Communicating with physicians in the Calgary area

February 2010

Vital Signs

A Calgary & Area Physician's Association publication

Advocating for physicians, caring for patients

THe AMA Olympic torch relay team in Banff!

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CAPA

CALGARY & AREA PHYSICIANS ASSOCIATION

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A Calgary & Area Physician's Association publication — Advocating for physicians. Caring for patients

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Vital Signs welcomes submissions (articles, notices, letters to the editors, announcements, photos, etc.) from physicians in the Calgary region. Please limit articles to 600 words or less.

Please send any contributions to:
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On the cover: Ron Kustra leads the AMA 2010 Olympic torch relay team in Banff on January 21.
Photo by Dave Lowery

Expectations

From the CAPA president

As you are all aware, we now have a new health minister. The Honourable Gene Zwozdesky. He was minister of aboriginal relations prior to his new appointment as the health minister. He was elected to his fifth term as MLA for Edmonton-Mill Creek on March 3rd, 2008. He was born in Saskatchewan and as I have been known to say in the past "I have almost never met anyone from Saskatchewan I did not like! He has a B.A and B. Ed from the University of Alberta. His previous occupations include teacher, administrator, professional musician and businessman. As health minister for this province he takes on a job that has enormous built in expectations from Albertans in general and from the medical professions in particular; expectations we hope he can live up to or at least come close.

That leads me into my focus for this months presidents message.

Expectations

They are what drive our daily life, what drive our thoughts of the future and our feelings in response to all that occurs around us personally and professionally. The question is; are we expecting too much of our healthcare system, our politicians, our administrators, our colleagues and our patients?

I must digress to what has brought me to wondering about our expectations. That is the recent horrific events in Haiti. How can anyone, not least a physician, watch what is happening in Haiti and not feel guilty about the level of healthcare we have here in Alberta. The thought of open, compound fractures being held in place by cardboard boxes with no pain relief, no antibiotics and no hope of surgical fixation is more than I can comprehend. Here, in Canada, patients will sue if their complex wrist fracture does not heal well and they are left with some decreased mobility. The overwhelming numbers of open wounds that will become complicated by infection and lead to amputation or death without antibiotic treatment available is beyond belief. This is a country situated next to the Dominican Republic. A favourite playground for Canadians in the winter. I cannot begin to answer for the Haitian government that is so obviously ineffective. What I can do is reflect on our healthcare here in Alberta and try and dissect our current turmoil into realistic and unrealistic expectations.

Clearly the Haitians are not even close to any reasonable expectations for a healthcare system. But do we, as Albertans, have unreasonable expectations? Is it unreasonable for a province, that can in such an emergency commit $500,000 immediately for aid, to expect that all mentally ill patients will have a hospital bed if they need one and not be forced onto the streets or into facilities ill equipped to cope with their complex needs? Is it unreasonable for a province that can host an Olympics to expect that all senior citizens be treated with dignity and offered the highest level of care to the end of their life . . . not in the hallways of the hospitals or in institutions staffed by our least trained professionals? I raise these questions as I ponder the really excellent healthcare system we have in stark contrast to countries such as Haiti.

Is that a meaningful comparison? Should we just be grateful for what we have and stop complaining? Or should we use the advantage we have, which is glaringly apparent, when one views countries such as Haiti in a disaster. Comparisons are always tricky and play into expectations. If we compare ourselves to Haiti we have far exceeded any expectations for a healthcare system. But we must not compare to those who are in a lesser situation as that will always make us feel superior and not in need of improvement. That has been our defence for years when we compare ourselves to the US system.

In fact we must not compare in order to develop expectations that fit our population, our economic realities, our workforce and our health needs. We need expectations that fit us today, as we are and what we can afford.

Dr. Linda Slocombe, CAPA president
Phone: 403-861-8423

The government needs to take the pulse of Albertans and determine our expectations for healthcare. Not if we are satisfied or not satisfied with our family doctor or our last hospital visit. What are our expectations for the healthcare system in general? The average Albertan does not know the difference between MRSA, VRE and C. Difficile. But they do know that their relative was in a crowded four bed room in the hospital sharing a bathroom with four other patients, seeing different nurses and doctors daily, being sent home with no follow-up except to see a family doctor that they do not have, returning to wait for hours in the emergency room with unresolved complications from their original hospital visit. This is all too often the reality for healthcare in Calgary in particular. Not for all but for enough to make it a problem. If our reality is that we are living in one of the richest provinces in one of the richest countries in the world, then I would argue that our expectations are not being met.

And I would also argue that they are not unrealistic expectations. How we pay for them almost seems immaterial when we see what is happening in countries such as Haiti. The question becomes not whether we have enough money, but are we meeting our expectations for the healthcare system. As a physician, my expectations are for a system that provides the best we can offer. Each Albertan with a family physician, with access to an acute care bed if needed, with access to highly trained specialists if needed, with access to all necessary medications and long term care provided with compassion. I do not think these are unrealistic expectations, just ones that involve money and commitment.

I would like to see our expectations detailed by our healthcare workers and our patients. Then I would like to see our politicians address those expectations not as unrealistic, as opportunistic or as self-serving . . . but as real goals that a rich province in a rich country can achieve. In the meantime I am truly grateful for the healthcare we have and am deeply saddened by the inadequate healthcare provided by many countries in the world to their citizens.

Antarctic ice edge to South Pole international ski expedition

By Bill Hanlon MD **November 2009 to January 2010 47 days/1200 Km**

I have just completed a 47 day, 1,200km international ski expedition from the edge of the Antarctic ice at Hercules Inlet to the South Pole to promote improved health care in remote communities across the globe. After 47 days of cold catabatic winds, -40C temperatures, uneven ice called sastrugi, challenging navigation in whiteout conditions, melting snow to provide adequate fluids and a 6500-calorie/day intake, we reached the geographic South Pole at 9,300ft on January 2nd 2010.

Arrival at the South Pole was the completion of a two-year project of preparation and planning to highlight the specific health needs of people living in remote communities across the globe. After 20 years of travelling and working in many high altitude communities across the globe, this was my first high latitude as well as high altitude expedition. The international team comprised of an American adventurer/polar explorer Eric Larsen, a Shanghai/Chinese resident Dongeng Liu (first Chinese person to ski from the edge of the ice to the South Pole) and myself.

We skied from 80 degrees to 90 degrees south latitude which is 600 nautical miles - almost 1200km distance. We pulled kevlar sleds carrying our food, fuel, tent, stove, sleeping bag and extra clothing. We tried to travel as efficiently as possible by reducing our weight to a minimum and tried to conserve energy as much as possible. We needed to be completely self-reliant as rescue was not always possible if needed. The Antarctic icecap is one of the most remote parts of the world. There is no animal or plant life, no rivers or trees. The only humans present on a temporary basis are adventurers and scientists working at the research stations. The South Pole research base has 250 residents during the summer and approximately 40 winter residents.

Based on the above, I thought taking on this challenge of skiing from the edge of the Antarctic ice to the South Pole to be an ideal environment to promote the health care needs of remote communities across the globe. There are a number of issues that may contribute to remote communities being disadvantaged when it comes to health care delivery both in the developed as well as the developing world. Issues such as limited access, isolation, limited support to resident health care workers, transportation issues, political and economic disenfranchisement, reduced access to formal education and public health care programs (i.e. vaccination programs, clean water, human waste disposal infrastructure etc), electricity and alternative power resources, environmental degradation and loss of natural resources to external sources. People can be isolated because of their geographic location; i.e. mountains, jungle, deserts, islands or weather; i.e. winter snow/rain or politically. Most high-density populations across the globe reside in the most accessible and convenient locations where interconnecting infrastructure is most convenient and affordable. Most of our populated cities in Canada are located close to the 49th parallel. Our populations rapidly fall off the further north one travels.

In Canada, 21 per cent of our population lives in towns with less than 10,000 people. However, this population has only 9.4 per cent of our family physicians and three per cent of our medical specialists. This discrepancy is often more obvious in the developing world. As part of Basic Health International Foundation, I have worked in many remote

Left to right: Dongeng Liu, Eric Larsen and Dr. Bill Hanlon at the South Pole with their Kevlar sleds.

communities in countries such as Peru, Tibet, Mongolia, Nepal, India, Ethiopia, Honduras and W Papua. I have seen many communities impoverished and disadvantaged in the area of health care as a result of their isolation and geographic location.

Basic Health International Foundation (BHI) has and continues to work on improving the education and support of community health workers through telemedicine opportunities as well as on site visits. Our focus is very much on education and prevention. Satellite technology and solar power improves greatly our goal of improving health care and support to remote communities across the globe. We are constantly striving to develop and bring improved health care delivery to those in greatest need. This recent expedition to the SPole was quite a challenge both physically and mentally for all three of us. Skiing at least eight hours per day for 47 days in such a harsh, remote but beautiful environment had its challenges. However, these were short term and self-inflicted compared to the constant day-to-day challenges many people living in remote communities across the globe face in the area of health care delivery.

Editor's note: Cochrane physician, Dr. Bill Hanlon, summitted Everest in May of 2007 (Vital Signs July 2007.) In October 2009 he summitted Carstenz to finish his quest to climb the highest peak on each continent. You can find out more about his non-government organization at: www.basichealthinternational.org

Dr. Bill Hanlon skiied for 47 days, 1200 km in -40C temperatures and consumed 6500 calories per day.

In memoriam

Sylvia Martin

Dr. Sylvia Evelyn Martin October 28, 1950 - December 23, 2009

Sylvia, beloved wife of Len Marx of Calgary, died on Wednesday, December 23, 2009 at the age of 59 years after a courageous battle with brain cancer. Sylvia grew up in Australia, then moved to Canada to pursue her medical studies. She practiced as a dermatologist in Calgary for fourteen years. Sylvia loved her life with Len and together they travelled to many incredible places. Her favourite place was the American Southwest where she hiked extensively in Utah, Arizona and Colorado. Besides her loving and devoted husband Len, Sylvia will be lovingly remembered by her stepchildren Marnie and Darryl, and their families, sister Ruth Markovic, brother-in-law Peter Kuhlman, sister-in-law Erni Martin, and many other relatives. Sylvia's best friends, June Smythe, Nancy Hamilton, Louise Starling, Carolyn Fleming and Lyn Thomson, were especially dear. Many other friends will miss her greatly. Sylvia was predeceased by her brother Julius, her parents and stepmother Eva.

AMA 2010 Olympic torch relay team

Photos by Dave Lowery

The briefing from Nadine. "Don't drop the torch." "Yeah, we know. How about a chant? Would 'go flames go' work!"

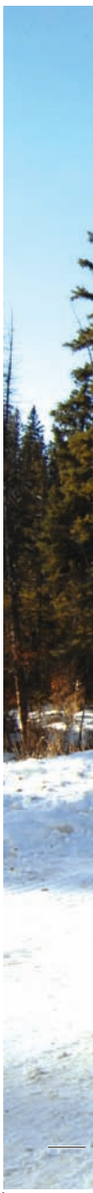
Practice on Banff Avenue.

Dr. Phillip van der Merwe carries the torch in Banff. "I had the privilege of choosing Canadian citizenship years ago and today I'm privileged to be chosen for the great honour of carrying the Olympic torch. This wonderful experience completes my Canadian dream."

Dr. Chip Doig, AMA president, shows the torch to an admirer in Banff on the relay route.

Ab

Front
Back



Above: Alexis Beamer takes the torch from Sean Smith.

Above: Dianne Maier hands off to PJ White.

Front row: Howard Evans, Maeve O'beirne, Wendy Tink, Chip Doig, Nadine from the torch organizers, Verna Yiu, Carolyn Lane,
Back row: PJ White, Sean Smith, Kevin Wasko, Dianne Maier, Michael Giuffre, Robin Cox, Ron Kustra, Noel Grisdale, T.K. Lee,
Nathaniel Day , Alexis Beamer, Phillip van der Merwe, Malcolm Campbell.

Allocation 101

Solving the mysteries of allocation, one step at a time!

To secure funding increases for physicians, the Alberta Medical Association (AMA) negotiates new trilateral agreements with Alberta Health and Wellness (AHW) and Alberta Health Services (AHS).

When a new fiscal agreement is reached, there is generally funding assigned to reimburse physicians for the medical services they provide through fee-for-service and alternate relationship plans (ARPs).

With trilateral approval, these funds are allocated to sections and then each section applies its funds to the health service codes in the schedule of medical benefits for which it is responsible.

Allocation 101

Understanding the allocation process can be daunting at best, and downright confusing at worst.

To assist section representatives in particular, and interested physicians in general, the AMA has developed a comprehensive manual to provide information and increase transparency about the:

- Allocation process - with the two major steps involved (macro- and micro-allocation)
- Current policy and policy under development
- Individuals and committees that participate in the process
- Timelines for allocation

The end result is Allocation 101 – a complete how-to guide about allocation, which includes a section version – an all-inclusive handbook for section representatives, and a physician version – a less detailed version for individual physicians.

The allocation process

The first step in allocation is macro-allocation.

Macro-allocation is the trilateral process by which the newly negotiated funds for physician services are divided among the sections. Funds are apportioned to three major elements:

- Overhead – an adjustment is calculated for each section to acknowledge business costs
- Targeted/priority funding – sometimes funds are targeted for specific fee items or sections
- Full-time-equivalent (FTE) payments – provides a set amount of funds per FTE physician in each section

When macro-allocation is complete and the amount of funding is determined for each section, micro-allocation begins. It is the process whereby sections apportion their new funds to the health service codes they own or share within the schedule of medical benefits.

Policy

Allocation 101 is one of nine strategic activities currently underway to address the AMA's objectives of equity, access and productivity. Among the other eight activities, and also related to policy for allocation, are the physician business costs study and the review of the definition of full-time-equivalent (FTE) physicians.

The purposes of the physician business costs study are to:

- Review physician business costs (overhead) throughout Alberta to better understand the various components and variations in costs associated with maintaining a medical practice
- Develop a set of indices and a process for periodically reviewing and updating the data.

The results of the study will provide more complete information on which to base macro-allocation decisions about adjustments for overhead.

Review the definition of full-time-equivalent (FTE) physician

The definition of full-time-equivalent has been raised by sections as an issue that needs to be addressed for fairness in calculating allocation of per-FTE amounts. The definition is being updated with a look at refining the way FTE is calculated.

In addition to the current policy under development, the AMA board of directors has established policies to guide the process and outcomes for allocation.

Allocation timelines and players

Allocation is not completed overnight. It is a 15-month process that involves individual physicians, sections, representative forum, AMA board of directors, internal AMA committees [physician compensation strategy board steering committee, fees advisory committee, AMA representatives to the schedule of medical benefits subcommittee(SOMBS) and the physician services committee].

The trilateral partners to the master agreement are also actively involved in allocation. Both AHW and AHS contribute their proposals for allocation. The trilateral SOMBS reviews proposals from all three parties and makes recommendations to the trilateral physician services committee for final decisions.

Calgary family physician Dr. Carolyn Lane is a co-chair of the ama's physician compensation strategy board steering committee. She says, "allocation is fundamental to physicians' remuneration, so it benefits physicians to understand the allocation process. We trust that the physician version of allocation 101 will provide them with the basics they need to comprehend what goes on in an allocation. As well, the section version should provide section representatives with a mini-tutorial to lead them through this complicated process and bring them out the other side . . . having successfully navigated the allocation maze."

Physicians can read the allocation 101 documents on the AMA website – sign in and look under fees and negotiations, then allocation. You can also provide feedback on allocation 101 – physician version. A link to a survey is available on the website, below the document.

For further information about allocation, please contact Marisa Bonuccelli, Manager, Physician Payment Services, at the Alberta Medical Association. Telephone: 1.800.272.9680

CAPA appreciates the funding support from AMA to help with their monthly submission publishing costs.

Changes in pharmaceutical services?

As Bob Dylan said "The times they are a changin." In November 2009, Alberta Health Services (AHS) announced that it would seek a private sector provider to take over outpatient pharmacy services currently provided at the Alberta Children's Hospital, Foothills hospital, Rockyview hospital and the Peter Lougheed hospital. Staff was told that this initiative was undertaken as the current services that are provided by AHS are not sustainable with current levels of funding. AHS believes a private sector provider will be found through an RFP process. AHS will also engage in the complex task of separating the prescription filling part (self explanatory) of the operation from the program based part of operation (HPTP, anticoagulation, liver transplant, kidney transplant, osteoporosis, oncology, hematology, metabolic disorders … all money losers.) I feel this is unfortunate as I perceive the two operations to be synergistic. The outpatient pharmacies and the staff who work there will be radically transformed by this process. This will impact patients and staff in a substantial way when the handover takes place in September of this year. I hope that my comments here will help readers to appreciate what is coming. Now is the time to begin thinking about how patients and staff will be impacted. I want to emphasis impact on staff. Even though we are a patient focused service, I have always believed that our activities help staff to do their jobs better.

I have worked in this department for 10 years now. The way I practice pharmacy has changed quite a lot in those 10 years. I have, of necessity, managed change and in many cases embraced change. I have never had any managerial or administrative duties within the department. This may be the reason why I fail to see how this initiative will help patients, staff and our department for that matter.

This is an extremely ambitious project given the broad range of services currently provided through the outpatient pharmacies. The outpatient pharmacy fills a variety of prescriptions. We fill prescriptions for most of the medications in the Compendium of Pharmaceutical Specialties (CPS) and for many medications that are not found in the CPS. Some prescriptions may require hours or days to complete due to their complexity. The cost of these prescriptions may range from a few dollars to a few thousand dollars to the patient, the insurer or the province. AHS expects the private provider to maintain this level of service or exceed it.

Amazing and complicated treatments are provided in a hospital setting by talented medical and support staff every day. It is exciting for our department to be a part of it all. The inpatient pharmacy does a great job of handling and supplying many very specialized medications. These are medications that may be hard to use, obtain, store or handle. In a hospital setting, well-trained staff uses these treatments safely and effectively. Things get a little tricky when some of these therapies are continued after discharge. Our department helps discharged patients on a routine basis with complex discharge prescriptions. Sadly, in some cases, patients spend days or weeks trying to get the medication and the information that they need when they leave hospital. Sometimes they come to an outpatient pharmacy or they give up. In my experience, our department helps the majority (i.e. certain treatments are just not feasible on an outpatient basis) of people who come to us with their special discharge prescriptions.

Privatization will definitely result in smaller outpatient pharmacies. The reduction I speak of is not about square footage. I refer to the capacity to solve problems for patients and staff. Hospital staff and patients currently enjoy synergies that arise from the work our pharmacists do in several outpatient programs. The work in these programs provides valuable ongoing training and awareness of issues that affect the patient, hospital staff and services delivered by the pharmacy. These relationships, with outpatient programs, make each pharmacist more effective at solving problems. Each staff member is like an iceberg where only the tip is visible above the surface of the water. Below the surface each pharmacist is presently connected to multiple programs, departments, hospitals and specialists. As well, pharmacists currently have access to Sunrise Clinical Manager and medical records. These connections make it possible for us to help patients who cannot provide the information we need. These tools are invaluable when the patient does not speak one of the official languages or is cognitively impaired or overwhelmed by medical information. The new pharmacists who work for the private provider will likely be well trained and well meaning. However, they will not have:

1) access to the information that we have
2) the direct connections to the various outpatient programs
3) the ability to group problem solve.

This creates the potential for

1) patient problems not to be solved at all
2) solved inefficiently
3) solved by some other healthcare provider.

Some problems that we solve for patients are not therapeutic in nature but process based. Our staff is familiar with various institutional and bureaucratic processes. Using that knowledge we help the patient to find a successful outcome. The current mix of pharmacists has a special blend of inpatient and community based expertise. They work effectively and collaboratively every day to find solutions to new and old problems. The new pharmacists will have to face these challenges; hopefully they will have equivalent knowledge and experience.

AHS says the private provider will be compelled to give equal or superior service as it will have to sign a service level agreement. I hope the new service level agreement is better than our unofficial service level agreement. That unofficial service level agreement, in my opinion, is "do whatever it takes to help the patient." Presently, "whatever it takes" is limited by our knowledge, training, experience, equipment and the number of hours in the work day. Until the next big thing comes along, we will continue to do the best we can for patients and staff. On a personal note, I do not intend to work for the private provider. I wish them good luck. I would prefer not to spend my time doing only part of the job that I do presently.

Glen Woo Bsc Pharm

Glen currently works at the outpatient pharmacy in the PLC and has been for the last 10 years.

The only true level playing field is the graveyard

I read, with interest, Dr. Lloyd Maybaum's article in the last Vital Signs in which he refers to being told that we didn't do a good enough job of lobbying in Calgary. Jack Davis spent many years advocating long and hard for the needs of Calgarians. Those in Edmonton did not appreciate this and the "one big happy region" was their way of silencing Jack's demands for fair treatment for our region.

I don't believe Calgary will EVER have the benefit of a "level playing field" any time soon. A simple example explains my belief. I was at a meet and greet gathering at the time Dr. Ducket arrived in Alberta. One of his first comments about Calgary was along the line of; "I don't know much about Calgary. All I know is that they've never come in on budget." My suggestion that he look at things factoring in population growth and cost of living was brushed off. Clearly the Edmontonians had managed to get to him and imbed in his mind their view of reality.

The Calgary reality is that there are those in power in Edmonton who do NOT like us down here and I doubt that ANY amount of lobbying will ever change their long cherished, inbred, beliefs. In this life the only truly level playing field is the graveyard. We shouldn't have to wait that long to be treated fairly.

Glenn Comm MD, CAPA past president.

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