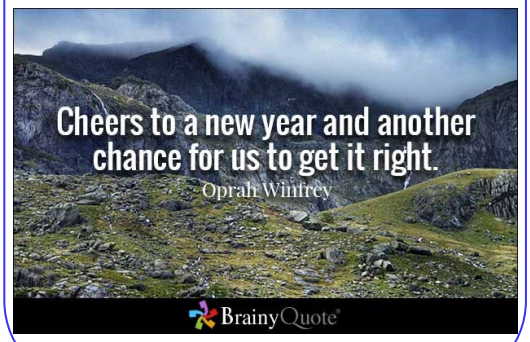
Northern Health Physicians
Partners in Wellness
Public Health Newsletter for Northern Health Physicians
Volume 13 . Number 1 . January 2017 ● Page 1 of 2

2016: Year in Review

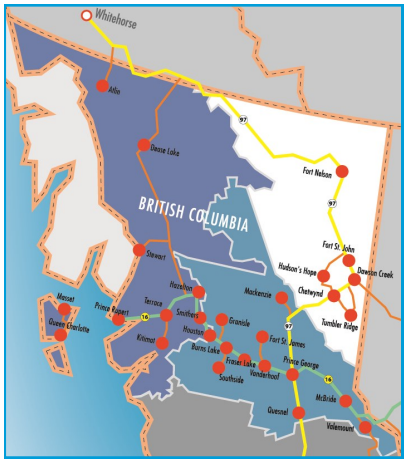
Volume 12:		
Month/link	Issue	Topic
January	1	(No regular issue) New Year Greeting and 2015 Year in Review Bulletins: Hepatitis A virus alert
February	2	Hepatitis A Outbreak-Dawson Creek/Alberta; Reporting Communicable Diseases; Changes to BC's Smoking Cessation Program; Pearls for Immunization Practice - Self-learning course; Antimicrobial Stewardship; Influenza Update
March	3	Zika virus Update; Pharmacy Awareness Month; Antimicrobials update; Influenza update Bulletins: Drug contamination Alert, Overdose Alert
April	4	Increased Syphilis rates in BC; Antimicrobials update; North Coast First Nations video for health care providers; Travel Health; Late Spike in Influenza; Deactivation of Ebola Public Health follow-up
May	5	Mumps, Zika virus update
June	6	"Growing up Healthy in Northern BC" Consultation Process/Child Health Report; Interim Syphilis Treatment Guidelines during the Benzathine Penicillin Shortage; June is Brain Injury Awareness Month; Public Health Emergency Declared: Unintended Opioid Overdose Deaths; Antimicrobials Update
July	7	No issue
August	8	Overdose Public Health Emergency; BCCDC Update: Sexually Transmitted Infections/Benzathine Penicillin once again available in Canada; Do your patients who smoke want to quit?; Quadrivalent Meningococcal Vaccine available for adolescents; The role of serological testing: Immunizing those with no or inadequate records; Concussion Ed: App now available; Cervical Cancer Screening Policy Change
September	9	Introducing: New Northern Interior Medical Health Officer, Dr. Andrew Gray; HPV 9 valent vaccine to replace HPV 4 in grade 6 program in BC-September; Smoke free grounds; Rare but Risky – Autonomic Dysreflexia; NH Overdose Response Updates
October	10	Special Issue on Influenza: 2016-017 season–what you need to know, including: Highlights; Campaign Start Date; Vaccine Ordering, Distribution, Storage (Eligibility; Recommended Influenza Vaccine Dosage by Age; Vaccines and Recommended Usage; Egg Allergies/Oculo-Respiratory Syndrome); Pneumococcal Vaccine; Reporting Requirements (Adverse reactions following immunization; Vaccine Administered); References; Additional Resources; Enterovirus D-68 (EV-D68) circulating in BC ; Influenza Control Program Policy for Health Care Workers; and, Community Vaccine Provider Influenza Vaccine Order Form
November	11	Refugee Health; Influenza Update
December	12	Regional opioid overdose response background and update; Reportable communicable diseases; Varicella (chicken pox) refresher; Options for sexual health (OPT); Influenza update

Inside this Issue:

Notable Quotable:



Back issues of *NH Physicians, Partners in Wellness* newsletters and bulletins are located on the NH Physicians website:
http://physicians.northernhealth.ca/physicianResources/PublicHealth.aspx



Northwest
Atlin, Dease Lake, Houston, Hazelton, Masset, Kitimat, Port Clements, Prince Rupert, Smithers, Stewart, Terrace, the Village of Queen Charlotte

Northern Interior
Burns Lake, Fort St. James, Fraser Lake, Granisle, Mackenzie, McBride, Prince George, Quesnel, Valemount, Vanderhoof

Northeast
Chetwynd, Dawson Creek, Pouce Coupe, Hudson's Hope, Fort Nelson, Fort St. John, Tumbler Ridge

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Escalating trends of ODs and OD deaths continue to occur

Overdose Situation in Northern Health

Across Northern Health (NH), 38 deaths occurred from January 1 to November 30, 2016. From June 5 to November 30, 2016, a total of 174 suspected opioid overdose presentations were reported by emergency departments in NH. Sites reporting the largest numbers of ODs include UNHBC (92) and Fort St John Hospital (23).

In response to this crisis NH is focusing on specific interventions to prevent OD deaths. These include:

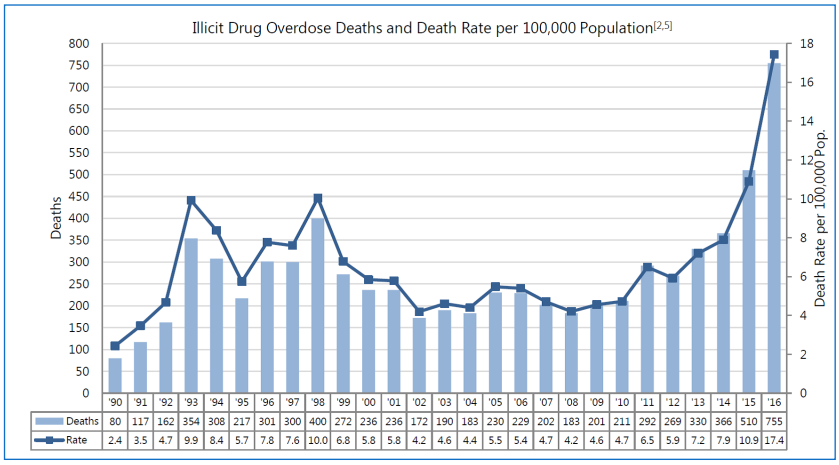
1. Surveillance of ODs presenting to emergency departments.
2. Rapid expansion of the Take Home Naloxone program and availability of harm reduction supplies and education for persons at risk of OD.
3. Establishment of an Overdose Prevention Site at the Prince George HIV/AIDS Prevention Program (Needle Exchange), where clients can be monitored for signs of overdose and receive immediate care when needed.
4. Exploration of Supervised Consumption Services in our highest risk communities.
5. Population-based prevention and health promotion through communications, media and stakeholder engagement.

Overdose Prevention and Response

What can you do to help?

Every Northern Health employee has the opportunity to be a resource of health information for their community in order to help prevent overdose deaths. Take the time to learn the tips to prevent an overdose:

- Don't mix different drugs (including pharmaceutical medications, street drugs, and alcohol).
- Don't take drugs when you are alone.
- Don't experiment with higher doses.
- Start with a small amount before taking your usual dose.
- Use less, especially if you took a break, were in detox, treatment or jail, or are new to use: your tolerance will be lower.
- Keep an eye out for your friends – stay together and look out for each other.
- Make a plan/know how to respond in case of an overdose.
- Carry a **Naloxone Kit** if you or someone you know may need it. Kits are available without a prescription and can be purchased at pharmacies or are available free to people who are at risk of overdose. A list of locations can be found at: Take Home Naloxone Kits or https://northernhealth.ca/Portals/0/Your_Health/OverdosePrevention/Take-home-naloxone-sites-Nov2016.PDF.
- Naloxone training is free and only takes a few minutes.



To November 30, 2016/Image Source: BC Coroners Services: Illicit Drug Overdose in BC, January 1, 2007-November 30, 2016

Tips to recognize and reverse an overdose

- Recognize an OD:
  - the person is breathing slowly or not at all
  - not moving and can't be woken up
  - cold clammy skin
  - blue lips and fingernails
  - tiny pupils
  - may be snoring, gurgling or choking
- Call 9-1-1 right away.
- Give breaths and give naloxone.

For more information on NH's **Overdose Response** please visit: Overdose Prevention or: https://ournh.northernhealth.ca/ClinicalPatientCare/ODPrevRspnc/Pages/default.aspx

Practice Support Update

- Northern Health now supports all community staff who work with people at risk for opioid overdose (OD) to administer naloxone and first aid in cases of suspected opioid overdose.
- For both dispensing and administration of naloxone, it is important to discuss these activities with your program manager/ direct supervisor.
- All staff carrying, administering, or dispensing naloxone must complete the appropriate education (see below). The average time to complete the online education is one hour.
- When any NH employed staff choose to administer naloxone from a Take Home Kit, outside of a hospital setting, whether during working or non-working hours, potential liability concerns are covered by either NH liability insurance or the *Good Samaritan Act.*

For full details, see Overdose Naloxone Practice Support Update or https://ournh.northernhealth.ca/oursites/NHCommittees/ODPrevRspnc/OurNH%20Documents/Overdose%20-%20Naloxone%20Practice%20Support%20Update.%20Final.pdf

Information for Schools

Four curriculum modules have thus far been created for teachers to address the current opioid overdose crisis in the classroom. With support from the Ministry of Health and developed by the Centre for Addictions Research of BC (CARBC), these new resources use progressive teaching methods that draw upon the competencies that aid in students making healthier choices with respect to substance use. http://www.uvic.ca/research/centres/carbc/publications/helping-schools/index.php .

First Responder Safety

With overdoses and fatalities stemming from fentanyl use reaching epidemic proportions, the Justice Institute of British Columbia (JIBC) has launched a fentanyl website for first responders which contains several useful resources: https://fentanylsafety.com.

Additional Suggested Resources

1. Know your Source or https://knowyoursource.ca/
2. Toward the Heart or http://towardtheheart.com/
3. Overdose Awareness in BC or http://www2.gov.bc.ca/gov/content/overdose
4. BC Coroners Reports or http://www2.gov.bc.ca/gov/content/safety/public-safety/death-investigation/statistical-reports

Thank you to our dedicated Northern Health Staff and Physicians working so tirelessly to address this crisis. Your compassion and commitment is truly appreciated.

Source:
Dr. Sandra Allison, Chief MHO
(Memo to all NH Staff and Physicians Dec. 23, 2016)

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Introducing:
New Northeast Medical Health Officer, Dr. Jong Kim

We are very pleased to advise that Dr. Jong Kim assumed the role of Northeast Medical Health Officer on Thursday, August 31st, 2017.

Dr. Kim was born in South Korea, and immigrated to Canada when he was 16 years old. He studied medicine at Queen's University. He also trained in Public Health & Preventive Medicine and completed his MSc in Community Health Sciences at the University of Calgary.

Dr. Kim is interested in how we can support the community with finite resources to improve health of its people, through building collaboration across public health, health care and community members.

Dr. Kim will be located in Fort St. John, where he will be working out of the Northeast Corporate Office. He can be reached at jong.kim@northernhealth.ca or 250-261-7235.

We are very happy to welcome Dr. Kim back to Northern Health!

Northern Health's Medical Health Officers:

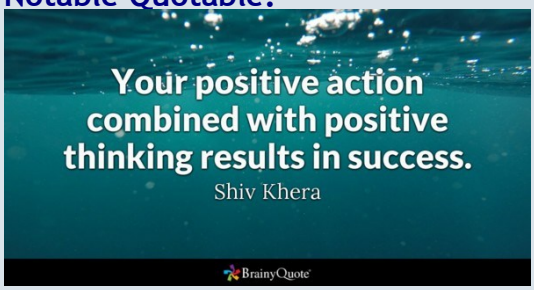
- Dr. Sandra Allison, Chief MHO
- Dr. Raina Fumerton, MHO — **Northwest HSDA**
- Dr. Andrew Gray, MHO — **Northern Interior HSDA**
- Dr. Jong Kim, MHO — **Northeast HSDA**
- Dr. Ronald Chapman will continue to work as an on-call MHO as needed.

◦ ***all after hours calls are to the Switchboard at UHNBC—250-565-2000*** *(5 p.m. to 8 a.m. weekdays, and 24 hours on weekends and Stat holidays), and ask for the "MHO on-call".*

Submitted by:
Dr. Sandra Allison
Chief Medical Health Officer

Inside this Issue:

Notable Quotable:



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Update on Syphilis Testing via Polymerase Chain Reaction (PCR)

As many of you know, the primary method by which syphilis is diagnosed is through serologic testing. However, in certain situations, it may be appropriate and clinically indicated to perform one of the direct tests (i.e. swab of a lesion). Historically, the only direct tests available were darkfield microscopy and direct fluorescent antibody (DFA)-both of which are reliant on specific equipment and expertise to perform and interpret.

In recent years, the BCCDC Public Health Laboratory (PHL) has been performing Treponema pallidum PCR on lesions collected via swab and stored in special buffer. This buffer has and will continue to be available to anyone requesting it for this purpose. More recently, the BCCDC PHL has validated the performance of syphilis PCR using the gonorrhea and chlamydia nucleic acid amplification test (NAAT) kits (i.e. the Aptima-branded kits). A photo of the relevant swabs is included on the following page (see **Figure 1**).

Key Points

- **If you see a patient with a genital, anal or oral lesion in whom you suspect syphilis, consider swabbing the lesion for Treponema pallidum PCR. Serology should also be done at this time.**
- **You can also send a slide for DFA of genital or anal lesions (DFA is not appropriate for oral lesions, given the presence of endogenous oral spirochetes; PCR is the only approved direct test for oral lesions).**
- **The sample should be collected by swabbing the lesion.**
  - **If you only have access to the NAAT kits, swab the lesion with the swab from the kit and place it as you normally would into the container. There is no need to pour out any fluid from the sample container. See Figure 1 for examples of NAAT kits.**
  - **If you have access to PCR buffer, swab the lesion with a Dacron or polyester swab and break off the tip into the buffer vial. See Figure 2 on the next page for a photo of the buffer vial and a representative swab type.**
- **Write "Treponema pallidum PCR; Att: Dr. Morshed" on the requisition.**
- **If you have any questions'**
  - **STI Physician: 604-707-5610**
  - **STI Nursing Line: 604-707-5603**
  - **Troy Grennan, Physician Lead, STI Program: 604-707-5606**

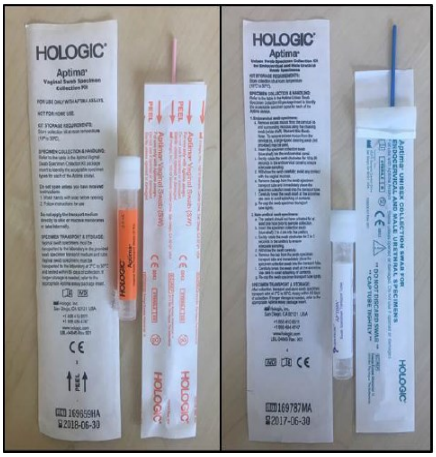

Figure 1: NAAT collection kits

Figure 2: PCR buffer and swab

Source: BC Centre for Disease Control

World Antibiotic Awareness Week

November 13 – 19, 2017 is World Antibiotic Awareness Week, a global campaign organized by the World Health Organization (WHO) to encourage the responsible use of antibiotics. This year, you can join the global movement by taking the pledge to use antibiotics wisely at antibioticwise.ca.

The BC Centre for Disease Control (BCCDC) is encouraging everyone to learn more about antibiotics, antibiotic resistance, and what individuals can do to help fight this growing threat to human health by pledging to use antibiotics wisely.

- Antibiotic resistance is one of the greatest threats to human health.
- You can help to prevent and stop the spread of antibiotic resistance.
- Antibiotics are medicines that can quickly help to heal some types of infection caused by bacteria, but when they're used too much or not used the right way, they may not work anymore. This is called "Antibiotic Resistance", when the bacteria that is causing you to be sick, no longer responds to the antibiotic and you continue to be sick. Antibiotic resistance is a defense mechanism of bacteria that allows them to survive and multiply, even when an antibiotic is present.

We all have a role to play in minimizing inappropriate antibiotic use to limit the development of antibiotic resistance. Inappropriate use of antibiotics has negative consequences at the population level and also for individual patients who consume antibiotics.

Learn more about supporting your patients in the correct use of antibiotics and the larger issue of Superbugs and Antibiotic Resistance.

- Bugs & Drugs is an antimicrobial reference guide for healthcare professionals. The Bugs & Drugs® resource is now available in a website format for BC users at the following link: bugsanddrugs.org.
- The website is available from an I.P. address located anywhere in Alberta, BC, Yukon and NWT.
- Bugs & Drugs® is a recommended reference for management of infectious diseases and appropriate antimicrobial use. It is peer-reviewed, evidence-based, and frequently updated.
- Bugs & Drugs® is supported by the Do Bugs Need Drugs?® program and is funded in BC by the BC Ministry of Health, Pharmaceutical Services Division.
- *For those preferring to use a mobile version of Bugs& Drugs®, further information can be found at bugsanddrugs.ca.*

Remember to take the pledge at antibioticwise.ca.

Source: BC Centre for Disease Control

Spread the Word: Seniors Falls are Preventable

Seniors' falls prevention is one of the three priorities set by the BC Injury Prevention Committee in 2016. In BC, falls are the #1 cause of injury-related death in seniors and every 10 minutes a senior is hospitalized for a fall.

BC Seniors Fall Prevention Awareness Week takes place from November 6 to 12, 2017 across British Columbia. Included in this update is an overview of the campaign as well as details on how you can help spread the message that falls are preventable. A provincial proclamation has been approved for the week of November 6-12, 2017.

Campaign Objectives:

- To build on previous Falls Prevention Awareness campaigns and execute a successful campaign for the 2017 Falls Prevention Awareness Week.
- To increase knowledge of the prevalence of falls and prevention strategies for falls among seniors in British Columbia.
- To execute a coordinated campaign across British Columbia and 7 health authorities.

Demand for distribution has been overwhelmingly positive, with posters going out province-wide. Over 4,500 posters were sent from September-October to:

- All interprofessional teams and Public Health Units for use at flu clinics
- 200+ BC First Nations Communities
- General practitioners' offices
- Major pharmacy outlets
- Trauma units
- Red Cross medical equipment loans locations

How you can Help:

- Print and display the posters found at **http://findingbalancebc.ca/campaign-toolkit/**

Remind patients to:

- Keep their body active: write a prescription for strength and balance exercises
- Have their eyes checked: optometrist appointments are fully covered for those over 65 years of age.
- Bring in their medications for review
- Make their home safer by visiting FindingBalanceBC.
- Screen patients by beginning the conversation, "have you had a fall, slip, or trip in the last year?" In addition to FindingBalanceBC, The GPSC Practice Support Program is equipped with Falls Prevention Resources.

Source: Regional Injury Prevention Program, Population Health

The Truth and Reconciliation Commission

The Truth and Reconciliation Commission's report was released in December 2015. The report details 94 Calls to Action (recommendations) for Canadians to redress the legacy of residential schools (Actions 1-42) and advance the process of reconciliation (Actions 43-94). This newsletter series will walk through the 94 Calls to Action to support Northern physicians and other providers to learn about the legacies and take actions towards reconciliation in their practices, relationships, and communities.

The categories to redress the legacy of residential schools include; child welfare, education, language and culture, health, and justice. This issue we highlight the 5 Calls to Action specific to Language and Culture and 4 of the 17 calls to Justice. The remainder will be shared in upcoming newsletters.

Language and Culture

13. We call upon the federal government to acknowledge that Aboriginal rights include Aboriginal language rights.
14. We call upon the federal government to enact an Aboriginal Languages Act that incorporates the following principles...
15. We call upon the federal government to appoint, in consultation with Aboriginal groups, an Aboriginal Languages Commissioner.
16. We call upon post-secondary institutions to create university and college degree and diploma programs in Aboriginal languages.
17. We call upon all levels of government to enable residential school survivors and their families to reclaim names changed by the residential school system by waiving administrative costs for a period of five years for the name-change process and the revision of official identity documents, such as birth certificates, passports, driver's licenses, health cards, status cards and social insurance numbers.

Justice

25. We call upon the federal government to establish a written policy that reaffirms the independence of the RCMP to investigate crimes in which the government has its own interest as a potential or real party in civil litigation.
26. We call upon the federal, provincial and territorial governments to review and amend their respective statues of limitations to ensure that they conform with the principle that governments and other entities cannot rely on limitation defences to defend legal actions of historical abuse brought by aboriginal people.
27. We call upon the Federation of Law Societies of Canada to ensure that lawyers receive appropriate cultural competency training, which includes the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal-Crown relations.
28. We call upon law schools in Canada to require all law students to take a course in Aboriginal people and the law, which includes the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal-Crown relations.

Source:
Dr. Sandra Allison, Chief Medical Health Officer

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Cannabis Legalization and Regulation

The Canadian government intends to legalize and regulate cannabis in July 2018. This move is widely supported by public health experts, and if governments adopt a comprehensive public health approach, this represents a significant opportunity to improve the health of the population and limit harms.

The status quo is that cannabis from uncontrolled sources is easily available and widely used, and both its risks and potential benefits are inadequately understood by the public, by health professionals, and by researchers. A tightly regulated and monitored legal market, coupled with greater investment in education, prevention, harm reduction, treatment, research, and evaluation, has the potential to reduce the overall harms of cannabis use, as well as eliminating the unnecessary harms that arise from criminalization and the black market.

This article aims to provide an introduction to the issues surrounding cannabis and the changing legal environment.

Direct Harms of Cannabis Use

- **Motor vehicle collisions and other injuries** associated with impairment, particularly when used together with other impairing substances such as alcohol.
- **Acute and chronic psychotic disorders**, particularly when used heavily prior to the age of 15 by individuals with a family history of psychosis.
- **Toxic effects of smoke inhalation**
- **Developmental effects on fetuses**, including cognitive effects and reduced birth weight.
- **Accidental acute intoxication** of children and others who did not intend to consume cannabis, particularly from edible forms that are unsecured or unlabelled
- **Substance use disorder** and its accompanying negative social impacts.

Unintended Consequences of Cannabis Criminalization

- Cannabis is easier for youth to access than tobacco. 35% of youth aged 12-19 in northern BC have tried cannabis (McCreary Centre, 2016), which is more than the number that have tried tobacco.
- Potency has steadily increased over the past several decades. This is a common consequence of prohibition, as a more "condensed" product is easier to conceal from authorities. Moonshine and fentanyl are other examples.
- Cannabis is frequently contaminated with mould, pesticides, or other toxic compounds.
- People who develop addiction may be reluctant to seek help, for fear of the criminal and social sanctions they may face if they reveal their use.
- Unnecessary social harms from criminalization, resulting from imprisonment and lifelong criminal records, which disproportionately affect Indigenous and Black people.
- Research on the health effects of cannabis is difficult and incomplete.
- Unnecessary costs of enforcement strategies, which have not succeeded in reducing the use of or trade in cannabis.

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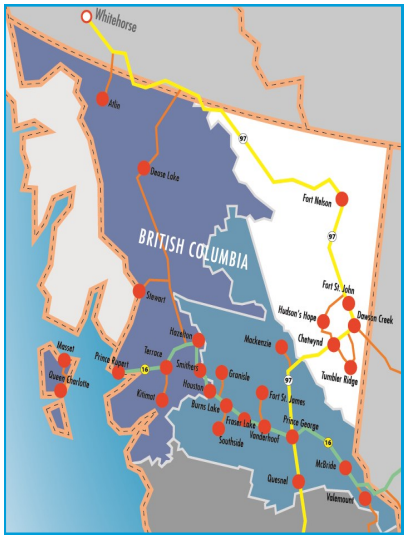

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Potential Risks associated with legalization and regulation

Legalization and regulation may also carry risks, particularly if cannabis use is actively promoted and regulation is too lax. This is most likely to occur when a for-profit industry, or a government seeking tax revenues, is allowed to market and encourage cannabis use: the logic of market growth requires increased consumption. We currently see this in the alcohol market, and to a lesser extent, in the tobacco market.

However, this risk can be mitigated by appropriate regulation and public education. Experiences in other jurisdictions have found that when effective controls are put into place, the level of cannabis use in the population does not increase post-legalization.

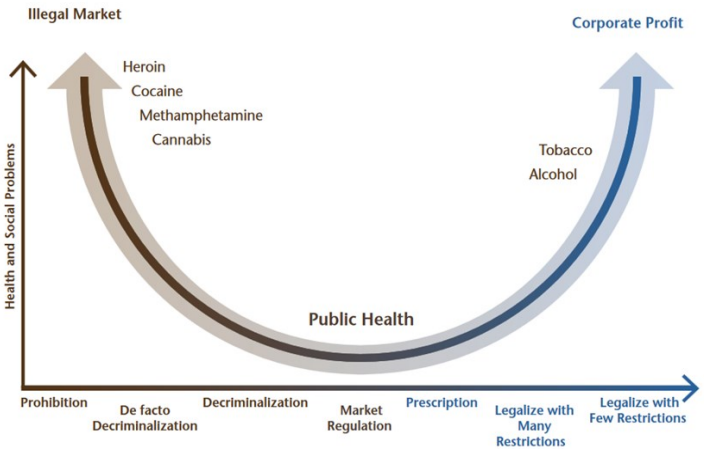

Figure: "The Paradox of Prohibition", reproduced without permission (CPHA, 2014).

Decriminalization vs. legalization and regulation

- **Decriminalization**: people who use a substance or are found to be in possession of small amounts would no longer face criminal penalties, such as incarceration. However, they may still face fines or other non-criminal penalties, and trafficking could still be criminalized, leaving the black market as the only source of the substance.
- **Legalization and regulation**: a substance becomes explicitly legal for direct sale to the general public, but only under certain conditions. Specific limits would apply to its production, distribution, and sale.

Public Health approach to cannabis legalization and regulation

Public health experts recommend the following strategies to minimize harms from cannabis use:

- Comprehensive supply chain regulation to minimize contamination, promote consistent potency, and enable product recalls where necessary
- State monopoly on distribution
- Arms-length public governance and oversight of distribution, with a mandate to promote and protect health rather than to generate revenue
- Limits on retail outlet density, hours, and prohibition of co-sale with alcohol or tobacco
- Prohibitions on providing cannabis to young people (ideally, a minimum age of 21)
- Minimum pricing, with tax revenues dedicated to health promotion and protection programs
- Limits on THC content (maximum 15%)
- Plain childproof packaging
- Mandatory labelling including potency and health warnings
- Including cannabis in existing efforts to reduce second-hand tobacco smoke exposure
- Public education on how to minimize harms from cannabis use
- Prevention efforts that target the broader psychosocial determinants of problematic substance use (which is much more effective than drug-specific education)
- Improved tools and laws to detect and reduce cannabis-impaired driving
- Ongoing surveillance and monitoring of cannabis use and its direct and indirect harms
- Ongoing evaluation of the effectiveness and equity of efforts to reduce harms

These strategies are discussed in detail by the Canadian Public Health Association, the Chief Medical Officers of Health of Canada, and the Urban Public Health Network (see references below).

Other potential benefits of legalization may include:

- Improved ability to study and limit the harms of cannabis
- Improved ability to study and realize any therapeutic benefits of cannabis
- Reduced stigmatization of people who use cannabis
- Reduced overall harms if people switch to cannabis from more dangerous substances, such as fewer fatalities from opioid overdose or motor vehicle collision linked to alcohol use

Upcoming legislative changes in Canada

While full details have not yet been announced, both the federal and provincial governments have declared an intention to follow public health principles in developing legislation around cannabis. The federal government's forthcoming *Cannabis Act* proposes federal regulation of cannabis production, prohibitions on selling or providing cannabis to people under the age of 18, and prohibitions on promotion/advertising. New offences for cannabis-impaired driving have also been proposed, and a public education strategy is under development.

As with alcohol and tobacco, the regulation of distribution will be up to the provinces and territories. The BC government recently completed a public consultation on cannabis regulation. Numerous public health professionals and academics submitted recommendations, including Northern Health's Medical Health Officers. An inter-ministerial working group is studying the issue, and details on the provincial government's legislative and regulatory intentions are expected within the next few months.

References

Task Force on Cannabis Legalization and Regulation, 2016. *A Framework for the Legalization and Regulation of Cannabis in Canada*. https://www.canada.ca/en/services/health/marijuana-cannabis/task-force-marijuana-legalization-regulation/framework-legalization-regulation-cannabis-in-canada.html

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Counselling your patients about non-medical cannabis use

Similarly to alcohol, patients should be queried about their cannabis use, with a focus on detecting and addressing high-risk use. People who choose to use cannabis should be counselled to reduce risks by following **Canada's Lower Risk Cannabis Use Guidelines**.

Summary of recommendations from Canada's Lower Risk Cannabis Use Guidelines

- Cannabis use has health risks best avoided by abstaining
- Delay taking up cannabis use until later in life
- Identify and choose lower-risk cannabis products
- Don't use synthetic cannabinoids
- Avoid smoking burnt cannabis—choose safer ways of using
- If you smoke cannabis, avoid harmful smoking practices
- Limit and reduce how often you use cannabis
- Don't use and drive, or operate other machinery
- Avoid cannabis use altogether if you are at risk for mental health problems or are pregnant
- Avoid combining these risks

People can also reduce the risk to others by ensuring that their cannabis is stored securely, away from the reach of children, and by not smoking cannabis indoors where the smoke may expose others.

These guidelines are published by the Canadian Mental Health Association and endorsed by the Canadian Public Health Association. Read more about the guidelines:

Public brochure: http://www.camh.ca/en/research/news_and_publications/reports_and_books/Documents/LRCUG.KT.PublicBrochure.15June2017.pdf

Evidence summary for health professionals: http://www.camh.ca/en/research/news_and_publications/reports_and_books/Documents/LRCUG.KT.Professional.15June2017.pdf

Academic publication: http://ajph.aphapublications.org/doi/10.2105/AJPH.2017.303818\

Cannabis use for medical purposes

Scientifically, the medical benefits of cannabis are less well-established than the harms, but this research is also in its infancy. The known medical benefits of cannabis have been exaggerated by some advocates, but there is some evidence that cannabis and/or cannabinoids may be effective for treatment of:

- chronic pain,
- chemotherapy-induced nausea,
- multiple sclerosis spasticity symptoms,
- sleep disturbance associated with obstructive sleep apnea, fibromyalgia, chronic pain and multiple sclerosis,
- HIV/AIDS-related wasting syndrome,
- Tourette syndrome,
- epilepsy, and
- symptoms of anxiety or post-traumatic stress disorder.

Access to cannabis in Canada for medical/therapeutic purposes has been granted as a result of court cases; it is not a medicine approved by Health Canada, though physicians have a role in authorizing its use by their patients. In the context of cannabis legalization, the federal government has signalled its intention to leave the existing medical cannabis system essentially unchanged in the short term.

For more information on the medical use of cannabis, consult Health Canada's web site at https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-use-marijuana/information-medical-practitioners.html.

For more information on the health effects of cannabis, consult the 2017 report of the National Academy of Sciences, Engineering and Medicine, *The health effects of cannabis and cannabinoids*: http://nationalacademies.org/hmd/~/media/Files/Report%20Files/2017/Cannabis-Health-Effects/Cannabis-conclusions.pdf

Submitted by:
Dr. Andrew Gray Northern Interior Medical Health Officer

Influenza Update

Influenza is circulating, but only at low levels. A(H3N2) has been the dominant strain so far this season, but it is too early to say if this will remain the case. A (H1N1) and B strains are also currently circulating in BC.

Vaccine effectiveness (VE) is expected to be fairly high for A (H1N1) and B strains, but there is concern that it may be fairly low for A (H3N2) strains.

In light of this, the Association of Medical Microbiology and Infectious Disease (AMMI) Canada recently published updated guidance on the use of antivirals (https://www.ammi.ca/Update/79.ENG.pdf):

- Antiviral (oseltamivir or zanamivir treatment may be considered for individuals at high risk of serious influenza complication (hospitalization or death) **regardless of whether they received the 2017-18 season's influenza vaccine**.
- Where influenza is reasonably suspected on clinical grounds, antiviral treatment of high-risk individuals should not await the diagnostic test result and should be initiated as soon as possible, ideally within the first 12 to 24 hours of influenza-like illness (ILI) onset, irrespective of influenza vaccination status.
- Effectiveness is reduced when treatment is initiated >48 hours after illness onset but may be considered at clinician discretion.
- Clinicians may consider personalized plans for timely antiviral drug access and use for patients at highest risk of serious influenza complications (in particular, elderly adults and people of any age with cardio-pulmonary conditions or severe immunodeficiency states).
- Where appropriate, this may include advance prescriptions to be filled and initiated for chemoprophylaxis or treatment in relation to an ILI that is likely due to influenza.

For dosage regimens and further details, please refer to the AMMI Canada Foundation Document on the use of antiviral drugs for influenza (https://www.ammi.ca/Content/Guidelines/Flu%20%28published%20version%29%20FINAL.pdf).

Other ways you can reduce the impact of influenza on your patients:

- Make sure your high-risk patients, and their close contacts, get **vaccinated**! It's not too late, and even if VE is low for A(H3N2), protection against the other strains is still worthwhile. Review our October 2017 newsletter at https://physicians.northernhealth.ca/PhysicianResources/PublicHealth.aspx for all the details on this year's influenza vaccine.
- **Pre-sign**, now, the *Regional Order Set: Oseltamivir for Influenza Outbreak Declared by Medical Health Officer*, for all your patients in long-term care facilities. That way, if an influenza outbreak occurs, staff will be able to initiate antiviral treatment or prophylaxis promptly.
- **Testing** outpatients with non-severe ILI for influenza is generally not necessary, as it will not change management in most cases. If antivirals would be indicated for influenza, they should be started immediately, without waiting for test results. The following patients generally should be tested:
  - Severe or unusual cases of ILI (e.g. requiring hospitalization)
  - Inpatients in acute care facilities and residents of long-term care facilities who develop ILI

Submitted by:
Dr. Andrew Gray
Northern Interior Medical Health Officer

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The Truth and Reconciliation Commission:
Calls to Action Relating to Justice

The Truth and Reconciliation Commission's report was released in December 2015. The report details 94 Calls to Action (recommendations) for Canadians to redress the legacy of residential schools (Actions 1-42) and advance the process of reconciliation (Actions 43-94). This newsletter series will walk through the 94 Calls to Action to support Northern physicians and other providers to learn about the legacies and take actions towards reconciliation in their practices, relationships, and communities.

The categories to redress the legacy of residential schools include; child welfare, education, language and culture, health, and justice. This issue we highlight the remaining 14 Calls to Action specific to justice. Others will be shared in upcoming newsletters.

To learn more about the Truth and Reconciliation Commission and the Calls to Action, visit http://nctr.ca/

29. We call upon the parties and, in particular, the federal government, to work collaboratively with plaintiffs not included in the Indian Residential Schools Settlement Agreement to have disputed legal issues determined expeditiously on an agreed set of facts.
30. We call upon federal, provincial, and territorial governments to commit to eliminating the overrepresentation of Aboriginal people in custody over the next decade, and to issue detailed annual reports that monitor and evaluate progress in doing so.
31. We call upon the federal, provincial, and territorial governments to provide sufficient and stable funding to implement and evaluate community sanctions that will provide realistic alternatives to imprisonment for Aboriginal offenders and respond to the underlying causes of offending.
32. We call upon the federal government to amend the Criminal Code to allow trial judges, upon giving reasons, to depart from mandatory minimum sentences and restrictions on the use of conditional sentences.
33. We call upon the federal, provincial, and territorial governments to recognize as a high priority the need to address and prevent Fetal Alcohol Spectrum Disorder and to develop, in collaboration with Aboriginal people, FASD preventive programs that can be delivered in a culturally appropriate manner.
34. We call upon the governments of Canada, the provinces, and territories to undertake reforms to the criminal justice system to better address the needs of offenders with Fetal Alcohol Spectrum Disorder, including …
35. We call upon the federal government to eliminate barriers to the creation of additional Aboriginal healing lodges within the federal correctional system.
36. We call upon the federal, provincial, and territorial governments to work with Aboriginal communities to provide culturally relevant services to inmates on issues such as substance abuse, family and domestic violence, and overcoming the experience of having been sexually abused.
37. We call upon the federal government to provide more supports for Aboriginal programming in halfway houses and parole services.
38 We call upon the federal, provincial, territorial, and Aboriginal governments to commit to eliminating the overrepresentation of Aboriginal youth in custody over the next decade.
39. We call upon the federal government to develop a national plan to collect and publish data on the criminal victimization of Aboriginal people, including data related to homicide and family violence victimization.
40. We call on all levels of government, in collaboration with Aboriginal people, to create adequately funded and accessible Aboriginal-specific victim programs and services with appropriate evaluation mechanisms.
41. We call upon the federal government, in consultation with Aboriginal organizations, to appoint a public inquiry into the causes of, and remedies for, the disproportionate victimization of Aboriginal women and girls. The inquiry's mandate would include an investigation into missing and murdered Aboriginal women and girls and links to the intergenerational legacy of residential schools.
42. We call upon the federal, provincial, and territorial governments to commit to the recognition and implementation of Aboriginal justice systems in a manner consistent with the Treaty and Aboriginal rights of Aboriginal peoples, the Constitution Act, 1982, and the United Nations Declaration on the Rights of Indigenous Peoples, endorsed by Canada in November 2012.

Submitted by:
Dr. Sandra Allison Chief Medical Health Officer

Northern Health Physicians
Partners in Wellness

Public Health Newsletter for Northern Health Physicians

Volume 13 . Number 3 . March 2017 ● Page 1 of 4

REMINDER: Research Project: Physical Activity - barriers and facilitators in Northern primary care practice

***The deadline has been extended to April 1st** to submit your feedback into a research project regarding physical activity barriers and facilitators in Northern primary care*

Cara McCulloch is a second year student in the Northern Medical Program, conducting a research project exploring physical activity promotion in primary care. Completion of this survey should take roughly 15 minutes of your time.

The research aims to determine:

- What are the barriers and what facilitators **to physical activity prescription for primary care providers** in Northern BC?
- What do primary care providers perceive as the barriers and facilitators **to participating in physical activity for their patients**?

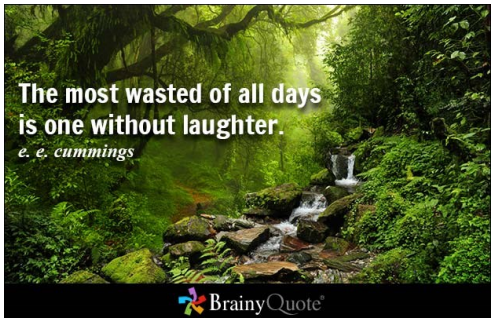
The project is supported by Dr. Sandra Allison (Chief Medical Health Officer) and Kelsey Yarmish (RegionalDirector, Population Health) at Northern Health, as well as Dr. Chelsea Pelletier (PhD) at the University of Northern British Columbia.

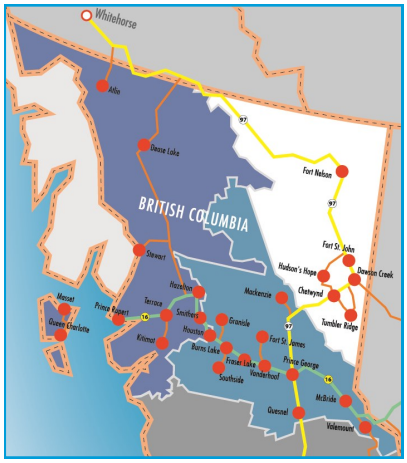
To sweeten the pot, and add even more incentive, upon completion of the survey you will be entered to a Starbucks gift card!

For further information regarding this survey, watch for the announcement and invitation by email. Or you can access the survey at: http://fluidsurveys.com/surveys/northernhealth/barriers-and-facilitators-to-pa-in-northern-bc/.

All Northern Health primary care providers are requested and encouraged to assist with this important survey through your participation.

Inside this Issue:





Northwest

Atlin, Dease Lake, Houston, Hazelton, Masset, Kitimat, Port Clements, Prince Rupert, Smithers, Stewart, Terrace, the Village of Queen Charlotte

Northern Interior

Burns Lake, Fort St. James, Fraser Lake, Granisle, Mackenzie, McBride, Prince George, Quesnel, Valemount, Vanderhoof

Northeast

Chetwynd, Dawson Creek, Hudson's Hope, Fort Nelson, Fort St. John, Tumbler Ridge

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After hours calls to UHNBC Switchboard 250-565-2000 and ask for MHO on-call

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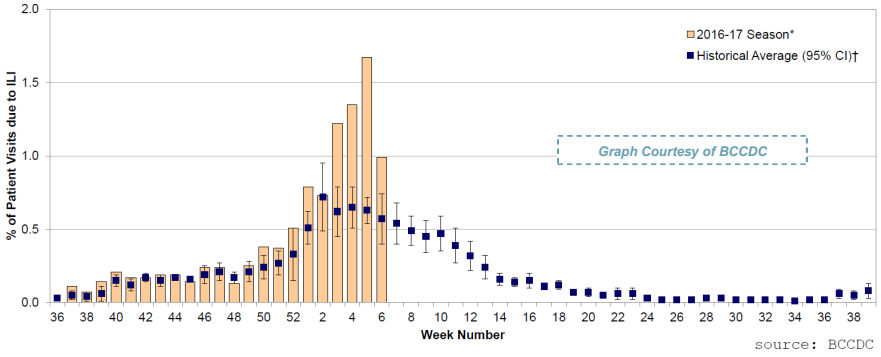
Influenza Update

In week 6, 498 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory (PHL). Of these, 122 (24%) tested positive for influenza, including 94 (77%) with influenza A [44 A(H3N2) and 50 with subtype pending], 27 (22%) with influenza B and one (1%) patient co-infected with influenza A and B. Overall influenza positivity continued to decline, falling below 30% in week 6 and concurrent with a decrease in test volumes. Influenza A(H3N2) remains the most frequently detected type/ subtype; however, an increasing number of influenza B viruses (comprising about one-quarter of influenza detections in week 6) have been detected in recent weeks.

Percent of patient visits to sentinel physicians due to influenza-like illness (ILI) compared to historical average, British Columbia, 2016-17



* Data are subject to change as reporting becomes more complete. One hospital ER site that reported ILI rates ≥5% was excluded from the graph.
† 10-year historical average for 2016-17 season based on 2004-05 to 2015-2016 seasons, excluding 2008-09 and 2009-10 due to atypical seasonality; CI=confidence interval.

Cumulatively since week 40 (starting October 2, 2016), 3014 (33%) patients tested positive for influenza at the BCCDC PHL, including 2896 (96%) with influenza A [1957 A(H3N2), 6 A(H1N1)pdm09 and 933 subtype pending], 117 (4%) with influenza B and one patient co-infected with influenza A and B. So far during the 2016-17 season, influenza A(H3N2) has been the dominant subtype among influenza detections. Elderly adults ≥65 years old are disproportionately represented among influenza detections, although younger age groups are also affected.

Source: BC Centre for Disease Control Influenza Surveillance Reports: Report No. 14, Feb 5-11, 2017 *(Week 6)*
http://www.bccdc.ca/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm

Naloxone update:
Training resources and scope of practice for nurses and allied health professionals

Take Home Naloxone Kits

- Naloxone is an effective antidote to opioids; it works by reversing the effects of opioid overdose.
- The Take Home Naloxone (THN) program provides kits free of charge to clients at risk.
- The THN program is in most communities. For a full list of sites see: https://northernhealth.ca/Portals/0/Your_Health/OverdosePrevention/Take-home-naloxone-sites-Nov2016.PDF

Summary of Key Points

- Northern Health now supports all staff to administer naloxone and first aid in cases of suspected opioid overdose.
- All staff carrying, administering, or dispensing naloxone must complete the appropriate education (see below). The average time to complete the Learning Hub education is one hour available at: https://learninghub.phsa.ca/.
- When any NH-employed staff choose to administer naloxone and first aid, whether during working or non-working hours, potential liability concerns are covered by either NH liability insurance or the *Good Samaritan Act*.
- An order is required to administer naloxone to an inpatient in an inpatient area of a hospital. **Anticipatory (prn) orders should be obtained for naloxone for all inpatients who are prescribed an opioid or are at risk of an opioid overdose.**
- Staff who respond to a suspected opioid overdose outside of a hospital must call 911 and initiate rescue breathing.
- Staff who discover a suspected opioid overdose in a hospital setting must activate the usual emergency response and initiate rescue breathing.

Scope of Practice - Nursing Administration:

- RNs, RPNs and LPNs may administer naloxone, without an order, for the purpose of treating suspected opioid overdose:
  - outside of a hospital setting
  - for persons anywhere on hospital property who are not inpatients, and
  - for inpatients who are not at the time in an inpatient area of the hospital.
- The RN, RPN or LPN must follow the Clinical Practice Standard "*Naloxone Administration in the Management of Suspected Opioid Overdose*" available at: https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/1-22-6-020.pdf
- *and* complete the Learning Hub module: ***"Naloxone Administration"***

An order is still required for naloxone administration for inpatients in inpatient areas.

(Continued on page 3)

Naloxone update:

Training resources and scope of practice for nurses and allied health professionals, Cont'd.

(Continued from page 2)

Dispensing:

- RNs and RPNs may dispense a Take Home *Naloxone* kit without an order from NH sites or programs (including hospital sites) to clients at risk of an opioid overdose or to family and friends of those who are at risk for overdose.
- LPNs *may* dispense a Take Home Naloxone kit without an order from NH sites or programs outside of a hospital to clients at risk of an opioid overdose or to family and friends of those who are at risk for overdose. An LPN requires an order from a physician to dispense a kit from a hospital setting.
- All nurses must follow the Clinical Practice Standard *"Dispensing and* distribution *for persons at risk of opioid overdose: Take Home Naloxone Kits"* available at: https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/1-22-6-030.pdf
- All nurses who dispense the kits must also complete the Learning Hub module: ***"Distributing and Dispensing Take Home Naloxone Kits".***

All nursing regulatory colleges support the administration and dispensing of naloxone. Please see the appropriate College's website for further information.

Scope of Practice: Allied Health Professionals, Unregulated Care Providers and Support Services Staff:
(Occupational Therapy, Physiotherapy, Social Work, Dietitians, and unregulated care providers (e.g. recreation therapy, life skills and community home support workers and support services staff)
Administration:

- Recently the provincial government announced a change to the *Health Professions Act* (HPA) that allows any health care professionals to assess and treat suspected opioid overdose with naloxone and first aid, available at: http://www.bccollegeofsocialworkers.ca/wp-content/uploads/2016/09/Gen-Reg-HPA.pdf
- The settings in which naloxone administration may occur include:
  - outside of a hospital setting
  - for persons anywhere on hospital property who are not inpatients, and
  - for inpatients who are not at the time in an inpatient area of the hospital
- The Colleges of OTs, PTs and SWs have recognized the changes to the HPA and have announced their intention to support registrants to administer naloxone for opioid overdose. In order to administer naloxone, registrants are responsible for acquiring the necessary training, adhere to clinical practice standards, and maintain current knowledge of policies, legislation, programs and issues related to this competency.

Unregulated care providers or support services staff whose work may involve an encounter with a person at risk of opioid overdose should be trained and prepared to use naloxone in response to a suspected opioid overdose.

- Northern Health supports all allied health professionals, unregulated care providers and support services staff to consider their need to take this competency training in order to reduce the risk of death as a result of an opioid overdose. Staff must follow the Clinical Practice Standard "*Naloxone Administration in the Management of Suspected Opioid Overdose*" available at: https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/1-22-6-020.pdf
- and complete the Learning Hub **module: "*Administration of Naloxone*"**

Dispensing and/or Distributing:

- At this time, NH will support the distribution of Naloxone Kits by social workers who have the appropriate training and competencies: Learning Hub module ***"Dispensing and Distribution of Take Home Naloxone Kits."***
- Social Workers who distribute Take Home Naloxone Kits must follow this Clinical Practice Standard, "Dispensing and Distribution for Persons at Risk of Opioid Overdose: Take Home Naloxone Kits" available at: https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/1-22-6-030.pdf
- All other allied health professionals or unregulated care providers should refer at risk clients to a Take Home Naloxone Site at: https://northernhealth.ca/Portals/0/Your_Health/OverdosePrevention/Take-home-naloxone-sites-Nov2016.PDF.

Professional colleges are in the process of developing statements to support this regulatory change. Please contact your college with specific questions about their current position.

For more information, please contact:

- **Clinical and Take Home Naloxone Program Questions:** Reanne.Sanford@northernhealth.ca
- **Scope of Practice and Professional Standards:** ProfessionalPractice@northernhealth.ca

Source:
Dr. Andrew Gray, MHO, NI HSDA

Mumps Refresher

Mumps has been in the news lately due to cases among professional hockey players. There have been no recent cases in northern BC, but your patients may be wondering what they can to do protect themselves against mumps.

About mumps

Mode of transmission: contact with respiratory secretions (contact or droplet), including by coughing, sneezing, sharing drinks, kissing, or contaminated surfaces

Incubation period: 12-25 days

Clinical presentation:

Acute parotitis (unilateral or bilateral tender swelling of the parotid), or inflammation of other salivary glands, typically preceded by a prodrome of fever, myalgia, malaise, headache, anorexia, or non-specific respiratory symptoms. Orchitis, oophoritis, or viral meningitis occur in a minority of cases, and are usually self-limited.

Complications such as infertility are rare.

Diagnosis requires laboratory confirmation by BCCDC:

- If 0-5 days from symptom onset: **buccal swab for viral PCR** (Starplex, S160V, blue top), ideally collected at Stensen's duct after milking the parotid gland
- If 6-14 days from symptom onset: **urine specimen for viral PCR** (sterile container), placed on ice or refrigerated and shipped immediately
- Ideally, acute and convalescent serology (IgM and IgG) should also be drawn, 3-5 days after symptom onset, and then 10 days to 3 weeks after symptom onset

Please call your MHO if you suspect mumps, as prompt control measures may be necessary.

How can mumps be prevented?

Immunization is the most effective way to prevent mumps. It is always worthwhile to verify whether a patient's immunizations are up to date.

A two-dose vaccination schedule with the MMR vaccine is 88% effective against mumps. In Canada, this schedule has been provided routinely to children born since 1996. In BC, the vaccine is given at 12 months and at 4-6 years old.

For the cohort born from 1970 to 1996, only one dose was provided. **People in this age group may benefit from receiving a second dose if they are at risk of exposure to mumps**. There is no harm in giving an additional dose if a patient's vaccination history is unclear.

People born before 1970 can generally be assumed to be immune due to prior infection.

Further reading

1. See the BCCDC Communicable Disease Manual for more details on this and other aspects of mumps at: http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/communicable-disease-control.

Source:
Dr. Andrew Gray, MHO, NI HSDA

Northern Health Physicians
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Public Health Newsletter for Northern Health Physicians

Volume 13 . Number 4 . April 2017 ● Page 1 of 2

Pediatric Nutrition Guidelines for Health Professionals

In February 2017, the Provincial Health Services Authority (PHSA) released the *Pediatric Nutrition Guidelines (Six Months to Six Years) for Health Professionals*. The guidelines are available at: http://www.health.gov.bc.ca/library/publications/year/2016/pediatric-nutrition-guidelines.pdf

These evidence-informed guidelines apply to healthy, full-term infants and children from about six months up to six years of age. The resource is intended to be a quick reference guide to support BC health professionals to provide high-quality care related to feeding and the identification of nutrition risk.

This BC resource is organized by age (i.e. 6-9 months, 9-12 months, 12-24 months, and 2-6 years) and includes:

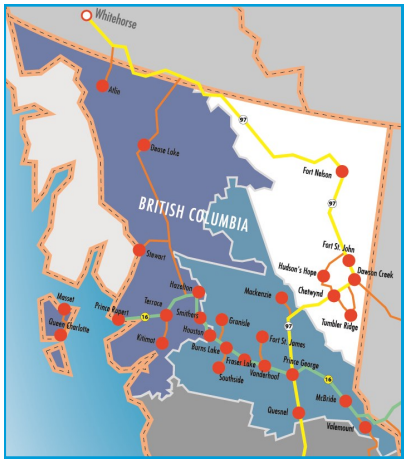
- relevant milestones related to feeding.
- guidelines for food and fluids.
- nutrition risk indicators that warrant additional investigation, intervention and/or referral.
- additional information related to: parental influences on eating habits, growth monitoring, informed decision making about infant feeding, food allergy prevention, iron and food safety.

Health professionals in Northern BC will find this quick reference guide to be a useful complement to Northern Health's *Infant-Toddler Nutrition Guidelines for Health Professionals, 5th edition (2015),* a resource that provides more in-depth information on numerous nutrition topics related to healthy, term infants and toddlers. The Northern Health resource is available at Document Source, order #1946. An eslectronic copy can also be emailed to you.

For more information, please contact:
Lise Luppens, MA RD Population Health Dietitian Lise.Luppens@northernhealth.ca.

Inside this Issue:

Notable Quotable:



Northwest

Atlin, Dease Lake, Houston, Hazelton, Masset, Kitimat, Port Clements, Prince Rupert, Smithers, Stewart, Terrace, the Village of Queen Charlotte

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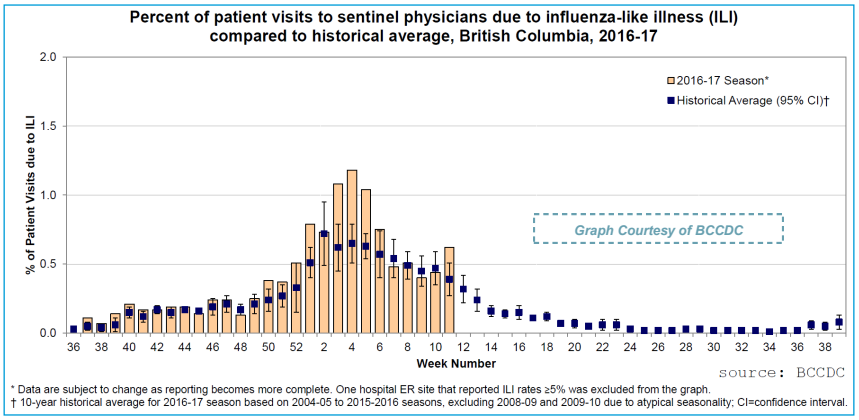
Influenza Update

In weeks 10-11, 821 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory (PHL). Of these, 184 (22%) tested positive for influenza, including 54 (29%) with influenza A [30 A(H3N2) and 24 with subtype pending] and 130 (71%) with influenza B. Overall influenza positivity remained stable above 20% in weeks 10-11, driven by the increasing number of influenza B detections. Since week 10, influenza B viruses have comprised the majority of influenza detections at the BCCDC PHL, representing >60% of all influenza detections in week 10 and >80% in week 11. Among influenza A detections, A (H3N2) remains the dominant subtype detected so far during the 2016-17 season.



Cumulatively since week 40 (starting October 2, 2016), 3679 (32%) patients tested positive for influenza at the BCCDC PHL, including 3318 (90%) with influenza A [3259 A(H3N2), 32 A(H1N1)pdm09 and 27 subtype pending], 358 (10%) with influenza B and three patients who had both influenza A and B detected during the season. Elderly adults ≥65 years old are disproportionately represented among influenza A(H3N2) detections, although younger age groups are also affected; whereas, adults 20-64 years old comprise a larger proportion of influenza B detections.

Source: BC Centre for Disease Control Influenza Surveillance Reports: Report No. 17, Mar 5-18, 2017 *(Weeks 10-11)*
http://www.bccdc.ca/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm

Continuing Medical Education Opportunities:

MAiD2017 — Medical Assistance in Dying

June 2-3—Victoria, BC

CAMAP, the Canadian Association of MAiD Assessors and Providers, invites you to participate in the inaugural conference on Medical Assistance in Dying—**MAiD2017** June 2-3 in Victoria BC.

MAiD2017 has been designed with the assessors and prescribers in mind: A year after the law has changed what is it they need to provide the best standard of practice in this field? What's happening across the country, what has worked, what obstacles remain and how can we support each other?

This CME accredited conference provides an opportunity for testing and a certificate for those wishing to be MAID assessors and/or prescribers. It is designed to support your application for non-core privileges in MAiD.

Source:

1. Medical Assistance in Dying 2017 Conference web site: http://www.maidconference.ca/

Back issues of *NH Physicians, Partners in Wellness* newsletters and bulletins are located on the NH Physicians website:
http://physicians.northernhealth.ca/physicianResources/PublicHealth.aspx

Northern Health Physicians
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Public Health Newsletter for Northern Health Physicians

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NH Antimicrobial Stewardship (AMS) program: Antimicrobials - Handle with Care

Northern Health's AMS program would like to welcome Dr. Abu Hamour as the official Medical Lead for the AMS program and look forward to future collaboration! We would also like to share with our prescribers in Northern Health, an upcoming change to outpatient management of uncomplicated skin and soft tissue infections (see information below).

Cefazolin plus Probenecid

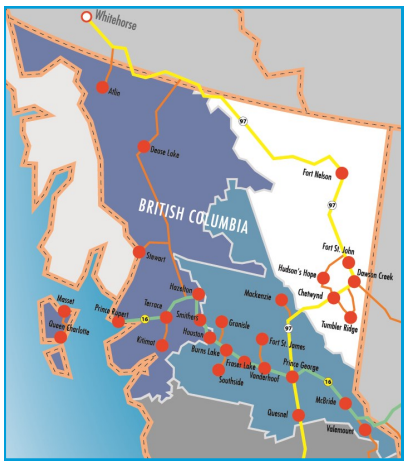
Previous practices in Northern Health (NH) for outpatient IV management of uncomplicated skin and soft tissue infections (uSSTI) relied on the use of cefazolin plus oral probenecid. In 2011, probenecid was removed from the Canadian Market. At that time, ceftriaxone replaced cefazolin plus probenecid in the outpatient setting for uSSTI. This is not an ideal practice because ceftriaxone has suboptimal activity against *S. aureus*, has a higher risk for developing *C. difficile* infection and provides unnecessary gram negative coverage promoting antimicrobial resistance.

Probenecid given orally prior to a once daily dose of cefazolin 2 g IV has been shown to increase serum concentrations and extend the half-life of cefazolin in a manner that achieves clinical resolution of cellulitis and related soft tissue infections compared to treatment with ceftriaxone 2 g IV daily. Prescribing cefazolin 2 g IV q24h plus probenecid 1 g PO daily 10 to 30 min prior to cefazolin in outpatient treatment settings for uSSTI will minimize use of ceftriaxone for uSSTI in outpatient treatment settings. However there will still be situations that warrant use of ceftriaxone in the outpatient setting (e.g. complicated infections such as: bone and joint infection, endocarditis, moderate/severe diabetic foot ulcers and animal bites)

(Continued on page 2)

Inside this Issue:

Notable Quotable:



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NH Antimicrobial Stewardship (AMS) program: Antimicrobials - Handle with Care, cont'd.

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Note that probenecid is contraindicated in patients with renal dysfunction and should not be used in patients with a creatinine clearance (CrCl) of less than 30 mL/min. Patients with CrCl of less than 30 mL/min could be treated with cefazolin at a reduced frequency (see below).

Creatinine Clearance (mL/min)	Cefazolin dosing
10 - 30	Cefazolin 2 g IV q 12h **(no probenecid)**
Less than 10	Cefazolin 2g IV q 24h **(no probenecid)**
Hemodialysis	Cefazolin 2 g IV after dialysis 3 x/week **(no probenecid)**

There is a Canadian manufacturer in Quebec that is now compounding probenecid capsules. Several other Health Authorities (HA) in Canada (including BC) are currently ordering from this manufacturer. The probenecid product being compounded is not available via community pharmacies (manufacturer will only sell to hospital pharmacies); therefore NH facilities will be required to provide patients with this oral medication. Providing patients with oral probenecid daily (when patient returns for cefazolin dose) will prevent any wastage, specifically in situations of undetermined duration of therapy; also probenecid should be taken 10 to 30 min prior to the cefazolin dose. If patients require a split dose twice daily to minimize GI side effects, compliance will have to be reinforced to ensure the 2nd dose is taken.

As per NH policy 1-5-1-060: Dispensing medications by health care providers, registered nurses are able to dispense a home dose (if needed) from a wardstock bottle into a child-proof bottle with appropriate medication label for the patient to take home. Pharmacy departments will provide generic labels that can be filled in by nurses with patient specific information.

Probenecid will be available for prescribing May 1st, 2017. There is a regional order set under development for use of IV antimicrobials in the outpatient setting which will include this treatment option. Keep watch for future communications regarding this new order set; if you are interested in being a stakeholder for this order set please contact the program coordinator listed below.

Submitted by: Alicia Ridgewell,
Antimicrobial Stewardship Pharmacist

Physicians can stock free STI medications, available from the BC Centre for Disease Control

Free STI medications are available through the BC Center for Disease Control to treat Sexually Transmitted Infections in your practice. **By stocking these medications in your clinic, you will be able to treat patients and their sexual partners at the time of presentation, without concerns about cost.** Easy access to timely treatment decreases the risk of sequelae and prevents further transmission and re-infection.

The following medications are available to order for your clinic:

Amoxicillin	Doxycycline
Azithromycin	Erythromycin
Cefixime	Metronidazole
Ceftriaxone	Benzathine penicillin *(requires maintenance of cold chain)*

For treatment indications and dosing, please refer to the *British Columbia Treatment Guidelines Sexually Transmitted Infections in Adolescents and Adults 2014* at **http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/sexually-transmitted-infections**.

If you choose not to order stock for your clinic, patients will continue to be able to access free STI treatment through local Health Units.

How to order medications for treatment of STIs

- The **STI Drug Order Request Form** can be downloaded from the BCCDC website at **http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/Pharmacy/STIDrugOrderRequestFormBWFeb2012_final2.pdf**
- Estimate and order a **2 month supply at a time**.
- Fax the completed order form to **604-707-2583**.
- For first time orders, a nurse may call your office to discuss quantities.
- Medication can be ordered as often as needed, in case you go through your supply sooner.
- Your medication order will be mailed to you from BCCDC in Vancouver. Please allow 14 days for delivery.

For more information:

- For more information regarding the STI Drug Order program, please contact BCCDC Vaccine and Pharmacy Service by phone at **604-707-2580** or by fax at **604-707-2583**.
- For other information on STI testing and management, please see the BCCDC web site at **http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/sexually-transmitted-infections**.

Submitted by:
Sujata Connors, Manager Community Programs
Sarah Brown, Public Health Resource Nurse

Opioid use disorder: New treatment guidelines and CME opportunities

New provincial guidelines on the clinical management of opioid use disorder have been released by the BC Centre on Substance Use, and are available at bccsu.ca. These guidelines provide practical clinical strategies and tools covering the following topics:

- Withdrawal management
- Opioid agonist therapy (OAT) and other pharmaceutical options:
  - Buprenorphine/naloxone (Suboxone™)
  - Methadone
  - Slow-release oral morphine
  - Naltrexone
  - Injectable medications (diacetylmorphine and hydromorphone)
- Psychosocial treatment interventions and supports
- Harm reduction strategies

See http://www.bccsu.ca/wp contentuploads/2017/02/BC-OUD Guidelines_FINAL.pdf for the full guidelines, which officially take effect on June 5, 2017. Until then, the previous guideline issued by the College of Physicians and Surgeons of BC relating to methadone and buprenorphine (https://www.cpsbc.ca files/pdf/MBMT-Clinical-Practice Guideline.pdf) remains in effect.

Upcoming CME opportunities relating to OUD treatment in northern BC include:

Thursday, May 11, 18:30 – North 54, Prince George
Provincial Guidelines for the Clinical Management of Opioid Use Disorde (Dr. Stephan Ferreira)
RSVP: Kathleen MacDonald at kathleen.macdonald@indivior.com

Friday, May 12, 15:20-16:10 – Prince George Civic Centre
Addictions: Treating Substance Use Disorder in the Office and Hospital (Dr. Gerrard Prigmore)
Part of the BC Rural Health Conferenc see http://ubccpd.ca/courseRHC2017 for details.

Saturday, May 13, 13:00-13:50 – Prince George Civic Centre
Plenary on Addictions (Dr. Granger Avery, Dr. Gerrard Prigmore, Dr. Keith Ahamad, Dr. Barb Kane)
Part of the BC Rural Health Conference – see http://ubccpd.ca/course/ RHC2017 for details.

Friday, June 2, 8:00-16:00 – Coast Inn of the North, Prince George
Prescribers' Course [for chronic pain] (CPSBC)
Register at https://www.cpsbc.ca/for-physicians/professional-development/ prescribers-course-2017-06-02

Saturday, June 3, 8:00-16:30 – Coast Inn of the North, Prince George
Methadone/Buprenorphine 101 Workshop (CPSBC)
Register at https://www.cpsbc.ca/for-physicians/professional-development/ methadone-buprenorphine-101-2017-06-03

We strongly encourage primary care physicians and others who may treat patients with addictions or chronic pain to consult these resources and develop their skills in this area.

Source:
Dr. Andrew Gray, MHO, NI HSDA

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Rabies in BC

As bat season is approaching, we thought it would be useful to provide some information to local physicians around managing potential rabies exposures in Northern BC.

Rabies is essentially 100% fatal and 100% preventable. Rabies Post-Exposure Prophylaxis (RPEP) includes one dose of immune globulin and a four-dose series of rabies vaccine for previously unimmunized individuals and, should always be given promptly when a significant risk of rabies exposure is identified. However, many animal exposures in BC are low risk and do not require RPEP. This article reviews rabies risk assessment in BC.

My patient was bitten or scratched by an animal – now what?

1. Irrigate and treat the wound.
2. Provide a tetanus booster if needed.
3. Assess the risk of rabies exposure based on provincial guidelines, summarized below.
4. If you believe RPEP is indicated, or you are unsure, call the Medical Health Officer on call at 250-565-2000 to confirm the risk assessment and arrange RPEP.

Release of RPEP requires the approval of the local Medical Health Officer. A Medical Health Officer is available 24 hours a day at 250-565-2000 to assist with the risk assessment process and coordinate RPEP administration when indicated.

What are the scenarios where RPEP is recommended?

RPEP is generally recommended when:

- A significant exposure (such as a bite, scratch, or mucous membrane or broken skin exposed to the animal's saliva) cannot be ruled out;

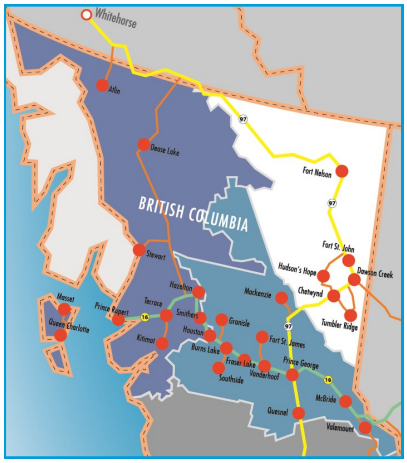
AND,

- There is a non-negligible risk that the animal had rabies.

(Continued on page 2)

Inside this Issue:

Notable Quotable:



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Rabies in BC

(Continued from page 1)

The risk of rabies in an animal is evaluated based on four elements:

Species. There are many different strains of rabies virus, and they are species-specific. Bats and terrestrial mammals (e.g. dogs, foxes, raccoons, skunks) are the main reservoirs. Rabies is extremely rare in small rodents (e.g. squirrels, mice, rats, hamsters).

Geography. Bat-variant rabies virus occurs worldwide; other strains are more limited in distribution. Asia and Africa have the highest burden of rabies in terrestrial mammals.

Signs of rabies in the animal, which are best interpreted by a veterinarian with expertise in this area. Signs may include abnormal gait, paralysis, erratic movement, hypersalivation, or excessive docility. Note that a brief but apparently unprovoked attack, by an otherwise physically well animal, is generally not considered a sign of rabies.

Test results, if the animal is available to be tested.

Usual recommendations are as follows:

Bats– RPEP usually recommended. Bat-variant rabies virus occurs worldwide and affects about 0.5% of bats in BC. There has only been one documented case of rabies in a human in BC history; this case was due to exposure to a bat.

Terrestrial mammals from BC-RPEP is usually recommended if:

- The animal has displayed signs of rabies, as assessed by a veterinarian; or,
- The animal has tested positive for rabies.

Non-bat strains of rabies have never been found to circulate in BC, and it is very rare for bat-variant rabies to "spill over" into other animals. There have been only 10 documented cases in history where a non-bat mammal from BC tested positive for bat-variant rabies. Although transmission of bat-variant rabies through other animals to humans is theoretically possible, no such cases have been reported (Brass 1994). In general, secondary hosts do not commonly transmit a rabies virus variant from a different species (CFIA 2011).

Terrestrial mammals from outside BC, including recently imported animals– The need for RPEP depends on the virus strains circulating in that part of the world. Outside BC, bats and terrestrials mammals (e.g. dogs, foxes, raccoons, skunks) may carry rabies virus.

For further details on how rabies risk is assessed, RPEP schedules and dosing, and other background, please see the BC Centre for Disease Control's recently revised rabies guidelines at http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%201%20-%20CDC/BCRabiesGuidelines.pdf

Submitted by: Dr. Raina Fumerton, MHO, NW HSDA

Medical Health Officers in Northern Health— *Who are we and what do we do?*

In response to inquiries from some of our clinician colleagues in Northern Health, the Medical Health Officer (MHO) team has created a brief overview of our roles and responsibilities. We hope you find this article informative.

1. *What are MHOs and what training do they have?*

Medical Health Officers (MHOs) are public health physicians who:

- are licensed to practice medicine in BC, and
- possess specialty training in Public Health and Preventive Medicine at either the Masters or Royal College Fellowship level, and
- hold an Order-in-Council appointment from the provincial government which bestows legislative authority for issues of public health importance.

2. *How many MHOs are there in Northern Health and how do I get a hold of them?*

There are three regional MHOs in the north—one for each Health Service Delivery Area (HSDA) and one Chief MHO. The MHO team provides 24/7 on call service:

- **Northwest HSDA MHO**: Dr. Raina Fumerton
- **Northern Interior HSDA MHO**: Position currently unfilled (position being cross-covered by MHO Team until filled)
- **Northeast HSDA**: Dr. Charl Badenhorst
- **Chief Medical Health Officer** for Northern Health: Dr. Sandra Allison

Dr. Ronald Chapman, VP Medicine (for on-call purposes)

Please contact your local HSDA MHO directly using the numbers listed on the right side of this page. After normal business hours, on weekends and Stat holidays, please call UHNBC switchboard in Prince George at 250-565-2000 and ask for the MHO on-call.

3. *What are the statutory responsibilities of the MHO?*

MHOs are named in and responsible for carrying out the legislated requirements of a number of pieces of legislation. Some of these include the *Public Health Act* and associated regulations, the *School Act*, the *Community Care and Assisted Living Act* and regulations, the *Drinking Water Protection Act* and regulations, the *Environmental Management Act* and regulations, the *Integrated Pest Management Act* and regulations, and others. The duties undertaken by Environmental Health Officers, Licensing Officers and Public Health Nurses

(Continued on page 2)

Medical Health Officers in Northern Health— *Who are we and what do we do? Cont'd.*

4. *What are some of the other roles of the MHO?*

MHOs carry several other roles and responsibilities within Northern Health and in our communities:

Role	Responsibilities
Community Medicine Consultant	▪ Work collaboratively with the Northern Health Board of Directors, and with other agencies and boards in the community (e.g., Municipal Councils and School Boards, Mental Health, Social services, Water Boards, Environmental agencies, Alcohol and Drug programs and volunteer community groups) to assist in promoting health and wellness and preventing illness and injury. ▪ Provide evidence-based recommendations to physicians as well as to community agencies and Boards on a wide variety of health issues including communicable diseases, environmental issues, and complex health related social and behavioral issues.
Population Health	▪ Monitor and assess the health status of the community and make recommendations to the Northern Health Board for strategies to address identified community health issues. ▪ Collect data over a broad range of health issues, analyze trends and problems, interpret these issues, and prepare reports and public information on the significant health and health-related issues in northern communities.
Planning, Evaluation, and Program Development	▪ Assist the Board in evaluating the effectiveness of Health programs and in designing new programs to address emerging health issues. ▪ Develop reports that compare the performance of the health care system in their region with accepted standards or with other regions.
Advocacy	▪ Advocate on behalf of the public's health and to speak on behalf of marginalized members of the community and those at risk. ▪ Communicate with the public through media and other means and with NH Board members and elected officials on health issues affecting northern communities.

5. *What are some examples where clinicians might consult an MHO?*

The MHO group serves as a resource to clinicians for any public health issues or questions. Examples of common scenarios where a clinician might consult an MHO include:

- a patient who has had an environmental exposure (e.g. a chemical contaminant)
- communicable disease issues (e.g. measles, bacterial meningitis, blood and body fluids exposures…)
- animal/bat bites, to assess the need for zoonotic diseases including performing a risk assessment of the need for rabies post exposure prophylaxis
- MHOs are also called for unexpected increased presentations in syndromes (GI, respiratory), outbreaks in facilities, and concerns around drinking water and air quality.
- Questions on how to become more involved in public health promotion events in their local practice or community.
- Diagnostic decisions: i.e. what test do I need to perform in order to rule out or confirm "X" communicable disease? (common examples include measles/mumps/pertussis/Hepatitis A etc…)

6. *When should a Physician report a notifiable communicable disease to Public Health?*

As Medical Health Officers we rely heavily on our clinical colleagues to notify us of any urgent or emergent communicable disease issues as laboratory reports can take time to process and result in delays around public health follow up (e.g. contact tracing and chemo or immunoprophylaxis of close high risk contacts/ outbreak control and management efforts).

Physicians are requested to provide a report of any reportable communicable disease to your Medical Health Officer, by contacting Public Health Nursing at your local Health Unit for the following list of communicable diseases:

Reportable Communicable Diseases

- suspect bacterial meningitis or meningococcal disease
- severe respiratory illness from suspected infectious etiology and symptom onset is within 10 days of return from overseas travel
- high risk contacts, including baby < 1 year old and pregnant women in their 3rd trimester, of lab-confirmed or probable pertussis cases
- invasive Group A strep
- invasive Haemophilus influenza Type B
- diphtheria
- measles
- mumps
- suspect or known infectious respiratory tuberculosis
- hepatitis A
- suspect polio
- botulism
- suspect viral hemorrhagic fever e.g. Ebola
- smallpox or anthrax
- new or emerging infections e.g. SARS, MERS-CoV
- unexpectedly high numbers of a suspected communicable disease or suspect food-borne outbreaks
- contamination threat involving food, water or air
- possible human rabies exposure:
  - ➢ any bat exposure with physical contact.
  - ➢ dogs or cats - any bite outside North America, or any bites in BC by a dog or cat behaving abnormally suspicious of rabies.
  - ➢ any animal bite outside BC, or, in BC if unprovoked and abnormal animal behaviour.

NOTE - provoked bites from hand-feeding small mammals such as squirrels, rabbits, and rodents do not require rabies vaccine or rabies immune globulin.

Submitted by:
Dr. Raina Fumerton
MHO, Northwest HSDA

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Cyclospora Outbreak in BC: Please be on the alert for cases

BC is experiencing an outbreak of *Cyclospora* infection with 6 locally-acquired cases reported since May 1. We are requesting your assistance to diagnose infected patients to assist with the outbreak investigation.

Cyclospora cayetanensis is a parasite which causes a prolonged gastrointestinal infection. Symptoms include frequent watery diarrhea, anorexia, abdominal cramps and bloating, nausea and flatulence. Symptoms typically last several weeks to over a month and wax and wane in intensity. People are infected by ingesting contaminated food or water. The infection is not spread from person-to-person. See here for more details on *Cyclospora* infection: http://www.bccdc.ca/health-info/diseases-conditions/cyclospora-infection

Cyclospora is not endemic in Canada. Most people are infected when visiting an endemic country in Latin America or South East Asia in the spring and early summer. When cases occur in Canadians who did not travel, an outbreak investigation is launched. Most outbreaks occur in the spring and early summer and are due to imported produce such as berries or herbs.

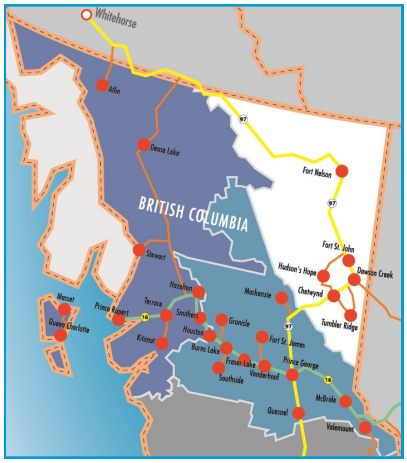
Cyclospora infection is diagnosed by a stool ova and parasite (O&P) examination. A special request must be made for *Cyclospora* diagnosis to ensure the appropriate stain is used by the lab. See here for BC Guideline for Ordering Stool Specimens: http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/infectious-diarrhea

If patients present with *Cyclospora*-compatible symptoms between now and August, please request a stool O&P and indicate on the lab requisition "*Cyclospora* diagnosis". This will help you accurately diagnose the infection and will assist the outbreak investigation.

Submitted by:
Dr. Andrew Gray, NI MHO at the request of Dr. Eleni Galanis, BCCDC

Inside this Issue:

Notable Quotable:



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Features included in NEJM Online:

- Articles from 1990 to present day including "online first" (before print access)
- Videos and audio summaries
- Slide sets for clinical teaching
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Submitted by: Julie Creaser, Regional Manager, Library Services

The Truth and Reconciliation Commission

The Truth and Reconciliation Commission's report was released in December 2015. The report details 94 Calls to Action (recommendations) for Canadians to redress the legacy of residential schools (Actions 1-42) and advance the process of reconciliation (Actions 43-94). This newsletter series will walk through the 94 Calls to Action to support Northern physicians and other providers to learn about the legacies and take actions towards reconciliation in their practices, relationships, and communities.

The categories to redress the legacy of residential schools include; child welfare, education, language and culture, health, and justice. This issue we highlight the 7 Calls to Action specific to Health. Others will be shared in upcoming newsletters.

Health

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends.

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21 We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to: increase the number of Aboriginal professionals working in the health-care field, ensure the retention of Aboriginal health-care providers in Aboriginal communities and provide cultural competency training for all health-care professionals …

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices.

Submitted by: Dr. Sandra Allison, CMHO and Hilary McGregor, Coordinator, Knowledge Implementation and Evaluation

Northern Health Physicians
Partners in Wellness

Public Health Newsletter for Northern Health Physicians

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Ticks, Lyme Disease and Tick Paralysis

The most common ticks found in the Northern Health region are Rocky Mountain Wood Ticks (Dermacentor andersoni) . Ticks with Lyme disease carrying potential (Ixodes pacificus and Ixodes angustus) are known to be present in low levels in the north, although we have not yet identified a tick in the north harbouring the Lyme disease bacteria (Borrelia burgdorferi). Although Rocky Mountain Wood Ticks have not been implicated with Lyme disease, they have the potential to carry rickettsial pathogens and also could cause tick paralysis. In general, ticks are known to cause other diseases in British Columbia (B.C.) as well, such as Rickettsial diseases (Rocky Mountain Spotted Fever) or tularemia, among others.

Tick Paralysis: This rare disease does occur in B.C., though it is not reportable.

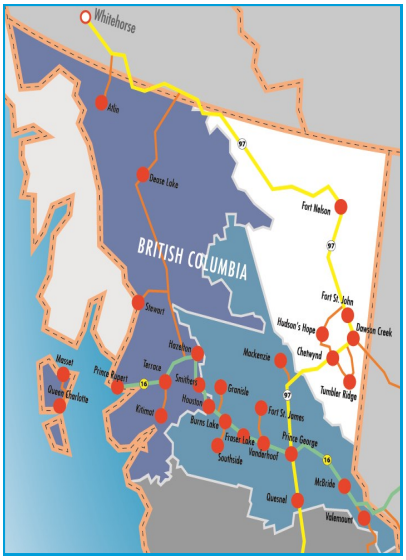
- Characterized by an acute, ascending, flaccid paralysis resulting from exposure to a neurotoxin released by tick salivary glands during feeding.
- Mostly occurs in younger children and elderly early in the spring.
- Ticks can be attached to the scalp or neck and concealed by hair.
- In patients presenting with tick paralysis, examination often reveals an attached tick.
- Once the tick is removed, paralysis usually resolves within 24 hours.
- There is no test to confirm tick paralysis as the neurotoxin produced by the tick and its mechanism of action are not fully understood.
- **Patients presenting with initial signs and symptoms of acute paralysis should have a physical exam searching for a tick.**

Acute Lyme disease: None of the Lyme disease cases that have been diagnosed in Northern Health were exposed locally (i.e. they were either exposed elsewhere in BC, Canada or internationally).

- Most people do not notice the tick bite or attachment when it occurs.
- About 60-70% of all newly infected patients with Lyme disease will develop an expanding circular red (erythma migrans) rash from 3-10 days after the bite.
- Laboratory tests support clinical care when used correctly and are performed using validated methods in an accredited laboratory.
- In B.C., laboratory testing to diagnose Lyme disease is done by the BCCDC Public Health Laboratory (PHL).

Inside this Issue:

Notable Quotable:



Northwest

Atlin, Dease Lake, Houston, Hazelton, Masset, Kitimat, Port Clements, Prince Rupert, Smithers, Stewart, Terrace, the Village of Queen Charlotte

Northern Interior

Burns Lake, Fort St. James, Fraser Lake, Granisle, Mackenzie, McBride, Prince George, Quesnel, Valemount, Vanderhoof

Northeast

Chetwynd, Dawson Creek, Hudson's Hope, Fort Nelson, Fort St. John, Tumbler Ridge

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After hours calls to UHNBC Switchboard 250-565-2000 and ask for MHO on-call

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(Continued from page 1)

Tick Removal:

Routine antibiotic prophylaxis is not indicated for tick bites in BC, as harm is more likely than benefit. Reassure patients who present with tick bite that Lyme disease is currently extremely uncommon in northern BC, but counsel patients to return for assessment if symptoms consistent with Lyme disease occur. Outcomes are generally very good when Lyme disease is treated early.

Grasp the tick by its mouth as close to the skin as possible with tweezers or other device and pull outwards, avoiding injecting the tick's stomach contents into the skin. Smothering methods for tick removal are ineffective and increase risk of injection of infected material into the client.
NOTE: Physicians wishing to test ticks are to contact BCCDC PHL's Parasitology Laboratory at (604) 707-2629.

For questions regarding testing of humans, call BCCDC PHL's Zoonotic Diseases and Emerging Pathogens Laboratory at (604) 707-2628. Ticks are not forwarded from Public Health (PH) Offices and patients should not be directed to PH offices with ticks.

For more information please refer to:
BCCDC information on Lyme disease: http://www.bccdc.ca/health-info/diseases-conditions/lyme-disease-borreliaburgdorferi-infection

BCCDC information on Tick paralysis: http://www.bccdc.ca/health-info/diseases-conditions/tick-paralysis
Health Canada/Public Health Agency of Canada: https://www.canada.ca/en/public-health/services/diseases/lymedisease.html

Submitted by: Dr. Raina Fumerton, MHO, NW HSDA

Article Credit: Interior Health Authority: Medical Health Officers Update for Physicians (May 24, 2017)
https://www.interiorhealth.ca/AboutUs/Leadership/MHO/MHO%20Updates/MHO%20Update%20-%20May%2024,%202017.pdf

Best Advice—Social Determinants of Health

The College of Family Physicians of Canada's *Best Advice Guide*, part of *Patient's Medical Home* (PMH) series, provides practical, hands-on advice for health professionals on how to improve their patients' social determinants of health (SDH). It is divided into four main sections:

- background on the social determinants of health
- importance of these issues for patient and population health
- commonly identified challenges to action
- incorporating the social determinants of health into your practice

Background:

Health and well-being are shaped by social and economic factors known as the social determinants of health (SDH), which are defined as the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The evidence base on the SDH dates back to the early 1800s and continues to expand. Many reports, summits, and studies corroborate the link between social factors and human health.

In Canada, the 1974 Lalonde Report encouraged health professionals to look beyond traditional medical care to improve the health of the population and to focus on prevention instead of mostly acute care. We have learned much about the mechanisms by which the SDH and health inequities operate. The idea that there is a social "ladder" to illness is widely accepted – further up or down on this ladder reflects better or worse health outcomes.

The College of Family Physicians of Canada, and other professional health organizations including the Canadian Medical Association and the British Medical Association, understands that there is sufficient evidence to take action on the SDH. This paper aims to provide family physicians and their teams of allied health professionals with practical advice on how to address the SDH both in practice and through broader advocacy.

Importance of SDH:

Attention to the SDH is integral to population health and family medicine. Many family physicians in Canada recognize that it is difficult to treat the immediate health concerns of their patients without addressing in some way the underlying social conditions that give rise to poor health. While most public health interventions target individual behaviours, an SDH approach reveals individual choice as being shaped and constrained by structural and environmental factors, often outside the direct control of the individual. For this reason, family physicians should work to intervene not just in the lifestyle and behavioural factors that impact individual patients' health but also in the social conditions that shape and constrain well-being.

The SDH include, but are not limited to,

- income (and its distribution)
- education
- unemployment and job security
- employment and working conditions
- early childhood development
- race
- gender
- sexuality
- food insecurity (i.e. hunger)
- housing
- social exclusion
- social safety net (welfare policy)
- health services
- Aboriginal status
- disability

Conclusion:

Family physicians play a vital role in improving the social determinants of health for their patients and all Canadians. The recommendations provided in this guide are just a starting point for future work. The tools and incentives to do work that focuses on SDH are being expanded across the country, and a Patient's Medical Home model of primary care helps facilitate incorporating the SDH into family practice. Implementing even one of these recommendations will go a long way to improving the social determinants of health for your patients. The evidence on the SDH is sufficient to merit action, and we at the Canadian Family Physicians of Canada are here to help translate that evidence into action.

A full copy of the report is available at: http://patientsmedicalhome.ca/files/uploads/BA_SocialD_ENG_WEB.pdf.

Source:
The College of Family Physicians of Canada, Best Advice—Social Determinants of Health March 2015.

For further information, please visit:
http://www.cfpc.ca/

Submitted by:
Dr. Sandra Allison
Chief Medical Health Officer

Expanded Eligibility for HPV Vaccination

On September 1st 2017, BC will expand its publicly funded HPV immunization program to include grade 6 boys and individuals 9-26 years of age who identify as transgender. These additions complement BC's current publicly funded HPV immunization program for grade 6 girls and males who are at a higher risk of contracting the virus, thus ensuring that the eligibility criteria for publicly funded HPV vaccine are comprehensive and equitable.

All individuals eligible for the publicly funded HPV immunization program in BC will receive the 9-valent HPV vaccine (Gardasil 9). This vaccine provides protection against nine types of HPV. This includes the types of HPV that cause about 90% of cervical cancers, as well as other HPV-related cancers of the vagina, vulva, anus, penis, mouth and throat. It also protects against two types of HPV that cause about 90% of anogenital warts. Although the grade 6 HPV immunization program ill be mainly administered through routine school-based immunization clinics, the vaccine may also be requested through health care providers, pharmacists and public health units.

HPV immunization coverage rates have not reached levels comparable to other vaccines administered to adolescents. As with all immunization programs, success depends on health care providers like you promoting the vaccine to your eligible patients. Your recommendation to vaccinate is a strong predictor of vaccine uptake.

For questions about the HPV immunization program, please contact your local public health unit or primary care home to speak with a primary care nurse or refer to the following resources:

BCCDC's Q&A for HCPs: Updates to the Human Papillomavirus (HPV) Immunization Program:
http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Immunization/Vaccine%20Info/HPV_ProgramQandA_Aug_2017.pdf

The BC Immunization Manual:
http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/Part4/HPV9.pdf

Submitted by:
Dr. Andrew Gray, MHO, NI HSDA

The Truth and Reconciliation Commission

The Truth and Reconciliation Commission's report was released in December 2015. The report details 94 Calls to Action (recommendations) for Canadians to redress the legacy of residential schools (Actions 1-42) and advance the process of reconciliation (Actions 43-94). This newsletter series will walk through the 94 Calls to Action to support Northern physicians and other providers to learn about the legacies and take actions towards reconciliation in their practices, relationships, and communities.

The categories to redress the legacy of residential schools include; child welfare, education, language and culture, health, and justice. This issue we highlight the 5 Calls to Action specific to Child Welfare. Others will be shared in upcoming newsletters.

Child Welfare

1. We call upon the federal, provincial, territorial and Aboriginal governments to commit to reducing the number of Aboriginal children in care by...
2. We call upon the federal government, in collaboration with the provinces and territories, to prepare and publish annual reports on the number of Aboriginal children (First Nations, Inuit, and Metis) who are in care, compared with non-Aboriginal children, as well as the reasons for apprehension, the total spending on preventive and care services by child-welfare agencies, and the effectiveness of various interventions.
3. We call upon all levels of government to fully implement Jordan's Principle.
4. We call upon the federal government to enact Aboriginal child-welfare legislation that establishes national standards for Aboriginal child apprehension and custody cases and includes principles that..
5. We call upon the federal, provincial, territorial and Aboriginal governments to develop culturally appropriate parenting programs for Aboriginal families.

Submitted by: Dr. Sandra Allison, CMHO and Hilary McGregor, Coordinator, Knowledge Implementation and Evaluation

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Partners in Wellness

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Special Issue on Influenza 2017-18 Season

HIGHLIGHTS

Vaccine roll-out:

- Week of **October 23, 2017** : Influenza vaccine will be available beginning October 23, 2017
- Week of October 30, 2017 : Northern Health community clinics may start, provincial campaign launches.
- Order your vaccines now!

Indications for specific influenza vaccines are unchanged since 2016□17, EXCEPT that the intranasal vaccine(FLUMIST®) which is indicated for children aged 2-17 years of age is **no longer considered superior** to the injectable quadrivalent vaccine. Flulaval Tetra Quadrivalent® or Fluzone Quadrivalent (depending on availability) should be used for children aged 6 months to 17 years of age. In order to simplify number of vaccine products offered, **Fluad** was not purchased by the province and will not be available this fall. Fluviral or Agriflu are the publicly-funded options that should be offered to seniors.

Eligibility for free/publicly covered vaccination is the same as 2016-17:

- Seasonal influenza vaccination is covered for people at high risk, their close contacts, and people who live or work in high-risk settings (see p.3).'
- One-time polysaccharide pneumococcal vaccine for people 65 or older or otherwise at high risk, plus one booster for certain very high-risk groups (see p.5).

Remember to report to your local health unit:

- influenza vaccine administration to children up to 8 years old, and
- all pneumococcal vaccine administration,
- any adverse events following immunization.

Order forms, reporting forms, and many more resources are available at:https://northernhealth.ca/Professionals/ImmunizationResourcesTools.aspx.

Read on for more details!

Don't forget to **report your own immunization status at https://medicalstaffhealth.phsa.ca/**.

Starting December 1, all physicians and staff are required to either be vaccinated or to wear a mask while in patient care areas in NH facilities.

Inside this Issue:

Also included:

Notable Quotable:

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2017-18 Seasonal Influenza: What You Need to Know

Introduction

The following pages contain information on influenza and pneumococcal vaccines to guide physicians, health care workers, and community vaccine providers on their use during the upcoming influenza season. For more information please see the references and resources at the end of this newsletter.

Immunization Campaign Start Date:

The official provincial campaign launch date for this season's influenza community campaign is **the week of November 1st, 2017**; however we plan on redistributing the vaccine as soon as we have sufficient quantity.

Vaccine Ordering, Distribution, Storage:

Vaccine Ordering:

Physicians and all other community vaccine providers (pharmacists, nurses in First Nation Communities, acute and residential care facilities and others) are required to fill out the Influenza Vaccine Order form when ordering Influenza and Pneumococcal vaccine this flu season. Your order for pneumococcal vaccine can be placed at the same time.

Please use the Influenza Vaccine Order Form which can also be found at the following link: https://northernhealth.ca/Professionals/ImmunizationResourcesandTools.aspx

Please fax your order to the local Health Unit at the number identified on the form. After receipt of your vaccine order, influenza vaccines will be available for pick up starting the week October 23rd (date dependent on vaccine delivery to local health units). If sufficient supplies arrive earlier, you will be notified of an earlier pick up date.

We expect to have a majority of our influenza vaccine by mid-October.

Please note that due to the incremental arrival of vaccines, we may not be able to fill all orders completely at the onset. We will endeavor to ensure fair and equitable distribution to all community partners and fill your complete order in as few installments as possible.

Reporting

All Community Vaccine Providers (CVPs) must complete the influenza Vaccine Utilization Report. This form is used to track the number of doses given and the age range. This form is to be completed and returned/faxed by CVPs to the appropriate community specific health unit by January 31, 2018.

Click here to access Influenza Order forms.

Reminders about Vaccine Distribution and Storage:

- Call the Biological Product Monitor (BPM) at your local health unit to arrange your vaccine order pick up date.
- Agriflu® packaging requires more storage space as it is a single dose pre filled syringe. Please bring additional coolers to accommodate the extra storage needs when you pick up your order.
- Keep your biological fridge between 2-8 degrees.
- Notify the local BPM of any cold chain break incidents and report accordingly.
- Return all unused and partially used vials of publically funded vaccines to your BPM. Do not dispose.
- Influenza vaccine can continue to be offered until the Health unit sends out a request for annual influenza vaccine return.

(Continued on page 3)

2017-18 Seasonal Influenza: What You Need to Know

(Continued from page 2)

Eligibility:

Influenza vaccine is recommended for everybody ≥ 6 months of age. It is provided free to:

Demographic Groups (and contacts where applicable)	People with higher risk health conditions (and contacts)	People residing in particular settings (and contacts)	People in higher-risk Jobs/workplaces/other settings (and contacts)
People 65 years and older and their caregivers/ household contacts	Children and adults with chronic health conditions and their household contacts	People of any age in residential care facilities	Health care and other care providers in facilities and community settings who are capable of transmitting influenza disease to those at high risk of influenza complications.
All healthy children 6-59 months of age.	Children and adolescents (6 months to 18 years) with conditions treated for long periods of time with Acetylsalicylic Acid (ASA) and their household contacts	Inmates of provincial correctional institutions	Individuals who provide care or service in potential outbreak settings housing high risk persons (e.g., crew on ships).
Aboriginal people (on and off reserve)	Children & adults who are morbidly obese (adult BMI>40; child BMI assessed as >95th percentile adjusted for age and sex)	Visitors to health care facilities and other patient care locations	People who provide essential community services (first responders, corrections officers)
Household contacts and caregivers of infants and children 0-59 months of age			People who work with live poultry.
Pregnant women at any stage of pregnancy during the influenza season and their household contacts			

Recommended Dosage of Injectable Influenza Vaccine by Age:

Age	Dosage (mL)	No. of doses
6 months to 8 years	0.5 IM	1 or 2[1]
≥ 9 years	0.5 IM	1

[1] Eligible children < 9 years of age receive two doses of vaccine 4 weeks apart ONLY if they are previously unvaccinated or if influenza vaccination history is uncertain. If one or more doses have been received in any preceding season, only one dose will be given.

For children requiring 2 doses within the season, QIIV or TIIV may be given interchangeably with LAIV-Q with either product used for the 1st or 2nd dose if LAIV-Q is not available.

2017-18 Seasonal Influenza: What You Need to Know

Vaccines and Recommended Usage

Influenza vaccine is safe and well-tolerated and may be given to persons starting from six months of age (noting-specific age indications and contraindications).

Five publicly-funded vaccine products will be distributed in Northern Health this influenza season. These products reflect the following World Health Organization recommended composition of influenza virus vaccines for use in the northern hemisphere during the 2017-2018 influenza season:

- A/Michigan/45/2015 (H1N1)pdm09-like virus
- A/Hong Kong/4801/2014 (H3N2)-like virus
- B/Phuket/3073/2013-like virus (in quadrivalent vaccines only)
- B/Brisbane/60/2008-like virus

The A/Michigan/45/strain was not contained in the 2016/17 season vaccine.

Note: In order to simplify number of vaccine products offered, **Fluad** was not purchased by the province and will not be available this fall. Fluviral or Agriflu are the publicly-funded options that should be offered to seniors. **Fluzone High-Dose** is a private pay option for seniors, recommended by NACI, and can be purchased without prescription at select pharmacies.

Vaccine	FLUVIRAL®	FLUZONE®	AGRIFLU®	FLUMIST®	Flulaval Tetra Quadrivalent®
Description	Inactivated Split Virion (IM) from GlaxoSmithKline Inc.	Inactivated Split Virion (IM) from Sanofi Pasteur Limited	Inactivated Subunit (IM) from Novartis	Live, attenuated (Intranasal) from AstraZeneca	Inactivated Split Virion (IM) from GlaxoSmithKline Inc.
Presentation	10 doses per vial without syringes	10 doses per vial without syringes	Single dose syringe	Box with 10 applicators	10 doses per vial without syringes
Client Age Group	Intended for use in eligible individuals 18 years of age or older.	Intended for use in eligible children 6 months to 17 years of age (inclusive) including those with contraindications to LAIV-Q.	Intended for use in eligible individuals 18 years of age and older.	Intended for use in eligible individuals 2-17 years or age (inclusive)	Intended for use in eligible children 6 months to 17 years of age (inclusive) including those with contraindications to LAIV-Q.
Storage temperature	2-8°C for all products				
Shelf-life, once opened	Multi-dose vial Discard multi-dose vials 28 days after first entry	A multi-dose vial that has been stored at 2-8 degrees C may be used up to the expiry date indicated on the vial label.	n/a single dose	n/a single dose	Multi dose vial Discard multi-dose vials 28 days after first entry.
Other considerations**	• may be used in children 6 months to 17 years of age if a quadrivalent vaccine is unavailable	• In the event of vaccine surplus in the provider's inventory beyond that required for those under 18 years old, this vaccine may be provided to those 18 years of age and older as part of the publicly funded program in BC.	• Preferential for use in individuals with a known hypersensitivity to thimerosal • May be used for pregnant women who request a thimerosal vaccine • May be used for children 6 months to 17 years of age if a quadrivalent influenza vaccine is unavailable • Requires nine times more storage space than the equivalent number of **FLUVIRAL®** doses		• In the event of vaccine surplus in the providers inventory beyond that is required for those under 18 years old, this vaccine may be provided to those 18 years and older as part of the publicly funded program in BC
	*contains thimerosal	*contains thimerosal	*contains neomycin and kanamycin	*contains gentamicin	*contains thimerosal

***See product monographs for additional details on contraindications and precautions.*

Complete details on 2017/18 Seasonal Influenza Vaccines is available at BC Centre for Disease Control, Communicable Disease Control Manual, Chapter 2, Immunization Program, Part 4-Biological Products at: **http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/immunization**

2017-18 Seasonal Influenza: What You Need to Know

Egg allergies/Oculo-Respiratory Syndrome (ORS)

Since the 2013/14 influenza season, British Columbia Guidelines have allowed for the immunization of egg allergic individuals with inactivated influenza vaccine. The live intranasal influenza vaccine (Flumist® Quadrivalent) is not contraindicated for egg allergic persons. It can be safely administered to egg allergic individuals, including those who have experienced anaphylaxis following egg ingestion, according to standard practices. This recommendation is supported by recent studies that assessed the safety of LAIV in egg allergic individuals.

For unresolved questions about egg allergies and severe Oculo-Respiratory Syndrome (ORS) you may contact your local health unit or MHO. For more information, please visit BCCDC Safety Issues Applicable to Influenza Vaccines for more details on egg allergies and ORS.
Accessed at: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/SectionVII_BiologicalProducts.pdf

Pneumococcal Vaccine

Polysaccharide Pneumococcal Vaccine

Secondary pneumococcal infections add to the morbidity from seasonal influenza viruses. Polysaccharide pneumococcal vaccine is recommended and provided free for:

- adults 65 years of age and older
- residents of extended or intermediate care facilities
- individuals 2 years of age and older with:
  1. ***Anatomic or functional asplenia***
  2. ***Sickle cell disease***
  3. ***Immunosuppression related to disease (e.g., malignant neoplasm (including leukemia and lymphoma), HIV, multiple myeloma) or therapy (e.g., high dose, systemic steroids, or severe rheumatoid arthritis requiring immunosuppressive therapy)***
  4. ***Congenital immunodeficiency states (e.g. complement, properdin, or factor D deficiency)***
  5. ***Chronic heart or lung disease (except asthma, unless management involves ongoing high dose oral corticosteroid treatment.***
  6. ***Chronic kidney disease***
  7. ***Chronic liver disease including cirrhosis, chronic hepatitis B, and chronic hepatitis C.***
  8. ***Receipt of hematopoietic stem cell transplant (HSCT)***
  9. *Solid organ or islet cell* transplant (candidate or recipient)
  10. Diabetes
  11. Alcoholism
  12. Cystic fibrosis
  13. Chronic CSF leak
  14. Cochlear implant (candidate or recipient)
  15. Homelessness and/or illicit drug use

Booster Doses

A once-only revaccination should be offered 5 years after the initial immunization to those who have:

- Anatomic or functional asplenia
- Sickle cell disease
- Immunosuppression related to disease (e.g., HIV, lymphoma, Hodgkin's, multiple myeloma) or therapy (e.g., high dose, systemic steroids)
- Congenital immunodeficiency states (as above)
- Chronic kidney disease
- Chronic liver disease including cirrhosis, chronic hepatitis B, and chronic hepatitis C
- HSCT recipients: see Part 2 – Immunization of Special Populations, Hematopoietic Stem Cell Transplantation (HSCT).

Complete details on the Pneumococcal Polysaccharide vaccine is available in the BC Centre for Disease Control, Communicable Disease Control Manual, Chapter 2, Immunization Program, Part 4-Biological Products at:

http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/immunization

We encourage family physicians to identify patients who are eligible for pneumococcal vaccine, and administer pneumococcal vaccine if not already done.

Important: Revaccination with pneumococcal vaccine is not routinely recommended. However, a **ONE TIME ONLY** booster dose of vaccine is recommended for people with specific medical conditions listed above under Booster Doses. This booster should be given five years after the first dose (with the exception of the HSCT recipients, who's post -transplant vaccination schedule is quite complex and is based on BC Centre for Disease Control Immunization for special populations guidelines)..For HSCT recipients: see Part 2 – Immunization of Special Populations, Hematopoietic Stem Cell Transplantation (HSCT)at:

http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/Part2/HSCT.pdf

Pneumococcal vaccine can be given at the same time as the seasonal influenza vaccine, using separate syringes/needles at separate sites.

Reporting Requirements

Adverse Reactions following Immunization (AEFI):
All significant and unexpected adverse events following immunization with any vaccine product are to be reported to the local health unit. Medical Health Officer recommendations for future immunizations will be sent to the immunizer.

The reporting form for AEFIs is available at: http://www.bccdc.ca/health-professionals/professional-resources/surveillance-forms
For more information on Adverse Events following immunization please visit http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/SectionIX_AdverseEventsFollowingImmunization.pdf

Reporting of Vaccine Administered
Community vaccine providers are required to report the following vaccines administered:

- All clients receiving the pneumococcal vaccine
- Children 8 years and younger who receive the influenza vaccine

This ensures Public Health records are up to date and avoids unnecessary doses of vaccine.

The Immunization Influenza Vaccine and Pneumococcal reporting form can be found at: https://northernhealth.ca/Professionals/ImmunizationResourcesandTools.aspx

Influenza testing and treatment

Testing: In most scenarios, testing cases of influenza-like illness (ILI)* for influenza does not alter clinical management. Influenza testing, by nasopharyngeal swab, **is** indicated:
-for severe or unusual cases (e.g. patients requiring hospitalization), and
-among patients in acute care facilities and residents of long –term care facilities (where there is potential for an outbreak).

Influenza-like illness (ILI) is defined as: fever **and** cough **and** at least one of headache, myalgias, arthralgias, extreme fatigue/weakness, sore throat.

Treatment: Antiviral treatment (oseltamivir or zanamivir) reduces the risk of complications of influenza when started within 48 ours of the onset of symptoms for most patients, or within 96 hours of symptom onset for severely ill patients requiring hospitalization. Greater benefits occur when antivirals

(Continued on page 6)

2017-18 Seasonal Influenza: What You Need to Know

(Continued from page 5)

are initiated as soon as possible. Therefore, during influenza season, **oseltamivir or zanamivir are recommended for patients at high risk of complications presenting with ILI, without waiting for a lab result.** Patients at high risk of complications are largely the same as those who are eligible for free vaccine:

- Patients with chronic medical conditions
- Residents of long-term care facilities
- Individuals 65 years of age or older
- Indigenous people
- Pregnant women and women up to 4 weeks post-partum, regardless of how the pregnancy ended.

Recommended treatment regimens for patients with normal renal function are:

- Oseltamivir 75mg twice daily x 5 days, or
- Zanamivir 10mg (two 5 mg inhalations) twice daily x 5 days

Chemoprophylaxis: is indicated among inpatients in the event of an influenza outbreak in a health care facility declared by the Medical Health Officer. Physicians who provide care in residential care facilities are asked to **pre-sign the standard antiviral order set**, so that it is ready to go in the event of an outbreak.

For more information on antiviral use, see:https://www.ammi.ca/Content/Guidelines/Flu%20%28published%20version%29%20FINAL.pdf

References

1. BCCCDC Communicable Disease Guidelines at http://www.bccdc.ca/dis-cond/comm-manual/CDManualChap2.htm
2. Recommended composition of influenza virus vaccines for use in the 2017-2018 northern hemisphere influenza season: WHO | Recommended composition of influenza virus vaccines for use in the 2017-2018 northern hemisphere influenza season
3. FluWatch: http://www.phac-aspc.gc.ca/fluwatch/

Additional Resources

1. Northern Health Influenza information is available at: https://northernhealth.ca/YourHealth/PublicHealth/InfluenzaInformation.aspx
2. The National Advisory Committee on Immunization (NACI) "Statement on Seasonal Influenza vaccine for2017-2018 available at: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/canadian-immunization-guide-statement-seasonal-influenza-vaccine/naci-stmt-2017-2018-eng.pdf
3. HealthLinkBC - Health Files: http://www.healthlinkbc.ca/servicesresources/healthlinkbcfiles/ or
   - Facts about Influenza (The Flu) (12b)
   - Inactivated Influenza Vaccine (12d)
   - Influenza (Flu) Immunization: Myths and Facts (12c)
   - Pneumococcal Polysaccharide Vaccine (62b)
   - Influenza (Flu) Season
4. Immunize BC website at: http://www.immunizebc.ca/
5. BCCDC Immunization Manual: Part 4 - Biological Products at: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/SectionVII_BiologicalProducts.pdf
6. BCCDC Immunization & Vaccines for Health Professionals at: http://www.bccdc.ca/health-professionals
7. Influenza Education BCCDC Influenza Courses: BCCDC Foundations of Influenza: Diseases and Vaccinations & Seasonal Influenza Update 2017/18 please visit: Immunization Courses at http://www.bccdc.ca/health-professionals/education-development/immunization-courses

Submitted by:
Dr. Andrew Gray
Medical Health Officer
Northern Interior HSDA

Pat Strim
Regional Immunization Lead
Northern Health Authority

Influenza Control Program for Health Care Workers

The Ministry of Health has confirmed the Influenza Prevention policy will be implemented throughout BC health care organizations this fall. Northern Health, together with all other health authorities, is in the process of implementing this policy for the 2017/18flu season.

The Influenza Prevention policy requires all employees, physicians, students, volunteers, contractors, and visitors to be vaccinated annually against influenza or wear a procedure mask at all times when in patient care areas during the Policy Application Period, which begins December 1, 2017.

During a declared influenza outbreak, the Influenza Prevention Policy is suspended and Northern Health's "Influenza Exclusion Criteria (Suspected and/or Confirmed Outbreak)" Policy is activated.

Physicians have access to influenza immunization from the following sources:

1. Workplace Health & Safety flu clinics: These dedicated flu clinics will be available at most Northern Health facilities during a three week period, beginning October 16th. Clinic schedules are posted on the OurNH Flu Page. (Clinics usually occur during business hours on weekdays). Peer Immunizers (PIs) are also available in a variety of sites and departments throughout Northern Health. They immunize within their departments, when they have time between regular duties.

   They may be available on evenings and weekends.
3. Public Health/Primary Care Nurses: Physicians may choose to access public flu clinics. Schedules for these clinics will be distributed by each community's Health Unit.
4. Participating pharmacies and physician's offices: Physicians may choose to receive their influenza immunization at participating pharmacies, or from a colleague.

Please note that in all cases, physicians are eligible for FREE influenza immunization, as per the criteria set out by the BC Center for Disease Control.

This year, physicians must report their immunization, or their decision to mask while working within Northern Health facilities, at the following address: https://medicalstaffhealth.phsa.ca/.

Working collaboratively with MHOs and physicians is an important part of Northern Health's flu campaign and physicians' support is an important factor for success. If you have any questions regarding the flu campaign, please email: influenza@northernhealth.ca and we will be happy to connect with you. There will be further information provided as the flu campaign progresses.

Submitted by:
Courtenay Kelliher
Occupational Health Nurse
& Safety Advisor
Workplace Health & Safety

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2017-18 Seasonal Influenza: What You Need to Know

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Community Vaccine Provider
Influenza Vaccine Order Form

Name of pharmacy/clinic/facility/other: _____

Contact person: _____ Date of order: _____

Address: _____ Phone #: _____ Fax #: _____

Vaccine		Doses requested	Doses remaining in fridge	Health Unit use only		
				Doses supplied	Date	Panorama req #
Pneumococcal polysaccharide						
See back of page for indications by age group	**Flumist** (Unable to provide to pharmacists)					
	Agriflu					
	Fluviral					
	Flulaval/Fluzone					

Community provider/designate: _____ **Pick-up date:** _____ **Health Unit staff signature:** _____
Sign upon receiving biologicals

Community provider/designate: _____ **Pick-up date:** _____ **Health Unit staff signature:** _____
Sign upon receiving biologicals

All vaccines supplied must be accounted for. Community vaccine providers are required to keep track of all influenza vaccines and doses given and the age groups they are provided to.

Health Unit will keep a copy of the order form.

Northwest	Northern Interior	Northeast
Atlin Health Centre T: 250-651-7677 F: 250-651-7687 **Dease Lake** T: 250-771-4444 F: 250-771-3911 **Hazelton** T: 250-842-4640 F: 250-842-4642 **Houston** T: 250-845-2294 F: 250-845-7884 **Kitimat** T: 250-632-3181 F: 250-632-7081 **Masset** T: 250-626-4727 F: 250-626-5279 **Prince Rupert** T: 250-622-6380 F: 250-622-6391 **Queen Charlotte City** T: 250-559-4933 F: 250-559-8037 **Sandspit** T: 250-637-5403 F: 250-637-2496 **Smithers** T: 250-847-6400 F: 250-847-5908 **Stewart** T: 250-636-2221 F: 250-636-2715 **Terrace** T: 250-631-4200 F: 250-638-2264	**Burns Lake** T: 250-692-2460 F: 250-692-2469 **Fort St. James** T: 250-996-7178 F: 250-996-2216 **Fraser Lake** T: 250-699-8960 F: 250-699-6987 **Mackenzie** T: 250-997-8517 F: 250-997-3253 **McBride** T: 250-569-2251 ext 2026 F: 250-569-2232 **Prince George** T: 250-565-7367 F: 250-565-7377 **Quesnel** T: 250-991-7571 F: 250-991-7577 **Valemount** T: 250-566-9138 ext. 2000 F: 250-566-4319 **Vanderhoof** T: 250-567-6900 F: 250-567-6170	**Chetwynd** T: 250-788-7300 F: 250-788-9877 **Dawson Creek** T: 250-719-6500 F: 250-719-6513 **Fort Nelson** T: 250-774-7092 F: 250-774-7096 **Fort St John** T: 250-263-6000 F: 250-263-6086 **Hudson's Hope** T: 250-783-9991 F: 250-783-9125 **Tumbler Ridge** T: 250-242-5271 F: 250-242-3889

10-400-7012 (LC - Rev. - 09/17)

2017-18 Seasonal Influenza: What You Need to Know

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Community Vaccine Provider
Influenza Vaccine Order Form

Orders will be filled based upon:
- Vaccine shipments from BCCDC over a period of 3 to 4 weeks
- Historic dosage reporting
- Availability

Note: Depending on the local health unit's inventory, specific brands may not be available and an interchangeable product may be supplied.

Instructions for Community Vaccine Provider (CVP)
- Using this form, submit your order by **fax** to your community Health Unit.
- Please keep a copy for your records
- The CVP or designate is required to sign for receipt of the influenza vaccine upon pick-up at the Health Unit.
- The CVP will need to submit a new order for subsequent orders.

Instructions for the Health Unit Biological Product Monitor/Designate

To fill the CVP's complete/partial order:
- Record the number of doses in the "doses supplied" column
- Record the date the vaccine is packaged and available for pick-up in the date column
- Record the Panorama Requisition Number
- Contact CVP for pick-up
- The health unit staff is required to sign when order is picked up

Influenza vaccine accountability
- Publicly funded influenza vaccine must be accounted for. Vaccine utilization must be reported in order to ensure vaccine supply for the following year.
  - Return expired/unused vaccine back to the local Health Unit when requested.
- The Publicly Funded Influenza Vaccine Tally form is available on the Northern Health website to assist with vaccine tracking.

Cold chain

Always maintain the cold chain (2° to 8°C) and contact the health unit immediately if you experience cold chain problems.

Age group	Vaccine	Comments
6 to 23 months	• Flulaval tetra • Fluzone quadrivalent	• For children 6 to 23 months of age, Flulaval tetra and Fluzone quadrivalent are the recommended product. If Flulaval tetra and Fluzone quadrivalent are unavailable, Fluviral or Agriflu should be used.
2 to 17 years of age	• Flumist quadrivalent • Flulaval tetra • Fluzone quadrivalent	• If a quadrivalent product is unavailable, Fluviral or Agriflu should be used.
18 years of age and older	• Fluviral • Agriflu	• Agriflu may be used for individuals with a known thimerosal hypersensitivity or for pregnant women who request a thimerosal-free vaccine. • Fluviral tetra or fluzone quadrivalent in the provider's inventory beyond that required for those under 18 years of age, may be provided to those 18 years of age and older.

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Public Health Newsletter for Northern Health Physicians

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Influenza Activity has increased sharply in BC

Influenza activity increased sharply during the last week of December 2016 and has remained high throughout January 2017. The A(H3N2) strain is predominant. As is typical of this strain, the majority of cases and hospitalizations have been in patients over 65. Residential care facilities in southern BC are experiencing a high number of influenza outbreaks. Northern BC has been relatively spared so far, but we can expect more facility outbreaks to occur soon.

It is not too late to vaccinate

While interim vaccine efficacy estimates are pending, viral sequencing data indicate a good match between this year's vaccine and circulating strains of Influenza A (H3N2) and Influenza A(H1N1). Influenza vaccine remains available for your patients. Please note, one batch of Flumist vaccine expired mid-January and the second will expire 09 February 2017. Please review and remove expired vaccine inventory (including Flumist) from your fridge, and return it to your local public health unit.

Organize early antiviral treatment for those at high risk

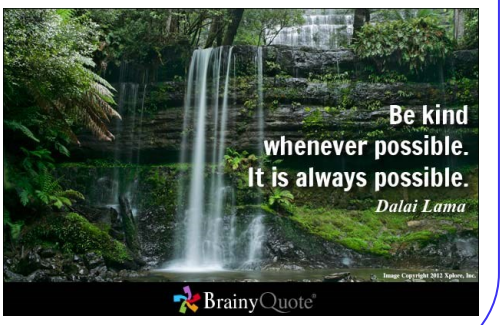
Circulating influenza strains are susceptible to both oseltamivir and zanamivir. Antiviral treatment reduces the risk of complications of influenza in patients at high risk, particularly when initiated within 48 hours of the onset of symptoms.

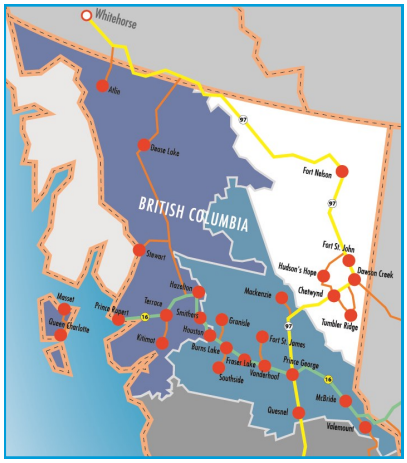
1. Patients at high risk of complications, who are most likely to benefit from antiviral treatment, include:
    - Patients with chronic medical conditions
    - Residents of long-term care facilities

(Continued on page 2)

Inside this Issue:

Notable Quotable:





Northwest

Atlin, Dease Lake, Houston, Hazelton, Masset, Kitimat, Port Clements, Prince Rupert, Smithers, Stewart, Terrace, the Village of Queen Charlotte

Northern Interior

Burns Lake, Fort St. James, Fraser Lake, Granisle, Mackenzie, McBride, Prince George, Quesnel, Valemount, Vanderhoof

Northeast

Chetwynd, Dawson Creek, Hudson's Hope, Fort Nelson, Fort St. John, Tumbler Ridge

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Dr. Andrew Gray MHO-NORTHERN INTERIOR HSDA
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andrew.gray@northernhealth.ca

Dr. Ronald Chapman, MHO and VP Medicine
Ph: 250-649-7653; Cell: 250-961-3234
ronald.chapman@northernhealth.ca

After hours calls to UHNBC Switchboard 250-565-2000 and ask for MHO on-call

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Influenza Activity has increased sharply in BC, *Cont'd.*

(Continued from page 1)

- Individuals 65 years of age or older
- Aboriginal peoples
- Pregnant women and women up to 4 weeks post-partum, regardless of how the pregnancy ended.

2. At this time, symptoms of fever and cough are highly predictive of influenza. For patients at risk of complications who present with influenza-like illness, treatment with antivirals should be started as soon as possible, ideally within 48 hours of symptom onset. There is no need for laboratory confirmation.
3. Providing a prescription for one of these antivirals to your adult patients at high risk of complications means they can start treatment as soon as they develop symptoms of influenza. Recommended treatment regimens for adults with normal renal function* are:
   a. Oseltamivir 75mg twice daily x 5 days
   b. Zanamivir 10mg (two 5 mg inhalations) twice daily x 5 days

*For dosing in children, or in adults with renal impairment, please see the AMMI Canada guideline "The use of antiviral drugs for influenza: A foundation document for practitioners" (2013) at https://www.ammi.ca/Content/Guidelines/Flu%20%28published%20version%29%20FINAL.pdf.

4. For all residents of long-term care facilities, we strongly recommend pre-signing the regional order set for antiviral treatment and prophylaxis. These orders facilitate rapid initiation of treatment and prophylaxis in the event of an influenza outbreak declared by the Medical Health Officer. This measure not only protects the individual, but also contributes to outbreak control, thereby helping protect other residents as well.

   These orders are available by signing on using your Northern Health email address here: http://docushare.northernhealth.ca/docushare/dsweb/Get/Document-83221/ (copy also attached to this newsletter on the Northern Health Physicians' external web site: https://physicians.northernhealth.ca/PhysicianResources/PublicHealth.aspx).

5. For adults at low risk of complications, antiviral treatment is not routinely recommended.

Source:

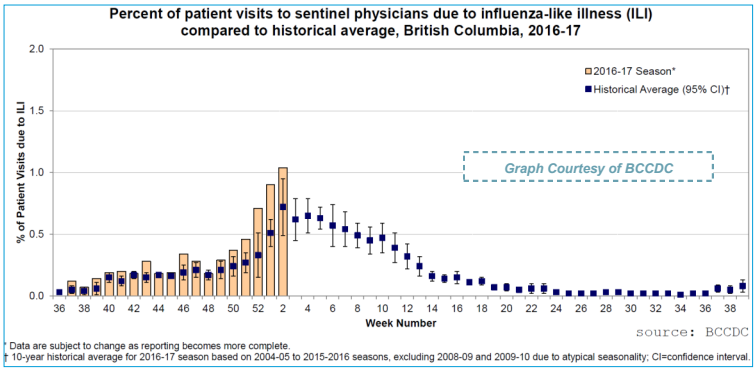
Dr. Andrew Gray, Northern Interior MHO
Contents adapted from the January 20, 2017 Physicians' Update from Vancouver Coastal Health.

Influenza Update

In week 2, 959 patients were tested for respiratory viruses at the BCCDC Public Health Laboratory (PHL). Of these, 430 (45%) tested positive for influenza, including 419 (97%) with influenza A [10 A (H3N2) and 409 with subtype pending] and 11 (3%) with influenza B. Overall influenza positivity remained elevated above 40%. The large number of influenza A specimens with pending subtype information reflects delays in laboratory testing, due to the high volume of specimens submitted during this peak period. Respiratory syncytial virus (RSV) activity also remained high during this period, with 12% of patients testing positive in week 2.

Cumulatively since week 40 (starting October 2, 2016), 1687 (28%) patients tested positive for influenza at the BCCDC PHL, including 1659 (98%) with influenza A [819 A(H3N2) and 840 subtype pending] and 28 (2%) with influenza B.

So far during the 2016-17 season, influenza A(H3N2) has been the dominant subtype among influenza detections. Elderly adults ≥65 years old are disproportionately represented among influenza detections, although younger age groups are also affected.



Source: BC Centre for Disease Control Influenza Surveillance Reports: Report No. 10, Jan. 8-14, 2017 *(Week2*
http://www.bccdc.ca/dis-cond/DiseaseStatsReports/influSurveillanceReports.htm

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Update on opioid overdoses

The opioid overdose emergency continues with no end in sight. 914 people died of illicit drug overdose in BC in 2016, including 49 people in the North. These are nearly double the numbers for 2015.

Naloxone kits and overdose response training have been made available through health units and other settings in nearly all Northern Health communities, and this program will continue to expand. We are also accelerating efforts to improve access to addiction treatment, especially opioid agonist therapy (OAT), which includes buprenorphine/naloxone (Suboxone™) and methadone.

Improving access to opioid agonist therapy (OAT):
OAT is the most effective evidence-based treatment in reducing non-medical use of opioids, improving physical health, and reducing mortality. Buprenorphine/naloxone (Suboxone™) is the first-line option in most cases and no longer requires a special license to prescribe. Northern Health's vision is for OAT to be available in all primary care settings.

Guidelines and learning resources:
Updated provincial guidelines on the treatment of opioid use disorder are expected to be released this month. In the meantime, we suggest consulting the 2015 guidelines developed by Vancouver Coastal Health and Providence Health Care, available at http://www.vch.ca/media/Opioid-Addiction-Guideline.pdf.

CME opportunities: Educational sessions to support the use of the new provincial guidelines are being planned by several Divisions of Family Practice in conjunction with the new BC Centre on Substance Use (BCCSU). Dr Gerrard Prigmore, Medical Lead, Addiction & Harm Reduction with Northern Health, will be in touch when dates and venues are finalised. If you are interested in hosting an educational session for your Division, please contact Cheyenne Johnson at cheyenne.johnson@cfenet.ubc.ca.

Medication coverage: As of February 1, 2017, buprenorphine/naloxone (Suboxone™) and methadone are both covered in BC under Plan G, which provides coverage for psychiatric medications for patients with financial barriers. For information on how to apply for Plan G coverage for your patients, please see http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage/coverage-of-methadose-and-buprenorphine-naloxone-under-plan-g.

Addiction medicine telephone consultations:
The BCCSU also provides addiction treatment expert support for GPs through the provincial Rapid Access to Consultative Expertise (RACE) shared care telephone advice line. It is available for general practice or other physicians and is open Monday through Friday, from 8:00 a.m. to 5:00 p.m., 1-877-696-2131.

Accidental exposure to opioids: are health care workers at risk?
Dr. Perry Kendall, Provincial Health Officer, issued the following statement on January 13, 2017 (emphasis added):

> "**The risk of unintended fentanyl and fentanyl analogue exposures to Health Care Workers (HCWs) and Emergency Medical Services (EMS) staff treating overdose victims is extremely low**. Unlike law enforcement, EMS and hospital medical staff are not exposed to environments where illicit drugs are being produced, transported or stored. In British Columbia, the epicenter of the Canadian opioid overdose epidemic, there have been no reported cases of secondary exposures of fentanyl to EMS, HCWs or private citizens administering naloxone, despite thousands of overdose reversals in the field and in health care facilities.
>
> "**No additional Personal Protective Equipment is required** when attending patients with drug exposures unless there is a risk of respiratory and/or bodily fluid exposure [*i.e. standard precautions against communicable diseases*]."

Call for community champions!
Are you passionate about improving options for addiction treatment in your community? Please contact Dr. Gerrard Prigmore, Medical Lead, Addiction & Harm Reduction (gerrardprigmore@me.com) to discuss how you can help bring better addiction treatment to your community.

Source:
Dr. Andrew Gray, MHO, NI HSDA

Research Project:

Physical Activity - barriers and facilitators in Northern primary care practice

Cara McCulloch is a second year student in the Northern Medical Program, conducting a research project exploring physical activity promotion in primary care.

The research aims to determine:

- What are the barriers and what facilitators **to physical activity prescription for primary care providers** in Northern BC?
- What do primary care providers perceive as the barriers and facilitators **to participating in physical activity for their patients**?

The project is supported by Dr. Sandra Allison (Chief Medical Health Officer) and Kelsey Yarmish (Regional Director, Population Health) at Northern Health, as well as Dr. Chelsea Pelletier (PhD) at the University of Northern British Columbia.

For further information regarding this survey, watch for the announcement and invitation by email. Or you can access the survey at: http://fluidsurveys.com/surveys/northernhealth/barriers-and-facilitators-to-pa-in-northern-bc/.

All Northern Health primary care providers are requested and encouraged to assist with this important survey through your participation.

Back issues of *NH Physicians, Partners in Wellness* newsletters and bulletins are located on the NH Physicians website:
http://physicians.northernhealth.ca/physicianResources/PublicHealth.aspx