Northern Health Physicians
Partners in Wellness

Public Health Newsletter for Northern Health Physicians

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Influenza Update

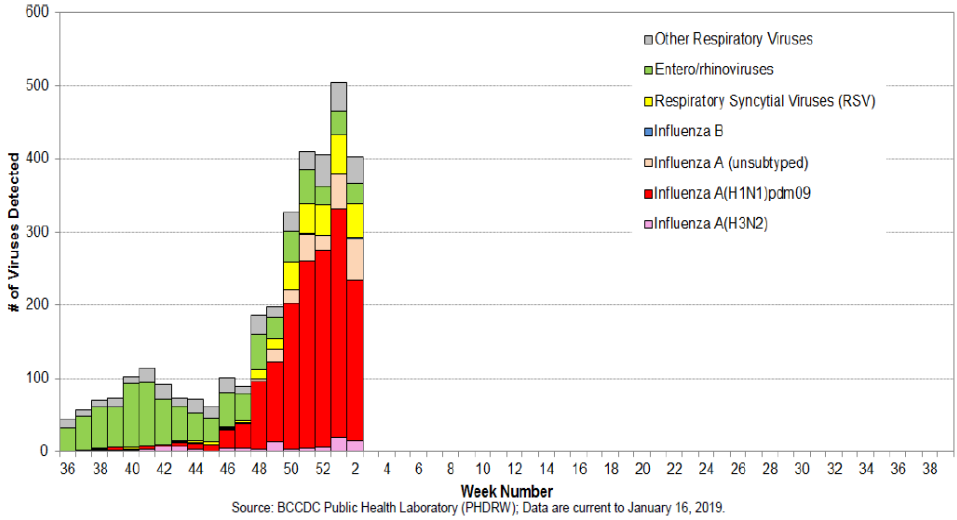
Peak of A(H1N1) pdm09 epidemic likely passed in BC but activity remains elevated.

During week 2, all surveillance indicators suggest that BC has likely passed the epidemic peak of influenza A (H1N1) pdm09 this season. However, influenza activity is likely to remain elevated for several more weeks, as expected following the epidemic peak and at this time of year more generally.

Among influenza viruses typed at the BCCDC PHL since week 40, virtually all have been influenza A and, among those subtyped, more than 90% this season so far have been A(H1N1)pdm09.

Children less than 10 years of age and non-elderly adults comprise 75% of all A (H1N1)pdm09 detections to date with children in particular disproportionately affected. Conversely, elderly adults are over-represented among A(H3N2) detections in BC, accounting for 67% of A(H3N2) detections thus far.

Since our last bulletin, 3 laboratory-confirmed influenza A outbreaks in long term care facilities (LCTF), have been reported. A total of 14 lab-confirmed LTCF outbreaks have been reported since the beginning of season (week 40). In contrast, between weeks 40 and 2 of the A (H3N2) dominant 2016-17 and 2017-18 seasons, 120 and 79 lab-confirmed LTCF outbreaks, respectively, had been reported. The lower number to date this season is consistent with fewer LTCF outbreaks expect during seasons of dominant A(H1N1)pmd09 compared to dominant A(H3N2) circulation.

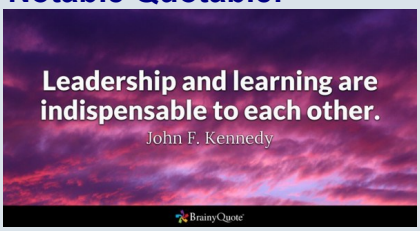


Source: BCCDC Public Health Laboratory (PHDRW); Data are current to January 16, 2019.

Source: BC Centre for Disease Control Influenza Surveillance Bulletin: Report No. 8, January 6 to January 12, 2019

Inside this Issue:

Notable Quotable:



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Poverty and Its Impact on Health: The Role of Clinicians

In the November issue of this newsletter, we discussed the new Cost of Eating in BC Report, which highlights that low-income households are most at risk for food insecurity. Household food insecurity is an indicator of poverty; it shows that a person's basic needs are failing to be met.

Poverty is the single largest predictor of health, more so than any behaviours or lifestyle "choices":

- Living in poverty causes chronic stress, in part due to coping with other determinants of health, such as unsafe housing, precarious work, fixed and low-income, gender discrimination, or racial oppression.
- The stigma, trauma, and social isolation that may precede or accompany poverty are strongly correlated with mental illness. As many as 90% of people with serious mental illness are unemployed.
- People living in deep poverty, (i.e. those living on social assistance and disability income), are affected more profoundly by adverse health conditions, such as cardiovascular disease, diabetes and mental health concerns. This is especially true for children and youth.

What does this mean for clinical practice?
When a person struggles to make ends meet, it becomes extremely difficult for them to eat well, engage in physical activity, and take other steps to support their health. Considering the determinants of health, rather than treating only a behaviour or symptom, means looking more deeply at how a patient's environment contributes to their overall health. While we can address the patient's immediate symptoms, we might feel powerless to improve the circumstances that are making them sick.

How can you take action on poverty reduction?
Understanding and addressing the determinants of health can happen at the individual, community, and societal levels. Decreasing poverty and increasing health equity is most effectively addressed at the public policy level (i.e. the macro level), but action can be taken at all levels of care.

Individual/clinician

- Challenge your and others' assumptions about what makes people sick
- Understand that a respectful and trusting client-provider relationship is critical for those who have been marginalized and stigmatized. People living with trauma, mental illness, substance use disorder or poverty often experience inequitable treatment within the healthcare system
- Screen for potential underlying social issues
  - Poverty: A clinical tool for primary care providers
  - Centre for Effective Practice: Poverty intervention tool
- Become familiar with local resources and community supports (e.g. low cost/free bus fare, childcare services, food programs, parenting programs, legal aid, etc.)
- Assist with navigating complicated social benefits programs (e.g. health supplement programs, disability services, income assistance)
- Adjust clinic hours to accommodate varying schedules Offer translation services or visual tools at your practice.

Organizational/community level

- Learn more about health equity, and the importance of providing culturally safe, and trauma informed care
- Engage the interdisciplinary team in patient care (e.g. social workers, Aboriginal Patient Liaisons, mental health clinicians, dietitians)
- Advocate for access to healthy food and safe drinking water, affordable and effective public transportation, mental health support and resources, etc.
- Foster community partnerships (e.g. with anti-poverty organizations)

Societal level - support healthy public policy:

- Take steps to address the social determinants of health (e.g. Health Providers Against Poverty).
- Lend your voice to poverty reduction efforts in BC.
- Advocate for income-based solutions to poverty (e.g. Basic Income Guarantee, expanded social safety nets).
- Explore how politicians at all levels of government can work to address income and health disparities.
- Advocate for safe and secure working environments, including affordable childcare.
- Support healthy housing policy (e.g. affordable, quality housing for all).

Northerners are resilient, knowledgeable, industrious and creative. Practicing upstream medical care means promoting health by working to improve the environments where people live, work, learn, play and are cared for. Engaging patients and communities can help support the development of safer, more inclusive, and health promoting environments, where Northerners can flourish; socially, mentally and physically.

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Additional resources:

- Canadian Benefits Finder
- Service Canada
- Canadian Family Physician: Practising social accountability
- The College of Family Physicians of Canada: Social Determinants of Health – member statistics
- Government of BC: What we heard about poverty in BC
- Bill C39 – Poverty Reduction Strategy Act
- BC Poverty Reduction Coalition: ABC's of poverty reduction
- Physicians for human rights
- Social Determinants of Health: The Canadian Facts

Submitted by: Laurel Burton, Population Health Dietician, Food Security Lead &
Dr. Jong Kim, Northeast Medical Health Officer

AMS Topic of the Month: Issues regarding fluoroquinolone use

Fluoroquinolone antibiotics (ciprofloxacin, levofloxacin, moxifloxacin) have broad spectrum antimicrobial activity and are used for a wide range of infections; however, there are often more appropriate narrow spectrum antibiotic agents that should be considered before jumping to a fluoroquinolone (i.e. uncomplicated urinary tract infections and community-acquired pneumonia). Some issues to consider with regard to fluoroquinolone use:

Resistance:
Rising resistance rates continue to be an issue across Canada and around the world and overuse of broad spectrum antibiotics is one of the major contributors to this issue. Ciprofloxacin is our **ONLY** available oral option for treatment of infections caused by *Pseudomonas aeruginosa* and in many health regions ciprofloxacin has been removed as an empiric treatment option due to high rates of regional resistance. In Northern Health, we are fortunate to have ciprofloxacin as a good empiric option for *Pseudomonas aeruginosa* as overall susceptibility is greater than 80% (84% as per NH Antibiogram 2018). We need to work to preserve this as an option for our patients moving forward.

Adverse Effects:
Fluoroquinolones have been associated with clinically significant adverse effects such as:

- tendonitis and tendon rupture
- peripheral neuropathy (sometimes irreversible)
- abnormalities in blood glucose (hyper- or hypoglycemia)
- dose-dependent QTc prolongation
- central nervous system abnormalities (dizziness, insomnia,
- seizures, tremors, confusion, hallucinations, psychiatric re
- actions)

Though relatively rare, these side effects can occur after just one dose and may be more pronounced in elderly patients. Gastrointestinal side effects continue to be the most common adverse effects of this drug class and though all antibiotic classes come with a risk of causing *Clostridium difficile* infection, fluoroquinolones are considered higher risk.

Oral versus IV Use:
As a class, fluoroquinolones have excellent oral bioavailability and oral formulations are considered equally potent to IV formulations. If a fluoroquinolone is deemed appropriate and required for treatment, consider using the oral formulation unless the patient has a contraindication (unable to tolerate and absorb oral medications, NPO status, unconscious with no OG/NG available, presence of GI abnormality, persistent nausea/vomiting/diarrhea etc.). If the IV formulation is warranted, assess the patient frequently for the potential to step-down to oral therapy (signs of clinical improvement: afebrile, WBC trending down, hemodynamically stable, and able to tolerate and absorb oral medications). Timely conversion from IV to PO administration reduces risks associated with IV access, in addition to benefiting the healthcare system with cost savings. For more information on IV to PO step-down see NH clinical practice standard 1-20-6-1-010.

References:

1. Article, Continue to Avoid Quinolones When Possible, Pharmacist's Letter Hospital, September 2018.
2. Clinical Resource, *Adverse Reactions with Systemic Quinolones*. *Pharmacist's Letter/Prescriber's Letter.* September 2018.

For additional resources/information related to antimicrobial stewardship practices in Northern Health please visit the NH Physicians website or the AMS website on OurNH.

Submitted by: Ryan Doerksen, Interim Antimicrobial Stewardship Program Coordinator

BC Centre on Substance Use Education, Discussion, and Planning Session for OAT and iOAT

Northern Health's Mental Health and Substance Use program and BC Centre on Substance Use would like to invite you to attend an information session about OAT and iOAT (Opioid Agonist Therapy and injectable Opioid Agonist Therapy).

- Content will include: clinical management of Opioid Use Disorder, iOAT and transitions between OAT, and capacity building and case discussions
- CME credits are available for the 1230-1430 education session on clinical management of Opioid Use Disorder
- There will be an opportunity to discuss local and Northern challenges and bring cases forward for discussion

More information:

When: Friday, February 22nd from 0900-1600
Where: Learning Center at UHNBC, Room 501
1475 Edmonton St., Prince George, BC
Videoconference and dial-in options are also available
(please RSVP with your site for VC arrangements)
Lunch for on-site participants will be provided

Please RSVP by January 31 to Heather Garfield, Administrative Assistant for the Mental Health & Substance Use and Child & Youth Health Programs
Heather.Garfield@northernhealth.ca
(250) 565-5989

Distribution Update

It has come to our attention that some physicians are not receiving this newsletter. If you would like to receive this newsletter by email please send an email to NHPhysiciansNewsletter@northernhealth.ca

As of January 1st, 2019 we are no longer distributing physical copies of newsletters to UHNBC.

All 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