. For the past five years, Kapani has also worked at Terra Nova Pharmachoice in Richmond, B.C.

Each year, the University makes two BCPhA scholarships available, with recipients selected at the recommendation of the Faculty of Pharmaceutical Sciences. The scholarships are given with preference to a fourth year student and for a student from rural British Columbia. The scholarship was established in 1971 and since then, 71 awards have been distributed totaling $58,800.

Graduating into practice

Why did you choose to enroll in pharmacy school?

I have always been intrigued by the science behind different drug therapies that exist. Understanding the different treatment algorithms and tailoring them to fit specific patient requirements is what I find to be a very rewarding part of the profession. Pharmacy is a continuous, dynamic career which involves constant learning and allows me to be able to pursue my passion of studying science in a lifelong manner. As a pharmacist, you are also able to develop trustworthy relationships with your patients and truly have a direct impact on their care as you are one of the most accessible health care professionals for them.

What has been some of the most rewarding experiences you have had working inside community pharmacy?

The most rewarding experience working inside of a pharmacy is when you get to regularly see your patients, monitor them and watch them improve in the long run. Being able to see the impact you are having on one's health is always very exciting to see! My goal as a pharmacist is to fulfill patients' needs and address their health concerns to the best of my ability.

What has been the impact of receiving the BC Pharmacy Association Scholarship to you?

As we know, the UBC pharmacy program is quite expensive! Receiving this scholarship has allowed me to be able to reallocate my time and energy towards other extracurriculars and student experiences which have contributed to my growth as an individual and a pharmacist. I am very grateful to receive this scholarship!

What's next? Where would you like to see your career in the next five years?

I would love to see how the scope of practice of pharmacists in B.C. further expands in this time period to allow for more opportunities. The profession is constantly growing! In the next few years, I see myself striving to pursue a more clinically oriented career. I have always wanted to work in an outpatient primary care setting where I could work alongside a group of other health care professionals to provide patient-centered care.

What pieces of advice would you share with people who are considering enrolling at UBC pharmacy?

Be confident! Don't be afraid to put yourself out there and reach out for help if you need it. There will be ample opportunities that will be available to you as students and I would say that when a door opens, take it and learn from your experiences and mistakes. Don't forget to enjoy the journey, meet new people and have a good time. The years pass by really fast and looking back, the most memorable moments that I had were those that I spent with my classmates. It is going to be a challenging trek but all of your hard work and energy will pay off in the end!

Is there a pharmacist role model who has had a particularly positive impact in your education and career? Who is it and how did they make a difference?

All of my preceptors and the pharmacists that I have worked with as a student have contributed to shaping me into the pharmacist that I am today. Every pharmacist is unique in their practice and learning from their styles can really teach you about the type of pharmacist you want to be in the future. Particularly, one of my preceptors, Mona Kwong, had a positive impact on me. As a preceptor she has also taken the role to be a personal mentor and has challenged me in ways that have encouraged me to step out of my comfort zone and grow. T

Left to right: Pharmacists Gordon Chow, Neesha Johal, pharmacy assistants Tiana Hu, Bhargavi Poranki, Ayah Kapani, and pharmacy owner Shawn Sandhu.

"I have the freedom to run my pharmacy the way I want to and have more impact on the health of my patients."

Becky Jiang
Pharmacist Owner • Port Coquitlam, BC

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B.C. publishes Cultural Safety and Humility Standard for health organizations

The first edition of the British Columbia Cultural Safety and Humility Standard was published on June 14, 2022. The standard, published by the Health Standards Organization with funding from the First Nations Health Authority (FNHA), outlines the responsibilities of health systems and health and social service organizations in British Columbia to establish a culture of anti-racism and cultural safety and humility in their services and programs.

Dr. Nel Wieman, Deputy Chief Medical Officer with the FNHA, was co-chair of the Technical Committee that oversaw the standard development process.

She said work on the new standard began in 2018 and is intended to partly respond to the *In Plain Slight* report by Dr. Mary Ellen Turpel-Lafond, which itself was a document to review Indigenous-specific racism in the provincial health care system. The part of the *In Plain Sight* report that the standard aims to address is the finding that, "Indigenous health practices and knowledge are not integrated into the health care system in a meaningful and consistent way."

Javed Jokhoo is pharmacy manager at Seabird Remedys Pharmacy, which is located on the land of the Seabird Island Band and serves almost exclusively First Nations clients.

Wieman said the intent of the standard is to guide health organizations to start making commitments to cultural safety, humility and practicing anti-racism.

"It defines the quality expectation of health and social services provided by organizations in British Columbia," Wieman said. "We all know, even before the *In Plain Sight* report, that widespread and systemic racism, stereotyping and discrimination against Indigenous Peoples in British Columbia has resulted in a whole range of negative impact, up to and including harm and even deaths."

Wieman said the standard is currently used for reference and is applicable to all types of health organizations in B.C. She said there are plans to eventually develop a national standard, and to accredit the current B.C. standard.

"Somewhere, some day, today, a First Nations, Metis, or Inuit person in British Columbia is having the worst day of their life — not just because they may be ill in some way, but because of how they are treated in the health-care system. They may be misdiagnosed, they may be not given the treatment that they deserve, they may be treated in a discriminatory or racist manner," Wieman said.

"That's why we do this work. First Nations people have a right to access a health-care system that is free from racism and discrimination, and to feel safe when accessing care."

Javed Jokhoo, pharmacy of Seabird Remedys Pharmacy, works almost exclusively with First Nations clients. Jokhoo's pharmacy is located in the Agassiz area on the territory of the Seabird Island Band. and he operates his pharmacy in a community health centre, along with several doctors, a dentist and nursing staff. He said the most important lesson for pharmacists working with First Nations is that trust has to be earned. All together, there are approximately 700 community members living in the area.

"We have to understand what they have been through before, especially the older generation, the residential schools, and we have to make it better for them," Jokhoo said. "There is always that generational trauma that keeps happening every generation after generation, and it's up to us to address that and make them feel reintegrated in the health system again."

Jokhoo said he first started at Seabird four years ago and had previously worked in Williams Lake, where there was also a significant First Nations population. At first, the majority of the First Nations community members did not trust him.

"For them, it was all of a sudden a complete stranger was here. It was a very long process. It started with me chatting with them, asking them here and there about their daily life. Eventually, they started talking to me about their childhood, their culture, you name it, but it's along process and it's all about communication and interaction," Jokhoo said. "I had to show them that I was not just a random pharmacist, or a random guy standing there telling them to take this pill."

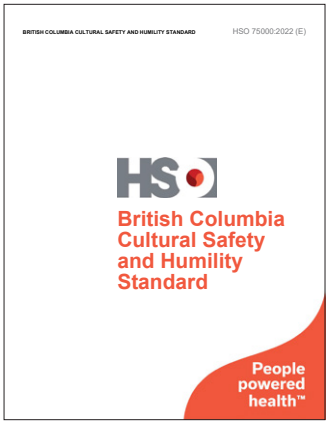
He said gaining that trust is a step that each health-care professional must earn. When Jokhoo hires new pharmacy assistants, the new staff member is introduced slowly, over time, to regular clients. Only when they are a familiar fixture in the pharmacy will the new employees start interacting with patients.

Even now that he has worked as the only pharmacist in the community for years, there are still many community members who are reluctant to access health services.

"A lot of people here use cultural medications, plants, and other types of ancestral medications. Where they might come to me is at the point when they believe the ancestral medications are no longer working for them. They will come to me and we will design a new plan," Jokhoo said. "It's how you build a proper communication, how to remove those barriers with the person."

Wieman said the B.C. Cultural Safety and Humility Standard is the first standard of its kind in Canada. A copy of the Standard is at **healthstandards.org** for purchase.

The eight standards of the British Columbia Cultural Safety and Humility Standard



1. **Support social, public and reciprocal accountability**
   a. The organizational leaders are accountable for the organization's commitment to anti-racism and cultural safety and humility.

2. **Establish inclusive and meaningful partnerships**
   a. The governing body and organizational leaders engage in purposeful, ongoing, and inclusive partnerships and effective communication with First Nations, Métis, and Inuit peoples and communities.

3. **Share governance and implement responsible leadership**
   a. The organizational leaders work with the governing body to establish governance and leadership structures that uphold the eradication of Indigenous-specific racism
   b. The organizational leaders work with the governing body to establish governance and leadership structures that demonstrate a commitment to anti-racism and cultural safety and humility.

4. **Invest in financial and physical infrastructure**
   a. The organizational leaders work with the governing body to invest in anti-racism and cultural safety and humility by establishing the financial and physical infrastructure necessary to ensure a respectful and welcoming environment for First Nations, Métis, and Inuit peoples and communities.

5. **Develop human capacity**
   a. The organization's human resources policies and practices address racism and discrimination and are developed in partnership with First Nations, Métis, and Inuit peoples and communities.
   b. The organizational leaders regularly provide the workforce with cultural safety and humility education and training that incorporates the views and experiences of First Nations, Métis, and Inuit peoples and communities.
   c. The organizational leaders embed cultural safety and humility into professional development opportunities and performance appraisals.
   d. The organizational leaders develop a First Nations, Métis, and Inuit workforce strategy.

6. **Build a culture of quality and safety**
   a. The organizational leaders and teams build a culture of anti-racism, quality, safety, and cultural safety and humility by establishing culturally safe processes to manage feedback and address safety incidents.

7. **Design and deliver culturally safe practices**
   a. The organizational leaders ensure culturally safe programs and services are developed, implemented, and sustained.
   b. The team ensures the delivery of care and provision of services are culturally safe.

8. **Collect evidence and conduct research and evaluation**
   a. The organizational leaders use a distinctions-based approach to collect data related to First Nations, Métis, and Inuit peoples and communities.
   b. The organizational leaders conduct research in partnership with First Nations, Métis, and Inuit peoples and communities.
   c. The organizational leaders evaluate the organization's commitments to anti-racism and cultural safety and humility and use the results for quality improvement.

A challenge of access

PHARMACY SERVICES AND REMOTE FIRST NATIONS COMMUNITIES

Community pharmacies in Prince George alone serve more than nine different First Nations communities. On the surface, this could seem like an impressive amount of support pharmacies in that community are providing for B.C.'s First Nations populations.

The reality, however, is that some of those nine communities are at least 13 hours away by dirt road, with flights only available once to twice a week, said Cindy Preston, Director of Pharmacy Health Benefits and Services at the First Nations Health Authority (FNHA).

"There are several factors that impact access to pharmacy services," Preston said.

"The health-care system structures and policies are definitely one huge impact and cultural safety within that and racism within the system. But geographic location is another huge impact to individuals' access to pharmacy care."

Preston and her team made a presentation in June to the College of Pharmacists of British Columbia, where she identified some challenges First Nations individuals and communities currently face in accessing pharmacy services.

The distance challenge is particularly aggravating for First Nations community members receiving treatment after being diagnosed with Opioid Use Disorder (OUD). Her team identified that 91% of pharmacies in B.C. serve First Nations clients, and many of these clients risk having their treatment disrupted due to multifaceted reasons, including travel and delivery disruptions.

These disruptions could happen when a champion community care provider moves away, or transportation is unavailable, or a pharmacy delivery gets delayed due to weather. The resulting harm, unfortunately, is on the patient, who risks possible destabilization and disengagement with the health-care system, and potential re-exposure to the toxic drug supply.

Nikhil Gandhi, pharmacist with the FNHA, said First Nations people in B.C. are disproportionately represented in toxic drug deaths at a rate of more than five times that of other B.C. residents in 2020. Some of the areas in B.C. with the highest rates of toxic drug deaths in 2021, he said, have been in the Northern and Interior health regions with significant rural and remote First Nations populations.

"Fewer people diagnosed with OUD receive Opioid Agonist Treatment (OAT) in rural and remote settings than urban settings, and also have lower retention than people in urban settings," Gandhi said.

"This clearly shows that there is a disparity between urban and rural remote OAT access … and while there are other factors involved for sure, we know that pharmacy access is a major contributor."

As a potential solution, part of the FNHA's proposal includes having pharmacies work directly with nurses who are already present in First Nations communities to store and administer OAT medication, instead of relying on frequent deliveries, or First Nations residents travelling to attend pharmacies in the nearest town.

"We know of stories where rural community members returned home from an urban setting for traditional activities such as gathering and harvesting food, only to find that they're unable to continue their OAT due to lack of pharmacy access," Gandhi said.

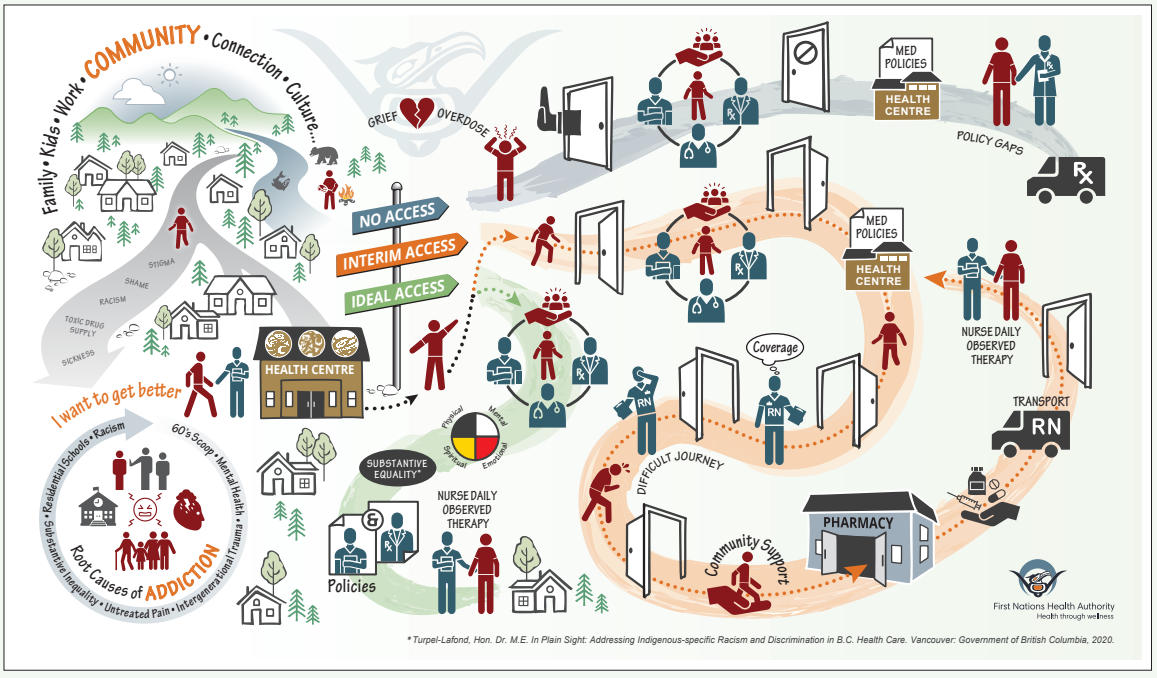
Twinkle Ruparel, another pharmacist with FNHA, said there are over 200 diverse First Nations communities in B.C., operating over 130 health facilities, with the majority self-determining their healthcare programs and services. The FNHA currently supports 31 such communities with opioid response programming, of which 14 involve distribution of Controlled Substances.

"Since the onset of the pandemic, our team collaborated with First Nations communities across B.C. in implementing community driven opioid response programs at health facilities," Ruparel said.

"With systemic supports and virtual clinician teams, these programs can be well-positioned to engage and retain clients in culturally safe care, and support with transitions and wraparound care." T

The FNHA recently presented to the Board of the College of Pharmacists of BC to discuss some short, medium and long-term recommendations for their consideration. The College is now in the process of reviewing these recommendations and determining a path forward to ensure greater support for Indigenous Peoples.

The FNHA co-created this visual, with feedback from health workers, people with lived and living experience, community health leaders, and First Nations colleagues. The FNHA learned about barriers and facilitators in rural and remote B.C. First Nations when accessing medications for OUD, the ongoing impacts of colonialism, and healthcare inequities as drivers and contributors to substance use. Community-led programs and services are central to advancing cultural safety and improving accessibility. There have been primarily two outcomes in the communities the FNHA has supported: no access to OAT (reflected in grey) or interim access (in orange).



No Access:

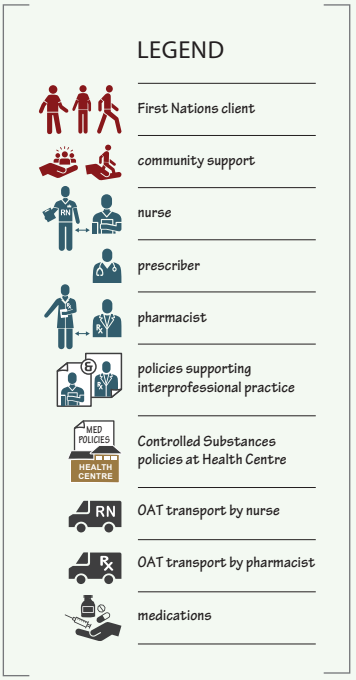
- Inconsistent or intermittent access to prescriber, nursing or pharmacy services
- Inconsistent or no access to Health Authority based services
- No implementation of medication management policies at community Health Centre
- No access to pharmacy services to meet provincial OAT policy requirements

Interim Access:

- Access to prescriber and pharmacy services via use of telehealth and virtual care
- Community health nurses lead multiple facets of programming and service delivery
- Prescriber-directed and nurse-led Daily Observed Therapy with nursing assessment
- Nurse transport of Controlled Substances from pharmacy
- Health Centre receiving delivery of medication and storage in a lock box
- Community member transporting client to pharmacy for pick up or Daily Witness Ingestion

Ideal Access:

- Access to consistent prescriber, nursing and pharmacy services via use of telehealth and virtual care pathway
- Clear interdisciplinary framework of practice and pharmaceutical policies that support team-based care models
- Community engagement and support in implementing services for substance use and harm reduction
- Balance of Indigenous perspective on balance and wellness: mental, physical, emotional and spiritual aspects of The Medicine Wheel. This includes services centred on Indigenous healing, cultural and traditional practices



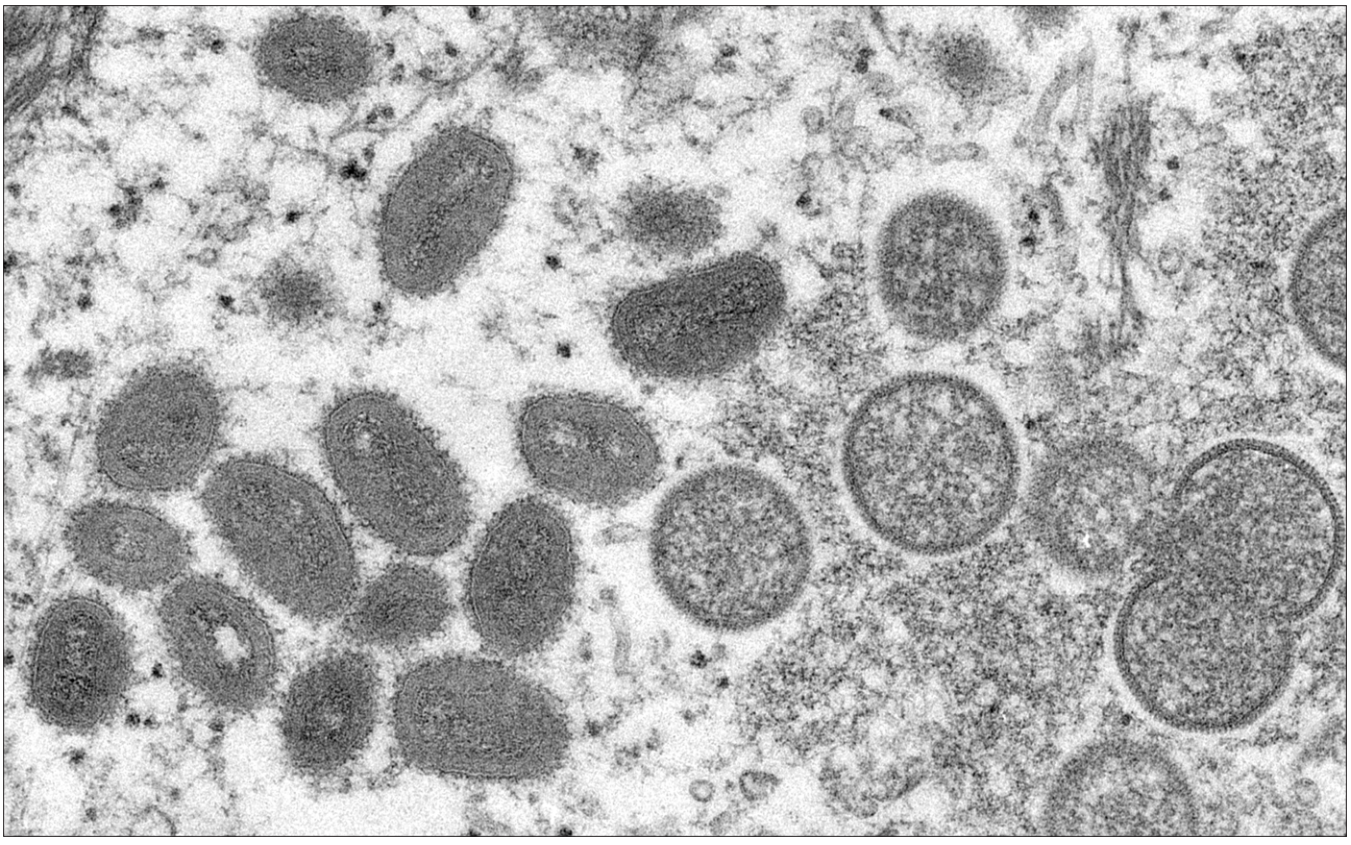


PHOTO: CYNTHIA S. GOLDSMITH, RUSSELL REGNERY, CDC

Monkeypox: a primer for pharmacists

FAWZIAH LALJI, BSC(PHARM), PHARMD, FCSHP, ACPR, RPH

Epidemiology

Monkeypox virus is a member of the Orthopoxvirus genus in the family Poxviridae, which includes variola virus (smallpox), cowpox, and others. Monkeypox is a zoonotic disease with transmission primarily occurring from animals, such as rodents and primates, to humans. Limited human-to-human transmission has been observed amongst close contacts of those infected with monkeypox.

The virus can transmit through contact with bodily fluids, wounds on the skin or internal mucosal surfaces, respiratory droplets, or contaminated objects. Monkeypox is not known to be sexually transmitted, but outbreak close contact with a case of monkeypox has been known to be a risk factor for acquiring the infection. In the current outbreak, it is believed that inoculation of the virus to skin and mucosal surfaces by direct, sexual or skin to skin contact, as well possibly through fomites such as towels, bedding, and sex toys are potential routes of transmission.

Two distinct clades of monkeypox have been identified: the West African clade, which is associated with milder clinical presentation and mortality (~ 1% case fatality ratio), and the Congo Basin (Central African) clade, which has been associated with greater human-to-human transmission and higher mortality (case fatality ratio 1-10%).

In 2021, 15 countries reported confirmed human monkeypox cases, with the majority of these cases being identified in Africa – that is, countries where monkeypox is endemic, such as Nigeria, Central African Republic (CAR), Cameroon, and Democratic Republic of Congo (DRC). The balance of these cases were individuals who travelled outside of monkeypox endemic areas to the United States, the United Kingdom, Israel, Benin, South Sudan, Singapore.

The current 2022 epidemic represents the first multi-country outbreak outside of the continent of Africa. Initial detection was in the UK in early May – a family cluster of 3 cases, with one case having a recent travel history to Africa. By July 18, at least 13.340 confirmed cases from 69 non-endemic countries had been reported according to the World Health Organization, with the majority (86%) of cases from Europe. Confirmed cases have also

been reported from the African Region (n=73; 2%), the Region of the Americas (n=381; 11%), Eastern Mediterranean Region (n=15; <1%) and Western Pacific Region (n=11; <1%). The first monkeypox cases in Canada were reported on May 19 2022, in Montreal and, as of July 18, 539 cases of monkeypox have been confirmed in Canada (299 Quebec, 194 Ontario, 2 Saskatchewan, 12 Alberta and 32 British Columbia).

Genomic studies in UK and Portugal have linked the recent outbreak with the West African clade. Demographic information and personal characteristics are only available for some of the WHO-reported cases, and 99% are men aged 0 to 65 years (Interquartile range: 32 to 43 years; median age 37 years), of which most self-identify as gay, bisexual and other men who have sex with men (gbMSM). Though the reported cases thus far have been primarily among gbMSM, it is essential to note that anyone can become exposed and infected. The recent cases among gbMSM are thought to be related to shared social networks and participation in large events that may have facilitated transmission.

Clinical Characteristics and Diagnosis

The incubation period for monkeypox ranges from 5–21 days, although typically, it is between 7–14 days. The disease is often mild, self-limiting and resolves within 14-21 days. Clinical presentation of monkeypox can be similar to smallpox but milder. Symptoms usually begin within five days of infection with fever, chills, intense headache, muscle aches, back pain, and rash. Unlike smallpox and chickenpox, individuals with monkeypox also have swollen lymph nodes. The characteristic rash occurs 1 to 5 days after the initial onset of symptoms, usually beginning on the face and spreading throughout the body, often to the extremities (75% of cases have a rash on palms of the hands and soles of feet) rather than the trunk, and mucous membranes (oral or genital areas). The rash/lesions begin as macules and further develop into papules, vesicles, pustules, and then form crusts. In the current outbreak, monkeypox cases have an atypical presentation with skin lesions occurring in crops at the site of inoculation, which explains why they are predominantly oral, genital, and/or anal lesions; patients do not always have a fever or systemic symptoms.

Due to the similarity in clinical symptoms between monkeypox and chickenpox, healthcare providers often face difficulties diagnosing cases based on clinical symptoms alone. Additionally, cross-protective antiviral immunity among adults who received childhood smallpox vaccination may lead to asymptomatic, mild or unrecognizable disease symptoms.

The differential diagnosis of monkeypox includes other poxviruses and herpesviruses (this includes chickenpox). Often diagnosis is made presumptively, based on clinical presentation and disease progression. The preferred laboratory test is polymerase chain reaction (PCR) detection of viral DNA, followed by confirmation of positive results by sequencing and/or PCR testing at the National Microbiology Laboratory. The best specimens are from skin, fluid, or open crusts - if these are present, BCCDC recommends collecting directly from skin lesions, or biopsy. For individuals who do not have skin lesions, oropharyngeal swabs, or nasopharyngeal swabs are to be collected; EDTA blood and urine can also be considered for testing. In general, antigen and antibody detection methods are not recommended due to the serological cross-reactivity among orthopoxviruses and the potential for false positive results among people recently or previously vaccinated against smallpox.

Infection Control

Infection prevention and control measures need to be put in place for suspected monkeypox cases. Thus, airborne, droplet and contact precautions are to be implemented, in addition to following routine infection prevention and control practices such as wearing medical masks, performing hand hygiene, wearing gowns, gloves, and eye protection. Preferred room placement is an airborne infection isolation room (i.e., negative pressure room). For environmental infections control, standard cleaning and disinfecting of equipment and surfaces is sufficient, but soiled laundry is handled with gloves to avoid contact with lesion material.

Treatment and Prevention

Currently, there are no proven treatments specifically for monkeypox. Most cases are mild and require supportive treatment based on symptoms (e.g., fever control, hydration). The antivirals cidofovir and brincidofovir (pro-drug of cidofovir), which work by inhibiting viral DNA polymerase, have been evaluated within in-vitro and in-vivo animal models with some effectiveness. In the treatment of CMV infections, nephrotoxicity or other serious adverse events have not been observed with brincidofovir, suggesting a more favourable safety profile compared to cidofovir. Although the data on safety and efficacy are limited, the FDA approved brincidofovir for treatment of smallpox in 2021. Tecovirimat (ST-246), an inhibitor of the viral envelope protein p37 that blocks the ability of virus particles to be released from infected cells, is another antiviral that could be used for monkeypox. However, there is no data on its effectiveness in humans. These three antivirals may be considered in severe cases of human monkeypox on a case-by-case basis as “off-label” use.

Another potential monkeypox treatment, available in the USA, is intravenous vaccinia immune globulin (VIG). Once again, use of VIG for monkeypox or smallpox has not been tested in humans and there is no data on effectiveness against either virus. As such, the use of VIG for monkeypox treatment would need to be used for special populations such as patients with severe monkeypox infection or as prophylaxis in exposed

individuals with T-cell immunodeficiency, for whom smallpox vaccination is contraindicated.

Smallpox vaccines used during the global smallpox eradication programs may provide some protection against monkeypox. However, international smallpox vaccination programs ended in 1980 when smallpox was declared eradicated, and vaccination for travel ended in 1982. Canadians born in 1972 or later have not been routinely immunized against smallpox (unless immunized for travel or work-related risks). For those who have been previously vaccinated for smallpox (i.e., eligible for vaccine in 1980 or earlier), the degree of protection conferred from the smallpox vaccine against monkeypox infection may be up to 85% (5), however the durability of protection and the degree of protection against the current strain of monkeypox remains unknown.

In the USA, there are currently 2 licenced smallpox vaccines: JYNNEOSTM (also known as Imvamune® or Imvanex®) and ACAM2000®. Imvamune® is also licensed for monkeypox, and this is the vaccine that Health Canada maintains a limited stockpile of, and would be available to Provinces and territories on a case-by-case basis.

Imvamune® is a Modified Vaccina Ankara-based (MVA) virus that was developed as a safer, third-generation smallpox vaccine. Like the previous smallpox vaccines, it is a live, attenuated vaccine. Imvamune® is capable of replicating to high titers in avian cell lines such as chicken embryo fibroblasts, but it has limited replication capability in human cells. This non-replicating nature of the vaccine differentiates it from the older generation, live smallpox vaccines. Initially authorized for use in Canada in 2013 for smallpox, it further received authorization in late 2020 for immunization against smallpox, monkeypox and related orthopoxvirus infections in adults 18 years of age and older determined to be at high risk for exposure.

Imvamune® contains trace amounts of host (egg) cell DNA and protein, tromethamine, benzonase, ciprofloxacin and gentamicin. No preservative or adjuvant is added to the formulation. The primary series is administered subcutaneously in 2 doses of 0.5mL (0.5×10^8 infectious units), given 28 days or 4 weeks apart. Booster dose is administered 2 years after the primary series and is one dose of 0.5mL (0.5×10^8 infectious units). Contraindications include patients who are hypersensitive to this vaccine or to any ingredient in the formulation and individuals who show hypersensitivity reactions after receiving the first dose of the vaccine.

Imvamune® is stored frozen at -20°C ± 5°C or -50°C ±10°C or -80°C ±10°C. After thawing at room temperature, the vaccine should be used immediately or can be stored at 2°C –8°C for up to 2 weeks prior to use. Refreezing is not permitted once thawed. The product is available as a single-dose vial that should be gently swirled for 30 seconds to ensure homogeneity upon thawing, prior to use.

NACI Recommendations and Evidence

The National Advisory Committee on Immunization (NACI) recommends vaccination in the following populations:

1 **Post-exposure prophylaxis (PEP) for adults with recent exposure:**

A single dose of the Imvamune® vaccine may be offered to individuals with high-risk exposures to a probable or confirmed case of monkeypox, or within a setting where there is ongoing transmission. PEP should be provided as soon as possible, preferably within four days after last exposure, but can be offered as late as 14 days after exposure; in this latter scenario vaccination may reduce the symptoms of disease but may not prevent disease. The latter recommendation is based on historical studies of the older generation smallpox vaccines, whereby the median effectiveness in preventing disease with vaccination is 93% if given within 0-6 hours, 90% if given within 6-24 hours, 80% if given 1-3 days after exposure. PEP should not be offered to symptomatic persons who meet the definition of suspect, probable or confirmed case.

A second dose may be offered to individuals who have ongoing risk of exposure after 28 days. Once again, the second dose should not be offered to individuals who are symptomatic (i.e., meet the suspect, probable or confirmed monkeypox case definition).

For individuals who had received a live replicating 1st or 2nd generation smallpox vaccine in the past and sustained a high-risk exposure to a probable or confirmed case of monkeypox, a single dose of Imvamune® PEP may be offered (i.e., as a booster dose).

2 **Pre-Exposure Prophylaxis (PrEP) for adults at high risk of occupational exposure in a laboratory research setting:**

Imvamune® PrEP may be offered to personnel working with replicating orthopoxviruses that pose a risk to human health (smallpox or monkeypox) in laboratory settings and those at high risk of occupational exposure. If Imvamune® is used, two doses should be given at least 28 days apart. A booster dose may be offered after two years if the risk of exposure extends beyond that time. This recommendation does not apply to clinical diagnostic laboratory settings at this time due to the very low risk of transmission.

For immunocompetent individuals who have received a live replicating 1st or 2nd generation smallpox vaccine and who are at high risk for occupational exposure, a single dose of Imvamune® may be offered

(i.e., as a booster dose), rather than the two dose primary vaccine series). This single Imvamune® dose should be given at least two years after the latest live replicating smallpox vaccine.

The evidence base behind NACI's recommendations for PEP and PrEP for adults is outlined in the sections below.

There is one phase 3 human study indicating the efficacy of Imvamune® vaccination against monkeypox infection or disease; most of the data is limited to immunogenicity studies. However, it should be noted that there is no established level of the correlate of protection, therefore the interpretation of the decline or boosting of immune responses remains unclear. In addition, clinical protection from symptoms of vaccinia infection may not be indicative of protection against monkeypox.

In a Phase 3, randomized, open-label active-controlled non-inferiority trial, 440 smallpox vaccine naïve adults were randomly assigned to receive: (1) two doses of Imvamune® at weeks 0 and 4, followed by one dose of the older generation, live/replicating smallpox vaccine at week 8 or (2) one dose of the older generation, live/replicating smallpox vaccine at week 0 alone. Imvamune® immune responses (binding and neutralization) were detectable by week 2. At week 6 after the second dose, immune responses (neutralizing antibody titers) were much higher in the Imvamune® arm (GMT=153.5) than those seen with the one-dose of the previous generation, replicating/live vaccine (GMT=79.3). At the time of peak titres, 100% of participants in the Imvamune® group had seroconverted and 97.3% of participants in the older generation group had seroconverted. At week 4 (a time point when previous the generation vaccine has historically been considered to be protective), seroconversion rates were similar between both groups. As a surrogate marker of efficacy, the investigators assessed the incidence of major cutaneous reactions in the two arms. At day 14, the median lesion area in the Imvamune® group was 0mm and the older generation smallpox vaccine group was 76mm, generating an area attenuation ratio of 98.2 (95% CI: 97.7-98.4) and meeting the prespecified threshold of over 40%. These data would suggest similar efficacy of the non-replicating vaccine compared to the replicating smallpox vaccine. Of note, there were considerably fewer adverse events in the Imvamune® arm compared to the traditional smallpox vaccine arm.

Previous vaccination with Imvamune® prevented the formation of a full major cutaneous reaction in the majority of participants (77.0%) after receiving the older-generation smallpox vaccine at week 8, as compared with a rate of full major cutaneous reaction of 92.5% in the older-generation vaccine arm. The maximum lesion area of the major cutaneous reaction was significantly reduced (by 97.9%) when vaccinia vaccination (i.e., older generation smallpox vaccine) was preceded by Imvamune® vaccination. These data, in addition to similar data from smaller immunogenicity studies would support the use of Imvamune® as a booster for individuals who have previously received the older-generation smallpox vaccine.

To determine waning of immunity with time, Phase 2 studies evaluated immune responses after one or two doses of Imvamune® and showed that they declined after 2 years. This led to the current recommendation of a booster dose being administered after year 2 providing the risk is ongoing.

The product monograph states that the safety of Imvamune® has been reported from 20 clinical trials where 13,700 vaccine doses were given to 7,414 subjects. The most common local adverse events following immunization (AEFI) were pain, erythema, induration and swelling. The most common systemic AEFI were fatigue, headache, myalgia, and nausea. Most of the reported AEFIs were of mild to moderate intensity and resolved within the first seven days following vaccination.

The safety of Imvamune has not been assessed in large clinical trials and therefore its safety data is limited. In some of the studies, cardiac adverse events of special interest were reported to occur in 1.4% (91/6,640) of Imvamune® recipients, 0.2% (3/1,206) of placebo recipients who were smallpox vaccine-naïve and 2.1% (16/762) of Imvamune® recipients who were smallpox vaccine-experienced. Among the cardiac events reported, 28 were asymptomatic post-vaccination elevation of troponin-I, 6 cases were symptomatic with tachycardia, electrocardiogram T wave inversion, abnormal electrocardiogram, electrocardiogram ST segment elevation, abnormal electrocardiogram T wave, and palpitations (none of the 6 events were serious). No confirmed case of myocarditis, pericarditis, endocarditis or any other type of cardiac inflammatory disease (or related syndromes) were recorded.

In summary, the newer generation smallpox vaccine shows protection against monkeypox with a favourable safety profile. But risks versus benefits of protection should be discussed with a healthcare provider, with a full discussion of the potential risk of recurrent myocarditis for individuals with a history of myocarditis/pericarditis linked to a previous dose of live replicating 1st and 2nd generation smallpox vaccine and/or Imvamune®. T

References available at bcpharmacy.ca/summer-22/monkeypox-primer

Maximizing Influenza Immunization for Older Adults in Canada

BY TIANA TILLI, BSCH, PHARMD, RPH, ACPR

Province-wide physical distancing and mask requirements have lifted in British-Columbia, setting the stage for the return of influenza season this Fall. When COVID-19 mandates were in place during the 2020-2021 influenza season, no community circulation of influenza occurred. In contrast, the 2021-2022 influenza season had a late onset in March 2022 as mask mandates were starting to be removed. The public must return to relying on influenza immunization to protect against flu-related morbidity and mortality this year.

Individuals at increased risk of influenza complications

Influenza and pneumonia, together, are ranked in the top 10 leading causes of death in Canada. As the rates of influenza-attributed mortality increase with increased age, adults 65 years and older represent a group for which annual influenza vaccination is particularly recommended (Table 1). A systematic review found that immunizing older adults lowered the incidence of pneumonia, hospital admissions, and death. A yearly flu shot is recommended as the body's immune response to influenza vaccines may diminish over time. Additionally, the specific influenza strains that circulate from year to year can change and so annual vaccination is needed to better match the strains expected to circulate that specific season.

Table 1. Individuals at high risk of influenza complications for whom influenza vaccines should be particularly recommended.

High risk due to age	• ≥ 65 years old • 6 - 59 months old • 6 months – 18 years old on long-term ASA
High risk due to health conditions	• Neurologic or neurodevelopment conditions • Heart, lung, or kidney disease • Diabetes • Anemia or hemoglobinopathy • Cancer • Immune compromising conditions
High risk specific populations	• Indigenous Peoples • Pregnant individuals • Residents of nursing homes • Residents of chronic care facilities • Individuals with BMI ≥ 40 kg/m^2

Influenza vaccines for the 2022/23 season

For the 2022/23 northern hemisphere influenza season, the strains recommended by the WHO for inclusion in the quadrivalent influenza vaccines are as below. There are differences between the strains recommendations for egg-based and cell- or recombinant-based vaccines because certain influenza viruses replicate differently in the different production systems. Different viruses, that have similar antigenic properties, are thus used to trigger similar immune responses.

Egg-based vaccines
• A/Victoria/2570/2019 (H1N1) pdm09-like virus • A/Darwin/9/2021 (H3N2)-like virus *new this year* • B/Austria/1359417/2021 (B/Victoria lineage)-like virus *new this year* • B/Phuket/3073/2013 (B/Yamagata lineage)-like virus

Cell culture- or recombinant-based vaccines
• A/Wisconsin/588/2019 (H1N1)pdm09-like virus • A/Darwin/6/2021 (H3N2)-like virus *new this year* • B/Austria/1359417/2021 (B/Victoria lineage)-like virus *new this year* • B/Phuket/3073/2013 (B/Yamagata lineage)-like virus

Influenza vaccine technologies

Various vaccine technologies have been leveraged to develop influenza vaccines that promote strong immune responses (Table 2). Influenza vaccines are designed to trigger an immune response to the virus' surface proteins, hemagglutinin (HA). HA proteins act as antigens that are recognized by the immune system and lead to antibody production. Improved immune response to antigen is especially important for adults 65 years and older because of their lower immune response after vaccination as a result of immunosenescence.

Making recommendations to protect older adults

Since protection is achieved by two weeks after immunization, it's best to recommend being vaccinated as early as possible in the Fall. Given the number of influenza vaccines available, it can be challenging to know which vaccine to recommend (Table 3). The top priority is ensuring your patient gets vaccinated. Additional considerations include the cost to the client, strains protected against and the resulting immune response.

In adults 50 years and older, the recombinant influenza vaccine was found to provide better protection compared to the standard-dose quadrivalent vaccine in a study of the 2014-2015 influenza season. The probability of laboratory-confirmed influenza illness-like illness was 30% lower with recombinant influenza vaccine.

In adults 65 years and older across the United States and Canada, the high-dose influenza vaccine was 24% more effective in preventing laboratory-confirmed influenza compared to the standard-dose vaccine. Another study found that nursing home residents aged 65 years and older who were immunized with high-dose influenza vaccine experienced lower rates of respiratory-related hospital admissions than those vaccinated with the standard-dose vaccine.

References available at bcpharmacy.ca/summer-22/flu-older-adults

Table 2. Vaccine technologies used in influenza vaccines marketed in Canada to promote immune response.

Vaccine technology	Mechanism	Efficacy and effectiveness in adults ≥ 65 years
High-Dose (IIV4-HD) FLUZONE® HIGH DOSE QUADRIVALENT	Contains four times the amount of antigen to stimulate the body's immune response.	"Expected better protection compared with IIV3-SD, particularly against influenza A (H3N2)"*
Adjuvanted (IIV3-Adj) FLUAD® FLUAD Pediatric®	An adjuvant (e.g., MF59, an oil-in-water emulsion) is added to the vaccine to augment the body's immune response to vaccine antigen.	"Insufficient comparative evidence with IIV3-SD"
Recombinant (RIV4) SUPEMTEK™	A gene with instructions for making influenza antigen is inserted into baculovirus which is then inserted into an insect cell line (vs. egg). The influenza virus antigen replicates before being purified.	"Potential better protection compared with IIV4-SD"

*Influenza A (H3N2) generally causes an increased burden of illness in adults ≥ 65 years old

Table 3. Influenza vaccines available for use in adults in Canada for the 2022/23 influenza season with authorization for use by recipient age group.

Vaccine	Format	Authorization for use by age group		
		18 - 59 years	60 - 64 years	≥ 65 years
AFLURIA® TETRA	IIV4-SD (pre-filled syringe and multi-dose	Yes	Yes	Yes
FLUAD®	IIV3-Adj (pre-filled syringe)	No	No	Yes
FLULAVAL® TETRA	IIV4-SD (multi-dose)	Yes	Yes	Yes
FLUZONE ® QUADRIVALENT	IIV4-SD (pre-filled syringe and multi-dose)	Yes	Yes	Yes
FLUMIST® QUADRIVALENT	LAIV4 (intranasal spray)	Yes	No	No
FLUZONE® HIGH DOSE QUADRIVALENT	IIV4-HD (pre-filled syringe)	No	No	Yes
FLUCELVAX® QUAD	IIV4-cc (pre-filled syringe and multi-dose)	Yes	Yes	Yes
INFLUVAC® TETRA	IIV4-SD (pre-filled syringe)	Yes	Yes	Yes
SUPEMTEK™	RIV4 (pre-filled syringe)	Yes	Yes	Yes

IIV4-SD: standard-dose quadrivalent inactivated influenza vaccine; IIV3-Adj: adjuvanted trivalent inactivated influenza vaccine; LAIV4; quadrivalent live attenuated influenza vaccine; IIV4-HD: high-dose quadrivalent influenza vaccine; IIV4-cc: quadrivalent mammalian cell-culture-based inactivated influenza vaccine; RIV4: quadrivalent recombinant influenza vaccine.

Lessons from the COVID-19 Antiviral Support Line for Clinicians

Pharmacists take centre stage to interpret drug interaction risk and patient safety with Paxlovid

MARK KERI, BA, CAPM

The Pharmacists in Primary Care Network Program (the Program) is pleased to have supported the roll-out of Paxlovid (nirmatrelvir/ritonavir) in BC through the COVID-19 Antivirals Support Line for Clinicians (the Support Line). Paxlovid became available in BC in February 2022 for patients who meet specific eligibility criteria. Paxlovid is available at no charge to eligible patients while in B.C., regardless of their Medical Services Plan coverage or usual place of residence.

Paxlovid is approved by Health Canada for patients in the community setting who test positive for COVID-19, have mild to moderate symptoms and are at high risk for severe illness. Treatment within 5 days of symptom onset reduces risk of hospitalization. Since ritonavir is a potent CYP3A4 inhibitor, Paxlovid is prone to many drug interactions of clinical significance. Careful patient assessment by a pharmacist is a critical clinical step in the Paxlovid assessment process.

The Support Line was created as a bridge service in the early days of Paxlovid availability in BC to help health care providers navigate complex patient assessments, evolving eligibility requirements and processes, and the urgency of getting Paxlovid treatment started for high-risk patients.

From its launch on February 14, 2022 until its end on June 24, 2022, pharmacists from the Program handled over 500 calls to support patient assessment and appropriate prescribing of Paxlovid. The Support line received 361 calls from physicians, 103 calls from pharmacists and 39 calls from nurse practitioners.

In addition to support with appropriate prescribing and managing clinically relevant drug interactions, callers often needed help with the prescribing process and navigating Paxlovid access. Early on, the supply of Paxlovid was limited and prioritizing access was necessary, leading to frustration with changing eligibility and instructions for prescribing Paxlovid. Many prescribers did not know how to use the Paxlovid prescription form, or where to send the prescription. The team at the Support Line guided callers to locate and use the prescription form appropriately and in some cases, called multiple community pharmacies to help the prescriber find a location with Paxlovid in stock.

Later, questions about how to categorize patients by level of clinical vulnerability, and the potential need for repeat prescriptions for patients with persistent or "rebound" symptoms became more common. Throughout the time of service, the Support Line team helped callers apply criteria and guidelines to specific complex patients.

The Support Line team learned some important lessons the past few months that are worth sharing:

1. Comprehensive, high-quality training and resources are available from the BCCDC, The Ministry of Health, the University of Liverpool COVID-19 Drug Interactions Checker and the British Columbia College of Pharmacists.
2. While general guidance from regulators and experts is important, individualized pharmacist assessments are necessary to support appropriate medication use in complex cases.
3. Callers need access to pharmacists who are up-to-date on the latest information, particularly when information and processes are evolving and changing.
4. Some patients taking cancer or HIV therapies needed extra assessment that is available via:

BC Cancer:

- 604-877-6000 x 67-2515 (voicemail only)
- Monday to Friday, 8:00 am to 4:00 pm PST; weekends 9:00 am to 5:00 pm PST

St. Paul's Hospital Ambulatory Pharmacy (HIV):

- 1-888-511-6222

As clinical guidance and processes stabilized, health care providers became more familiar with using Paxlovid, and processes for community pharmacists to claim a Paxlovid Assessment (PAX-A) were established, the need for clinical support through the Support Line lessened and the Line was stopped effective June 24, 2022.

Health care providers with questions about Paxlovid for a specific patient are now encouraged to contact the patient's local community pharmacist for assistance. The Ministry of Health has also made a phone line available to support Paxlovid prescribers and pharmacists at 1-844-915-5055 (available Monday – Friday, 8:30 am-4:30 pm).

Paxlovid is one more example of how the COVID-19 pandemic has highlighted the important role for pharmacists in the care of British Columbians. T

Parm Johal (left) poses with his team outside the Wilson Pharmacy Group warehouse in Port Coquitlam.

Staffing Shortages

How to retain and maximize your human resources

BY PARM JOHAL, BSC(PHARM), RPH

The COVID-19 pandemic and the additional demands brought onto health workers across Canada was a perfect storm. In British Columbia, from early on, the government began setting up vaccination clinics for at-risk populations, which required the use of community vaccine providers such as pharmacists and licensed practical nurses to help administer injections.

This began putting a strain on the labour system relied upon by community pharmacies. We began seeing some of the initial impacts from pharmacists we would rely on for on-call. Normally, when something came up, there was the possibility to call on pharmacists who were off-shift or on the pharmacists pool within our organization to see if they were available. Some of those pharmacists were no longer available, and this particularly affected our long-term care services team.

The pandemic also impacted support staff. Federal wage subsidies for the pandemic meant that it was becoming harder to retain support staff such as delivery drivers. So that pool shrank as well. In addition, like many other workplaces, we had split our staff into A and B shifts to shield them from COVID-19, which put an additional strain since that meant staff from the A team couldn't step in to help out during B shifts, and vice versa.

Recruiting agencies were also exhausted as the pool of pharmacists wasn't big enough. This reduction in available labour meant that prospective employees also began asking for higher and higher starting salaries. This created an additional challenge for ownership and management.

As the pandemic wore on, we had additional issues in the form of severe weather and supply disruptions. Meanwhile, pharmacists are being pulled to do more in the area of COVID-19 vaccines and dispensing therapeutics such as Paxlovid. In a way, it was the perfect storm.

I think one of the primary things we had to do was to pivot. Pharmacists are a resilient bunch. We took on these challenges and we are still here now, and we faced this adversity together with our team. There were a few things we did to ensure we could continue maintaining services at our pharmacies.

One of the most key things that allowed us to retain our team and continue to provide our services in spite of the pandemic's impacts on staffing was our relationships. We were unable to hire additional staff to come in because there was no one available, so this meant our existing team had to work harder, and they rose to the challenges.

With our employees, I have always promoted a culture of understanding and of camaraderie, where we all understood that we are in this together. As an owner, there is no job I considered to be beneath me. I would be unwilling to ask one of my employees to do something I was not willing to do. This means if I needed to come in and plug myself into any position that was required, I did. Our existing relationships meant that when some of our pharmacists took on relief shifts or did shifts at public health clinics, in their minds we were still their primary employer. Even though they might go off to work relief to earn additional income, they came back. I heard of some employers who prohibited their full-time pharmacists from taking on outside work, but to me, I felt that would be burning bridges and I didn't want to do that. We would be supportive of our team and make sure they were taken care of, whether they have adversity in other areas of their lives or not. These relationships also extended to pharmacist friends we have made over the years, some of whom are now retired. We were able to talk to

Parm Johal at Wilson Pharmacy on Wilson Avenue in Port Coquitlam.

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Parm Johal (centre) with his team inside the Wilson Pharmacy Group warehouse, which prepares prescriptions for long-term care homes.

a few of them and one of them was able to step in and help us out.

Creating a back-up team was also very important. We have four pharmacies and three home health-care business units, with approximately 65 employees in total. At our pharmacies and warehouse, we began creating a dedicated back-up team using our management team and also my family, which includes my sons and my wife. Effectively, this meant we had a C shift that could step in on short notice to fill in any gaps in case we were hit with COVID-19. Sometimes this requires some of the family to come in during holidays, such as Easter, to help catch up.

Reducing our hours was also effective. We moved from the pre-pandemic eight hours per day, five days a week schedules to 10 hours per day, four days a week, for many of our staff. We began by canvassing our team members first on their feedback, and received pretty resounding agreement. This flexibility in scheduling allowed our team to get a break to catch up, and also gave staff three days off per week for that additional break. We also try to ensure we have scheduled 80% of staff vacations on the calendar in the first quarter of each fiscal year to minimize the impact of holiday breaks, so there aren't gaps from sudden vacations.

At our long-term-care pharmacy, we decided to close for some Saturdays. We serve numerous mental health facilities within the Lower Mainland. The value of our relationship also came into play with our partners in long-term care where they understood our decision to close on Saturdays to operate one day less a week.

Over the last few decades, I have seen the cycles where at times there are an abundance of pharmacists, and other times, a shortage of pharmacists. However, these were extraordinary events that we

experienced in the last two years.

For the most part, I am optimistic that the worst of the pandemic impacts are behind us. First, our pharmacists have now been through this. We have created processes and experience to better manage our resources during these crises. We hope it will never happen again, but if it does, we have the experience for extra preparedness.

As time goes on, we will see new graduates enter the workforce and there will be more pharmacists available. As pharmacists, I think it is important to takeaway from this pandemic that we are in a very privileged position in the community. We are the first point of contact of health-care for the public and each day we have an opportunity to change the health outcome and wellbeing of people.

As a positive note, the pandemic gave an opportunity to showcase our profession. We have demonstrated that we can make a difference. We demonstrated that we can stand up, we add value to society, and we help British Columbians fight the adversity that our society faces. We believe that the community and the decision-makers have taken note in our ability to decrease the social and economic burden of our health-care system. We remain hopeful that the pharmacists will be given opportunities for more expanded scope of practice in the near future like in other provinces. T

Parm Johal has been a community pharmacy leader for the past 35 years. Parm opened his first independent pharmacy in Squamish, eventually becoming a cornerstone of health-care in a community with limited access to primary care services. In 2001, Parm relocated to Port Coquitlam where he established the successful independent Wilson Pharmacy and has expanded to Wilson-Davies Group. He continues to be actively involved in the community, including strong advocacy and support in mental health.

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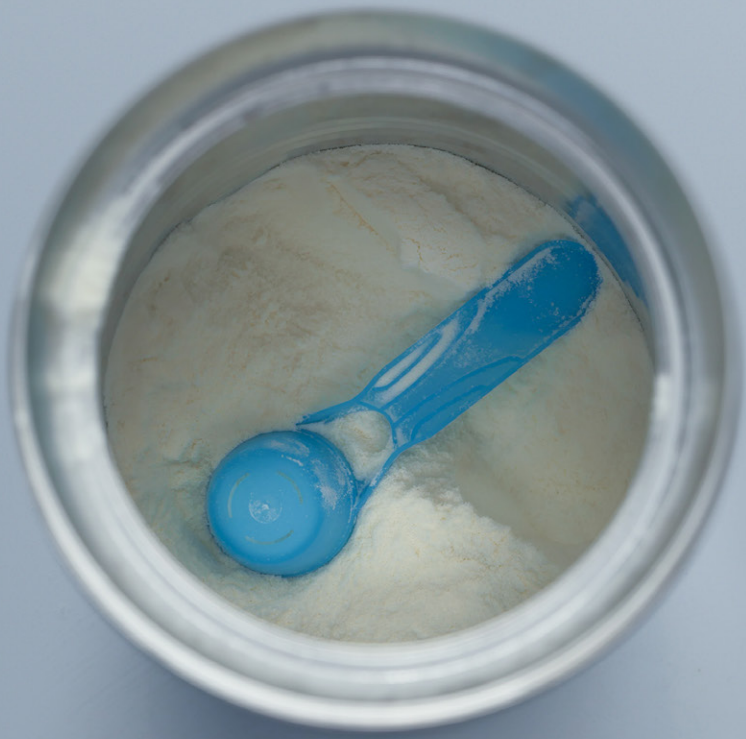
Managing specialized infant formula during a shortage

Due to a closure of a facility in the United States earlier this year, there has been a shortage of hypoallergenic infant formula available in Canada. **Chris Chiew** serves as Vice-President on the BC Pharmacy Association Board of Directors and is Vice President, Pharmacy and Healthcare Innovation, at London Drugs Limited. He answered a few questions about his company's role, as a distributor and also as dispensary pharmacies, in managing the specialized infant formula supply.

How are specialized infant formula supplies being received by distributors?
Chiew: They are sent to various wholesalers. Our stores only order supplies from the distributors when a family comes in requesting. 100% of the specialized infant formula are imported under the *Emergency Use Act*. With each unit we sell, we must include the Health Canada Approved directions for use and the information sheet that is available in both English and French. At the time of writing, the various wholesalers are currently out of stock and are not expecting the next shipment to arrive until July 24.



What processes have you put in place to predict where the supply will be to ensure pharmacies in high-demand regions have specialized infant formula?
Chiew: When there was stock, our system would look at ordering patterns and sets quantities to order accordingly. However with this shortage, the system is not able to plan correctly. Right now, the stores only order when a parent comes in requesting. We do not hold stock at the store or display the specialized formulas in store. The inventory is tightly controlled by the various wholesalers — they monitor where the product is going to ensure all families in need receive some until the situation stabilizes.

What is the demand from patients like?
Chiew: We have not had a significant spike in demands. These are very specialized products. Parents are respectful of the shortage and getting what is needed. We have not noticed any stock piling by parents. Parents have been getting two weeks supply per order.

Are patients able to ask pharmacists to hold stock when they return at a later date?
Chiew: We will not hold stock for patients. To date, parents have been shopping around to try to find the product.

Are there instructions pharmacists are providing patients who switch from one formula to another?
Chiew: Parents have seen pediatricians prior to coming in. We have not had to make suggestions on changes. The Canadian Pharmacists Association has provided great resources on switches that can help pharmacists if needed. T

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