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NOVEMBER 2019

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With 16 YRC fun runs hosted by schools across the province last spring, we wrapped up the school year in busy style!

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SUBMISSIONS:
Vital Signs welcomes submissionsfrom physicians in Alberta. Please limit articles to 1,500 words or less.

Please send any contributions to: Dr. Scott Beach, Medical Editor, zmsaadmin@albertadoctors.org

Vital Signs reserves the right to edit article submissions and letters to the editor.

The deadline for article submissions for the next issue of Vital Signs is Friday, November 22nd.

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SAVE THE DATES!

CAMSS

AGM: November 13, 2019 | Fort Calgary, 5:30-7:30 pm

ZAF: December 4, 2019 | Meredith Block – Boardroom 347, 5:30-7:30 pm

CZMSA

Executive Meeting: November 21, 2019 | WebEx, 7:00-8:30 pm

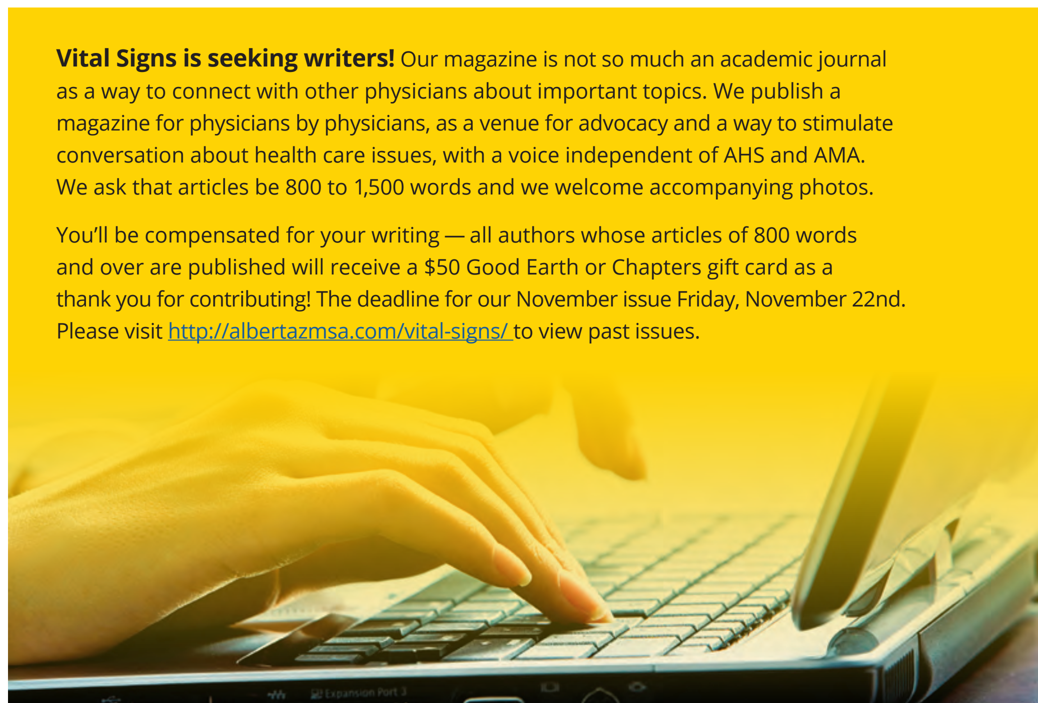
Executive Meeting: December 19, 2019 | WebEx, 7:00-8:30 pm

EZMSA

General Meeting: November 12, 2019 | TBD, 6:00-9:00 pm

Vital Signs is seeking writers! Our magazine is not so much an academic journal as a way to connect with other physicians about important topics. We publish a magazine for physicians by physicians, as a venue for advocacy and a way to stimulate conversation about health care issues, with a voice independent of AHS and AMA. We ask that articles be 800 to 1,500 words and we welcome accompanying photos.

You'll be compensated for your writing — all authors whose articles of 800 words and over are published will receive a $50 Good Earth or Chapters gift card as a thank you for contributing! The deadline for our November issue Friday, November 22nd. Please visit http://albertazmsa.com/vital-signs/ to view past issues.



View from the Beach

Message from Vital Signs Medical Editor Dr. Scott F. Beach

The first hint of its inevitable arrival was the deep chill that settled in the West on the evening of October 21st. The cool Blue blanket that fell across the prairies was the first harbinger to highlight the challenges that lay ahead for Albertans.

Dr. Scott F. Beach

The frost that formed following the pronouncements from the North on the afternoon of October 24th was the second sign of a cooling climate, as the crows of restraint rang from King Kenny's keep.

From that parliamentary pageant, what brought the deepest chill was not what was said, but that which was left unsaid. Health, known by all as the ripest of the lowest hanging fruit, is the most tempting and easiest of targets. Inevitable changes (read: cuts) are coming, potentially breeding many unintended consequences. Health will be plucked by eager hands, with physicians sitting squarely in their sights.

None who grasp the basics of math and the rudiments of budgetary control will deny that health, as a single line item consuming 42% of the whole, reflects a sustainable state. Not one stakeholder is unaware of the need for change. What shivers the spines of doctors in the province is the looming vilification of those who heal as the ones causing all the hurt. In our hearts and deep in our guts, the scrutiny of the PSB has great potential to leave all physicians SOL, so to speak.

As those in power espouse collaboration, the Blue Ribbon edict suggests dictation is the better way to go. Willful ignorance of the millions in savings that physicians have found through arduous work and honest remediation of the Schedule of Medical Benefits (SOMB) may be part of convenient amnesia in the larger dialogue. Negation tends to transform into arbitration, likely ending in what will be, in essence, appropriation. The breast- beating conviction that front line elements will go unscathed is incongruent with the desire and need for system change. In other words, Paul will most likely get the best of Peter.

Yet, as in times past, we will remain in high order and focused on our poignant mantra: patients first. Those from the patient's ranks who are aware of our compassionate provisions of healing measures will stand with us, much needed allies for the road ahead.

And how will this long winter unfold? Negotiations well underway will be under the storm clouds of a fickle economic state. Though physicians are a collaborative and highly fiscally aware ensemble, our system-stabilizing and patient supportive suggestions will be at best politely dismissed by the repeated saw of 'think of the beans', by those who count them.

An agreement once written will speak between the lines of reduced remuneration that will decrease support for overhead and expenditure address, both of which seem immune to our economic realities and continue to climb inexorably. Asked to pay more to do our jobs, and being 'paid' less for doing so, will begin an avalanche of unintended ends. For many physicians, Trump Town may begin to look more warm and inviting as the sun and fun of the South will be hard seductions to ignore. Those that remain will have no choice but to change how care is delivered, even as the resources for it fade. Carrying on the way we currently are, but with with less, will breed painful endpoints for all involved: patients, providers, and the system.

As the journey unfolds, as it has in times past, physicians may be defined in terms most unkind: rich, greedy, and selfish. Yet, as in times past, we will remain in high order and focused on our poignant mantra: patients first. Those from the patient's ranks who are aware of our compassionate provisions of healing measures will stand with us, much needed allies for the road ahead.

Unlike times past, however, there is no economic boom in sight, and the frozen state of our revenue stream shows no signs of a pending resurrection (see the eve of October 21st). Within this climate, I fear those in charge may push the needle toward painting us with a bright red bulls-eye, overwritten with 'Public enemy number one', across all our backs.

To further the 'Starkness' (pardon the Game of Thrones reference) of it, once this is worn by all, it may end as a tattered banner above the battlements of the Northern keep, where cephalic remnants may line the walls adjacent to that of old Ned. All this may come at the end of a ministerial order clutched in a mailed fist. Though not here as of yet (with the hopes that it will never be) we should be diligent, vigilant and prepared. Winter is coming.

Scott F. Beach, MD, CCFP
Medical Editor, Vital Signs

Honouring the trailblazers:

A thank you to Dr. Anne Fanning Binder and Rose Carter

Dr. Richard Bergstrom

Dr. Richard Bergstrom

Here's a challenge: think back to the late 70's. Oh right — I assume most of you can't, since you were not on this planet; perhaps a hope, but not yet a reality. Well, I can: I graduated from medical school in 1981.

It was fascinating to see how a group of more than 100 young people were tossed together and eventually became the class of '81. As we all know, it was a feat; we were busy with classes that started at 8 a.m. each day, with little time left over for even a coffee break with friends.

We were exposed to a variety of people throughout our time in school, but I want to celebrate two individuals who stood out, and I know inspired us all: Dr. Anne Fanning Binder and Rose Carter.

There are many others who were inspirational and taught us a lot: people who mentored, instructed, and helped us grow into the physician workforce. But I thought I would write about Anne and Rose, as they stood out as fantastic examples of professionals. Not to mention they are both women, and stood out even further at a time when medicine was far more male dominated than it is today.

Remember, it was the late '70s. The late 60's started a revolution: both with sexual freedom, and with women being able to choose the career they really wanted and were qualified for. My sister-in-law is a nurse practitioner, and she grew up in a house where women could be nurses, but never doctors. She should have been a physician — she is smart, kind, gentle and serving. She is doing a great job in her role, but I feel she was denied something because of her gender. This is perhaps why Anne and Rose stand out in my mind now, as I recognize the barriers they had overcome to be in their respective positions.

I was incredibly fortunate to be invited to a celebration dinner back in March for Rose, as she has stepped down from her role as Council for the Canadian Medical Protective Association (CMPA). When I received the invitation, I was gobsmacked — me, getting an invite from her? It was held at the Hotel MacDonald in Edmonton, and Rose was honoured for her work. The comment was made that most of us could not remember the first time we met Rose, but all of us remembered her vividly.

As discussed that evening, her story is that she came from a very humble background, and though she wanted to be a lawyer, this was not to be at first. She, too, was denied choice due to her gender. But Rose is a person of great strength, and she eventually became a lawyer. Her path brought her to have a key role with the CMPA. Rose came and spoke to us medical trainees about the law and our role as physicians. It's interesting for me now to think of a lawyer teaching doctors how to be good doctors, but Rose did it well; she inspired and also frightened us a little.

The fear she put in my mind was grounded in being 100% sure that, as a doctor, the patient's well being came first. She also taught us to reflect on how you speak and what you say, but more importantly, who is listening and what they hear. Sometimes medicine can be a culture of complaint and destructiveness. Rose taught me to put that aside, to serve and to push away that negativity that can grow like a cancer.

Rose Carter

Dr. Anna Fanning Binder

When Rose spoke, she delivered an impassioned message. There was always a bit of fire and brimstone in her talks. It was not to frighten people, but rather to teach people the implications of their work, their messaging, and their attitude. Rose spoke to the privilege of being a physician. She noted the compassion we need to grow, the listening we need in order to evolve, the service we must take to heart. No one was ever bored during one of her sessions. All I experienced was a crowd that was completely engaged, listening avidly and leaving the hall wiser, humbler, and feeling incredibly fortunate to have had the opportunity to listen to this amazing woman.

The same goes for Dr. Fanning Binder. Anne is a force to be reckoned with: she holds determination, strength, insight, focus, and the ability to command a room. Who thinks tuberculosis is deeply interesting? No one, until you meet Anne. She is passionate about it and she shares that passion with you — her enthusiasm is infectious in that you are almost immediately as driven to end and advocate for TB as she is.

Her and I can relate, as we are both of a certain age and have seen the evolution of social change over the years. I noted that in the late 70's, although the number of women in medical school was growing, there was still a sense of male superiority, or should I say opportunity. Nobel Prizes were given to men. Science was a male driven endeavour. Deans were men, surgeons were men, cardiac surgeons were definitely men. I told Anne that when she spoke, every single guy in the room wanted to be her. She commanded power, but not by taking power from others; rather, she gives the opportunity for empowerment.

She was also someone who served and worked incredibly hard; she would help you achieve TB testing whenever she could, and she was an active mentor to everyone. Her presence is powerful, her knowledge inspirational, and her humanitarian side ever-present. I felt lucky to be able to bestow upon her the title of Physician of the Year by the Regional Medical Staff in 2004. It may be small in the context of the other awards she's received, but it came with the cheering of a massive community that was glad to let her know that she is truly one of the best.

Rose and Anne, you are trailblazers and visionary women who have made a difference for so many of us. You both carry a legacy of excellence. You've taught us — physicians and otherwise — living in a sexist world that we were culturally immature. I want to personally thank you and publicly celebrate your lives, your gifts and your talents. All of your hard work has helped individuals and communities around the world, and you both continue to be icons for excellence. Your names will continue to ring through the halls of hospitals and medical schools, but most importantly, the hearts and minds of all the people you have inspired. Thank you.

Dr. Anne Fanning Binder is a global expert in tuberculosis and a renowned physician and educator. She was inducted into the Alberta Order of Excellence in 2017 for her advocacy work with TB, and for her efforts to raise awareness about pressing social justice issues in healthcare.

Rose Carter, Q.C. is a partner at Alberta's Bennett Jones law firm, and holds more than 25 years of experience in administrative and health law. She is a go-to authority for legal issues pertinent to the medical community, and also serves as an adjunct professor in the faculty of medicine at the University of Alberta.

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EZMSA ANNUAL PATIENT ACCESS SURVEY

EZMSA values good quality patient care. Purpose of this access survey is to compile data for benchmarking and to identify emerging access and resource issues in our zone.

The survey has been conducted annually since 1997. It is presented and discussed with the Major Provincial Stakeholders, including the Minister of Health.

Progressive change and innovative developments within health care, which improve waitlists, patient care, outcomes, system efficiencies, and affordability are to be encourage and are fully supported by the Medical Staff Associations.

Various concerns have been identified such as:
Insufficient Operating Room Time | Bed Shortages, Acute, Sub-Acute, ALC | Physician Resources, Workload, Long Wait Lists
Administration inefficiencies | Referral Delays

We value your input and appreciate your comments.

Thank you for taking the time to complete this survey! **https://www.surveymonkey.com/r/EZMSA_WaitlistSurvey2019**

Dr. Ernest Schuster, *President, EZMSA*

Gender equity & equality:

What these words mean, and why they matter in medicine

Dr. Shannon Ruzycki

Dr. Shannon Ruzycki, with reporting and editorial support from Shauna McGinn

The terms inequity and inequality are often used either interchangeably or incorrectly when discussing gender-based disparities between men and women physicians.* Equity and equality are distinct terms that have different definitions, interventions, and consequences for organizations. It's crucial that we understand what these terms mean, because confusing them can lead to disagreements about how and if these disparities should be addressed. Importantly, the pursuit of equality may lead to, or worsen, inequity.

It is also an important time to discuss this topic, as AHS has begun taking steps to address gender disparities following its report on women physician leaders last December. The response to this report spoke to the need for systemic change in medicine, and in order for that to happen, we need to understand why and how these inequalities and inequities exist.

Equality vs. equity

Equality refers to sameness[1]. Equality may refer to the same outcomes; for example, having identical numbers of men and women hired, promoted, or given leadership positions within an organization. When referring to equal numbers of individuals from each group, the term 'parity' is often used to be more specific[2]. It could also mean sameness in compensation, research funding, or administrative support.

Equal treatment, referring to the same treatment of individuals from different groups, includes access to opportunities, cultural expectations, and requirements for admission or promotion[1]. Equality in how individuals are treated is more

Parity — meaning a 50/50 split of men and women physicians — doesn't mean that equality has been achieved, and physicians tend to agree that this isn't necessarily the goal of gender equity efforts[38]

difficult to demonstrate, though most people agree — and it is enshrined in our nation's laws — that individuals should be treated equally, regardless of their gender, sex, sexual orientation, race, or religion.

In contrast, equity requires the recognition of differences between groups of people, and differential action to reduce the barriers that these groups face because of these innate differences[1]. These differences may be due to biological factors, or different cultural expectations. Equity is about fairness, which requires subjective judgement and depends on an individual's personal values, morals, ethics, and priorities.[1]

What this looks like in practice: pregnancy, childbirth, and parenthood

Experiences of pregnancy and parenthood provide a good example of what equality and equity — or lack thereof — can look like on the ground for many physicians. Equity is especially important in this case, because of how childbearing and parenting lead to unequal treatment and outcomes between male and female physicians.**

After delivery, physician mothers may require at least 6 weeks to physically recover from childbirth, whereas physician fathers typically do not require this kind of recovery. If we were to advocate for strictly equal treatment, we might suggest that men and women should both have 3-week long parental leaves, evenly splitting the difference between no time for recovery, and 6 weeks. However, this does not acknowledge innate biological differences between parents who give birth and parents who do not; though it would be equal, childbirth clearly requires an equity-based approach.

Available evidence demonstrates that female physicians are not receiving equitable treatment as related to parenthood. Female physicians who become pregnant, or are trying to conceive, have different needs compared to their peers; they require more time off for prenatal care, are at greater risk of miscarriage and infertility, and may benefit from reduced shift work or overnight call.[4-8] When returning to work, physician mothers may require structural support, such as adequate space and time to continue pumping breastmilk for their children, whereas physician fathers do not.[9-11]

This does not even begin to address differences based on cultural expectations of women and men that lead to increased domestic work for female physicians.[12, 13] Despite legal requirements that protect female physicians from discrimination due to pregnancy or parental status, and that require workplaces to provide adequate support for pumping breastmilk, most female physicians report ongoing gender-based inequities.[3, 8, 14] These inequities require additional physical and mental energy for women to overcome these challenges.

Addressing these gender-based inequities faced by physician mothers requires medical culture to value and prioritize these issues, and serves as an example of something that would require unequal — but equitable — treatment.

Equality when it comes to harassment & discrimination

Equity can be subjective, and decisions about equitable treatment are value-based and can be controversial. Remember: Canadian law requires that people be treated equally. Most arguments refuting the need for gender equity work in medicine emphasize that men and women physicians should be treated equally, and not "specially."[15] However, this argument ignores important barriers to the equal treatment of men and women in the first place, including the extensive documentation of implicit and explicit bias against women in the workforce.[16-18]

Differences in the documented rates of workplace harassment and discrimination between men and women physicians demonstrate that women physicians are not only treated differently, but worse, than male physicians. In Canada, more than 50% of female physicians reported gender-based harassment, including sexual harassment, compared to fewer than 5% of male physicians.[19, 20]

In fact, women physicians and medical students consistently report rates of workplace gender-based harassment and discrimination that are higher than their male peers (for examples, see references.[20-22]) This is direct evidence that men and women physicians are not receiving identical treatment at work. Sexual harassment and other forms of gender-based discrimination continue to be a persistent barrier that women physicians must overcome.[21, 23-26]

Why parity does not mean equality

Parity — meaning a 50/50 split of men and women physicians — doesn't mean that equality has been achieved, and physicians tend to agree that this isn't necessarily the goal of gender equity efforts.[38] Still, the argument that parity exists in some settings is often used as evidence that equality has been achieved, and that these efforts are no longer necessary.[3] However, this isn't the case — the goal should be equity; a fair, values-based way to remove barriers, not just easier-to-measure outcomes like parity.[1]

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Dr. Belanger says the goal is to have a highly qualified medical leadership that is adequately representative of all medical staff from an intersectional perspective, because ultimately, "Diversity is a strength not a weakness."

An example of this is the common — but incorrect — assumption is that the higher numbers of women in medical school indicate that we have achieved equality and equity in medicine. Numerical parity in men and women admitted to medical school was reached in Canada in 1996 — nearly an entire generation ago[27] — but we have yet to achieve numerical parity in the total number of practicing physicians.[28] This experience has been similar in Australia[29-32] and the U.K.,[33] where there has been numerical parity in medical students for over twenty years but persistent inequities and inequalities.

Parity is an outcome that may, but does not necessarily, result from equality or equity. Even when present in increasing numbers, women physicians continue to be paid less than their male colleagues,[34-37] experience greater discrimination when becoming parents[4-6, 8] and are less represented in academia[17, 38, 39] and medical leadership.[39-42]

What this tells us is that it is too reductive to use equality in one outcome (medical school admissions) as evidence that all other outcomes and experiences are invalid. Gender inequity in medicine is an issue that requires a nuanced understanding, and a multifaceted approach.

Addressing this issue in Alberta

Last year's report on women physician leaders in AHS has garnered widespread discussion about the leadership gap and other gender disparities within AHS, and more broadly in all medical settings in Alberta.

Dr. Francois Belanger, Vice President, Quality, and Chief Medical Officer of AHS, says the report was a necessary starting point. "We knew we had a blind spot there, and I have to say it really opened up our eyes, both as a group of senior leaders within the organization, but also for me personally," Dr. Belanger says.

One of the first steps taken to respond to the issues raised was the hiring of Dr. Debrah Wirtzfeld, who joined AHS in August as Associate Chief Medical Officer for Physician Health, Wellness and Diversity. Dr. Wirtzfeld will help oversee a plan that includes three targets: the gender inequity rooted in medical culture itself, organizational support for developing women physician leaders, and personal and professional support systems for wellbeing and self-care.

Dr. Belanger says a major part of this has to do with mitigating personal and implicit biases. "We want to ensure we have transparent processes for hiring, and how we address gender bias and other biases, and train people effectively," he says. A policy has since been developed that includes the assessment of bias as part of the AHS search and selection processes.

Over the past few months, Dr. Belanger and Dr. Wirtzfeld have been meeting with physician groups throughout the province to discuss gender disparities, and hear feedback on the best way to move forward. "There are, among our female medical staff, a lot of potential for leadership, and we recognize we're not tapping into that now, and we need to in order to be successful in the future," Dr. Belanger says.

Dr. Wirtzfeld says that the level of engagement at these sessions has been an encouraging sign that physicians are ready and willing to collaborate to address these difficult issues. "The culture shift is going to take many years to effect change. But I think really, the focus of this is to ensure that leadership brings forward and supports wellness and diversity, so that can spread across the culture over time," she says.

Dr. Belanger says the goal is to have a highly qualified medical leadership that is adequately representative of all medical staff from an intersectional perspective, because ultimately, "Diversity is a strength not a weakness."

A way forward

In order to realize the goal of a properly representative medical leadership, we need to advocate for both equality and equity in their respective forms. We need to understand that as physicians, different walks of life require different approaches, in order to ensure that every one of us is able to reach our fullest personal and professional potential.

Equality is about sameness: the same opportunities, the same respect, and the same level of support and safety regardless of the setting in which you practice. Equity is about looking at a person holistically and understanding why they need certain spaces, policies, and structures in order to overcome the barriers they may face.

As the AHS report shows, and the research has proved, there are persistent gender inequalities and inequities in medicine. Women and other minority physicians face inequities that must be addressed in order to, as Dr. Belanger indicated, unlock the untapped potential for leadership and the improvement of medical culture in Alberta and beyond

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Notes:

**Gender-based disparities in medicine have been most extensively documented for women physicians but also impact transgender, non-binary, and gender non-conforming physicians. These disparities likely disadvantage gender minority physicians more greatly than women physicians. In this article, I will specifically discuss women and men physicians because there is the most evidence for this comparison, but readers should note that this promotes a false binary for gender.*

***In this section, I discuss both biologic differences and cultural expectations of cisgender women physicians compared to cisgender men physicians. Please note that any individual with a uterus, including transgender men, non-binary individuals, and cisgender women, can become pregnant and can breastfeed/ chestfeed. Since the cultural expectations of parents and pregnancy-based discrimination facing transgender men and non-binary people who become pregnant will be different than cisgender women, this section will discuss primarily cisgender women physicians. This discussion also oversimplifies the experiences of adoptive parents.*

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The doctor as a teacher

Dr. Gregory Sawisky

As doctors, we are often expected to teach our younger colleagues, helping carry on a grand tradition in medicine that traces its roots back more than 2,000 years.

Dr. Gregory Sawisky

But where is the emphasis on the importance of being a teacher to our patients?

Not a single medical student makes it through their degree without being told — sometimes repeatedly — that the origin of the word "doctor" can be traced to the Latin word docēre, meaning teacher. This is the backbone to one of medicine's core beliefs: see one, do one, teach one.

However, a pithy phrase that captures the very real and important idea that we are also teachers to our patients doesn't seem to exist. Perhaps this idea has never been fully appreciated in the waning days of paternalism in medicine. And as medicine began to embrace shared decision making and patient values, the idea of a potentially patriarchal relationship with the doctor as a teacher, and the patient their student, was thought best to be avoided.

In my experience thus far in the practice of general medicine, I've come to realize that a large majority of what I do every day is teaching; to learners, certainly, but far more time is spent in my attempts to teach my patients.

We all innately know that in order for patients to understand their disease, their prognosis, and their treatment, some element of teaching always occurs during a consultation. But sometimes we are rushed, and some patients so trusting, that they may simply accept our explanations and therapies without necessarily understanding the rationale.

During my medical training there was extensive discussion around the role I would inevitably fill as a teacher to medical students and residents. Modules were completed on how to teach medical students, and how to ask probing questions and explore differentials.

Approaches to being a teacher for junior learners were taught and reviewed like the One-Minute Preceptor and the SNAPPS approach (i.e., summarize, narrow, analyze, probe, plan, and select for further learning), each a variant on the idea of focusing on understanding a medical presentation, and the ability to navigate through it.

But there was very little focus on how to teach patients. Certainly, many medical curriculums now involve interpersonal skills and communication, but I do not recall any lecturer speaking about how I would eventually be expected to not only diagnose and treat disease, but also teach the patient about causes and treatments.

I know my viewpoint is one of a generalist and my role is that in the primary care of the patient, while many specialists may often not need to focus their attention in the same way.

But certainly the majority of us in medicine are teachers when it comes to our patients. The pediatrician teaches the parents, the endocrinologist teaches the diabetic patient, the cardiologist teaches the patient with heart failure; the list goes on.

So what is the point of this mental and verbal gymnastic exercise?

Because, like every aspect of medicine, I have learned that if I can help a patient to understand the why, that can help them manage the how. When I was in journalism school, we were taught that the average adult reads at a Grade 7 comprehension level. When was the last time you picked up a book written at that level? If you ever do, the simplicity of the writing will shock you. However, we must understand that this is the average reading comprehension level, meaning there are many patients whose comprehension is below (or above) that level.

It is relatively easy to prattle on about diabetes for a few minutes discussing the pancreas, alpha and beta cells, insulin resistance, microvascular complications, and the need for glycemic and blood pressure control. However, I would be fascinated to know if, after a patient met with a physician and was asked to report back what they heard and what they learned, what differences might appear.

That is why there should be an emphasis in medical training to embrace the philosophy that our ability to enable our patients to understand what is going on in their bodies and minds may reap the biggest benefits. This may mean acknowledging the need for some degree of paternalism in medicine — heretical words, I know — and by understanding our patients' level of cognitive and literary function.

It will do us no good to offer patients explanations that they can't understand. Medicine should explore how we can become preceptors to our patients, and by doing so, we may be rewarded with better results and better outcomes.

Gregory Sawisky, MD CCFP
Ponoka, Alberta

FOOTNOTES

[1] https://www.merriam-webster.com/words-at-play/the-history-of-doctor

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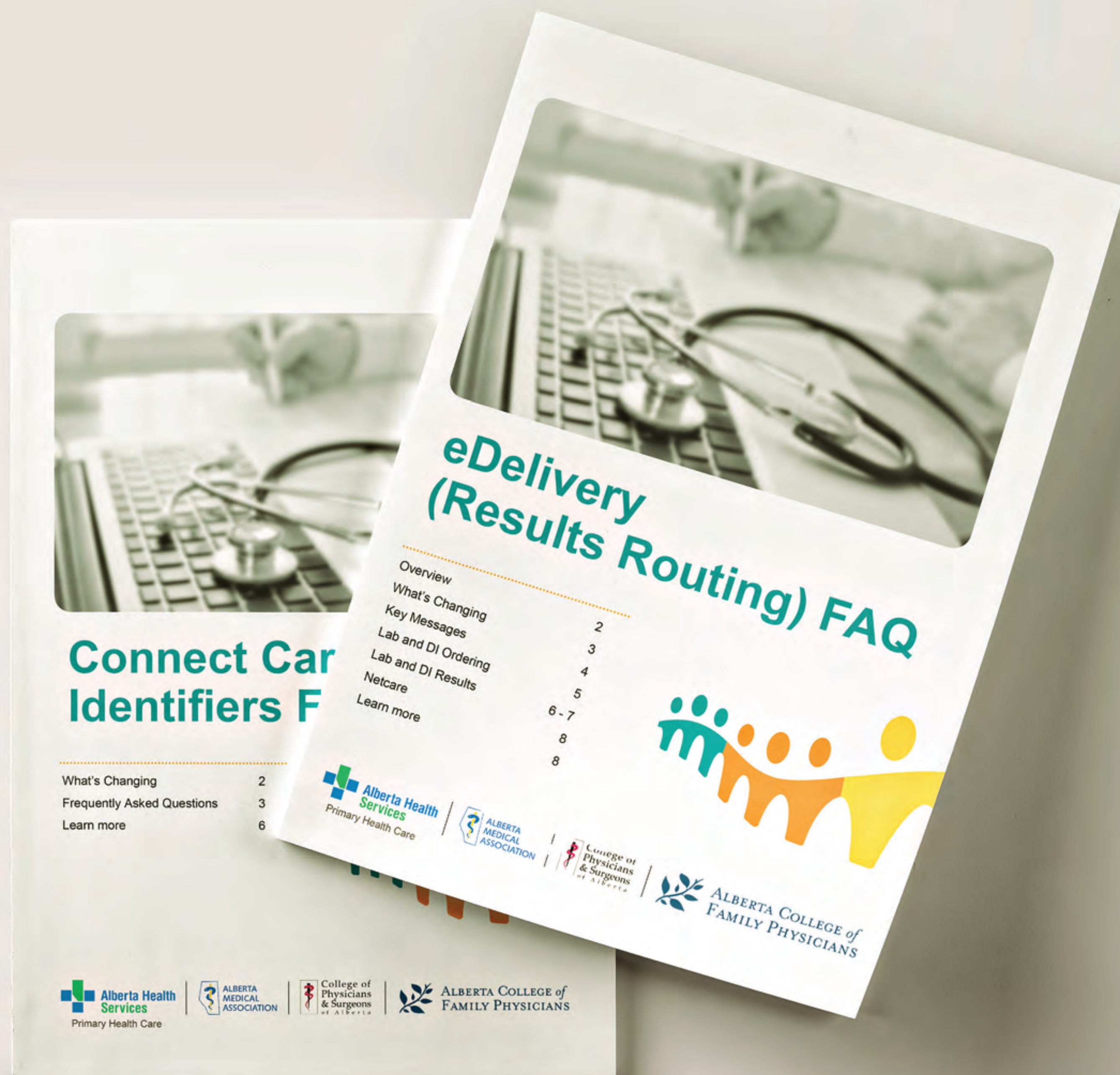
Connect Care FAQ

As of November 3rd, Connect Care has been rolled out in some healthcare settings in the Edmonton Zone, and waves of implementation will continue throughout the province over the coming years. Connect Care is a new health information system that providers across Alberta will need to learn and use going forward.

To help with this change, Alberta Health Services (AHS) has created detailed information documents.



Connect Care Identifiers FAQ

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Alberta Health Services
Primary Health Care
Alberta Medical Association
College of Physicians & Surgeons of Alberta
Alberta College of Family Physicians

The most important thing you need to know about Connect Care Identifiers

All providers across Alberta who order laboratory tests, diagnostic imaging, and other interventions will be given new Connect Care Identifiers (IDs) to use when ordering.

There are three types of identifiers:

1. *Connect Care Provider ID:* A single ID that identifies the ordering provider regardless of their location
2. *Connect Care Department ID:* Identifies the clinic location where diagnostic imaging is ordered from
3. *Connect Care Submitter ID:* Identifies the clinic location where laboratory tests are ordered from

These identifiers will be mailed to all impacted Alberta providers by mid-October, 2019. They will also be sent directly to EMR vendors. Use of Connect Care IDs will be phased-in as the program expands throughout Alberta. Providers should continue to their full name and address on requisitions during the phase-in period.

Connect Care IDs are distinct from Medical Record Numbers associated with individual patients and do not impact Netcare access.

Newly standardized requisitions will be phased-in for some orders.

This FAQ provides key information about Connect Care IDs and how providers will use them in ordering.

1. How and when will providers receive their new IDs?

New Connect Care provider IDs, submitter IDs, and department IDs will be mailed to ordering providers throughout the province by mid-October, 2019. Please watch the mail for this important comunication from Alberta Health Services. There will also be an online portal where providers can look up their IDs.

2. Will EMR vendors automatically update community-based EMRs?

Yes, AHS will send the new IDs to EMR vendors. The vendors will ensure that these identifiers are in their EMRs in advance of the November 3, 2019 Connect Care launch, so that eDelivery can route results to the correct provider. Most vendors are also configuring the new IDs onto requisitions that are printed from EMRs.

Connect Care Provider Identifier

The Connect Care provider ID is a unique number used to identify each ordering provider in the province.

This number will be used to identify providers in all areas and functions touched by Connect Care. It will be used to order laboratory tests, diagnostic imaging and other interventions.

Connect Care Submitter Identifier

The Connect Care submitter ID is one of two numbers used to identify the unique location (clinic or site) from which an order is placed. The identifier will ensure that results are delivered back to the correct clinic. The submitter ID will be used to identify unique clinics in lab orders and results.

Connect Care Department Identifier

The Connect Care department ID is the other identify used to identify a unique ordering location (clinic or site). The department ID is used on orders for and results of diagnostic imaging, endoscopy, and cardiology interventions.

3. When do providers start using the new IDs?

To find out when your area will be implementing Connect Care, visit:

- ahs-cis.ca/waves

Connect Care IDs will replace current lab and diagnostic imaging identifiers as the program expands throughout Alberta. At each implementation, some legacy IDs will be transitioned to Connect Care IDs. As the various Connect Care implementation waves proceed, interim state processes may require providers to enter legacy and Connect Care identifiers on requisitions for a short period of time.

4. Will there be new DI requisitions?

Diagnostic Imaging requisitions for imaging completed at community sites will not change. There may be minor changes to requisitions for imaging to be completed at AHS sites.

Updated diagnostic imaging requisitions for AHS imaging sites are always located at:

- ahs.ca/info/page9911.aspx

5. Will there be new lab requisitions?

Yes. Alberta Public Laboratories (APL) and DynaLIFE Medical Labs have developed a new standard provincial "Community Requisition." There is a DynaLIFE version and an APL version of the new requisition.

The new requisition will be introduced to community physician offices/clinics in alignment with the Wave 1 Connect Care implementation.

This requisition in Wave 1 is to replace the current "DynaLIFE General Community Requisition (1289-11/17)".

The remaining community requisitions will be replaced with the new APL "Community Requisition".

Old requisition forms will continue to be accepted during transition periods in order to support patient care. Providers are strongly encouraged to promptly adopt the new requisition forms.

More information about the DynaLIFE version of the requisition will be available in mid-October. Please watch out for Lab Bulletins.

6. Will new information be required when ordering tests?

Requisitions continue to require patient identifiers, clinic name, and clinic address. New Connect Care provider and location identifiers will also be required to ensure that the results are delivered to the correct location.

7. What do I need to do to prepare for the Connect Care IDs?

Step 1: Watch your mail for a letter from AHS containing your new Connect Care Identifiers.

Step 2: Verify that your identifiers are correct in your clinic EMR.

or

Add the new Connect Care identifiers to your clinic information on stamps used to add clinic information to requisitions. Clinics are responsible for obtaining new stamps.

Step 3: Begin using the Connect Care IDs on November 3, 2019.

8. How can I follow developments?

More information and further updates will be shared as they become available at a Connect Care bridges website at:

- ahs.ca/ccproviderbridge

The eDelivery FAQ, which contains additional information about how lab, DI, and other results will be sent to providers:

- ahs.ca/assets/info/cis/if-cis-cc-faq-edelivery.pdf

9. I have additional questions – who do I contact?

More information and further updates will be shared as they become available via the website and blog listed above. Please direct queries to:

- Email: ccproviderbridge@ahs.ca

Learn more about Connect Care

Connect Care:

Community: ahs.ca/ccproviderbridge

General: ahs.ca/connectcare

Blog: bridges.connect-care.ca

Email: ccproviderbridge@ahs.ca

Phone: *Coming soon!*

Alberta Netcare:

albertanetcare.ca

eDelivery:

ahs-cis.ca/edelivery

CII/CPAR:
topalbertadoctors.org/cii-cpar
albertanetcare.ca/learningcentre/cii.htm
albertanetcare.ca/learningcentre/cpar.htm

Alberta Health Services Primary Health Care | Alberta Medical Association | College of Physicians & Surgeons of Alberta | Alberta College of Family Physicians

eDelivery (Results Routing) FAQ

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Alberta Health Services
Primary Health Care
ALBERTA MEDICAL ASSOCIATION
College of Physicians & Surgeons of Alberta
ALBERTA COLLEGE of FAMILY PHYSICIANS

Clinics with a Community-based EMR using eDelivery

Continuity of care is about a patient and provider healthcare experience that is coherent, connected, coordinated and consistent with patient goals. It is hard to achieve if information does not flow smoothly across the continuum of care.

Community-based Electronic Medical Records (EMRs) support health information management for primary and specialty healthcare. The Connect Care clinical information system (CIS), implementing everywhere Alberta Health Services (AHS) is accountable for information management, will help bridge CIS and EMR spaces.

One bridge is Alberta's provincial Electronic Health Record, Netcare, which gains a wider range of information because of Connect Care integration. Another bridge is provided through 'eDelivery' of health information from the CIS and Netcare to Community-based EMRs, with Connect Care contributing more information that is easier for Community-based EMRs to capture and organize.

This FAQ reviews changes to eDelivery services that relate to launch of the Connect Care CIS.

1. Do eDelivery changes affect me?

If you provide care at a **single location** which uses a community-based EMR (e.g. Wolf, Practice Solutions, MedAccess, Accuro, Healthquest, Juno, etc.), and currently have lab or diagnostic imaging (DI) results delivered electronically to your EMR (without manually attaching them to a record), then eDelivery enhancements apply to you.

If you work in more than one location, with more than one EMR, or with both CIS and EMR, know that more information will be forthcoming.

We are working to provide specific guidance for providers who work in more than one location or who work both with the Connect Care CIS and one or more EMRs. Instructions will be posted on ahs.ca/ccproviderbridge

and blogged on

bridges.connect-care.ca.

2. What will eDelivery deliver?

If you receive at least one result type (e.g. lab, DI, or reports) via eDelivery today, you will be supported to receive ALL Connect Care results made available via eDelivery in the future. The CIS integrates AHS laboratory and other clinical support information services provincially. This brings a wide range of consistent information into eDelivery via a single standardized feed. As Connect Care spreads across Alberta over the next 3 years, a broader set of result types will be delivered to physician EMRs via eDelivery. You will start seeing these new reports when your patients attend a facility that has launched the Connect Care CIS.

3. How will I receive eDelivered results?

You will receive results in the same way as you do now through your EMR.

4. What about locums and trainees?

Continue to use the same processes that you do now when cross-covering or delegating test ordering or result review within your EMR.

The most important thing you need to know about coming changes

Providers currently receiving lab and diagnostic imaging (DI) results to their EMR via eDelivery will be given a new Connect Care Provider ID to put on all requisitions. They must also provide identifiers for their ordering location.

As always, requisitions require identifying patient information as well as the responsible provider’s name, clinic name, and address.

In addition, specific identifiers are needed to ensure that the right results get to the right provider, EMR, and location. These include a new Connect Care Provider ID and clinic identifiers (Department and Submitter IDs) that are unique to each ordering location. These changes relate to the integration of provincial laboratory information services and are not specific to eDelivery.

An important implication is that all providers at a single location must agree whether or not they want to receive eDelivery at their location. Previously, each individual chose whether they wanted to receive eDelivery or not. Now the ordering location as a whole is turned on or off for eDelivery of results and reports.

More information about Provider, Department, and Submitter IDs will be available in upcoming communications and FAQs.

5. Doesn't eDelivery have information about my practice location(s) already?

If you practice within Alberta and receive results today, AHS has information about you within existing systems, including eDelivery. AHS Health Information Management is validating provider information contained in Alberta's provider registry. This draws from College of Physicians and Surgeons of Alberta (CPSA) and other sources. You may be contacted for clarifications. You can contact AHS.ProviderRequests@ahs.ca at any time with concerns or corrections.

6. Who needs to know about practice location change(s)?

- Please continue to inform the CPSA of any changes in your practice location.
- Please direct Connect Care provider identity queries or corrections to: AHS.ProviderRequests@ahs.ca

7. Will lab test-ordering change?

You can continue to order labs the way you presently do. EMR result review workflows should not change. When Connect Care deploys in your part of the province, there will be new standard community requisitions. While old requisitions will continue to be accepted for a transition period, providers should adopt the new requisitions as soon as possible. EMR Vendors are aware of and are supporting the requisition changes.

8. Will DI test-ordering change?

You will continue to order diagnostic imaging (DI) in the same way that you do now. For DI exams performed in AHS facilities, current forms and processes will continue to be accepted. There will be other additional ways to order DI tests within AHS as Connect Care CIS implementation proceeds. Ordering DI performed at non-AHS facilities will not change.

Community Lab and DI eDelivery Timelines

- After the Connect Care CIS deploys in some parts of the Edmonton Zone on November 3, 2019, expanded eDelivery content will start to show for patients receiving care in facilities using the CIS.
- Results delivery tests performed in community DI facilities (e.g. Insight Medical Imaging, Medical Imaging Consultants, EFW, Mayfair, etc.) will not change.
- The following service areas transition to the CIS in time for the November 3 2019 Edmonton Zone Wave 1 launch:

Service Area	Connect Care Impact
General Labs	All lab services collected and/or performed by DynaLIFE at the following locations: • Northwest Health Centre (High Level) • St. Theresa General Hospital (Fort Vermillion) • La Crete Community Health Centre • Northern Lights Health Centre (Fort McMurray) • DynaLIFE Diagnostic base lab (Edmonton) • All community collection sites in Edmonton, Red Deer, Camrose, Lloydminster, Beaumont, Fort McMurray, Fort Saskatchewan, Sherwood Park, Spruce Grove, Evansburg and St Albert • Home collections performed by DynaLIFE
Clinical Pathology	All lab services collected and/or performed by Alberta Public Laboratories at the following locations: • University of Alberta Hospital • Kaye Edmonton Clinic • Mazinkowski Heart Institute • East Edmonton Health Centre • Cross Cancer Institute
Anatomic Pathology	All anatomic pathology in the Edmonton Zone including Alberta Public Laboratories and DynaLIFE
Transfusion Med	All transfusion medicine laboratory services in the Edmonton Zone
Diagnostic Imaging (DI)	Exams performed at the University of Alberta Hospital, Stollery Hospital, Mazankowski Heart Institute, Kaye Edmonton Clinic and Boyle-McCauley Health Centre
Endoscopy	Adult & pediatric endoscopies performed at the University of Alberta and Stollery Hospitals

9. What will results look like?

Via eDelivery:

The same clinical information will be provided in the same way via eDelivery. There may be slight changes to things like normal (reference) ranges; as these have been provincially standardized through Connect Care.

Not via eDelivery:

Faxed or mailed results may also appear slightly different. They will contain the same clinical information, including provincially standardized reference ranges, as eDelivered results.

10. Do I need to request to be set up for Connect Care eDelivery?

If you are receiving at least one result type via eDelivery today, you do not need to do anything more. You will receive Connect Care results via eDelivery when they become available.

If you do not receive results by eDelivery today, and would like to begin, visit ahs-cis.ca/edelivery for guidance.

11. Can I receive all results from Connect Care via eDelivery?

Most lab results and DI related to facilities using the Connect Care CIS will be delivered via eDelivery. A small subset of results will be delivered by fax or mail until new interfaces are developed. Results from independent DI facilities may not be included in eDelivery.

12. Will my EMR be ready for these changes?

AHS and the Alberta Medical Association work closely with EMR vendors to ensure that all EMRs are ready for enhanced eDelivery.

13. What is happening with Netcare?

Netcare also benefits from the integration that Connect Care brings to many lab and DI information services, with enhancements starting to appear this fall:

- Flowsheets and cumulative result displays will be able to consolidate information from all parts of the province
- Support for Gender X is introduced
- Some test results are more consistent by virtue of provincial standards for things like reference ranges
- Additional clinical documents and reports become available
- Categorization of results and reports (folder names in the Netcare outline) is more consistent, with some new categories for new information types.

More details will be provided in the coming months, including training suggestions. See:

- albertanetcare.ca/EHRData.htm
- albertanetcare.ca/LearningCentre

14. How can I follow developments?

More information and further updates will be shared as they become available at a Connect Care bridges website at:

- ahs.ca/ccproviderbridge

And a Connect Care Bridges blog at:

- bridges.connect-care.ca

15. I have additional questions – who do I contact?

More information and further updates will be shared as they become via the website and blog listed above. Please direct queries to:

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Alberta Netcare:

albertanetcare.ca

eDelivery:

ahs-cis.ca/edelivery

CII/CPAR:
topalbertadoctors.org/cii-cpar
albertanetcare.ca/learningcentre/cii.htm
albertanetcare.ca/learningcentre/cpar.htm

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The ZMSA annual membership process is conducted through the AMA. You can expect to receive an email from AMA Membership Services providing you with a link to complete your renewal. If there is no email address on file for you, the membership form is sent by mail. If you wish to switch to online renewal please contact the ZMSA Admin Office at **zmsaadmin@albertadoctors.org** to provide your email address.

Your zone membership options will default to what you selected last year, if applicable. You can make changes as you wish.

Have questions? Please feel free to contact the ZMSA office at zmsaadmin@albertadoctors.org.You can also find step-by-step instructions with screen shots on our website: **www.albertazmsa.com**

Your Voice Needs to be Heard

Please take the opportunity to share your voice with us. Vital Signs exists to inform, inspire, and advocate for physicians in Alberta by sharing issues and ideas pertinent to the profession. We do this by publishing articles written by physicians that have something to say, and are looking for a place to translate and discuss their ideas. The Vital Signs team can help see your ideas to fruition, so that your story is told in the strongest way possible.

Whether you have contributed countless articles or you merely enjoy reading Vital Signs, thank you for your time and attention.

With that said, we've got big plans for Vital Signs and we hope you'll join us on our journey. Certainly continue to keep reading Vital Signs but we encourage you to do more. Tweet about the things you read and interest you, share links to our online version with friends and colleagues and write for Vital Signs. The doctors who have contributed always find it a rewarding experience.

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CONTENT:
Content submitted to Vital Signs should be of interest to and advocate on matters pertinent physicians in Alberta, such as:

- Patient care: quality, safety, and interdisciplinary aspects
- Service planning and delivery
- Medical and workplace culture, and wellness — Specific issues within your field that other physicians should be aware of
- Medical Staff bylaws and rules

Content submitted should be original and is published at the discretion of the Editorial Committee. Content should reflect the goals of the ZMSAs and be respectful and constructive. It's also important to remember that this is not an academic paper: this is a chance to use a more casual tone — Vital Signs is an ongoing conversation, physician to physician.

FORMATTING:
Articles submitted should be approximately 800-1,000 words in length (sometimes longer depending on the subject matter) and in MS Word format with sources cited and trademarks and copyrights honoured.

Please observe writing conventions:

- Be brief, but engaging. Limit unnecessary words and adopt plain language where possible.
- Use action words and make it clear how this information will directly benefit the reader.

*__Note:__ *With the addition of a Staff Editor/Writer to the Vital Signs team, there is now the option to have an article produced via interview or a writing framework, should you prefer that. Please get in touch with the Staff Editor/Writer (e-mail given below) for more details.*

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