

The Messenger

College of Physicians & Surgeons of Alberta

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The Messenger

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Deadline for submission of articles is June 29. Please send any submissions to info@cpsa.ab.ca.

2010 Council

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The College of Physicians & Surgeons of Alberta (CPSA) is responsible for licensing physicians, administering standards of practice and conducting/ resolving physician-related complaints. We also provide leadership and direction on issues of importance to the health care system such as access to services, quality improvement, patient safety and privacy.

Registrar's Report

Performance targets, measures and feedback for health care costs



I find it interesting that Alberta spends more on health care per capita than other provinces yet, as best we know, gets no better results. Up front I will state that we do not have a good system for capturing measures of quality – with some notable exceptions – and that having targets, measures, feedback and reporting is one of the themes I wish to promote.

As the US went through its agonies of health care reform, researchers and commentators offered some very interesting observations and possible solutions. I suggest readers who are interested in the costs of health care in the US read the *New Yorker* article by Atul Gawande (*McAllen, Texas and the high cost of health care*; *The New Yorker*: June 1, 2009) and recent articles in the *New England Journal of Medicine* by Elliot Fisher and colleagues from Dartmouth Medical School (e.g. *NEJM*: Volume 361: 2301-2303; December 10, 2009).

Gawande's article emphasizes the role that physicians can play in driving health care costs, and the negative correlation between cost and quality of health care. The articles from Dartmouth reinforce these points, explaining that, in the US, higher spending regions do not get more effective care (evidence-based care), do

not get more preference-sensitive care (like hip and knee replacements), but do get more 'supply sensitive care'. That is, those higher spending regions spend more on total in-patient days, days in ICU and CCU, on specialty consultations and on DI and laboratory testing, but all of that spending does not translate into better outcomes. In fact, the outcomes are worse.

Without proper measures we don't know where we are, and we won't know if the changes we make are for the better.

When examined more closely, higher spending between regions and between physician groups in the US is largely due to overuse of supply sensitive services. This seems to be related to the payment system and to capacity (e.g. the more specialists and hospital beds available the higher the costs), and to clinical decisions made by physicians (e.g. how often one sees a patient with controlled hypertension) rather than to patient preferences. The more specialists in an area, the more consultations and testing will be requested. In contrast, those areas in the US with stronger primary care practices and presence experience both more cost-effective care (less expensive care) and higher quality care (better outcomes). Stated differently, physicians in the US, particularly specialists rather than primary care physicians, often drive the costs of health care.

Fisher advocates for the formation of accountable care organizations, provider-led organizations whose mission is to manage the full continuum of care and

to be accountable for the overall costs and quality of care for a defined population. This idea is very appealing to me.

Translating this concept to Alberta's health system, one could see a greater emphasis on, and support for, primary care networks (PCNs), with more defined authority and responsibility being accepted by these entities. If such an approach was taken, the health system and PCNs would require more useful measurement of quality processes and outcomes to verify that the public being served is receiving safe, effective, appropriate care.

Whatever approach is taken, I believe we desperately need more and better measurement in Alberta. Without proper measures we don't know where we are with respect to our provision of quality services, and we won't know if the changes we make are for the better. We should be able to do much better than just dividing the budget of Alberta Health and Wellness by the number of people in Alberta and coming up with a per capita cost of health care. If we are to have a better system, we must be able to measure it!

While I doubt that we would find the same magnitude of regional variations in Alberta that Gawande found in Texas, I am pretty sure we'd find quite dramatic individual variation among physicians. As the group that directly costs the people of Alberta about \$3 billion per year and drives many of the costs in the system, I think it is time that the medical profession takes responsibility for the costs it incurs. It should demand performance targets, measures and feedback, and, within 'accountable care organizations' like primary care networks or departments of surgery or psychiatry or internal medicine, it should address

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the variation in practice quality and costs of its members. That would be 'self regulation' on a level that would be very meaningful to the public, other health professionals and payers.

At some time in the near future, Alberta will have new health legislation – the *Alberta Health Act* – replacing and consolidating a number of key pieces of legislation such as the *Hospitals Act*, the *Alberta Health Care Insurance Act* and the *Health Care Protection Act*. The Minister's Advisory Committee on Health (MACH), appointed last fall and whose report has been published, made a number of recommendations that will help form this new legislation. I am very

excited to have been appointed to the (new) advisory committee assisting MLA Fred Horne in implementing the MACH report and assisting in the development of this new legislation.

The agenda and scope of work planned for this committee is very ambitious. Not only are five pieces of legislation to be merged, but the new legislation is intended to:

- state the principles under which health care in Alberta will be organized and delivered,
- develop a patient charter,
- create an arm's length organization to provide evidence based decision making to health, and

- consider the definition of what services will be covered (insured) by the publicly funded health care system.

I am committed to working with the Council of the CPSA, the Alberta Medical Association, my fellow committee members and interested stakeholders to assist in the creation of legislation that will fulfill the Premier's mandate of having the best performing publicly funded health care system in Canada.

As always, your feedback is welcomed.

Dr. Trevor Theman, Registrar
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College registers as an organizational lobbyist

What is lobbying and why is it important?

In March of 2010, the College of Physicians & Surgeons formally registered its government relations activities with the Office of the Ethics Commissioner of Alberta. As a result of the registration process, the College is now officially an organizational lobbyist under Alberta's *Lobbyist Act*.

When any member of the public talks to government on important issues, hoping to influence its direction on specific issues, it is called lobbying.

Governments encourage this long-standing practice as free and open access to elected government members and their staff. It is seen as an essential pillar in the delivery of good democracy.

Contrary to general perception, communicating with government is not discouraged or frowned upon. Reminding government it is not the expert in all areas of public interest is a good thing. Offering sound evidence and sensible



rationale on matters where organizations or individuals are the experts directs better public policy. Trying to get government to understand and accept a specific point of view is what lobbying is all about. The *Lobbyist Act* simply legitimizes the process.

Leadership

The College believes that talking to government is its responsibility and its right. Registering as an organizational lobbyist declares to the public that we intend to

communicate with government – openly and often. We want to operate in accordance with lobbyist legislation, and the Office of the Ethics Commissioner has given us permission to do so.

As one of the first regulatory medical bodies in Canada to take this step, the College is once again leading the way for other self-regulating bodies who may wish to expand or formalize their lobbying activities.

Managing physicians with health concerns

The College's primary responsibility is to ensure Alberta physicians provide safe, quality care to their patients.

An important factor in meeting this responsibility is ensuring physicians do not have health concerns that affect their ability to practise.

Ideally, every physician would have access to a family doctor and would seek appropriate advice when health concerns arise. Unfortunately, as physicians, we often neglect our own health needs, focusing instead on providing services to patients and colleagues. It is surprising how many physicians do not have a family doctor, or how often physicians neglect to seek care when they are depressed or struggling.

The question about *when* a health condition should come to the attention of the College is a difficult one. On the one hand, physicians should be able to access confidential medical care just as any other patient would, without needing to report their information elsewhere. On the other hand, physicians work in a safety-sensitive occupation and make significant decisions about the care of their patients.

Other safety-sensitive occupations require regular medical examinations and ongoing oversight of medical conditions to ensure an individual's health does not affect his or her ability to carry out du-



ties. Medicine does not have that formalized safety net, so the College works with individual physicians to manage their health concerns.

Management of health issues occurs outside the College's disciplinary process and most physicians can return to work with appropriate supports. Restrictions or loss of a licence are extremely rare and occur only if an independent assessment determines the physician is unfit to practise.

Some physicians have expressed concern about the privacy of personal health information provided to the College. Let me assure you this information is confidential with extremely restricted access - it is not available to general College staff or third parties.

Even after clarifying the College's approach, it is understood that some physicians will still experience anxiety when their health issues are brought to the

attention of the College, or will "go underground" and not seek care if required to report the details to the College. To help address some of these concerns, we are sharing our policies in a more public manner. For details on how the College manages physician health conditions, go to www.cpsa.ab.ca/Services/PHMP/Policies.

These policies explain the College's approach for conditions such as blood-borne illnesses and infections, addiction and substance abuse, other medical conditions, boundary violations and disruptive behavior. Although some of these policies are being reviewed to ensure compliance with the *Health Professions Act*, the overall approach will not change.

I welcome your feedback and comments.

Dr. Janet L. Wright, Assistant Registrar
JanetL.Wright@cpsa.ab.ca

New notification process for annual licence/practice permit renewal!

The College's notification process for licence/practice permit suspension has changed. What you can expect later this year:

- Physicians will continue to receive notices in mid-October, November and December with information on how to renew and the applicable deadlines.
- After December 31st, those physicians with an outstanding fee and/or an incomplete Registration Information Form (if applicable) will receive a registered letter during the first week of January notifying them that they will be suspended as of January 17, 2011 if the required items are not received by the College.
- **The College will no longer provide courtesy phone calls prior to suspension.**

Prescribing Corner

Highlights of new opioid guideline recommendations

Introduced in the last *Messenger* and released in May, the *Canadian Guideline for Safe and Effective Use of Opioids in Chronic Non-Cancer Pain* offers 24 recommendations to help physicians safely use opioids to treat patients with chronic non-cancer pain.

For easy reference, the recommendations are organized into five clusters, each of which will be featured in issues of *The Messenger*, beginning with Cluster 1 below:

Cluster 1: Deciding to Initiate Opioid Therapy

R01: Before initiating opioid therapy, ensure comprehensive documentation of the patient's pain condition, general medical condition and psychosocial history (Grade C)¹, psychiatric status, and substance use history. (Grade B)¹

Comprehensive knowledge about the patient's medical history and appropriate documentation is important. Consider reviewing prior medication use by accessing data from the CPSA's Triplicate Prescription Program and/or information from the Pharmaceutical Information Network.

Note: It is appropriate to decline prescribing opioids until you have compiled the patient's medical history and decided on a treatment plan.

R02: Before initiating opioid therapy, consider using a screening tool to determine the patient's risk for opioid addiction. (Grade B)¹

The key risk factor for addiction is current or past history of addiction – this should be explored before initiating opioid therapy. The Canadian Guideline offers a variety of screening tools to help physicians assess the risk of addiction.



Note: Opioid addiction has a prevalence of 3.3 per cent in patients receiving opioids for chronic non-cancer pain.²

R03: When using urine drug screening (UDS) to establish a baseline measure of risk or to monitor compliance, be aware of benefits and limitations, appropriate test ordering and interpretation, and have a plan to use results. (Grade C)¹

Urine drug screening and other adherence monitoring methods have been shown to reduce the risk of substance abuse but are generally underutilized.³ The Canadian Guideline describes point-of-care testing and laboratory options, including the advantages/disadvantages of each version and how to interpret unexpected results.

To employ these methods of monitoring, determine what tests are available at your lab and specify which medication you are monitoring.

R04: Before initiating opioid therapy, consider the evidence related to effectiveness in patients with chronic non-cancer pain. (Grade A)¹

Part A of the Canadian Guideline examines the literature review and evaluation of the evidence that support the

guideline recommendations. The results demonstrate:

- Opioids were shown to be more effective than placebo for both pain and function.
- Opioids were found to work better for pain than for function.

More specifically:

- Opioids were shown to be effective in placebo-controlled trials for the chronic non-cancer pain conditions nociceptive pain of musculoskeletal origin and neuropathic pain.
- Two randomized trials of the weak opioid Tramadol, used for Fibromyalgia, showed a small benefit in pain reduction only.

Note: Chronic non-cancer pain conditions that have not been studied in placebo-controlled trials include headaches, migraines, irritable bowel syndrome and pelvic pain.

R05: Before initiating opioid therapy, ensure informed consent by explaining potential benefits, adverse effects, complications and risks. (Grade B)¹

Informed consent is important for all medical treatments, including opioids.

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Set realistic goals with your patient early on, such as improved pain intensity by 30 per cent and/or increased function. Consider using a treatment agreement with firm boundaries - many physicians find this tool useful.

Note: Physicians and patients should be aware of the adverse effects and medical complications that stem from long-term opioid use.

R06: For patients taking benzodiazepines, particularly for elderly patients, consider a trial of tapering (Grade B)¹. If a trial of tapering is not indicated or is unsuccessful, opioids should be titrated more slowly and at lower doses. (Grade C)¹

The combination of opioids and benzodiazepines increases the risk of sedation,

overdose and diminished function in patients. Opioids should be prescribed more slowly and at lower doses for patients on benzodiazepines. The Canadian Guideline offers practical advice for conducting a benzodiazepine taper in its Appendices.

(Next issue: Cluster 2: Conducting an Opioid Trial)

The complete guideline and practice tools are available on the National Pain Centre website at McMaster University⁴ or from the College website. Practice tools can be downloaded or printed for clinical use. If you have feedback or comments on this month's Prescribing Corner, contact Dr. Susan Ulan, Senior Medical Advisor at: 780-969-4930, 1-800-561-3899 ext. 4930 (in Alberta), or email Susan.Ulan@cpsa.ab.ca.

References:

¹McMaster University; National Pain Centre website, Recommendation Grading (http://nationalpaincentre.mcmaster.ca/opioid/cgop_a10_literature_search_methods.html#table_a10_03_02).

²Fishbain, DA et al. *What percentage of chronic non-malignant pain patients exposed to chronic opioid analgesic therapy develop abuse/addiction and/or aberrant drug-related behaviors?* Pain Medicine. 2008 May-June; 9(4):444-59.

³Manchikanti, K et al. *Does adherence monitoring reduce controlled substance abuse in chronic pain patients?* Pain Physician. 2006;9:57-60.

⁴McMaster University; National Pain Centre website (<http://nationalpaincentre.mcmaster.ca/opioid/>).

Prescribing
CORNER

Next issue: Cluster 2: Conducting an Opioid Trial

83rd Annual North-South Doctors' Golf Tournament

Join us for Alberta's most historic golf event

8 a.m., Monday, July 26th -- Red Deer Golf and Country Club

Registration is \$250 per person and includes 18 holes of golf, power cart, full breakfast, BBQ steak luncheon, use of driving range and practice facility, souvenirs and opportunities to win great prizes. The first 100 people registered will also receive a souvenir golf umbrella.

Register Online: https://www.regonline.ca/83rd_annual_north_south_golf



Spotlight on Standards of Practice

In this issue of *The Messenger*, Spotlight on Standards of Practice will highlight:

- Completing Discharge Summaries, and
- Transfer of Care

Standards of Practice are required under the *Health Professions Act*. They outline what the College expects of Alberta physicians regarding professional behaviour and good medical practice.

Physicians are welcome to contact the College for help in interpreting the Standards of Practice by calling 780-423-4764 or 1-800-320-8624 (in Alberta).

General inquiries regarding the Standards of Practice can be directed to policy@cpsa.ab.ca, 780-969-4968 or 1-800-320-8624 ext. 4968 (in Alberta).



important information in the medical record is more immediately available to other health care providers who assume the care of that patient.

The standard of practice intentionally does not impose detailed requirements for discharge summaries. This provides more latitude for hospitals and health care facilities in designing their own policies and procedures.

Transfer of Care – Ethics, Integrity, and Professionalism

The underlying principle in the Transfer of Care standard is to ensure the continuity of care for the patient who is discharged from or transferred within a health care facility. The standard highlights the need for the receiving physician to get all relevant and timely information to ensure that the expectations and needs for ongoing care can be implemented.

When information is shared in a timely manner, the receiving physician does not have to chase down the information from the institution. It also ensures that appropriate follow-up and additional treatment is not delayed.

The quality of the information provided is important. If there is critical information to be provided to the receiving physician before a written discharge summary can be provided, a physician must ensure that information is transferred verbally if appropriate. The amount of information provided will be determined by the care needed by the patient.

Note: The College does not hold a physician responsible for systematic issues where delays in transcription and delivery of information are outside of the physician's control.

Completing Discharge Summaries – Ethics, Integrity, and Professionalism

When a patient is discharged from or transferred within a health care facility, a physician has a professional responsibility to ensure relevant information for continued care follows the patient. Completing a formal discharge summary is one common practice that helps to ensure the interprofessional transfer of patient information.

The standard of practice on Completing Discharge Summaries describes a physician's obligation to not only provide relevant information but also to do so in a timely fashion. Timely discharge summaries help to ensure medical records are not tied up waiting for paper work to be completed. A timely process also ensures

CPSA Registration Department

Focusing on customer service

The number of registered physicians in Alberta, and the number of applications coming into the College, have been growing steadily over the last decade.

Over the last five years, the College has responded to a 56 per cent increase in physician registrations, a 56 per cent increase in professional corporations registrations, and a 53 per cent increase in the number of Certificates of Standing being issued.

College staff regularly seek ways to revise internal processes and improve the timeliness and accuracy of their work. Recent department accomplishments include:

- Pre-application screening process via eligibility review
- Web-based online application forms
- Online application process for medical residents and students developed in collaboration with Alberta's faculties of medicine
- Web-based application process for physician extender registration
- Development of an online annual renewal process
- Electronic transmission of Certificates of Standing
- Online annual renewal for professional corporations
- Online application process for limited practice and courtesy registers
- Development of a quality review process
- Development of an online registration eAppointment

All of these initiatives are focused on providing better service to Alberta physicians. We welcome your feedback.

Bruce Leisen, Registration Manager
Bruce.Leisen@cpsa.ab.ca

As the volume of work continues to increase, the department is planning for future enhancements, including:

New physician members by year

| Year | New Members | Per Cent Change |
|------|-------------|-----------------|
| 2009 | 2231 | 3.6 |
| 2008 | 2154 | 4.0 |
| 2007 | 2072 | 10.9 |
| 2006 | 1868 | 8.9 |
| 2005 | 1715 | 13.1 |
| 2004 | 1516 | 1.7 |
| 2003 | 1491 | 0.0 |
| 2002 | 1490 | 19.1 |
| 2001 | 1251 | 11.7 |
| 2000 | 1120 | - |

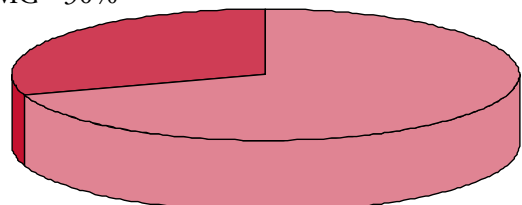
New physician members each year by register

| Year | Full | Special | Post Graduate | Physician Extender | Under Graduate |
|------|------|---------|---------------|--------------------|----------------|
| 2009 | 651 | 367 | 752 | 121 | 340 |
| 2008 | 619 | 368 | 753 | 106 | 308 |
| 2007 | 532 | 371 | 781 | 93 | 295 |
| 2006 | 517 | 332 | 681 | 64 | 274 |
| 2005 | 485 | 315 | 591 | 90 | 234 |
| 2004 | 416 | 234 | 567 | 67 | 232 |
| 2003 | 426 | 225 | 510 | 85 | 245 |
| 2002 | 402 | 253 | 458 | 140 | 237 |
| 2001 | 384 | 194 | 435 | - | 238 |
| 2000 | 340 | 180 | 371 | - | 229 |

Members in practice

Domestic vs International Graduates:

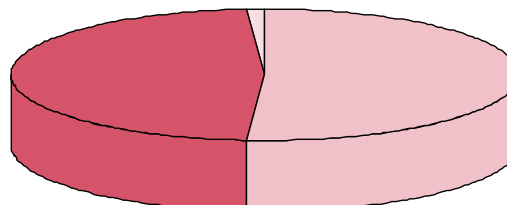
IMG - 30%



DMG - 70%

Nature of Practice:

Non-Specialist restricted to specialty discipline - 1%



General/Family Practice - 48%

Specialist - 51%

For your information

Halifax 10: The Canadian Healthcare Safety Symposium

The Anniversary Meeting
October 21 to 23, 2010
The Marriott Waterfront, Halifax, NS

The Halifax Symposium has changed significantly over the last 10 years, as has health care safety, both nationally and internationally.

For this Tenth Anniversary, the Organizing Committee has invited back some of our great faculty from previous programmes. We wish we could bring back every speaker who has contributed to the legacy of this series, but because of time and financial limitations, we have had to limit our choices for this year's program. These speakers have been challenged to reflect on what they previously presented and to provide an update on their topics in light of current thinking. We have also asked them to give their perspectives on what the next decade should or might bring. We hope you like our choices and we look forward to welcoming you to this, our final Symposium. Keynote Speakers include Dr. James Reason, and Dr. Charles Vincent.

Two Pre-Conference events will also take place on October 21: Pre-Conference 1: Disclosing, Informing and Investigating; Supporting a culture of safety, and Pre-Conference 2: The economics of health care safety.

Visit the Symposium website at www.buksa.com/halifax.

September ECG Examination

Date: Tuesday, September 14, 2010
Time: 9:00 am to 12:00 pm
Location: Edmonton; CPSA Office;
2700-10020 100 ST NW

The fee, including GST, is \$500. Registration forms are available at

www.cpsa.ab.ca (under Programs and Services - Accreditation/Quality of Care - ECG).

For more information, contact Ms. Laurel MacKinnon at 780-969-5008 or by fax at 780-428-2712.

College Chaperone Training Course

The College of Physicians & Surgeons of Alberta (CPSA) promotes the presence of a chaperone during intimate examinations and is once again offering a chaperone training course for staff working in physician offices.

Date: Monday, September 20, 2010
Time: 10:00 am to 4:00 pm
Cost: \$250 (plus GST)
Location: Edmonton; CPSA Office;
2700-10020 100 ST NW

To register call 780-969-4941 or email Charlene.Hiemstra@cpsa.ab.ca.

Patient Safety Course

If you are a health care professional who wants to expand your understanding of patient safety and quality concepts, the University of Calgary is offering *Certificate in Patient Safety & Quality* - an 11 session course scheduled for Fall of 2010 and Winter 2011. Course is approved for CME credits.

Learning objectives include:

- Distinguish and describe the components of a health care safety & quality model
- Describe core principles of patient safety & quality
- Identify key strategies for designing & delivering safer / higher quality health care
- Explain the critical role that micro-system and macrosystem leadership has for patient safety & quality
- Describe how a health care system should respond when the outcomes

of health care design and delivery are not optimal

- Develop and present a patient safety / quality project

For more information and to register see course brochure at www.cpsa.ab.ca.

WCB - Use the right codes and get paid on time

For faster and more accurate processing of WCB invoices, here are some helpful tips to save you time and money:

Payments for Injection

- ✓ Bill for tetanus shots under code 13.59A.
- ✗ Don't bill for local infiltration injections (13.59H) in conjunction with suturing codes 98.22B or 98.22A.

Business Cost Fees

- ✓ Bill a business cost fee only when services are provided in an office setting.
- ✓ Use business cost fee BCP02 when a patient is seen in Calgary or Airdrie and BCP01 for all other locations in Alberta.
- ✗ Don't bill a business cost fee when services are provided in any hospital setting (e.g. hospital outpatient clinics or cast clinics).

If you have any questions about billing codes, please contact the WCB Health Care Services team at 780-498-3219.

HQCA endorses national standards for automated ID of pharmaceuticals

In an effort to increase patient safety, the Health Quality Council of Alberta (HQCA) is encouraging everyone in Alberta's health care system to familiarize themselves with a newly published document entitled *Joint Technical Statement on Canadian Pharmaceutical Automated Identification and Product Database Requirements*.

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The document provides technical requirements for Canadian pharmaceuticals in the following areas: bar code components and symbologies, product database ele-

ments, medications to be included in the categories to be bar coded, and packaging levels and bar code placement.

More information can be found online at the Institute for Safe Medication Practices Canada (ISMP) website: <http://www.ismp-canada.org/barcoding/index.htm>.

New physician search results on CPSA website Additional information displayed to meet HPA requirements

The College has enhanced its Physician Search function on its website to meet requirements outlined in the *Health Professions Act*. Additional information now displayed in the search results includes:

- Physician's full name and previous names,
- Practice Permit Status,
- Conditions on Practice, and
- Hearing Information.

To accommodate the additions, information is now organized into tabs for easy navigation (tabs include Summary, Qualifications, Discipline and Map). Physicians are encouraged to check out their profiles by accessing the Physician Search at www.cpsa.ab.ca (home page). Requests for changes to your profile information can be directed to physicianinquiries@cpsa.ab.ca or by calling 780-969-4925; 1-800-320-8624 (ext. 4925).

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| Dr. Ken Gardener, Assistant Registrar, <i>Physician Assessment and Remediation, Peer Review</i> | 780-969-4928 | Ken.Gardener@cpsa.ab.ca |
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| Dr. Kate Reed, Assistant Registrar, <i>Registration</i> | 780-969-4907 | Kate.Reed@cpsa.ab.ca |
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| Dr. Janet L. Wright, Assistant Registrar, <i>Prescribing Practices including the Triplicate Prescription Program, Ethics, Physician Health Monitoring Program</i> | 780-969-4940 | JanetL.Wright@cpsa.ab.ca |
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| Ms. Kelly Eby, Manager | 780-969-4973 | Kelly.Eby@cpsa.ab.ca |
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