DocTalk

Billing for Obstetrical Ultrasound

Third Party Forms

Heartland Health Region By-Election

New Licensure Options for IMGs

Regulations change for Medical Marijuana

Dr. Corrine Jabs 2016

Kendel Award Presented to Regina Surgeon

College of Physicians and Surgeons of Saskatchewan cps.sk.ca Volume 3, Issue 3, 2016

DocTalk
Volume 3, 2016
Issue 3

REGISTRAR

Dr. Karen Shaw

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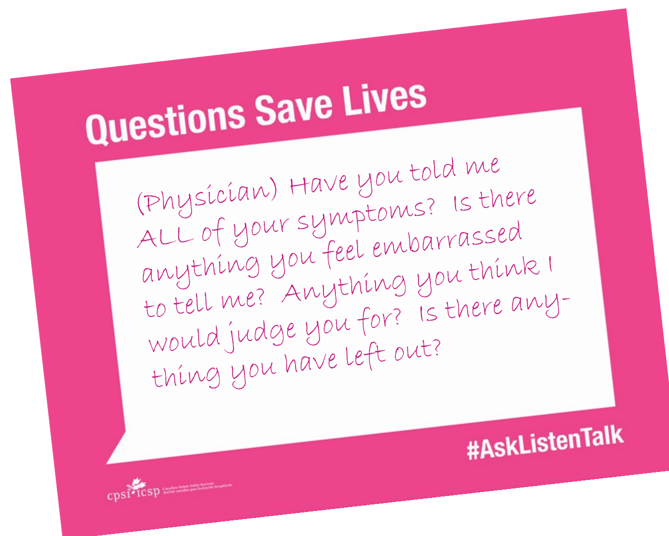
Canadian Patient Safety Week



QUESTIONS SAVE LIVES! *From October 24 to October 28, 2016, the College joined in with the* **Canadian Patient Safety Institute** *(CPSI) for CANADIAN PATIENT SAFETY WEEK by decorating its lobby with a variety of important questions that physicians, staff and patients can ask to ensure safe, quality care! Below are some of the questions submitted by our participants.*

How are you feeling?

Do you go to the doctor if you think you just have the flu?

How will you be getting home?

Do you have any history of this disease in your family?

Do you understand everything we have discussed today?

What else could it be?

(For hospitalized patients) Do you understand why you are admitted? Do you understand what the plan of treatment is?

Do you go back to the doctor if you don't get better after a couple of days?

When is a fever dangerous?

Has the patient been provided with all of the necessary information to make an informed decision?

Do you have someone at home who can help you?

What is my diagnosis and how can it be prevented in the future?

What are my treatment options? The benefits to each option? The side effects to each option?

What will the medication you are prescribing me do? Are there any side effects?

Is there anything else you need to talk about?

What is the absolute benefit of this intervention versus doing nothing?

How do I obtain specialized treatment that is beyond your scope of knowledge?

What can be done about my weight? Is this the average weight for my age?

What counts as an emergency?

Visit the CPSI website at **www.patientsafetyinstitute.ca** for a variety of **tools and resources** you can use in and around your practice!

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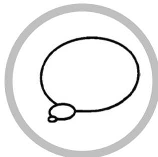

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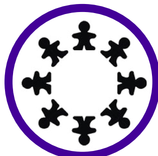

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Do you have feedback to provide or a suggestion for an article to include in the next issue of DocTalk?

Submit your ideas & articles by **MARCH 15, 2017** to COMMUNICATIONS@cps.sk.ca

FROM THE PRESIDENT

A World of Change for One Short Year

As we approach the end of my current term as President, I would like to express my gratitude to the members of Council who entrusted me with this responsibility. I would like to share with the membership a few highlights of 2016 as they pertained to the work of Council.

Medical Assistance in Dying

Medical Assistance in Dying (MAiD) continues to be topical at all levels of care in Canada. The Council has worked diligently to ensure that our policy protects the rights of patients, while respecting the values of our membership. We believe that we have crafted a policy that adheres to all national legislation, but that also offers our membership clarity with respect to their responsibilities and aspects of conscientious objection.

There have already been several cases of medical assisted dying in Saskatchewan. As we proceed along this path, it is essential that the members continue to stay abreast of the evolving aspects of its service provision. The College policy guides clinicians, but there is a balance of responsibility between the College of Physicians and Surgeons of Saskatchewan (CPSS), the Regional Health Authorities (RHA) and the membership.

Provision of this service relies on each provider obtaining privileges from their RHA to take part in MAiD. For those physicians whose normal practise does not involve obtaining IV access and a clear understanding of the delivery and pharmacology of the medications required, an expressed alteration to your **scope of practise** must be documented at the College via the Office of the Registrar. Dr. Shaw and her staff are available and willing to help individual practitioners ensure that regulatory details are covered appropriately.

In addition, it must be understood that at the present time, *there is no established or approved standard* for the prescription of any combination of oral medications to be prescribed for medical assisted dying. For now, prescriptions are to involve approved IV delivered medication only, and must be administered in the presence of the assisting physician. As the provincial working group continues its work, the medication options for providers may be expanded to include oral medications, but this is not the current situation. Practitioners who are considering this aspect of care are encouraged to access the online and face-to-face professional development courses available from the CMA: Education on end-of-life care and medical assistance in dying.

Transformational change of the health care system

I have attended the Representative Assemblies (RA) of the Regional Medical Associations (RMA) this year in my role as CPSS president. I am always encouraged to see several of my fellow CPSS councillors in attendance as RA delegates for their respective jurisdictions. This epitomizes the collaborative role of the CPSS and the Saskatchewan Medical Association (SMA) that I have been so impressed with this year.

At the recent RA, I was interested to hear the discussions regarding the upcoming transformational change to health delivery in Saskatchewan. As provincial purse strings tighten out of necessity, the delivery of health care cannot expect to proceed unchanged. Changes to jurisdictional alignment seems to be likely as RHAs are merged or reshaped. The CPSS watches intently as these changes occur and we look forward to establishing new relationships between our Council and the evolving senior medical offices. We also predict that reassessment of our electoral districts for Council will result from geographical alterations to the RHAs.

We anticipate that delivery models including care teams, expanding nurse practitioner roles, telehealth, teleradiology and new laboratory jurisdictions will all be factors in the upcoming year. Council and the College look forward to supporting the implementation and regulatory changes required as our delivery models evolve.

With the end of the year and the holiday season fast upon us, I would like to encourage all of us to take time from our busy schedules to be with family and friends. Have a wonderful holiday season and may 2017 find you rested and ready to continue the often challenging, but always rewarding work of delivering quality health care to the people of Saskatchewan.

Dr. Alan Beggs
President, CPSS

FROM THE REGISTRAR

Prescription Drug Abuse Update and the Provincial Disability Strategy

Prescription Drug Abuse Update

Since the last publication of Doctalk there have been an increasing number of reports of overdoses and deaths related to the use of Opiates in our province and across Canada.The Federal Government now considers this a national public health emergency and has advised that the solutions must address not only the immediate crisis of poisoning and overdoses but also the underlying causes of Opiate addiction.

The Honourable Jane Philpott, Federal Minister of Health and the Honourable Dr. Eric Hoskins, Ontario Minister of Health and Long-Term Care, Co-Chaired a national Opioid Summit which occurred November 18, 2016.

A Joint Statement of Action to address the opioid crisis was released, which sets out the priority actions to address the opioid crisis and a commitment to the public reporting on progress. The statement was developed with input from 42 partner organisations including several provincial and territorial health ministries, dental, nursing, physician, and other health professional associations and regulatory bodies. Our national regulatory body, the Federation of Medical Regulatory Authorities of Canada attended, as did some of the provincial Colleges.

Key action items to address the root causes and reduce the harms associated with Opiate use identified were:

1. Empowering health care professionals with new tools and guidance on opiates;
2. Increasing access to Suboxone in First Nations' communities;
3. Improving addictions services;
4. Increasing access to Naloxone; and
5. Increasing critical monitoring and surveillance activities across the country.

These key actions are in addition to Health Canada's current Opioid Action Plan, Action on Opioid Misuse, where they have pledged to:

1. **Better inform** Canadians about the risk of opioids: new warning stickers, patient information sheets, review of best practices;
2. Support **better prescribing practices**: promote prescription monitoring programs, examine pharmacy records, share information with Provincial and Territorial licensing bodies, Canada Health Infoway e-prescribing solution;
3. **Reduce easy access** to unnecessary opioids: contra-indications for approved opioids, requiring a prescription for low-dose Codeine products, mandatory risk management plans for certain opioids;
4. Support **better treatment options** for patients: better and faster access to Naloxone, expediting the review of non-opiate pain relievers, re-examining special requirements for Methadone;
5. Improve the **evidence base**: bringing together experts in the field to discuss how to improve data collection and the Canadian evidence base.

The last edition of the Newsletter included an incorrect reference to the 5 A's, which are a tool for safeguards in monitoring. While that was corrected in the website version of the Newsletter, the error appeared in the version emailed to physicians.

The 5 A's involve a determination of: 1) whether the patient is experiencing a reduction in pain (**A**nalgesia), 2) whether the patient has demonstrated an improvement in level of function (**A**ctivity), 3) whether there are significant **A**dverse effects, 4) whether there is evidence of **A**berrant substance-related behaviours, and 5) mood of the individual (**A**ffect). The tool is from the Model Policy on the Use of Opiate Analgesics in the Treatment of Chronic Pain, FSMB, July 2013. I apologize for not having caught this error prior to publication.

The Joint Statement of Action to address the Opioid crisis can be found at: http://www.healthycanadians.gc.ca/healthy-living-vie-saine/substance-abuse-toxicomanie/opioids-opioides/conference-cadre/statement-declaration-eng.php

Our Saskatchewan Ministry of Health is committed to:

- Continue to provide aid and financial support to the College of Physicians and Surgeons of Saskatchewan to operate the Prescription Review Program to reduce the abuse and diversion of opiates.
- Continue with the Provincial Pharmaceutical Information Program to allow authorized health care professionals to electronically view current and past prescriptions of Saskatchewan residents.
- Continue to support the Rx Files, a Saskatchewan based academic detailing program that provides ongoing education to healthcare professionals on various aspects of drug therapy, including pain management and prescription misuse.
- Continue the work initiated in 2015 to provide training and take-home Naloxone kits at no cost to eligible Saskatchewan residents in collaboration with regional health authorities.
- Work with the provincial Coroner's Office to ensure the Saskatchewan Ministry of Health has up to date information on the number of opiate overdose deaths and monitor regions and populations for risks.
- Increase the number of locations across the province to provide the training and distribute take-home Naloxone kits to individuals at risk of an opiate overdose and work with pharmacy associations in Saskatchewan to have take-home Naloxone kits in retail pharmacies and to ensure that complimentary training occurs in these situations.

The College will continue its work using the Prescription Review Program to review the prescribing and use of opioids and a number of other medications of potential abuse. It will continue to identify possible misuse and diversion and will continue to alert physicians to double doctoring. As the College of Physicians and Surgeons has no diagnostic information on patients, physicians who prescribe opioids and other PRP medications can expect to receive letters requesting information about the medical condition and the rationale for the use of a particular medicine or dosage if the review of prescribing raises concerns. The PRP Program may also select specific physicians to undergo a comprehensive review of prescribing of PRP medications if there is not an adequate explanation for the prescribing.

The College will continue to use its monitoring program to the best of its ability and will continue to work with physicians in addressing prescribing that suggests possible misuse, abuse or diversion.

The Provincial Disability Strategy

At our most recent Council meeting the Council reviewed a copy of the Provincial Disability Strategy. The Deputy Minister of Health, Mr. Max Hendricks, advised the College that the Ministry of Health is currently in the process of surveying the regional health authorities to review the accessibility of their health facilities specifically as it relates to access to adjustable examination tables. The Ministry requested that the College of Physicians and Surgeons encourage physicians to ensure their practices are not only physically accessible, but that physicians also make reasonable efforts to accommodate patients who need additional accessibility supports, including adjustable examination tables.

Council directed College staff to work with the Saskatchewan Medical Association (SMA) to assist physicians in turning their minds to how patients experiencing disability can be accommodated. Over the next few months the College will engage with the SMA to consider how we can tackle this issue to accommodate patients experiencing disability and avoid potential human rights' challenges. If any of you have a special interest in disability and accommodating disability please notify me as your expertise would be appreciated.

Dr. Karen Shaw
Registrar, CEO

Addressing Addictions and Prescription Drug Abuse

What are your ideas to help eliminate prescription drug abuse?

ACTION PLAN

In 2015, the College of Physicians and Surgeons (CPSS) signed an agreement with the First Nations and Inuit Health Branch (FNIHB) to assist in the work being done to address the ongoing issues related to prescription drug abuse (PDA) in Saskatchewan. As a result of this agreement, FNIHB has provided funding to CPSS to support this work for First Nations and Inuit people.

call to action

The College wants to hear from YOU about what more we should be doing.

Send us any **additional strategies** you may have and let us know how you are interested in helping.

prp@cps.sk.ca

New Regulations for Medical Marijuana

Bryan Salte
Associate Registrar and Legal Counsel

Until August of 2016, a patient who received a prescription for medical marijuana was required to obtain the marijuana from a licensed producer. Today, patients have other options.

Obtaining Medical Marijuana

The Canadian Government's regulations related to medical marijuana were changed in August 2016 to allow patients to obtain medical marijuana in one of three ways:

1. submitting the medical document directly to a **licensed commercial producer**;
2. registering with Health Canada to **produce** a limited amount of marijuana for their own medical purposes; or,
3. registering with Health Canada to **designate someone else** to produce the marijuana for them.

The patient is not limited to using dried marijuana, but can obtain dried or fresh marijuana, cannabis preparations and derivatives such as oil.

The patient must still obtain a **medical document** from a physician or a nurse practitioner. That physician or nurse practitioner must state in the medical document the daily quantity of dried marijuana, expressed in grams, that they authorize for the patient.

Expectations for Physicians

The College adopted a bylaw which establish expectations for physicians who prescribe marijuana for their patients. Regulatory bylaw 19.2, available at the College website, http://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_and_Bylaws.aspx?Legislation_BylawsCCO=2#Legislation_BylawsCCO establishes a number of expectations, including:

1. A physician may only prescribe marijuana for a patient for whom the physician is the **primary treating physician** for the condition for which the marijuana is prescribed.
2. Prior to prescribing marijuana, a physician must review the patient's **medical history**, review relevant records pertaining to the condition for which the marijuana is prescribed and conduct an appropriate **physical examination**.
3. A physician who prescribes marijuana may only do so after the patient signs a **written treatment agreement** which includes the patient's agreement not to seek authorization from any other practitioner and to use the marijuana as prescribed.

...continued on p.9

...continued from p.8

Additional Information and Resources

Health Canada

Health Canada has produced a document, ***Information for Health Care Practitioners,*** available at:

http://www.hc-sc.gc.ca/dhp-mps/marijuana/med/index-eng.php

A link to a sample medical document that can be completed by physicians or nurse practitioners is also included at:

http://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/marijuana/info/med-eng.pdf

Canadian Medical Protective Association

The CMPA has provided a guidance document for physicians entitled ***Medical marijuana: Considerations for Canadian doctors*** available at:

https://www.cmpa-acpm.ca/en/legal-and-regulatory-proceedings/-/asset_publisher/a9unChEc2NP9/content/medical-marijuana-new-regulations-new-college-guidance-for-canadian-doctors

College of Physicians and Surgeons of British Columbia

The College of Physicians and Surgeons of British Columbia has developed a professional standard, ***Cannabis for Medical Purposes***, available at:

https://www.cpsbc.ca/files/pdf/PSG-Cannabis-for-Medical-Purposes.pdf

Canadian Medical Association

The Canadian Medical Association produced a document in 2015 which has not been updated to include the most recent changes to the Federal Government Regulations. That document, entitled ***CMA Statement Authorizing Marijuana for Medical Purposes*** (Update 2015) is available at:

https://www.cma.ca/Assets/assets-library/document/en/advocacy/CMA_Policy_Authorizing_Marijuana_for_Medical_Purposes_Update_2015_PD15-04-e.pdf

Canadian Centre on Substance Abuse

A Guide to Facilitate Discussions about Youth Cannabis Use is available to help you engage your community on the topic of marijuana and its effect on youth and families. The guide is geared towards hosting a knowledge-sharing event in your community and includes a video of a live panel with researchers in neuroscience, psychosocial development and mental health; a guide for hosting these discussions in your community; practical tools to help you plan your event, including a sample agenda, a checklist and budget considerations; answers to commonly asked questions on the topic; and an evaluation form to collect participant feedback.

http://www.ccsa.ca/Resource%20Library/CCSA-Community-Discussions-Youth-Cannabis-Guide-2016-en.pdf

Policy, Standard and Guideline Updates

The Policies, Standards and Guidelines adopted by the Council are reviewed regularly and are updated as required. Physicians should review the list of policies which may apply to them to ensure that they are aware of the College's expectations. At the September and November Council meetings, Council updated six policies as summarized below:

POLICY - Medical Assistance in Dying

The previous policy entitled Physician-Assisted Dying was changed to reflect the new legislation adopted by the Government of Canada. Council approved a new, largely redrafted policy entitled *Medical Assistance in Dying* which includes background information relating to the new legislation, definitions, new information on the requirements for access to medical assistance in dying, the College's procedural requirements for physician assessments, decision-making capacity, informed consent and other requirements of the Federal Legislation.

The policy also outlines the specific requirements of the administering physician, and provides the forms that must be filled out for each request.

POLICY - Patient-Physician Relationships

Council reviewed the policy and adopted changes to include:

- the expectation that a specialist who wishes to terminate a patient-physician relationship remains responsible until care is transferred to another similarly-qualified specialist or the care is transferred back to the primary provider for referral to another specialist.
- that physicians must provide patients with the opportunity to address the concerns when they are being discharged for failing to keep appointments or pay outstanding fees, in addition to appropriate advance notice.

POLICY - Medical Examinations by Non-Treating Physicians (NTMEs)

Council changed a number of aspects of the policy, including the following:

- It is recommended that a request by the patient for a physician of his/her choice to be present for an NTME be granted if possible.
- Record retention is now required to be compliant with the appropriate bylaws.
- Audiotape, videotape, images or recordings should be used for NTMEs.
- The section on *Issue of Probablility* was removed.

POLICY - Physicians/Surgeons Leaving Practice

Council changed the policy to include more detailed information on requirements for Notification, Continuity of Care and Medical records when a physician or surgeon makes the decision to leave pratice, move or retire.

POLICY - The Practice of Telemedicine

Council reviewed the policy and adopted a new sunset date of November 2018. No changes were made.

POLICY - Physician Completion of Work Absence or Accommodation Due to Illness or Injury and Completion of Third Party Forms

This policy merges two previous policies, *Sick Slips* and *Role of Physicians in Certifying Illness and/or Assessing Capacity for Work*, into one policy, *Physician Completion of Work Absence or Accommodation Due to Illness or Injury and Completion of Third Party Forms*. Among the changes in the new document is an expectation that a physician will generally complete forms requested by a patient within 30 days.

The full versions of all CPSS Policies, Standards and Guidelines are available on the College Website at **www.cps.sk.ca**

New options for licensure for internationally educated physicians

Most internationally trained physicians who practise medicine in Saskatchewan are aware that the bylaws of the College of Physicians and Surgeons of Saskatchewan have been continually revised over the past number of years as the College works to align Saskatchewan's registration requirements to the National Registration Standards that have been developed by the Federation of Medical Regulatory Authorities of Canada (FMRAC).

Barb Porter
Director, Physician Registration

The bylaws were revised at the end of September 2016 to allow another option for internationally educated specialists and general practitioners to move from provisional to regular licensure. The most recent changes impact those internationally educated physicians who have eligibility for the specialty examinations of the Royal College of Physicians and Surgeons of Canada **OR** are eligible for certification with the College of Family Physicians of Canada.

The net effect of the new bylaws is that internationally educated physicians with certification from the relevant Canadian Certifying College may convert from a provisional to a regular licence with Canadian certification, a pass standing on the Medical Council of Canada Qualifying Examination Part 1 and five years of successful practice under supervision.

New applicants who are internationally educated physicians will continue to be required to select their desired pathway to achieve regular licensure – examination or summative assessment route.

Physicians registered prior to September 18, 2014 who have obtained certification as well as a pass standing on the Medical Council of Canada Qualifying Examination Part 1 are also eligible to be considered for a regular licence once they have successfully practiced in Saskatchewan for a period of at least five years.

The College of Physicians and Surgeons of Saskatchewan is pleased to introduce these registration changes.

The relevant portions of the bylaws state:

2.5 Requirements relating to provisional licensure

International Specialists:
(h) If the applicant has completed postgraduate medical training elsewhere than in Canada or the United States of America and seeks licensure to practise in a specialty, the applicant is eligible to challenge the certification examinations of the Royal College of Physicians and Surgeons of Canada (RCPSC);
OR
International General Practitioners:
(j) If the applicant has completed postgraduate medical education elsewhere than in Canada or the United States of America, and seeks licensure to practise family medicine, the applicant is eligible to attain CCFP without examination;

Please contact Barb Porter at the College office if you have questions or concerns:

barb.porter@cps.sk.ca
(306) 244-7355

2.6 Conditions of provisional licensure

Licensure – specialist physicians with International Postgraduate training and eligibility to challenge the examinations of the Royal College

(bb)A physician who is licensed under paragraph 2.5(h) who has elected to seek regular licensure by attaining certification with the Royal College of Physicians and Surgeons and attaining a pass standing in the MCCQE1 and successfully engaging in practice in Canada for five years is required to:
(i) successfully practise with a supervisor until the physician meets the requirements for regular licensure; and,
(ii) attain certification within the period of eligibility with the Royal College of Physicians and Surgeons of Canada; and,
(iii) attain a pass standing in the MCCQE1 within 3 years of first licensure on a provisional licence.

Licensure – family physicians with international postgraduate training and eligibility for CCFP without examination

(kk)A physician who is licensed under paragraph 2.5(j) who has elected to seek regular licensure by attaining CCFP and attaining a pass standing in the MCCQE1 and successfully engaging in practice in Canada for five years is required to:
(i) successfully practise with a supervisor until the physician meets the requirements for regular licensure; and,
(ii) attain CCFP within the period of eligibility of the College of Family Physicians of Canada; and,
(iii) attain a pass standing in the MCCQE1 within 3 years of first licensure on a provisional licence.

Continuing Medical Education

Mainpro is Now Mainpro+

The College of Family Physicians of Canada recently introduced Mainpro+, the new and improved Mainpro program.

The **Key Features** of the new program include:

- new cycle dates. Mainpro to Mainpro+, cycle dates have changed from calendar year (January 1 - December 31) to July 1 - June 30; this applies to both annual cycles and 5-year cycles.
- all member and non-member Mainpro+ participants were given a six month extension at the end of their current five year cycle;
- credits in your Mainpro account have been migrated to your new Mainpro+ account; your Mainpro-M1 and Mainpro-C credits were converted to “Certified” credits, and all Mainpro-M2 credits were converted to “Non-Certified” credits.
- you will continue to be required to accrue a minimum of 250 credits (at least 125 must be certified) per 5-year cycle;
- you will be required to accrue a minimum of 25 (certified or non-certified) credits per year;

New Credit Categories

- Certified (formerly Mainpro-M1 and Mainpro-C)
- Non-Certified (formerly Mainpro-M2)

New Activity Categories

- Group Learning,
- Self-Learning, and
- Assessment;
- Wider variety of credit eligible activities.

The College of Family Physicians website contains information about the new Mainpro+ program at www.cfpc.ca

Physicians with a cycle date ending in 2015 will not have access to the completion certificate - they will need to contact the CFPC to request the certificate. Physicians who require a transcript will have access to view and print a transcript if requested to do so by our College.

Before you renew your registration in the fall of 2016, login to your Mainpro+ account to confirm your cycle dates as they may have changed since last year. The new dashboard provides all of the information that you need about your Mainpro+ account in one quick glance.

Questions? mainprocredits@cfpc.ca

A sneak peek of the new **Mainpro+** Dashboard

Professional Development Opportunities for your Learning Cycle

The College website features a section with links to several different conferences and other educational opportunities which may be of interest to you.

Physicians must remember that they are obligated to complete a certain number of educational credits over a learning cycle period in order to be eligible to renew their licence.

The College’s website features some information concerning online and in person educational opportunities for your convenience. Many of the suggested conferences and workshops listed are accredited.

For the lastest list of upcoming continuing medical education opportunities, visit cps.sk.ca and click on the CME-Professional Development Opportunities link (blue box to the right on the homepage).

Completing Third Party Forms

Whose responsibility is it?

Dr. Micheal Howard-Tripp
Deputy Registrar

The intake team in the Quality of Care Department frequently notices trends in enquiries and complaints coming in to the College. In an effort to inform the profession and as a reminder of the College's expectations, the Quality of Care department will periodically highlight issues that we believe 'need attention'.

In recent months the intake team of the Quality of Care Department has received a number of enquiries regarding completion of third party forms by emergency room physicians.

The Council of the College recently revised the policy: *Physician Certification of Work Absence or Accommodation Due to Illness or Injury and Completion of Third Party Forms*. Members are advised to be familiar with the requirements of the College's Bylaws, College Standards, Policies and Guidelines, College information and advice to the Profession, as well as authoritative information from the Saskatchewan Medical Association, the Canadian Medical Association and the Canadian Medical Protective Association.

The College would advise physicians that they recognize there may be several pressing/conflicting priorities that take precedence in an emergency department setting, but the expectation is that the emergency room physician will not unilaterally shift responsibility to the family physician. It is understood that third party forms requiring details of a patient's longitudinal medical history may not be appropriate for completion in an emergency department setting, but other forms, such as **WCB or SGI initial reports, require that they be completed by the attending physician**.

It is the expectation that **emergency department physicians will make arrangements to complete appropriate third party forms** either at the bedside or outside of clinical time in a timely manner so as not to negatively disadvantage the patient. Complaints to the College will be reviewed on a case-by-case basis and physicians are reminded that failure to comply with College policies could result in a charge of unprofessional conduct being brought against the physician.

While it is hoped that the above information will provide clarification of some of the issues, members of the Quality of Care Department and Legal Department, are available to assist with any specific enquiries. The policy is also provided below for your convenience.

POLICY

PHYSICIAN CERTIFICATION OF WORK ABSENCE OR ACCOMMODATION DUE TO ILLNESS OR INJURY AND COMPLETION OF THIRD PARTY FORMS

This document is a policy of the College of Physicians and Surgeons of Saskatchewan and reflects the position of the College.

Practising medicine involves much more than preventing, diagnosing and treating illness. Caring about the patients' well-being are attributes of a physician.

STATUS:	**APPROVED**
Approved by Council:	**June 24, 2016**
Amended:	**September 2016**
To be reviewed:	**September 2021**

SICK SLIPS

Physicians regularly find themselves petitioned to certify time off work via the completion of "sick slips" or third party forms from a patient's employer or disability insurer. This task is, most often, arduous and consumes substantial amounts of time.

When places of employment request information related to their employee's illness, they are trusting that the physician will provide accurate, appropriate details concerning the em-

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ployee's absence. It is expected that the medical profession will be objective in determining the contents of the Sick Slip. Many times the doctor/patient relationship can be strained when the patient disagrees with the contents of a sick slip or disability form as completed by the physician.

It is imperative that a physician is convinced of the facts around the illness, and conscientiously determines the appropriate period of work absence due to disability or the degree and duration of work accommodation required.

Issuing a Sick Slip is a very important matter. Stakeholders rely on a physician's expertise in determining what is right or fair. The same parties work under the assumption that a treating physician has had specific training in determining disability and work accommodation. This assumption is, in most circumstances inaccurate. Therefore it becomes incumbent on the physician to ensure the contents of the note or form are objective and formulated based on accurate assessment of patient reported complaints, and careful physical examination.

The following is a list of suggestions which should provide a balanced, common-sense approach to issuing Sick Slips:

1. Always assess the patient for true disability.
2. When possible, recommend appropriate alternative level of employment or reasonable work accommodations, if not totally disabled.
3. Carefully document the facts as presented to ensure reproducibility.
4. When determining the duration of work absence it is important to take into account the perspectives of the patient and the employer. These perspectives should inform decision making but should not be the sole basis of decision making.
5. Estimate an appropriate period of disability based on objective assessment of the injury and illness. "Normal" expected recovery periods should be used to predict return to work while allowing for patient specific factors as modifiers.
6. If you perceive that a patient disagrees with your assessment, have a frank, honest discussion with the patient prior to releasing the Sick Slip.
7. Never accept telephone or digital information regarding an illness for the purpose of issuing a Sick Slip.
8. A signed consent for release of information must accompany the sick note on the medical record. Consent should specifically state if diagnosis is to be released.
9. Sick slips should be based on physical examination during the period of illness or injury. In the event that a patient requests a slip validating an unverifiable illness or injury, the physician should not feel obliged to provide such a note. Any retroactive note provided should validate the patient's accurate reporting of an illness, rather than validating the illness itself.

Assessment of Capacity for Work and/or Accommodations Required

The purpose of the above is to verify an illness/injury to an employer or insuring agency and to provide relevant information to enable the patient/employee to return to work as soon as medically possible.

While "Sick Slips" are a brief certification of illness or injury, they often contain a certification of a brief absence from work for illness or injury. In the case of more severe illness or injury, a longer time off work is often required, and a graded return to work (6RW) or assessment of accommodations may also be required.

The Canadian Medical Association has identified **four elements to the role of the treating physician** in helping a patient return to work.[1]

1. Providing **medically necessary services** to the patient related to the injury or illness to achieve optimum health and functionality.
2. Providing objective, accurate and timely medical information for the consideration of **eligibility** of insurance benefits.
3. Providing objective, accurate and timely medical information as part of the timely **return-to- work** program.
4. Considering whether to serve as a **Timely Return-to-Work Coordinator** when requested by the employer/employee or other third party.

Employers and their insurers will be relying on the information provided to them and in so doing, they may incur financial liability for sick leave, or disability pay. Completion of more exhaustive documentation may be required in order to validate

...continued on p.15

1 The Treating Physician's Role in Helping Patients Return to Work After an Illness or Injury http://policvbase.cma.ca/dbtw-wpd/Policvpdf/PD13-05.pdf

...continued from p.14

compensation to the ill or injured worker. The employer is also relying on the physician's opinion that the employee is fit to return to work. Misinformation, or erroneous opinions, could result in harm to those relying on this information.

Factors to consider when certifying major illness or injury and assessing capacity for work include:

1. Some illnesses/injuries may impair a person's capacity to do their regular work or alternative work. However, planning for return to work should begin at the first visit. A patient's limitations should be evaluated and emphasized to him/her. Work and other activities should be encouraged within the patient's evolving limitations.
2. It is the responsibility of the *employer* to manage the worker's return to modified or usual work duties with the benefit of objective professional input from physicians and/or other health care professionals. It is incumbent on the employer to provide the physician with clear documentation of the worker's duties in order to guide discussion as to capacity for work or accommodations required.
3. With respect to worker injury/illness incurred in the workplace, the procedures defined by the Workers' Compensation Board (WCB) apply.
4. The responsibility of the *physician* is to do an objective evaluation and to report the impact of an injury/illness and the limitations that the patient/worker's injury/illness places on their ability to perform certain functions. In circumstances where a physician does not have the formal training required to make such an assessment, recommendation of a formal physical or occupational therapy assessment may be indicated.
5. To the extent that it is possible, functional capacity and limitations should be assessed objectively. It is, however, recognized that in formulating any professional opinion regarding a patient's/worker's functional capacity or limitations, a physician may be substantially reliant upon information from the patient/worker regarding subjective elements related to their injury such as pain, anxiety or dizziness.
6. It is prudent to avoid long-term prognostic opinions but rather to re-evaluate an injured worker's functional capacity at regular intervals. Many employers can align a modified job if they know an employee's capabilities and/or restrictions and will be counting on a physician's report to enable this process. An employer needs to know approximately when they can reasonably expect an employee to be able to return to their regular duties. This way they can properly manage and plan for the changes in their workplaces. They will generally be looking to the physician for an anticipated return to an employee's regular work date.
7. Any release of information to an employer should be strictly on a "need to know" basis, limited to the worker's injury/illness and only after the patient has provided a signed consent for the release of such information. Consent must be specific as to the release of a diagnosis, as compared to release of information pertaining to accommodations or return to work dates.
8. With respect to more extensive illness/injury that may involve early return to work with modified strategies, the following sequence of assessment and reporting is recommended:
    a. At the time the injured/ill patient attends a physician pertinent history and physical are performed. If information is to be passed on to an employer/insurer then informed consent must be obtained.
    b. An initial form or assessment note is completed and returned to the employer indicating the nature and extent of the condition and functional limitations.
    c. The employer discusses a modified work option that might allow the employee to return to work.
    d. The employer sends a summary of the modified work plan with the employee to the physician for review.
    e. The physician certifies the ability of the patient to undertake the proposed modified work plan and establishes and appropriate date for review.
    f. Following review, the patient/employee may increase the scope of work as the limitation of the medical condition allows
9. Completion of forms, notes or letters certifying illness or injury are often **time dependent**. It is the responsibility of the physician to complete such documents in a reasonable time frame. In general, such documents should be completed within 30 (thirty) days of receiving the request. This guideline applies to, but is not limited to the following:
    a. Sick Slips
    b. Third party insurance forms solicited by the patient
    c. Third party disability forms solicited by the insurer with appropriate patient consent
    d. Third party return to work forms solicited by employers
    e. Third party progress notes required for ongoing assessment of benefits
    f. Responses, either favorable or not, to requests for medicolegal opinion
    g. Responses to requests for information from a third party engaged in the treatment of the patient
10. Completion of forms is a non-insured service. As such, physicians should be clear with patients as to any cost incurred by the completion of the form. In general, a physician should adhere to the recommendations of the SMA with respect to fees for form completion. The physician should assess the patient's ability to pay for forms, and should not unduly penalize a patient who is legitimately unable to pay.

College Disciplinary Actions

The College reports discipline matters in the next issue of the Newsletter after the disciplinary action is complete. The College website also contains information on discipline matters that are completed, and matters where charges have been laid but have not yet been completed.

There were five discipline matters completed since the last Newsletter report.

Dr. Adarine Mary Anderson

Dr. Anderson was charged with unprofessional conduct for making disrespectful comments to a patient who was in the process of transitioning from female to male. The comments made were unrelated to the patient's presenting complaint.

Dr. Anderson did not attend the hearing before the discipline committee. The discipline committee concluded that the charge had been proved. The decision stated:

> *[I]t appears that Dr. Anderson's judgment became clouded, to the detriment of her patient, by her preoccupation with a personal agenda that failed to put the patient first. Dr. Anderson's words were shocking and hurtful to her patient – the very last things he needed to hear having shown the courage to take the steps he needed to take in order to be true to himself. Such language, coming from a member of a respected and trusted profession, was disrespectful and inappropriate. It is disappointing that, if Dr. Anderson did have a fundamental and genuine religious objection to the patient's transitioning process, she failed to avail herself of the basic option of referring the patient to another physician, rather than berating and humiliating her patient who attended on her for entirely unrelated reasons.*

The Council imposed a reprimand, a fine of $2,500 and an order that Dr. Anderson pay the costs of the investigation and hearing in the amount of $16,885.69 plus the College's costs for legal counsel and one member of the discipline committee which had not been provided to the College at the date of the penalty hearing. Dr. Anderson was required to participate in and successfully complete, to the satisfaction of the Registrar, an educational program related to Diversity Training on Sexual Orientation and Gender Identity Issues approved by the Registrar. Dr. Anderson's ability to practise was to be suspended if she failed to pay the costs as required or failed to participate in and complete the educational program.

Dr. Serhii Haidash

Dr. Haidash admitted unprofessional conduct by accessing information from the pharmaceutical information program without the consent of the persons whose information he accessed and without a legitimate need to know the information.

The access occurred in 2009. The pharmaceutical information program conducted an audit which disclosed Dr. Haidash's access to the information.

Council imposed penalty on the basis that Dr. Haidash had accessed the information for the purpose of training a member of his office staff and that the information was not further disclosed or used by Dr. Haidash.

Council imposed a reprimand, an order that he pay $2,400 in costs and an order that he complete an educational program related to confidentiality of personal health information.

Dr. Ramatsiele Petrus Masekoameng

Dr. Masekoameng admitted he had a sexual relationship with a patient.

Council revoked his licence. Council also imposed a requirement that he will not be eligible to apply for restoration of his licence until the Council receives a satisfactory report from a professional person, persons or organization chosen by the Council which attests that Dr. Masekoameng has undertaken counseling at his expense for sexual impropriety, has gained insight into the matter and has achieved a measure of rehabilitation which protects the public from risk of future harm.

Dr. Masekoameng will not be eligible to have his licence restored until a minimum of 9 months have passed from the date of the Council's decision.

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Dr. Yagan Pillay

Dr. Pillay was charged with unprofessional conduct related to his examination of a female patient. Dr. Pillay denied the allegations in the charge.

After a hearing, the discipline committee concluded that Dr. Pillay was guilty of unprofessional conduct. The decision of the discipline committee stated:

> *We find that the College has proven, according to the standards required by* McDougall, *that Dr. Pillay hugged the complainant and then asked if he could kiss her. As soon as it was plain that the complainant was uncomfortable with his advances, to his credit, Dr. Pillay backed off and did not pursue the matter further. Nevertheless, we find that Dr. Pillay failed to maintain the standard of practice of the profession and committed an act of sexual impropriety with a patient.*

The penalty imposed by the Council consisted of a one-month suspension, a requirement that he have a chaperone present for future examinations of female patients, an order that he pay the costs of the investigation and hearing in the amount of $27,561.78 and a requirement that he participate in a boundaries course.

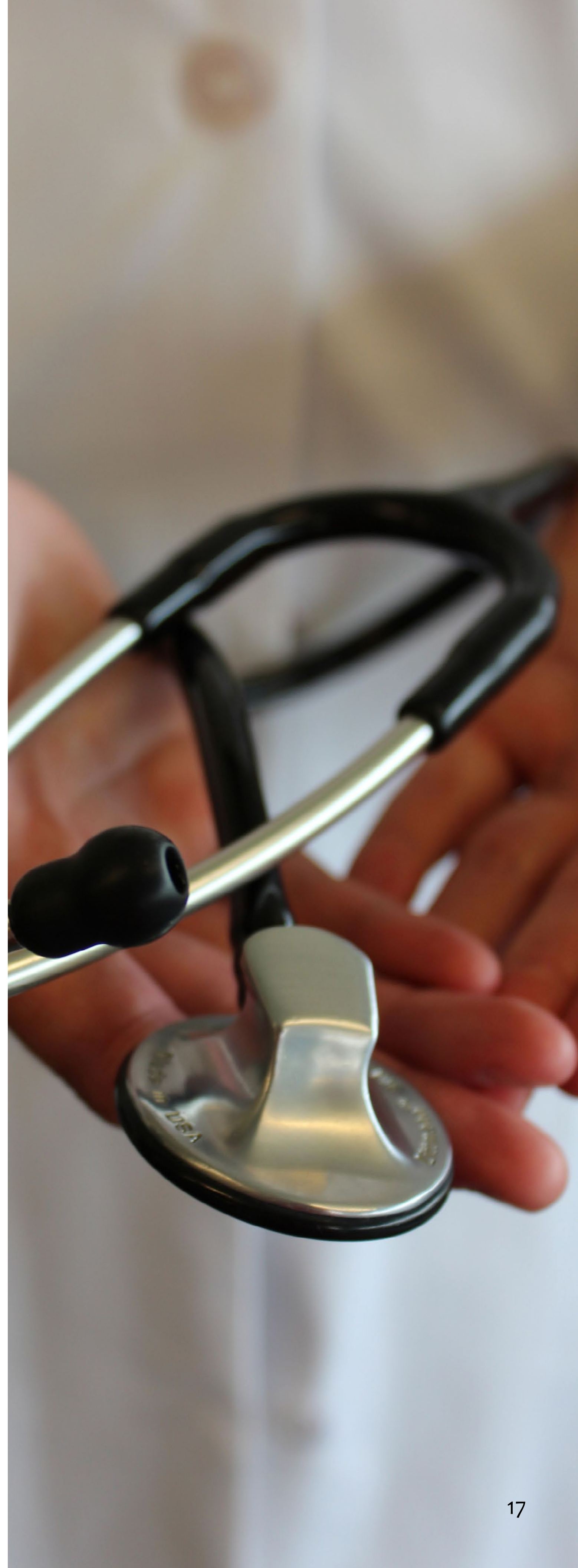
Dr. Pillay has appealed the decision of the discipline committee to the court. His suspension has been stayed pending that appeal. No date has yet been set for the appeal to be heard.

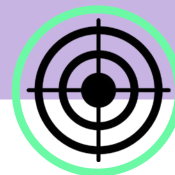
Dr. Mozwa Taratibu

Dr. Taratibu left his practice in Saskatoon. He was charged with unprofessional conduct for failing to make arrangements for continuity of care to his patients, failing to notify his patients of his intention to cease practicing in Saskatoon, failing to make arrangements for the security of his patient records and failing to respond to communications from the Registrar.

Dr. Taratibu did not appear for the hearing before the discipline committee. The discipline committee concluded that the charges were proved.

At the time of the penalty decision, Dr. Taratibu no longer held an active licence to practice in Saskatchewan. The Council imposed the maximum fine allowed under the Act of $15,000 with respect to the abandonment of his practice and a fine of $2,500 with respect to his failure to respond to communications from the Registrar. He was ordered to take a course in ethics and pay costs of the investigation and hearing in the amount of $20,043.08.





Billing for Obstetrical Ultrasound

A message from the Advisory Committee on Medical Imaging and the Medical Services Branch

What can and can't be billed?

The Advisory Committee on Medical Imaging (ACMI) and the Ministry of Health have found that some obstetrician gynecologists who are performing ultrasound in their offices may be erroneously billing what is really a Point-of-Care Ultrasound (POCUS) as a "Limited Ultrasound" billing code.

Physicians should be aware that **POCUS is not a billable procedure**.

Ultrasound for things such as presentation, placentation, fetal heart rate and number of fetuses are competencies of every obstetrician gynecologist (Objectives of Training in Obstetrics and Gynecology, Royal College of Canada. Part 5.1.1.2); recorded in the notes for a patient assessment, whether it be consultation or visit. In these cases the ultrasound is an adjunct to the examination and there is no separate unique billing for the ultrasound.

To assist physicians in avoiding any billing errors, the ACMI and Medical Services Branch would like to provide the following clarification of the different types of ultrasound:

Point-of-Care Ultrasound is intended as an adjunct to a physical exam, usually for a single determination. It is not intended as a 'diagnostic' scan. It is a focused exam, to answer the clinical question, in order to proceed with treatment. It should be recorded in the patient chart, along with the physical examination, as part of patient assessment, not as a separate procedure.

Full/Complete Obstetric Ultrasound

- **(2nd trimester)** must include image documentation of Presentation, Lie, Placentation, Fluid, Fetal Heart Rate, Cervix, Fetal anatomy (see SOGC/CAR standards for specifics), Biometry, EFW, +/- Maternal findings. This includes an interpretation and comprehensive report.
- **(1st trimester)** must include Fetal Heart Rate (m-mode where at all possible), biometry with Estimated Gestational Age, sagittal and transverse embryo/fetus images (if visible yet), yolk sac (if seen), sagittal and transverse gestational sac images plus other planes as required to document the sac fully, especially in regard to peri-gestational collections or other abnormalities (e.g. fibroids), cul-de-sac especially for fluid and maternal ovaries/adnexal areas, with interpretation and comprehensive report.

Limited Obstetric Ultrasound

- **(2nd/3rd trimester)** is for problem solving, such as rechecking a low placenta, high/low AFV, LGA/SGA, rechecking anatomy previously obscured or questionably abnormal. Typically, such scans should include all 'Full' 2nd trimester scan findings except not repeating a full anatomy scan. Limited obstetric scans must also include interpretation and comprehensive report.

**Full and Limited Obstetric scans require archived image documentation of all of the included above definition findings, to support the diagnostic interpretation.*

Medical Services Branch (Ministry of Health) notes the Payment Schedule for Insured Services Provided by a Physician stipulates that "Ultrasound is an insured service where: (c) a hard copy of the diagnostic ultrasound examination(s) plus a written signed interpretation or report of that examination is retained by the physician providing the services."

Physicians performing any type of ultrasound should be knowledgeable of the most recent Canadian Association of Radiologists (CAR) and Society of Obstetricians and Gynaecologists of Canada (SOGC) ultrasound standards; as well as, the CAR Position Statement on the Use of Point of Care Ultrasound.

QUESTIONS or CONCERNS?

Write to cpssinfo@cps.sk.ca or call **306-787-8239** .

SAVE THE DATE!

Opioid Substitution Therapy Conference 2017

APPRECIATE the benefits of Opioid Substitution Therapy to enable the transition to recovery. **LEARN HOW TO** manage and monitor methadone and Suboxone safely, in the context of a Substance Use Disorder, and manage co-morbid physical and psychological conditions. **UNDERSTAND** the importance of an integrated, multi-disciplinary approach to the continuum of care, and the value of a coordinated community-based approach to Substance Use Disorders.

Physicians, pharmacists, nurses, pharmacy technicians, counselors and other individuals working with patients undergoing methadone and suboxone opioid substitution therapy would benefit from the valuable information and presentations that will be offered at this conference.

The next Opioid Substitution Therapy Conference will be held

April 29 and 30, 2017

in Saskatoon

QUESTIONS?

Write to methadone@cps.sk.ca or call 306-667-4655.

CCENDU IS ON FACEBOOK!

Stay updated on drug news in Saskatchewan and across Canada!

Be sure to like the "CCENDU Saskatchewan" Facebook page.

The Canadian Community Epidemiology Network on Drug Use (CCENDU), is a nation-wide network of community partners that informs Canadians about emerging drug use trends and associated issues.

Stay Informed,
Like us on Facebook!

PRESCRIPTION TIP!

With the concern of brand name narcotics being diverted in Saskatchewan, did you know that *you*, as a prescriber, can write:

"generic only – no substitution"

on the prescriptions you write for your patients?

By implementing this, you are helping keep drugs of abuse off our streets in Saskatchewan!

Regina Surgeon Receives Kendel Award

During a special awards banquet held in Saskatoon on November 18, 2016, the Council of the College of Physicians and Surgeons of Saskatchewan presented Dr. Corrine Jabs (see biography below) of Regina with the prestigious Dr. Dennis A. Kendel Distinguished Service Award for outstanding contributions to physician leadership and/or to physician engagement in quality improvements in health care in Saskatchewan.

Dr. Corrine Jabs

"I am honoured to receive this award. Quality improvement is a team sport and I am fortunate to work with physician and administrative colleagues who understand why I am never satisfied with the status quo." stated Dr. Jabs, who has served as Department Head of Obstetrics and Gynecology in RQHR since 2011.

Among her accomplishments are the development and establishment of three clinics to improve patient access to healthcare services for women in her health region. Today, she also manages to provide sub-specialty services as an Urogynecologist, and is an Associate Professor, a Clinical Researcher, a strong, active and innovative leader and a tireless advocate for women's health in Saskatchewan.

Dr. Jabs' personal mission statement is to do the most good for the most women possible. Her continuing challenge is determining how best to accomplish that goal in collaboration with colleagues, Regina Qu'Appelle Health Region and Saskatchewan Ministry of Health.

"Council is very pleased to present the fifth edition of the award to a candidate who has distinguished herself by advocating for and dedicating her career to improving access to health care services for women. Dr. Jabs has shown remarkable leadership and has had multiple measurable positive impacts on health services in her workplace," said Dr. Alan Beggs, President of the College Council, who presented Dr. Jabs with the award.

The Dr. Dennis A. Kendel Distinguished Service Award was named in honour of Dr. Dennis Kendel, who retired in 2011 after a long career as Registrar of the College of Physicians and Surgeons of Saskatchewan. Past recipients are Dr. Oberholzer and Dr. Helms of Radville (2012), Dr. Marilyn Baetz of Saskatoon (2013), Dr. William Albritton of Saskatoon (2014), as well as Dr. Ryan Meili and Dr. Mark Wahba of Saskatoon (2015).

Do you have a colleague worthy of mention?

Nominate them for the 2017 edition!

The Dr. Dennis A. Kendel Distinguished Service Award is a prestigious award presented to an individual (or group of individuals) who has made outstanding contributions in Saskatchewan to physician leadership and/or to physician engagement in quality improvements in healthcare.

The award is presented during a special annual banquet organized by the Council of the College of Physicians and Surgeons of Saskatchewan in November of each year.

***Nomination packages** are available on the College website at*
http://www.cps.sk.ca/iMIS/Documents/Dr%20Kendel%20Service%20Award%20-%20Nomination%20Package.pdf
or by contacting Sue Robinson at:

OfficeOfTheRegistrar@cps.sk.ca

21 Recipients Honoured with Senior Life Designation

Each year, the College of Physicians and Surgeons of Saskatchewan celebrates its physician members who have been fully licensed to practice in Saskatchewan for forty years (or more). New inductees to **Senior Life Designation** *are honoured at Council's Christmas (holiday) banquet which is held in November of each year, and receive a certificate and commemorative plaque depicting 100 years of medicine in the province of Saskatchewan.*

Senior Life Designation is for honourary purposes only. It conveys no right to practice medicine in Saskatchewan, to hold office, or to vote. Members, including inactive members, are still required to pay registration fees to retain their licensure status. As a result, a physician may concurrently hold a Senior Life Designation and another form of licensure.

Above, L-R: Dr. Judd, Dr. Rudachyk, Dr. Norman, Dr. Cardoso-Medinilla, Dr. Jabs, Dr. Datta

Dr. Carol Norman

Dr. Lila Rudachyk

Dr. Reynaldo Cardoso-Medinilla

Dr. Biswa Datta

Dr. Andrew Judd and Dr. Alan Beggs (CPSS President)

Held in conjunction with the Dr. Dennis A. Kendel Distinguished Service Award, a total of twenty-one physicians were awarded with **Senior Life Designation for 2016** (for having held a license to practice medicine in Saskatchewan for a cumulative total of 40 years). Five physicians were able to join us for the evening, with a further 16 recipients honoured *in absentia* for their lifelong contribution, as per *The Medical Profession Act, 1981*.

These are:
Dr. Reynaldo Cardoso-Medinilla (Regina)
Dr. Biswa Datta (Regina)
Dr. Andrew Judd (Saskatoon)
Dr. Carol Norman (Regina)
Dr. Lila Rudachyk (Saskatoon/Prince Albert)
Dr. Thomas Blackwell (Saskatoon)
Dr. Thomas Coneys (Gravelbourg)
Dr. Anthony Courtney (Regina)
Dr. Jyoti Das (Regina)
Dr. Ernesto De Leon (Moose Jaw)
Dr. Brenda Hookenson (Prince Albert)
Dr. Jacqueline Joseph (Regina)
Dr. Nasir Koudsi (Yorkton)
Dr. Bernard Lawlor (Saskatoon)
Dr. Yellepeddy Nataraj (Wadena/Saskatoon)
Dr. Gregory O'Byrne (Regina)
Dr. George Pylypchuk (Saskatoon)
Dr. Ole Rasmussen (Regina)
Dr. Alwyn Rose (Regina)
Dr. Mark Sheridan (Saskatoon)
Dr. Gill White (Regina)

Giving credit where credit is due

Do you know someone who has reached a remarkable milestone in their practice?

Tell us about it!

Send their story to communications@cps.sk.ca

Have you been practicing for 40 years or more in Saskatchewan?

If you have practiced in Saskatchewan for 40 consecutive years or more, or if the only interruptions in your practice were for service in the armed forces or to take postgraduate training, and you have not yet received your Senior Life designation, please contact:

Sue Robinson at 306-244-7355 or at OfficeOfThe Registrar@cps.sk.ca

Educational Session

NOTICE: In lieu of the traditional format of holding its AGM in conjunction with a series of short presentations on a viariety of topics, Council has elected to hold a **full-day educational session on one topic of current relevence.**

The session is expected to be held in September 2017 or September 2018. More details will be made available in a future issue of DocTalk.

Council By-Election for HEARTLAND HEALTH REGION

YOUR CHANCE to make a *difference* in Professional Regulation

New Call-out for Nominations

The recent resignation of your Council representative, Dr. Lynda Keaveney, has left a vacancy on Council for the Heartland Health Region.

A new call-out for nominations has been sent to you via e-mail. The elected* physician will serve the remainder of the current term (one year) and be eligible for re-election in the next election in Fall 2017.

To nominate a candidate:

- Check your e-mail for information and a nomination paper (or write to OfficeOfTheRegistrar@cps.sk.ca to obtain a new nomination package).
- Send your completed nomination paper **no later than December 21, 2016**. by fax to (306) 244-2600, by email to sue.robinson@cps.sk.ca or via regular mail to the College address listed at the back of this publication.

**If more than one candidate is nominated, ballots will be mailed out after the election slate is determined for an election in February. If only one candidate is elected, that person will be declared elected by acclamation.*

Patient Navigation in the Health Care System

By Alyssa Van Der Woude, CPSS

Language barriers, cross-cultural issues and difficulty understanding how the health care system works are a problem for many people trying to access health care.

To help with these many problems, Dr. Harold Freeman developed the concept of patient navigation in the 1990's. Dr. Freeman developed **nine principles of navigation** (Haver, 2014; Freeman, Muth & Kerner, 1995):

1. Patient navigation is a patient centered healthcare service delivery model, which focuses on promoting timely movement of an individual patient through complex healthcare systems.
2. The purpose of patient navigation is to eliminate barriers to timely care across all phases of the healthcare experience.
3. Patient navigation may serve to integrate a fragmented healthcare system for individual patients.
4. Patient navigation should be defined with a clear scope of practice that distinguishes the navigator role from other support workers.
5. Patient navigation services should be cost-effective and should correspond with the training and skills necessary to navigate a patient through a specific phase of the care continuum.
6. The navigators should possess the necessary skills at each phase of navigation.
7. In a given healthcare system, there should be a point where the navigation begins and ends.
8. Patient navigation can serve as a process that connects disconnected healthcare systems.
9. Patient navigation systems require coordination, which may best be carried out by assigning a navigator coordinator. The navigator would be responsible for overseeing all phases of navigation within a healthcare system.

Patient navigation support has shown that underserved patients have a better understanding of their illnesses and treatment plans and an overall increase in satisfaction with their care. In Saskatchewan we have several programs that can help the public navigate through their health care experience, including interpretation services for First Nations, Metis and Francophone patients.

Health Accompagnateurs

The "Accompagnateur" service is a pilot project organized by the *Réseau de Santé en français de la Saskatchewan* to help French speaking patients navigate the health system. Their project goal is to pair health accompagnateurs with vulnerable patients (immigrants, seniors and families) so that they may have access to quality health care in French.

The pilot project was launched in Saskatoon, Regina and Prince Albert in April of 2016 with the support of the College, the concerned health regions and other partners in health care.

Trained accompagnateurs will have to meet the established selection criteria and be approved by the Advisory Committee and the *Societé Santé en français*. An engagement contract, code of ethics and practise agreements will be signed by the

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Check it Out!

The **IPAC Link Letter** is a monthly review of highlights and linked updates from the ever-changing world of Infection Prevention and Control to help you stay current and informed

http://www.ipac-canada.org/IPAC-SASKPIC/PICNSlinkletter.php

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accompagnateurs before beginning any duties. The significance of this project, as expressed by Francine Proulx-Kenzle, a Regina-area base accompagnateur, is that it is "a very simple idea, but very beneficial for patients".

In an interview, Ms. Proulx-Kenzle described the process of being an accompagnateur.

First, the coordinator for the program contacts her with all the necessary patient information; for example, the patient name, the address where the appointment is to be held, etc.

Ms. Proulx-Kenzle then arrives to the appointment ahead of time to listen to the patient and hear their story. During the appointment, the accompagnateur will interpret for the doctor exactly what the patient says, word for word.

Ms. Proulx-Kenzle advised she makes it clear to the patient that *they* need to be the one to explain everything to the doctor -- she would just repeat it.

At the conclusion of the appointment the patient fills out an evaluation form to describe their experience with the accompagnateurs.

INFORMATION: 1-844-437-0373

First Nations and Metis Health Services

The FNMHS program addresses health system concerns for First Nations and Metis people by navigating them and providing culturally appropriate care in the Saskatoon Health Region (SHR) (Haver, 2014).

The FNMHS provides the following services (Haver, 2014):

1. **Cultural Support:** Culturally appropriate manner and offers links to traditional services.
2. **Interpretation:** Language interpretation for Dene or Cree. Support through all processes of care.
3. **Facilitation of Health Services:** Helps patients and families with any issues that may arise.
4. **Community Service Referrals:** Refers patients to community programs and funding for patients who are not covered by insurance.
5. **Patient Advocacy:** Advocates on behalf of the patient to address any cross-cultural issues that may arise.

INFORMATION:

St. Paul's Hospital (Saskatoon): 306-655-0518
Royal University Hospital (Saskatoon): 306-655-0166

Eagle Moon Health Office (Regina): 306-766-6995

*Programs like these are helping to make health care in Saskatchewan a more **patient centred** service.*

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Majority of Physicians Ordering Appropriate Lab Tests

An Update from the Saskatchewan Disease Control Laboratory

By Patrick O'Byrne, Executive Director, Ministry of Health

Improving Appropriateness of Care is one of the Saskatchewan health care system's strategic priorities. The Saskatchewan Disease Control Laboratory (SDCL) has begun an in-depth analysis of specific laboratory testing looking at the consistency and appropriateness of laboratory testing. This work has found that most physicians have very consistent and appropriate ordering practices for SDCL laboratory tests. However, in the review of each of these tests there were a small number of physicians who have ordering practices that are very different from their peers, utilizing a disproportionately large volume of testing.

This work is based on recommendations from Choosing Wisely Canada and is supported by the Senior Medical Officers and other clinical specialists. With our partners, SDCL has started working with some individual physicians on the appropriateness of their test ordering practices for Vitamin D testing, fecal immunochemical testing (FIT) and drugs of abuse testing. As most physicians' practices are consistent with those of their peers, only a small number of physicians have been contacted by their region, the Saskatchewan Cancer Agency (SCA) or SDCL.

As an example, the fecal immunochemical test (FIT) work illustrates the consistency of practice among physicians. In 2013, the FIT test was implemented provincially as a screening test for colorectal cancer. SDCL and the Saskatchewan Cancer Agency have worked together to ensure all the results from both Programmatic Screening FIT (FIT mailed to the clients' home from the Screening Program for Colorectal Cancer) and Opportunistic Screening FIT (ordered by the physician via laboratory services requisition) are tracked by the Saskatchewan Cancer Agency, and follow-up occurs by physicians who receive a positive FIT test on their patients.

Working with the Saskatchewan Cancer Agency, the SDCL analyzed physicians' laboratory test ordering practices on a per patient basis. Province-wide, only a few physicians had ordering practices that were markedly different from that of their peers. The table below illustrates how this laboratory test has been used.

Recognizing that the Saskatchewan Cancer Agency's recommended period between screening tests is two years and that occasionally patients may clinically require a diagnostic FIT test, this table shows that the vast majority of patients are receiving services as recommended. A very small number of physicians have been ordering this screening test frequently (more than annually). The Saskatchewan Cancer Agency will submit an article on the Screening Program for Colorectal Cancer in the next issue of DocTalk.

Saskatchewan Disease Control Laboratory
(Photo courtesy SDCL)

Similar analysis of Vitamin D and Urine Screening for Drugs of Abuse testing have also shown overall consistency in practice among the vast majority of Saskatchewan physicians. Again, only a small number of physicians had ordering practices markedly different from that of their peers. In cooperation with the Regional Health Authorities, SDCL has reached out individually to these physicians to understand their practices.

The SDCL recognizes its responsibility to physicians to inform them about their practice in comparison with their peers. Without this information from the laboratory, it is impossible for physicians to know whether their practice differs from that of their peers.

In most cases where the laboratory has been working with individual physicians to understand their practice, physicians have been supportive of evidence based guidelines. ***Thank you to these physicians for their professionalism and openness to practice examination.***

In conclusion, as we have examined individualized services predominately offered at SDCL, we have noted two consistent trends:

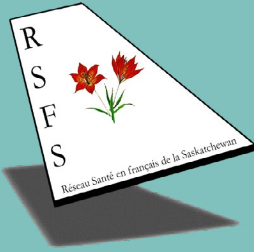
- The vast majority of physicians have very consistent ordering practices.
- There is a small number of individual physicians who have ordering practices markedly different than their peers and use a disproportionately large volume of testing.

We are committed to working with this small group of physicians on these practice variations as we continue to work towards ensuring Saskatchewan residents receive more appropriate lab testing.

The SDCL wants to thank our physician customers for the quality care they provide to patients every day.

FIT Testing in Saskatchewan: January 2013 to October 2016.

Total Tests Per Patient Since January 2013	Patients	Percent of Patients	Number of Tests	Percentage of Test
1	150,357	62.59%	150,357	42.95%
2	74,116	30.85%	148,232	42.34%
3	12,462	5.19%	37,386	10.68%
4	2,682	1.12%	10,728	3.06%
5 or more	616	0.26%	3,369	0.96%
	240,233		350,072	



In partnership with the College of Medicine, Department of Community Health & Epidemiology, the Saskatchewan Network for Health Services in French/ Réseau Santé en Français de la Saskatchewan (RSFS) is in the process of updating the directory of health professionals who are willing to speak at least some French when providing health services in Saskatchewan.

We are also seeking to add professionals who are new to the province, recently graduated or simply newly interested. Professionals are added to the directory on a volunteer basis and there are no legal obligations associated with being listed.

If you would like more information or are willing to be listed, please contact **Katie Pospiech** at katie.pospiech@usask.ca or (306) 966-1270

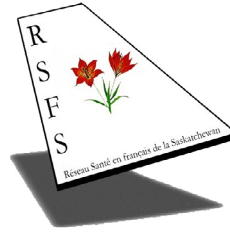
Do you speak, write or understand a language other than English?

How about sign language?

Register your language proficiencies online with the College at:

https://www.surveymonkey.com/r/cpss_language_survey

Write to communications@cps.sk.ca if you are experiencing difficulty entering your information online.



HEALTH ACCOMPAGNATEUR

INTERPRETATION SERVICES IN FRENCH

As health professionals, you may come across Francophone Newcomers who are:

- Unable to navigate the Saskatchewan health system;
- Needing to consult a health professional but cannot do so because they have no or limited capacity to explain their health issues in English;
- Unable to understand your explanations in English.

You may also come across Saskatchewan Francophone Seniors and Families:

- Needing to use French in their interactions with health professionals.

This free and confidential service has been established to help you as a health professional interact more effectively with your patients.

Patients who need an interpreter are encouraged to call **1-844-437-0373**.

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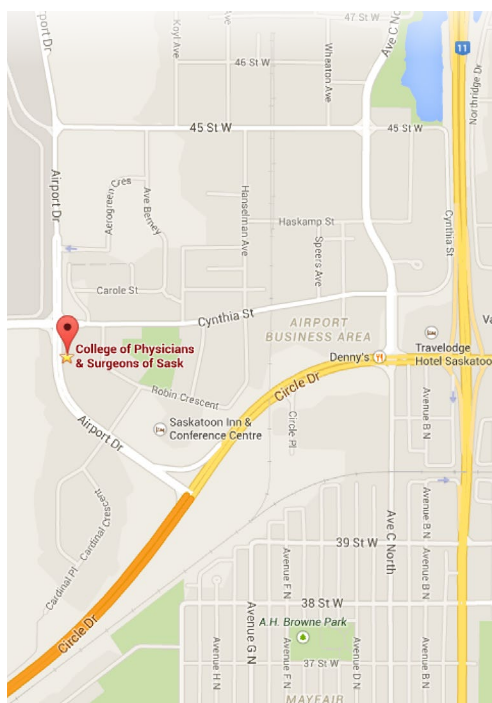

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Quality of Care (Complaints)

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