Communicating with physicians in the Calgary region

Vital Signs

July 2006

A shared publication between the Calgary & Area Physician's Association and the Calgary Health Region

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Editors:
Dave Lowery, CAPA – bethere@shaw.ca
Barbara Balfour, Calgary Health Region
–barbara.balfour@calgaryhealthregion.ca

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

Please send any contributions for the attention of:
CAPA
Dave Lowery: E-mail: bethere@shaw.ca, tel: 243-9498.

Calgary Health Region
Barbara Balfour: E-mail
barbara.balfour@calgaryhealthregion.ca
tel: 943-1295

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Contributors:
The opinions expressed in *Vital Signs* are those of the authors and do not necessarily reflect the opinions or positions of the CAPA, CAPA executive or the Calgary Health Region.

CAPA executive - *Please feel free to contact your representative with any concerns or issues.*

Dr. D. Glenn Comm, CAPA president
Phone: 943-5554

Dr. Michael Giuffre, CAPA past president
Phone: 943-7858

Dr. Peter Davids, CGH MSA president & treasurer
Phone 943-5437

Dr. Laurie Pereles, RGH MSA president
Phone: 228-4844

Dr. Douglas Thorson, RGH MSA vice-president & treasurer
Phone 253-7355

Dr. Tom Mainprize, FMC MSA president
Phone: 944-1636

Dr. Martin Liam, FMC MSA vice president & treasurer
Phone: 220-7725

Dr. Robin G. Cox, ACH MSA president
Phone: 943-7260

Dr. Cheri Nijssen-Jordan**,** ACH vice-president & treasurer
Phone: 943-7295

Dr. Alison Clarke, rural MSA president
Phone: 934-4444

Dr. Patti Edgar, rural MSA vice-president & treasurer
Phone: 762-4846

Dr. Noel Grisdale, CAPA treasurer, AMA RMO & rural MSA past president
Phone: 933-4368

Dr. Linda Slocombe, PCPA president
Phone: 277-3333

Dr. Blythe K. Brown, PCPA secretary treasurer
Phone: 269-9488

Dr. Remo Di Palma, PCPA member at large
Phone: 202-3486

Dr. F.D. (Dean) Collett, Calgary Med. Society representative
Phone: 249-0611

Contributing members

Dr. David Megran, CMO
Phone: 943-1180

Dr. Ted Braun, chair, medical advisory board
Phone: 943-1277

Dr. Bob Johnston, CPSA representative
Phone: 943-1180

Dr. Martin H. Atkinson, U of C representative
Phone: 943-3889 or 220-4245

Sean Smith, director, practice management program
Phone: 266-3533

Web site: www.capa.cc
Administration office phone: 943-1270
Administration office fax: 943-1297

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On the cover: Drew Schemmel in the radiology department at the PLC. Photo by Dave Lowery.

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Editorial

Jim Dinning, the former chair of the Calgary Health Region, one position among many in his long political career, addressed the CAPA AGM on Wednesday June 21. While noting the obvious . . . "how come you call this an annual general meeting when you have two per year?" *(not sure myself-DL)* Dinning said the relationship between CAPA's physicians and the region seemed to be "at a good note." One week ago, Dinning launched his bid to become the new leader of the Alberta PCs and he took the chance to talk about "healthcare reform — Canada's never ending story." During his whirlwind first week, he said Albertans talked a lot about health care and he sensed frustrations across the whole province. And while professing to not be an expert in health care . . . "I was present for my kid's births but that's the closest I've been" he did suggest five plot lines to improve the system. They were:

1. Get more serious.
2. Forget about big plans. Pick priorities
3. Innovation — infuse the system with more of it
4. Increase supply of health care providers.
5. Find practical ways for containing costs and increases.

And while he wouldn't mention the "third way" (calling it t & w) he did say he feels that advocates for private care have not convinced Albertans that their concerns are unfounded.

"Let us get on with the job and get the government out of the way," Dinning said. "We need more doctors, nurses and health care providers. The problem is not unique to Alberta. It is a worldwide problem but there are no silver bullets. We need a game plan for expanding the supply of docs and other health care providers."

What do you think should be in the game plan? We would love to hear from you.

Dr. Glenn Comm, CAPA president (left), talks with Jim Dinning at the June AGM. Dave Lowery photo.

Sunrise, sunset?

From the CAPA president | **An old dog tries to learn a new trick**

I'm not a fossil…yet? I'm not a computer geek. I have a nice wide screen computer that I use for e-mail, presentations, and writing . . . okay, and a bit of web surfing. But if things go wrong I have to get my wife to fix it. Almost all my anesthesia charting is done using our electronic anesthesia charting system. It's unstable and dysfunctional but it *always* produces a better record than any of my hand written attempts. Having never learned how to use the patient care information system (PCIS) I don't know how to find any information about patients on my list before they arrive at the operating room (OR). I suspect that there are others out there with similar (dis)abilities. But that is about to change.

For years we have known that TDS/OSCAR has to be replaced. It will soon fade into the setting sun and Sunrise Clinical Manager (SCM) will rise to replace it. I recently had the opportunity to be an" alpha tester" (crash test dummy?) of the training module that has been designed to help train CHR staff in the use of SCM. My learning style is scan instructions, identify a few key concepts, then jump in and learn by trial and error. Two and a half hours later I was encouraged. I *will* be able to learn to use SCM when it is introduced and it will make my life better. I will need a couple more runs through the training module but I know I can do it. Those whose learning style is more methodical will likely learn even faster.

While the goal of 100 per cent electronic order entry will not come easy, I believe that many things are being done right in planning this change. The system has been designed by doctors, not technicians, and there have been representatives from all divisions and departments. Every department has had order sets designed, many based on best evidence, but there is flexibility for individual physicians to tailor orders to individual patient needs. In addition, the Calgary Health Region (CHR) has shown its commitment to bringing doctors on board by putting money behind its words. Time spent training (whether in classroom or remotely) will earn physicians CME credit, and those who opt for classroom training will be compensated at the region's standard hourly rate.

We have the daunting task of training 14,000 staff in our region. Training begins on July 16 and will be round the clock. When SCM first goes live at the Rockyview General Hospital on September 9 it will be important to remain gracious and keep a sense of humour. *All* staff will be experiencing the stress of change and it will behoove us to work collegially with nurses and other staff during the first few days when we will all be on the steep learning curve. There *will* be glitches, there always are. There will be ongoing support for staff and areas of problems will be identified and corrected. We are all in this together and we'll get through it.

Concerns have been expressed that we might lose some of the older physicians who are nearing retirement age. The fear is that the hurdle of learning to use the system may be the tipping point in their decision to retire from hospital care. The region is going to great lengths to try to make the transition as painless as possible. Super users, all of whom have a week of training and who are presently training others, will be available on every unit and every shift once SCM goes into operation. In addition, SCM is far more intuitive and user friendly than PCIS was. We hope that with all the available support we won't lose any of our valued doctors because of the change challenge.

Dr. D. Glenn Comm,
CAPA president
Phone: 943-5554

"Why do I have to enter my own orders?" you might ask. Safety is the most important answer. There is good evidence that computerized physician order entry (CPOE) can cut medication errors by nearly one half. This is one reason for *everyone* to be involved. SCM is a proven system currently used at institutions such as John Hopkins, Memorial Sloan Kettering and Baylor. Initially there may be an increase in the time it takes to enter orders but the ability to create one's own order sets, to enter orders on multiple patients without having a stack of charts around you and the ability to enter orders from anywhere in the hospital (or even from your office) will actually improve efficiency. It won't be easy for the first few days but I believe we will emerge from the change a better, safer and more efficient system.

"Our study (of clinical informtion systems) examined the dynamics between...users and implementers - and showed how critical a factor it can be in the outcome of the implementation."
Lapoint & Rivard, CMAJ May 23, 2006

Local physicians prepare for pandemic influenza

Part 5 in an ongoing series on disaster and emergency planning

By Dr. Brent Friesen, medical officer of health and head of the Calgary Health Region's pandemic advisory committee

Family physicians know from experience that the public turns to them during emergencies. In fact, a recent national study reveals that 86 per cent of Canadians believe it is important, or somewhat important, that they could turn to their family doctor's office in the event of a widespread flu or natural disaster. (*The Role of the Family Doctor in Public Health and Emergency Preparedness*, College of Family Physicians, www.cfpc.ca)

The study also gauged physician preparedness. Only 20 per cent of family doctors feel equipped or somewhat equipped to handle a public health emergency such as pandemic influenza or a natural disaster. Clearly more work needs to be done for family doctors to reach a sense of pandemic preparedness where they can meet patient expectations.

In an effort to increase physician preparedness at the local level, the department of family medicine, disaster services, the office of the chief medical officer and the office of the medical officer of health collaborated to create two continuing education sessions titled "pandemic preparedness for the community physician office," hosted in May. I presented the keynote address and Dr. Wendy Tink, tegional clinical department head, department of family medicine, spoke about specific office preparedness considerations.

The sessions discussed how local, community-based practitioners can prepare their offices and staff for a pandemic influenza health emergency. At the sessions the department of family medicine presented a handout called *Toolkit for Community Physicians* as well as other printed tools for physicians to use during their current office planning. These tools are also available upon request (see contact information below).

Despite the busy calendars of family doctors and their clinics, the presentations were well attended by over 120 guests, and, after addressing personal preparedness, infection prevention and control, personal protective equipment, anti-virals, vaccines, ethics of care, clinical case definition and assessment and business continuity planning, a robust discussion period resulted.

In their evaluation of the sessions the attending physicians indicated that they were very satisfied with the context we provided for them, as well as the package of preparedness tools. As medical officer of health, I appreciated the level of physician engagement on this complex issue, as well as the feedback and ideas from community physicians.

As our advisory group continues to refine the pandemic influenza response plan, which is a living, dynamic document, this type of physician insight and perspective is invaluable to our ongoing planning and, ultimately, imperative to our community during a pandemic influenza crisis.

The survey by the Canadian College of Family Physicians shows the high expectations and trust that the public has in their doctor during public health emergencies. Despite any fears that we may have about being front-line responders during public emergencies, the public trusts us to help them and honour our duty to care. During a pandemic influenza health emergency, the public's faith in us and expectations certainly won't change. We need to make sure that our offices and practices are as prepared as possible to respond.

After all, it's easier to explain why we prepared than why we didn't prepare.

We want to hear from you

Provide comments and questions by calling 944-2106, 1-866-944-2060 or through email at info@calgaryhealthregion.ca.

Pediatric complex pain program

Musculoskeletal services is pleased to introduce the pediatric complex pain program. Although most people are surprised to learn that children can have chronic pain, it is estimated that five to six per cent of Canadian children experience pain that impacts their daily lives. This new program will be strategically aligned with the regional pain program to ensure that CHR pain services are integrated and coordinated across a lifespan.

The pediatric complex pain program is a multidisciplinary outpatient clinic staffed by Dr. Peter Farran (anesthesiologist), Dr. Debbie McAllister (anesthesiologist) Dr. Christine Korol (psychologist), Tracy Hyndman (clinical nurse specialist), Janet Trotta (secretary) and a physiotherapist (to be announced). The goal of this service is to care for children who experience chronic difficult to manage pain. Pain must be the primary complaint and the reason that the child is being referred to the program. Children should always first be assessed and treated by the appropriate ACH clinic, specialist or sub specialist prior to referral to the program. Referral is by physician only.

This program is located at the Alberta Children's Hospital and will be relocating to the new site in September. For more information about the pediatric complex pain program, call 943-7430.

RBC donation supports development of seniors health campus

By Wendy Beauchesne, CHR communications

Audrey Sissons enjoys getting out and being active. But not so long ago, the 79-year-old was afraid to do much after she fell while leaving her home, fracturing her pelvis.

"I was going too quickly trying to do more than I was able to," said Sissons. "I was trying to prop a door open, it was a very hot summer day and I pushed the door, which was really quite heavy, and the door pushed me."

While this wasn't the first time Sissons had fallen, it was the first time she sustained a serious injury because of a fall. When she fell again a few months later while walking in a mall, she was referred to the region's falls prevention clinic where she underwent a comprehensive assessment followed by targeted interventions that included balanced training.

Sissons recovered, but many older adults are not so fortunate. In fact, falls are the leading cause of admission into a care facility and one of the leading causes of injury-related death among seniors.

"About one out of three older individuals in our country will have a fall in a given year," said Dr. David Hogan, medical director, calgary fall prevention clinic, and the Brenda Strafford Foundation chair in geriatric medicine. "Falls are important because of the injuries associated with them. About five per cent of falls among seniors will lead to fractures and about one per cent will lead to a hip fracture."

In an effort to combat the problem RBC Financial Group has donated $2 million – its largest gift to date in Alberta to help establish a seniors health campus where falls prevention for seniors will be a flagship program.

The gift from RBC is the lead gift in the *Reach!* fundraising efforts to establish a seniors health campus. The regional falls prevention program for seniors is a reality now and will continue as part of the new seniors health campus.

The campus will be a virtual and physical centre of excellence and serve as a hub to coordinate activities including advancing knowledge of healthy aging through research, and developing leading-edge educational initiatives to link research to evidence based geriatric care.

"Our most effective treatment approach – a careful clinical and environmental assessment of the older person who has fallen coupled with a plan to deal with all modifiable fall risk factors is then implemented – can decrease the likelihood of further falls by about one-third," said Dr. Hogan. "Applied research to find better interventions so we can close the gap on the remaining two-thirds is urgently needed."

Planning and fundraising for a seniors health campus is still in the very early stages. Many stakeholders, including physicians, employees and seniors groups will participate in the planning process.

RBC's gift was made to the Reach campaign, a five year, $300 million joint fundraising partnership between the University of Calgary and the Calgary Health Region.

On behalf of RBC, Bill Sembo, vice chairman, RBC Capital Markets, presented a cheque for $2 million to Dr. Grant Gall, dean, faculty of medicine, University of Calgary; Jack Davis, president & CEO, Calgary Health Region and Ken King, co-chair, *Reach!* Photo by Chris Kindratsky

Department of pathology & laboratory medicine

By Dr. J. Wright, RCDH

Executive summary

Department structure and organization: The department of pathology and laboratory medicine is composed of seven divisions and has 58 primary clinical MD appointees and eight clinical PhD scientists. There are 31 members with University of Calgary GFT academic appointments and 30 with clinical or adjunct academic appointments. Medical/scientific staff are located at all acute-care hospital sites, at the Calgary Laboratory Service's Diagnostic and Scientific Centre, and at the University of Calgary Health Sciences Centre. The department is affiliated with Calgary Laboratory Services (CLS), a private-public partnership between the CHR and MDS-Kasper Laboratories (n.b., CLS will become a wholly-owned subsidiary of the region on April 1, 2006). CLS provides regionally integrated service, with one centralized laboratory, specialty testing laboratories, four hospital-based rapid response laboratories, 18 community collection sites, a mobile collections service, a centralized transportation system and a single region-wide information system. CLS is responsible for the majority of laboratory tests performed in the Calgary Health Region, including quality control of some point-of-care testing performed by non-laboratory personnel. The provincial laboratory and other specialized laboratories provide some selected services to the region and surrounding communities. For the first half of the year, Dr. Martin Trotter was acting department head. Dr. Jim Wright was appointed university and regional department head on July 1, 2005.

Accomplishments and highlights: CLS performed over 16 million laboratory tests in 2005, which equates to almost 44,000 tests every day. This represents an 8.1 per cent increase in workload compared to 2004. Of the department's many accomplishments in 2005, some that stand out include CPSA accreditation, completion of the department's five year workforce plan (in conjunction with Social Sector Metrics), implementation of LEAN/Six Sigma programs (methodologies focused on process speed and efficiency, elimination of waste, and minimization of errors developed by the Japanese automobile industry) at several CLS sites, ASHI accreditation of the CLS tissue typing laboratory and implementation of many new diagnostic tests. As the new department head, I would personally like to thank Dr. Martin Trotter who provided able leadership as acting department head for the past year.

Academically, our postgraduate clinical training programs (anatomic pathology, neuropathology) continue to grow with 15 residents and three fellows in 2005. Department members had $1.3 million in principle investigator grant funding, 61 peer-reviewed publications, and 89 presentations. Faculty contributed to over 1100 hours of undergraduate medical education teaching.

Quality programs: CLS has a comprehensive quality assurance program which has facilitated the implementation of the NCCLS quality system model across the organization. Laboratory-wide performance indicators are reported monthly. There is a formal critical incident reporting and resolution process.

Challenges: Operationally, the department's biggest challenges are manpower, providing continually increasing services to meet the region's expanding needs without proportional increases in funding, assuring appropriate interface between laboratory and regional information/ordering systems, replacement of the department's PathNet Classic Laboratory Information system (this is a huge complex, multiyear process involving purchase of proprietary hardware/software and then building appropriate interfaces), and promoting appropriate laboratory utilization.

Workforce planning: Considering the growth of the CHR which results in increasing workload and workload complexity, workforce is probably our major current and future challenge. Current staff are working at an unsustainable pace and additional medical/scientific staff are necessary to bring the workload levels down to the upper limits of national/international standards. Because pathology and laboratory medicine are services, we have no ability to control workload on our own as this is determined by numbers of surgical procedures, orders for laboratory tests, etc. To further complicate workforce matters, laboratory physicians are not fee for service and are funded from the health region's budget, and, thus, there is no simple mechanism to fund new positions based upon workload expansion. Because of this, the department of pathology and laboratory medicine is considering the possibility of moving toward an academic alternate relationship plan (ARP); however, forming an academic ARP will require buy in from multiple parties and, possibly, restructuring all of laboratory medicine on a province-wide basis. Thus, this can be considered only as a potential long-term solution and there is still a need for additional funded positions to get the department through the short-term. To complicate matters even more, the pathology and laboratory medicine workforce across Canada is graying and there are inadequate numbers of new graduates entering the workforce. Therefore, recruitment to replace retirements and retention will also become major challenges.

Future directions and initiatives: The department's five year workforce plan has also recommended establishing a clinical informatics and utilization unit within CLS, effective immediately. CLS's PathNet Classic laboratory information system (LIS) is obsolete and will no longer be supported by Cerner after 2010. The selection and design of an LIS is a long and complicated process. This process requires the undivided attention of a medical informatics specialist (i.e., a pathologist with formal fellowship training in laboratory medicine informatics). This is critical because our LIS underlies almost every report that we generate. LIS responsibilities cannot be layered on to the duties of our current medical and scientific staff members. Such a unit could also help diminish inappropriate or duplicate lab test ordering and could help prevent incidents like the issues experienced with lab test result history (LTRH) database last July.

Additional important issues for 2006 will be outfitting and opening a new clinical laboratory at the new Alberta Children's Hospital, short-term renovations of the sixth and eleventh floor laboratories at Foothills Medical Centre (as well as planning for the move to the new west tower), planning for laboratory needs resulting from other CHR capital projects, further implementation of LEAN/Six Sigma to reduce costs, pandemic planning and implementation of new diagnostic modalities. The department will attempt to be proactive and consult with other departments to learn of new programs and program expansions so that we can be better positioned to provide state-of-the-art laboratory support.

Our regional integrated model for pathology and laboratory medicine is unique in Canada. With a coherent organizational structure and strong medical leadership, this will allow us to develop a dynamic, productive department, leading nationally and internationally in clinical service, teaching and research.

Alberta Children's Hospital physician's association report

The A.C.H. medical staff are busy in the final stages of preparation to move to the new site in the fall. The exact date of the move awaits final confirmation, but it is looking like mid to late September. Bby the time this goes to print, the move date will likely be settled. Physicians have been attending the general orientation sessions in the new building and more focused orientations will follow for the specialized areas. Parking, always an issue of interest to physicians, will be plentiful in the new building. Physicians will have access to the parkade, which is covered, heated, and attached to the hospital. Unfortunately, the usual regional parking fees will apply.

The A.C.H. medical staff association enjoyed a wonderful evening at their annual dinner/dance, this year held at the Glencoe Club on June 9. This was attended by around 100 physicians and guests including many residents and fellows. A splendid buffet dinner was enjoyed, and entertainment was provided by *Penguins on Broadway*, including vocalist Dr. Roxanne Goldade, a Calgary pediatrician. Numerous well deserved teaching awards were given out and the A.C.H. Physician of the Year was announced – Dr. Ross Truscott. Ross will be presented with this award at the next quarterly medical staff meeting.

As there is still a question about the exact move date for the hospital, there will be an announcement in July as to the date of the next quarterly meeting, and its location, so please be on the lookout for my emails. In the meantime, I wish everyone a great summer.

Dr. Robin Cox,
ACHMSA president
Phone: 943-7260
E-mail:
robin.cox@calgaryhealthregion.ca

Expansion of cardiac function clinic aids hundreds of patients

By Shela Shapiro, CHR communications

Although Gale McBee was suffering from heart failure, she didn't know it at first. What she originally thought was pneumonia was actually the inability of her heart to pump blood at a level required for the rest of her body to function normally.

Thanks to the region's newly expanded heart function clinic, people like McBee who have congestive heart failure can get the help they need. The clinic, previously located at the Foothills Medical Centre, has expanded to include the Peter Lougheed Centre and the Rockyview General Hospital.

"The cardiac clinic has really helped get my condition under control," said McBee. "Staff members at the clinic really listen to patients and are very attentive. It's convenient, and appointments are always on time."

This condition can also impact young people and affects from one to two per cent of Canadians, with symptoms ranging from shortness of breath and fatigue to swelling throughout the body. Medications have helped balance McBee's condition, enabling her to do regular activities.

"Before I became a patient at the clinic, I got to the point where I couldn't do anything," she said. "I found it challenging to perform my daily job as a manager of a veterinary clinic because I had no breathing capacity and was completely fatigued."

The clinic provides patients with increased access and current treatment, while also reducing visits to emergency. It sees approximately 475 patients, a number that is quickly expanding because of the additional locations.

"It's widely accepted that the most efficient way to deal with chronic heart failure is through a clinic environment," said Israel Belenkie, medical director of the cardiac function clinic. "The clinic provides high quality optimal care, ready access and as frequent a follow up as required, which is difficult to accomplish in a standard office practice."

Patients with the condition are referred to the clinic by their family physician or specialist and are followed up by nurses and other care providers supervised by specialists in heart failure management. Nurse clinicians will follow up on the medications and symptoms, work with patients to adjust medications to get the best effects and provide education for the patient, family members and health care team.

"The clinic has provided increased access for people who live across our region. Rural patients can access the clinics as well, or they may work with nurse practitioners or physicians in their communities to make use of the services offered by the clinic," said Judy Backlund, cardiac clinic manager. In a rural setting, family physicians or other medical specialists can refer people with the confirmed diagnosis of heart failure to the clinics for management of heart failure and follow up.

For more information, contact the RGH at 943-8623, the PLC at 943-5579 or the FMC at 220-8300.

Cardiologist Michael Connely uses a model of the heart to demonstrate potential problems to patient Gale McBee while nurse clinician Leslie Reed looks on.

Paul Rotzinger photo.

Medical advisory board report

By Ted Braun, MD, CCFP, FCFP, chair, regional medical advisory board

Since the last report to Vital Signs, the medical advisory board has dealt with a wide variety of issues. Of note are the following.

Annual reappointment process

MAB has completed the annual reappointment process for the medical staff. This year there were 1872 annual renewals. The medical staff office and MAB coordinator are gratefully acknowledged for their considerable efforts to make this huge undertaking a success.

Patient care information system (PCIS)

Phase two implementation of PCIS is imminent. It is very important that physicians be prepared for implementation which is planned for RGH (September 9), PLC (October 7), FMC (November 11) and ACH (tentatively June 2007).

Physicians are required to undergo training prior to implementation. A training schedule will be made available over the summer months. Physicians and trainees who will first interact with PCIS at RGH will need training prior to Sept 9. Training is either classroom or self-directed on line. A letter, to be sent to all physicians, will provide more information regarding training opportunities.

MAB remains supportive of a goal of 100 per cent computerized provider order entry by physicians (CPOE) within 18 months and a stretch target of six months. This goal refers to CPOE that does not interfere with immediate care. It is important to understand that this decision was made because of the benefits to patient safety.

Finally, unit clerks will continue to enter handwritten orders after implementation of Sunrise Clinical Manager. However, the order will not be processed (i.e. sent to performing departments such as lab, DI and pharmacy) until electronically verified by a physician or by a nurse on the physician's behalf. Again, this is primarily to ensure safe patient care.

Continuous professional improvement

Dr. Bryan Ward, deputy registrar of the College of Physicians and Surgeons of Alberta, attended MAB to discuss future directions for continuous professional improvement of physicians. The college has been a leader in the area of practice assessment through the development of the PAR program. It is now looking to enhance efforts with two goals: 1) to promote quality improvement in individual medical practices and 2) to promote a culture of continuous quality improvement in the medical profession. It is still early on in the process and the strategies are yet to be defined. However, the college is committed to working to develop effective strategies to ensure a high standard of medical care. The college has made it clear that the development process will be a collaborative one with the medical advisory boards of the RHAs providing input along the way.

Establishing new clinical departments and divisions

MAB has recently received proposals for several new clinical departments and a variety of requests from clinical departments to form new divisions. Faced with these requests, MAB struck a working group to develop some principles and processes by which MAB could assess such requests. The working group, led by Peter Jamieson, chair elect, succeeded in developing a series of criteria to be considered.

Dr. Ted Braun, MD, CCFP, FCFP.
Chair, regional medical advisory board
Phone: 943-1277

In the course of the discussions leading up to the approval of these criteria, it became apparent that there are many things to be considered. Some of these are diametrically opposed. On the one hand, there are arguments to be made for the continued splitting of our clinical departmental structure. For example, the trend toward increasing sub-specialization in medicine might support a desire for new departments and more divisions within our current departments. On the other hand, some departments such as the departments of clinical neurosciences and cardiac sciences have demonstrated success with bringing together the medical and surgical specialties into a single department. The complex co-morbidities of many of our patients, particularly the increasing numbers of those with chronic illness, might speak to the need for closer working relationships (both clinical and academic) between different specialties.

Other jurisdictions are exploring alternative structures. For example, the university hospital in Groningen, Netherlands is moving to dissolve their 26 clinical departments and reform their medical administrative structure into six sectors. The driver, they believe, is the need to better reflect the needs of their patients in their organizational structure. With increasing numbers of patients having care needs that span several departments, the silos of many different departments are inadequate. The traditional body system, or disease model, approaches do not work optimally for patients with chronic disease. They intend to have multidisciplinary teams assigned to one of six sectors. The six sectors are: chronic disease management, oncology, surgery and anesthesiology, diagnostics, obstetrics and gynecology, pediatrics, genetics, psychiatry, education and research.

MAB will proceed with evaluating the requests for new departments and divisions using the new criteria in the fall. I suspect that, at some future date, we will also have to change our administrative structure to reflect our patients' needs.

Best wishes for a safe and enjoyable summer.

Not just x-rays . . . interventional radiologists

Story & photos by Dave Lowery with files from Dr. Drew Schemmer

Perhaps we're not attracting physicians for the right reasons. Most of us already know that we have state-of-the-art programs in Calgary and top notch physicians who attract the cream of the crop from around the world. But one of the main reasons Drew Schemmer, 37, says he moved here, and has no plan on leaving in the near future, wasn't related to medicine at all.

"I was attracted to the Rockies," he says smiling. "But I also wanted to do my fellowship with Dr. Gray as he is well respected." Now an assistant professor at U of C, Schemmer went to medical school at McMaster University in Ontario. He worked for a year after completing his fellowship at the FMC before moving to the PLC in 2002 and says the professionalism, progressive and laid back attitude he finds at the PLC makes his work constantly rewarding and fulfilling.

"As an interventional radiologist, it's so interesting to do arterial endovascular work, cardiac/coronary CTA imaging, multisystem interventions, assist surgeons with aortic repairs and spinal kyphoplasty, just to name a few of the functions. The PLC is the leader in non invasive vascular imaging and we provide the best care for patients in Calgary. If you don't have to put a needle in someone, why would you? It's nose to toes imaging."

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CALGARY & AREA PHYSICIANS ASSOCIATION

Schemmer says the boom in interventional radiology (IR) can create some misunderstanding but, with education and time, he feels physicians from other specialties will utilize the services IR has to offer.

"The challenge is to reveal the scope of our practice to best assist clinicians understand our job and help to choose the best test," he says. "Every test has limitations and consequences — there is no best single test. But sometimes the best person to pick a test is the radiologist. We're also trying to help the region understand that, because radiologists help patients through minimally invasive procedures and tests, we reduce wait lists and save money."

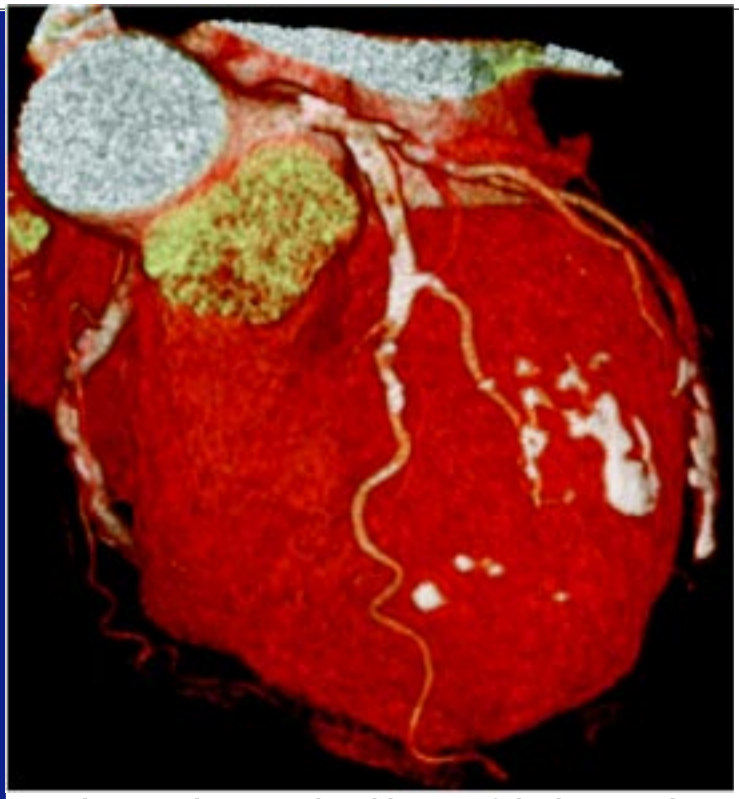
Frank Brandschwei, 53, also an IR at the PLC, echoes Schemmer's philosophy. Branschwei was born in Edmonton, went to medical school there and ended up in Calgary because, he says smirking, "I needed a job!"

Below: Dr. Peter Bromley — "IR is very high technology and a cutting edge specialty with a combination of imaging technology and treatment where you're involved in procedures a lot of other people want to do."

Because of rapid advancements in medicine, interventional radiology is continually adapting and developing innovative, non-invasive, ways to image, diagnose and treat various multisystem disease processes. Did you realize that we can use cutting-edge technologies to assist in the following areas:

1. **Non-invasive imaging: Carotid, cardiac/coronary, visceral/renal, peripheral arteries and veins.**
   CTA – CT angiography: robust, excellent resolution
   MRA – MR angiography: non-ionizing and no renal damaging contrast
2. **Vascular interventions: Cutting balloon angioplasty, Cryotherapy angioplasty, stenting of carotid arterial stenoses.**
3. **Kyphoplasty: minimally invasive treatment of acute and subacute vertebral compression fractures.**
4. **Uterine fibroid embolization: minimally invasive treatment of fibroids**
5. **Liver: TIPS for UGI bleeds and refractory ascites; chemoembolization, drainages, and more.**
6. **Urological: CTA/MRA evaluation, RAS (renal artery stenosis) therapy, drainages.**
7. **And more!**

Drew Schemmer



Above: Volume rendered image of the heart and coronary arteries, 64 channel CT.

Below: Dr. Frank Brandschwei — "We are in need of a new x-ray machine which we have been requesting for quite a while. But we can cope on a daily basis."

"Because IR touches on every area, which is what drew me to the specialty, there are still a number of areas where we could offer more limited invasive/non invasive procedures and surgical procedures than what we do now," he says. "It's a growth thing. Some physicians may not be aware of what we can do and sometimes it affects the way people practice. Attitudes are a little slow to change but there are more things we could be doing which are available now. Patients are finding out what's available due to internet and other research and they are the ones who are convincing some physicians to look for alternative ways to deal with a disease."

As in most specialties, IR is not a cheap specialty though ultimately the radiologists at PLC say costs could be reduced by spending more in IR.

"But the region has been quite good to us in general," Brandschwei says. "Once we explain that our specialty leads to less hospital days, inpatient costs, and that some patients can go back to work the next day . . . if you look at the bigger picture, we are actually cheaper. Things that are proven in the literature sometimes are slow to catch on so the onus is on us to educate. We're always talking to clinicians on a daily basis, one on one, groups or in rounds. Sometimes we can do something that totally surprises clinicians. With IR we can do things that are minimally invasive and get to parts of the body without any major cuts or incisions. Patients are out of the department quickly with very satisfactory results. As the whole discipline is evolving, we are

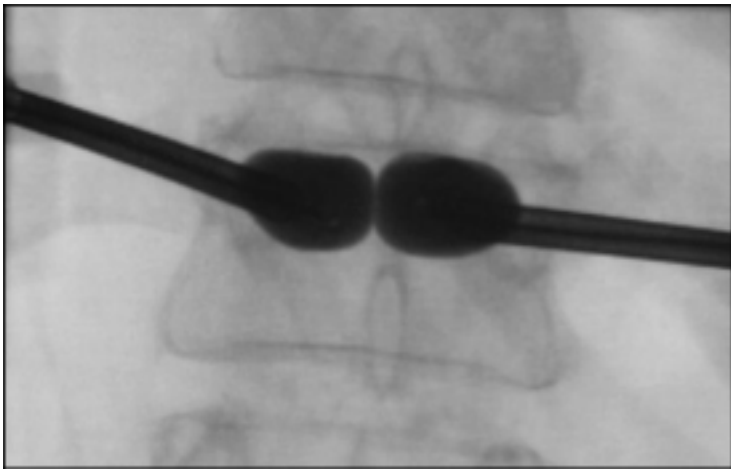
dong more and more things. I think as time goes by there will be more things we can do. There's always research being done."

That pioneering spirit has led to PLC IR firsts in southern Alberta. Dr. Peter Bromley, also a PLC interventional radiologist who trained at the renowned Dotter Institute at OHSU in Portland, Oregon, has recently introduced the new technique of cryoplasty. It is an angioplasty process with simultaneous application of cold thermal energy to the artery wall capable of inducing apoptosis to biologically alter the angioplasty injury cascade into a more benign healing process. This procedure reduces expectant re-stenosis and has an 85 per cent patency rate in femoropopliteal arteries at nine months.

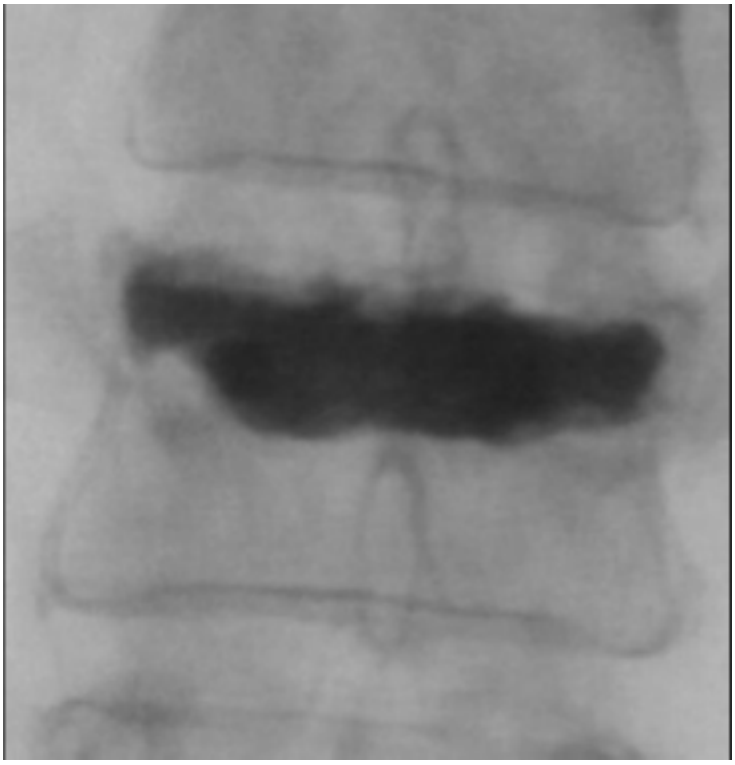
Born in St. John's, Newfoundland, Bromley also went to medical school in Edmonton and after post-graduate training at UBC and OHSU returned to Alberta because he knew someone working with the PLC group. He is happy for the coincidence and relishes the complex IR work at PLC.

"In the last five years I've had very few complaints from administration about the, sometimes, expensive disposable instruments we use in IR. I hear colleagues in other parts of the country have more of a problem," Bromley says. "Access to these tools makes the work more enjoyable and rewarding. At the PLC, we work very closely with vascular surgeons. My primary training in IR was vascular, so it's very good to be at the hospital in southern Alberta recognized for its vascular work."

Below: Volume rendered image, RPO projection, showing a thoracoabdominal aortic dissection.



AP projections during kyphoplasty at T12. (above) Bilateral balloons inflated with 'Kissing' approximation and (below) final image after cement installation for treatment of the vertebral compression fracture at T12.



Carewest's comprehensive community care

By Lynne Koziey, communications coordinator, Carewest

The moment Donna McCalder walked through the front doors of Carewest's comprehensive community care (C3) program, she knew she was in the right place.

"The first thing I saw when I came here was a beautiful young lady with blonde hair that I had taught in grade four and she came running over and gave me a big hug. I was thrilled to death and felt very welcome," said the 73-year-old former teacher.

That young lady was in fact a community care assistant with the C3 program who proved to be a fitting start to McCalder's journey back from ill-health and depression.

"I couldn't be alone in my house, which is what I wanted, and I certainly didn't want to go into a care facility. Then I heard about C3 – so I could have my house and I could have my care," said McCalder, who was in acute care recovering from five-valve bypass surgery before coming to C3.

"This program has given me my life. I was so down and now I'm back to being a person."

C3 is a unique, long-term support day program offering primary care to seniors who live in southwest Calgary and who are medically complex, physically frail and require support to remain living in their own homes. A multidisciplinary team provides 24-hour health care through a medical health clinic, day program, home support, transportation, designated beds and emergency response telephone system.

Dr. Diana Turner, one of two physicians at the C3 program, has been working with complex frail elderly for 10 years, including five years at a similar program in Edmonton.

"The C3 program treats complex frail people holistically. It treats their medical problems, but it also provides social and rehab therapy, which gives them a more dignified life and helps them feel more like a part of their community again," said Dr. Turner.

"C3 represents sustainable, appropriate chronic disease management care in the community. It's not the only way, but it shows that we in the medical community can do it better and patients can be happy. This is an example of how we can get better outcomes and patient satisfaction while reducing utilization of acute care and emergency room care."

Jennie Hollings, C3's client service leader, said through the work of Dr. Turner and the rest of the C3 team, McCalder has become just one of the program's many success stories.

"Donna was very anxious about her health when she came here and was very, very sick. She was also very depressed and isolated. Now she's stronger, can walk with a cane and her mood has totally improved. She knows she has the support that she needs to have."

In fact, McCalder has improved so much in the year she's been at C3, she recently belly danced for staff and clients and brings in her painting and artwork for everyone to enjoy.

On June 14th the C3 program – a success story in itself – celebrates its fifth birthday.

"We never thought this was going to be as successful as it is," said Hollings. "This program has totally surpassed our expectations, I can't even explain how well it works."

Hollings said chronic disease care provided by the program not only stabilizes and strengthens clients physically, it also shores them up emotionally.

"Our clients come to us very medically unstable, which affects their whole being. Because they're sick all the time, they've had to come to terms with not being able to do a lot of things. For them it's a lot about losses: 'I can't do this, I can't do that.' I think in a lot of ways this program gives them hope. They become the person they were before."

McCalder agrees.

"The best part of this program is the people, staff and clients. When I'm off the beaten track (the staff) put me back on track and do so very delicately," she laughed. "They're so good here."

C3 is currently accepting new clients. Clients can be referred by physicians or through self or family referral. Call 686-8140 for more information.

Donna McCalder with Jennie Hollings, client service leader for the C3 (comprehensive community care) program at Carewest Sarcee. Lynne Koziey photo.

Tissue program among first to meet federal standards

By Jennifer Lomas, CHR communications

The Southern Alberta tissue program (SATP), based at Foothills Medical Centre, has been recently identified as fully compliant with stringent new Health Canada standards. It is one of the first tissue banks in the country to be inspected and achieve this distinction.

"The Health Canada inspectors praised our program for their safe tissue handling processes, robust record keeping and tracking system, and their highly-trained and dedicated team of healthcare providers," said Shanda Naylor, director of surgical suites and processing. "To have this group providing such a vital service to patients throughout southern Alberta is something I'm very thankful for."

The vigorous two-day Health Canada interview examined all aspects of the SATP's operations, including quality, tracking, and tissue procurement processes.

"This achievement is a testimony to every SATP staff member's daily devotion to excellence. They are absolutely awesome," said Dr. Manuel Mah, the region's deputy medical director of infection prevention and control.

The newest standards for tissue banks, developed by Health Canada and the Canadian Standards Association, were issued in Dec. 2005. They are part of a larger initiative, started in 2000, to harmonize tissue procurement and transplantation practices across the country. Although compliance with the standards is not yet mandatory, it's anticipated that this will occur soon.

"People have to trust us, and the tissues we provide, 100 per cent. Full compliance with the Health Canada standards provides further validation that we're supplying tissues to southern Albertans that adhere to the highest standards for quality and integrity," said Randy Toporowski, manager of the Southern Alberta tissue program.

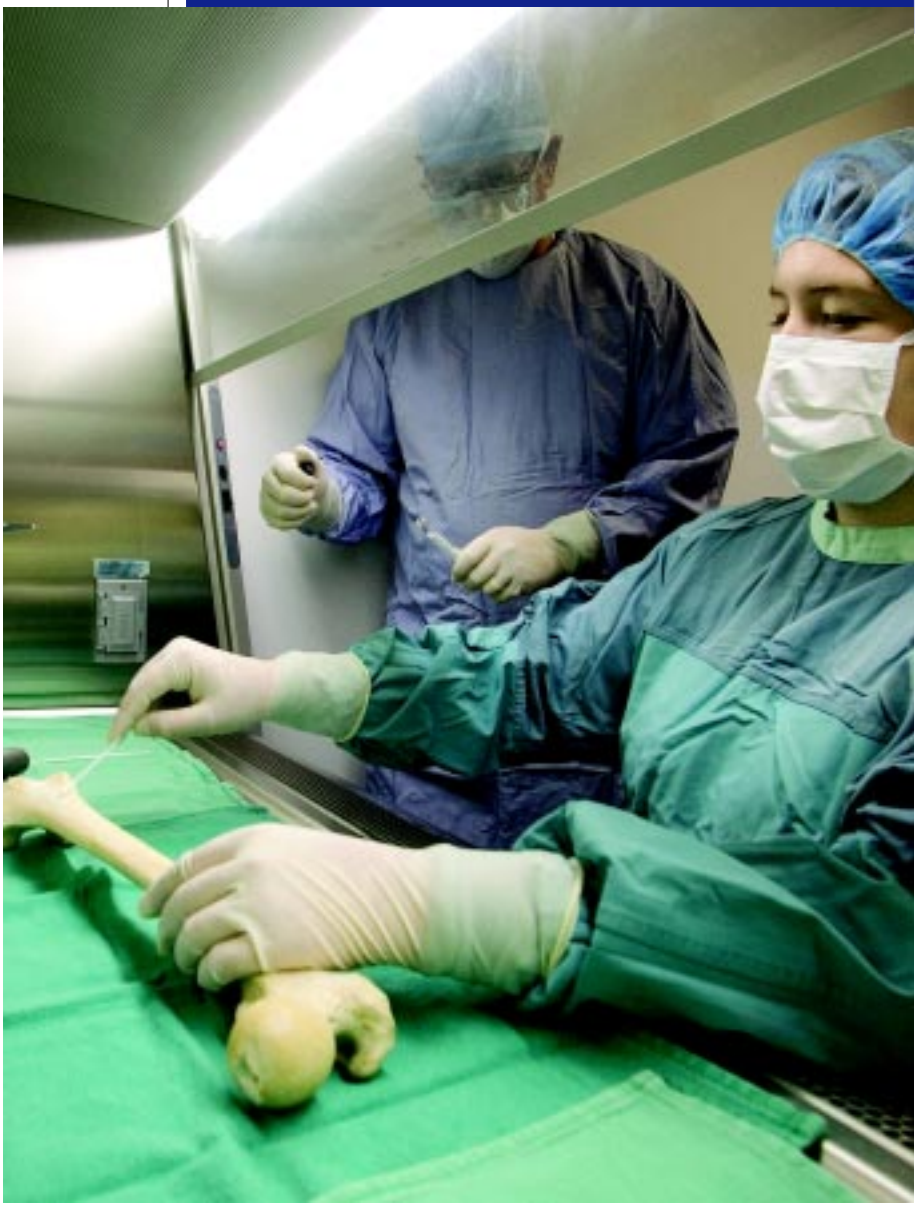
The SATP, also fully-accredited with the American Association of Tissue Banks, recovers, processes, stores and distributes human tissue for the purposes of transplantation. The population served by the tissue program includes Albertans from Red Deer south to the US border.

"Accreditation and full adherence to regulatory standards informs the public that a tissue program, in its policies and practices, has the highest commitment to their safety and health. The Southern Alberta tissue program has set the bar for programs across Canada," said Dr. Mah.

Did you know?

Tissue stats and facts

- **Tissue donation includes eyes, bones, skin, heart valves, connective tissue and veins.**
- **Donated tissue has many life-saving functions including orthopedic and spinal reconstructive surgeries, the repair of damaged joints, the replacement of heart valves and the treatment of burns.**
- **Living surgical bone donors, who donate a portion of their hip when they undergo total hip replacement surgery, comprise 82 per cent of tissue donor activity within the Calgary Health Region. Cadaveric donors account for the remaining 18 per cent of tissue donor activity.**



Right: Jim Vandevoorde, co-ordinator of the Southern Alberta tissue program, at left, and Natalia Csomor, tissue bank assistant, process human tissue for transplantation. Greg Fulmes photo

Digging begins for new downtown health centre

By Tim Morrison, CHR communications

The construction of downtown Calgary's new Sheldon M. Chumir Health Centre reached a significant milestone recently as ground was broken during a ceremony featuring government, Calgary Health Region and community representatives.

"The new health centre will give people who work, visit and live in Calgary's downtown and inner city greater access to health services," said David Tuer, board chair, Calgary Health Region. "The hard work by the project team, the Calgary caucus and local community members has paid off for Calgarians."

Scheduled to open in early 2008, the Sheldon M. Chumir Health Centre is expected to serve over 250,000 people per year. The facility will offer urgent care, primary care and chronic disease services, as well as become home to the Elbow River Healing Lodge. These services will be moved from other locations, such as the 8th and 8th clinic, and consolidated in the new eight-storey facility.

In addition to the public groundbreaking, region board members Lynn Martin, George Pinchbeck and Robert Moskovitz joined Piikani Nation Elder Leonard Bastien and his assistant Grant Little Mustache in a private pipe ceremony to bless the site of the new health centre.

"The aboriginal community has strong ties to the area and will be a very important part the new health centre," said Martin, a member of the aboriginal health committee. "I was very honoured to be a part of a ceremony that continues the history of healing and well-being at the site."

Pinchbeck also recognized the importance of having the site blessed. "The new health centre will be a place where people can go to heal their mind, body and soul," he said. "This reflects some of the traditional beliefs of our aboriginal community."

The Sheldon M. Chumir Health Centre will be approximately one-third larger than the current building and take up about one-third the space. A 485-stall underground parkade will provide parking for staff and visitors.

Ald. Madeline King, from left, Elder Leonard Bastien of the Piikani Nation, Calgary Health Region Board Chair David Tuer and Alberta Solicitor General Harvey Cenaiko break ground for the new downtown health centre.

The west wings of the old Colonel Belcher Veterans' Hospital, which now operates as Health on 12th, will remain open during the construction. When construction of the new health centre is complete, the services will be relocated and the west wings dismantled.

The health centre is named after the late Sheldon Chumir, who grew up eight blocks from the site. He served the community as a Liberal MLA for Calgary-Buffalo and was active as a philanthropist, tax lawyer, university lecturer and businessman. He is remembered for his compassion and caring toward the community he served.

Learn more about the Sheldon M. Chumir Health Centre at www.calgaryhealthregion.ca/capital

Below: Park view of the future Sheldon M. Chumir Health Centre

Continuing care & home care physician update

Continuing care **Home care**

Long term care standards

The recent release of the provincial standards for continuing care has initiated a review of the document and sessions will be offered for discussion of the details (early June). From the physician view, this is well timed since we can see the envisioned role of the physician in continuing care.

Physician standards of care

We have had a handbook for physician work in LTC for several years. This is now in review and we will ensure the standards meet those of the province. Privileging of physicians is through the department of family medicine (210-9231 for information). The south east portfolio/supported living group includes a medical leader working with an administrative leader. The group works with the contract providers of long term care in this region. Where standard-related issues arise, there is an algorithm of response.

MDS and standards

With the introduction of this minimum data set, there will be the availability of numerous indicators to review the team activity in long term care. This is a step forward, though from the physician view, the indicators are not necessarily those we would request. We will need to work with the other team members to ensure quality care of long term care residents.

Dr. Randall Sargent, medical director, supported living, Calgary Health Region E-mail: sargent@ucalgary.ca

Safe spaces

The region has embarked on another major quality improvement exercise called safe spaces. The main thrust of this initiative is the development of stronger safer teams around patient care. Home care will participate in the fall as a team that will look at the complexity of its relationship with other providers including physicians and how it can be improve its delivery of care in the community.

Ethics

A reminder to physicians that any individual , including patients, may refer to the home care ethics team on matters of individual patient care, policy or educational needs. Contact Brian Farewell at brian.farewell@calgaryhealthregion.ca or 943 1290

Standards

New standards were announced last month by the Department of Health and Wellness in regard to continuing care specifically LTC. There will be implications for home care. As an example, health authorities will be expected to ensure that patients with unmet medical needs have access to appropriate medical care. This will have to mean more than simply referrals to the emergency dept.

Assisted living

If you enjoy working with older patients and feel you might be interested in letting your name stand as a 'house physician' with an assisted living site please let me know so I can connect you with a site in your area.

Dr. Paddy Quail, medical director, home care, Calgary Health Region. E-mail: quail@ucalgary.ca

In memoriam

Robert Edward Pow, MD 1919 - 2006

Robert Edward Pow died on June 18, 2006 at Windermere Lake, B.C. at the age of 86 years. He will be lovingly remembered by his wife of sixty years, Joan; his children, Barry (Willi), Bonnie (Bruce), Randall (Diane), David (Lois), Laurie and Brian (Mary Jo); his grandchildren, Stephanie, Kerri (Todd), Emma, Cameron (Celine), Geoff, Brad, Lindsay, Jessica, Kristen, Daniel, Jordan and Nicole.

Born on August 22, 1919 in Cranbrook, B.C. he was the youngest of seven children and is survived by his sister Ruth Danard of Edmonton, AB. Robert graduated from the University of Alberta with a doctorate of medicine in 1943. He served in the Canadian Army Medical Corp during World War II from 1944 through 1946. Upon returning to Canada, he completed his fellowship of the Royal College of Surgeons in Toronto in 1949 and started his first surgery practice at the Peterborough Clinic in Peterborough, Ontario. He returned to Calgary in 1953 and established his general surgical practice which continued until his retirement in 2003. During those fifty years he dedicated himself to the Calgary medical community and the advancement of medicine. He was an active staff member at the Holy Cross Hospital, Calgary General Hospital (instrumental in developing the trauma unit), Rockyview Hospital (first chief of staff 1966 to 1968), Colonel Belcher Hospital (chief of surgery) and the Peter Lougheed Centre. He also worked at the Alberta Cancer Board, Tom Baker Cancer Clinic and Grace Women's Centre Breast Health Clinic. Throughout his many years of practice he displayed unconditional care and compassion for his patients. Robert was an active member and supporter of the Calgary Medical Society and the Alberta Association of General Surgeons, through which he expressed his views on the future direction of medicine. He served many hours as a member of the admissions committee for the University of Calgary Medical School, screening future medical students. He was also interested in the historical aspects of medicine and regularly attended the history of medicine lectures. Robert's love for teaching was fulfilled through his associate professorship in the surgical residency program. He was a trainer and examiner for the advanced trauma life support (ATLS) course. The skills, expertise and wealth of knowledge he offered to his colleagues and all who knew him will be gratefully remembered. Robert had many interests outside of medicine. He was an avid reader, having a particular interest in Western Canadian history. His incredible memory for historical facts and information made him a wonderful storyteller. He loved nature and spent many hours being in the mountains, hiking and cross country skiing. He was a skilled curler, playing regularly as a skip at the Glencoe Club and in the Calgary Medical League. Many enjoyable hours were spent in his workshop honing his woodworking skills. Two of his major accomplishments were building the family's powerboat and sailboat. His major passion was spending time with family and friends at the cabin at Windermere Lake. These special times with him will be etched in our memories forever.

Stem cell cardiologist recipient of Libin/AHFMR Research Award

By Jennifer Lomas, CHR communications

The viability of stem cells in treating patients with heart failure is just one of the leading-edge research initiatives that this year's recipient of the Libin/AHFMR prize in cardiovascular research has undertaken during his illustrious career.

Dr. James T. Willerson, a world-renowned cardiologist, president of The University of Texas Health Science Center at Houston, and president-elect and medical director of the Texas Heart Institute, has been awarded the 2006 Libin/AHMFR prize in cardiovascular research, given annually by the Libin Cardiovascular Institute of Alberta and the Alberta Heritage Foundation for Medical Research (AHFMR). The award recognizes outstanding international cardiovascular research that is deemed to have had a major impact on the understanding, prevention, recognition or treatment of cardiovascular disease and/or the understanding and promotion of cardiovascular health.

"I'm honoured to have been selected to receive this award. It is meaningful to be recognized by the Libin Institute and AHFMR, and I appreciate the support this award will give to my research," says Willerson.

Recent highlights of Dr. Willerson's research include investigation into the prevention of unstable angina and acute myocardial infarction, the detection and treatment of unstable atherosclerotic plaques and the discovery of genes and abnormal proteins responsible for cardiovascular disease.

Now, in the first FDA-approved trial of its kind in the United States, Dr. Willerson is working with a team of researchers to transplant bone marrow-derived stem cells directly into the hearts of patients with severe heart failure. So far, the results have been very encouraging and the Libin/AHFMR prize will contribute further to this research.

"Dr. Willerson's research is making an important contribution to our understanding of heart disease and how it can be treated and managed," says Dr. Brent Mitchell, director of the Libin Institute. "We are thrilled to recognize him with this year's Libin/AHFMR prize in cardiovascular research."

Dr. Willerson and his colleagues began transplanting bone marrow-derived stem cells directly into the heart of a patient with severe heart failure in 2000, when researchers from the Texas Heart Institute in Houston and the Hospital Procardico in Rio de Janeiro launched a research initiative in Brazil.

"That study showed that there were clinical improvements in patients who had received stem cell treatment. Among other indicators, they exhibited enhanced blood flow to their hearts and improved contractile function," describes Willerson.

In addition to looking for these improvements, the FDA-approved trial will pave the way for further studies that will attempt to measure the efficacy of various types of stem cells in treating heart disease.

"In the future, we'll be looking to determine whether stem cells from other parts of the body, in addition to bone marrow-derived stem cells, can be used to repair the heart and whether certain types of stem cells are better than others for this task," says Willerson.

"We are proud to support groundbreaking research, such as Dr. Willerson's with the Libin/AHFMR prize," says Mitchell. "Exciting and leading-edge enquiries such as these will greatly enhance our understanding of heart disease and eventually improve heart health worldwide."

Dr. James Willerson, left, recipient of the 2006 Libin/AHFMR prize in cardiovascular research, discusses his stem cell research with Dr. Brent Mitchell, director of the Libin Cardiovascular Institute.Greg Fulmes photo

Phlebotomy appointments, cls patient service centres (PSCS)

By Dr. Erik Larsen, vice president medical operations, Calgary Laboratory Services

CLS performs between 4,000 and 5,000 phlebotomies per day at our 18 patient service centres. Most of the blood draws occur early in the morning as patients are required to be fasting. In order to smooth out the workload over the entire day as much as possible, we are implementing phlebotomy appointments in five PSCs - Market Mall, Marlborough, Southcentre, Glenbrook and Glenmore Landing.

Patients with appointments are attended to within a few minutes of arriving for their designated time, eliminating waiting. This service has proven to be very popular and in the future it is anticipated that additional patient service centres will accept appointments.

Appointments at all sites can be booked by calling 777-5136. Please let your patients know about this. We are currently preparing posters for your offices, however we know that you likely have limited space available for such things on your walls.

Incomplete requisitions

Patients who present to have their blood collected as outpatients often have requisitions that are incompletely filled out. One audit that we performed indicated that over 80 per cent of patients had information missing on their requisitions. The missing information varies and can include the Alberta Health Care number, ordering physician and location and sometimes even the tests themselves! As you can imagine, this causes problems because all patients have to wait while laboratory staff gather and collate the information. I'm sure you would become frustrated if a patient came to you with incomplete information sent from another physician. We are looking at methods to increase the compliance on receiving this information but, in the end, it's the patients who will have to be inconvenienced as a result. Please ensure that the demographic information is completed on laboratory requisitions and that you use your CLS physician stamp. If you don't have a stamp for each of your practice locations, please phone 770-3612.

Communication of stat results

Currently, phone calls are the default mechanism for communicating results from test requested STAT from community patients. Beginning August 1, 2006, when community laboratory tests are ordered STAT, results will be faxed by CLS to the ordering physician's office unless otherwise specified. After that date, if you would like your results phoned instead of faxed, please check the 'phone to' request box on the CLS community requisition and please ensure that your contact phone number is clearly entered on the requisition. Please refer any questions to Sharon Lengsfeld, manager of client services at 770-3825 or sharon.lengsfeld@cls.ab.ca.

Cls mobile phlebotomy services

CLS provides mobile phlebotomy services for patients who are critically ill and cannot leave their residence. In order to qualify, patients must meet one or more of the following criteria:

1. Patient is home and/or bed bound.
2. Patient has a mental health problem such as agoraphobia, debilitating anxiety, or a psychiatric condition that prevents him/her from leaving home.
3. Patient has a dementia or brain injury that would present a safety risk traveling to a CLS patient service centre.
4. Patient suffers from a medical condition such that a trip of an hour or more outside the home would compromise the health of the patient.
5. Patient has high oxygen needs that cannot be safely met by portable oxygen.

As you can imagine, this service is very costly – please ensure that this service is used judiciously. For more information, please call 770-3351.

Children's mental health training

Continuing professional development in children's mental health is available online throughout Alberta for primary health care professionals and is approved for up to 51 hours of CME credits for physicians. Focusing on practical assessment tools and intervention strategies for working with children and youth, upcoming topics include child development, behavioral issues, ADHD, self injurious behavior, suicide and more! Learn online anywhere, anytime! Each four-week online module is $50 and includes a voice narrated presentation by experienced specialists and primary care providers, written discussion with other professionals and the presenters, and links to resources. This program is fully funded by the Mental Health Innovation Fund through Alberta Health and Wellness and is provided through partnership of the Southern Alberta Child and Youth Health Network, Alberta Mental Health Board, Capital Health Region, and the Calgary Health Region.

For more information, call healthy minds healthy children at 403-220-4310 or kristyplotsky@calgaryhealthregion.ca

Regional clinical policy framework adopted

By Morag Mochan, policy analyst

In January 2006, the Calgary Health Region's executive management adopted the regional clinical policy framework, which clarifies the development of regional clinical policies and describes accountabilities of those involved in the process. The regional clinical policy committee and the regional clinical policy secretariat are integral to the process outlined by the framework.

Under the direction of the chief clinical officer team, the regional clinical policy committee authorizes the development of new regional clinical policies and provides advice on the available options (i.e. departmental policy, clinical pathway, etc.) if the development of a regional policy is not appropriate.

Committee membership consists of representation from the medical advisory board, medical staff office, nursing council, professional practice council, regional policy services, professional practice and development – nursing, professional practice and development – allied health, ethics, and quality, safety and health information. The committee is responsible for securing support and endorsement from the professional practice council, nursing council, and the medical advisory board prior to approaching executive for policy approval.

The clinical policy secretariat's role is to direct and advise members of the region who request new regional clinical policies. The secretariat assists with the formulation of a policy development plan, and subsequently with the development and review of a draft policy, its implementation plan, and resource requirements. The policy and completed planning strategies are presented by the secretariat to the regional clinical policy committee as the first stage in policy endorsement.

The secretariat is accountable to the regional clinical policy committee and is comprised of representation from professional practice and development – allied health, and regional policy services. As required, representation from professional practice and development - nursing and the medical/physician community (medical staff office/medical advisory board) will be present.

Resource information for regional clinical policies is located on the regional policy Website at http://iweb9.calgaryhealthregion.ca/policydb/. General questions may be directed to Jennifer Sullivan, policy consultant - allied health, professional practice and development. Tel: 944-3118, E-mail: Jennifer.Sullivan@calgaryhealthregion.ca or Morag Mochan, policy analyst, regional policy services. Tel: 943-0966, E-mail: Morag.Mochan@calgaryhealthregion.ca.

Code 66 to decrease code blues – increase patient safety outcomes

By Sheila Rougeau, CHR communications

Code 66, commonly referred to as a pre-code blue, is a new code that can now be called when a patient shows indicators of acute physiologic instability. The philosophy behind code 66 is that prevention provides better outcomes with less treatments and procedures needed.

Currently, only five to 20 per cent of patients who have an in-hospital cardiac arrest survive compared to an overall ICU mortality rate of 10 to 20 per cent.

The introduction of code 66 in a six-month pilot project at the Rockyview General Hospital decreased the number of code blues called by 40 per cent. Now fully operational at Rockyview, code 66 is being expanded to Foothills Medical Centre on July 1 and the Peter Lougheed Centre in September.

"It's a proactive approach rather than reactive," explained Elaine Rose, RN and ICU outreach program coordinator. "A large number of patients who have a cardiac and/or respiratory arrest display physiological changes for several hours before the arrest. The sooner we identify the problem, the sooner we can treat the problem."

Quicker treatment translates into shorter hospital stays, decreased treatment costs and less chance of adverse events. Ultimately, it means better patient care – safely and cost effectively.

"If we can keep patients out of the ICU, so much the better," said Dr. Chip Doig, medical director for the Foothills multisystem ICU. "But if they do need to be in ICU, it's best to identify them sooner and hopefully prior to a cardiac arrest. We know that well-timed intervention optimizes patient outcomes. It is essential that if a ward calls for help for a patient, the ICU is organized to respond immediately no matter where the patient is in the acute care setting. We should be taking the additional services provided by an ICU outside its geographic walls to the patient. We should not be doing this only at the time of cardiac arrest. Rather, we can provide caregivers the indicators of physiologic instability which research has validated as identifying patients at risk, and promise them that we will come and help."

The same approach for a code blue is used for a code 66. Call 600. State that you have a code 66. Give your location.

Criteria for calling a code 66:

- **Any patient you are seriously worried about**
- **Airway threatened.**
- **Resp. Rate < 8> 30**
- **Change in O2 saturation < 90% despite O2 >5L/min.**
- **Pulse Rate < 40 > 140**
- **Syst. BP < 90**
- **Sudden change in LOC**
- **GCS drop of more than two points**
- **Prolonged or repeated seizures**
- **Acute change in urinary output to < 50 ml in four hrs**

Temporary telehealth medical advisor

Calgary Health Region telehealth medical advisor Clinical telehealth is the use of telecommunications and videoconferencing technologies to provide health care services at a distance. Telehealth is a widely-used method of providing outreach and remote care to Calgary Health Region communities. Dr. Cheri Nijssen-Jordan, Calgary Health Region telehealth medical advisor, will be taking a sabbatical to work with Lifeline Malawi in Africa from July 1 ,2006 - December 31, 2006. Dr. Ben Gibbard will be providing cover for Dr. Nijssen-Jordan during this period.

For all telehealth inquires, contact Catherine Keenan, regional telehealth manager or Jason Kettle, telehealth operations manager. E-mail: Telehealth.Support@Calgaryhealthregion.ca Tel: 943-1285.

GP needed to cover sickness

GP required immediately (due to illness) for busy FP/walk in clinic. Professionally managed, great support staff. Located five minutes from Foothills Hospital. Minimal call and competitive split.

Please call Diane at (403) 990-0398

PCIS iWeb site launched

As regional implementation of the patient care information system (PCIS) nears, the PCIS project is pleased to launch its new iWeb site. Accessible at: http://iweb.calgaryhealthregion.ca/pcis, the redesigned site now serves as the primary source of relevant, credible and current PCIS info, training news and support. Physicians will find site content prioritized, sorted logically, and largely by user group – ensuring efficient navigation to specific information.

Be prepared; get informed – visit the PCIS at:

http://iweb.calgaryhealthregion.ca/pcis

Your comprehensive source of the right information, right now.

Shannon M. Davies, CHR communications

Medical office spaces for lease

Dr. Susan Poon has 900, 1800sf and 2500 sf for medical office use, located on Centre Street N and close to downtown and 16 Ave N. Parking at the back and free street parking. Existing medical use facility and will renovate to tenant specification.

Call Bruce Liang (403) 606-0112

Rockyview General Hospital Physician Association annual general meeting

By Stella Gelfand, RGH physician office secretary

The Rockyview General Hospital Medical Staff Association held its Annual General Meeting on June 13, 2006 in Millarville Rancher's Hall at Heritage Park. Guests were entertained by the hilarious Canadian Stand Up Comedian Cory Mack.

The following physician awards were presented:

Department of anesthesiology

To Dr. David Hardy by Dr. Charles Davies

Department of clinical neurosciences

To Dr. A. Keith Brownell by Dr. Laurie Pereles

Department of family medicine

To Dr. Douglas Thorson by Dr. Sy Lam

Obstetrics program

To Dr. Linda Lambert by Dr. Deborah Hitchcock

Department of internal medicine

Gastroenterology division

To Dr. Terry Fridhandler by Dr. Jeffrey Schaefer

Geriatrics division

To Dr. James Silvius by Dr. Jeffrey Schaefer

Respirology division

To Dr. John Chan by Dr. Jeffrey Schaefer

Department of obstetrics & gynecology

To Dr. Albert Rosengarten by Dr. Jaelene Mannerfeldt

Department of psychiatry

To Dr. David Li by Dr. John Tuttle

Department of surgery

Otolaryngology division

To Dr. Thomas Gillis by Dr. Laurie Pereles

At the meeting, the Rockyview General Hospital Physician Association executive was announced as follows, as of June 2006: Dr. Douglas Thorson, RGH MSA president, Dr. Laurie Pereles, past president, Dr. Gerald Lazarenko, Dr. James Janzen, Dr. Borys Hoshowsky - members at large. Dr. Glenn Comm, the new president of the Calgary and Area Physicians Association, was introduced.

Rockyview General Hospital Physician Association meetings for 2006-2007 are as follows: September 12 2006, December 12, 2006, March 13, 2007, June 12, 2007, September 11, 2007, December 11, 2007