

DocTalk

Physician Engagement

Resident Prescribing

Gabapentin
& Overdose Risks

The Saskatchewan Hub Tables

Indigenous Wellness in Regina Clinic

Registration Renewal is Coming Soon!

Council Elections - Call for nominations



Kendel Award: Nominations open until Sept 30

In this issue

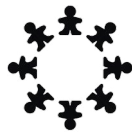
Not yet subscribed?

Write to
communications@cps.sk.ca
for your free e-mail subscription.

** Registered members of the College are automatically subscribed to DocTalk as part of their duty to keep up with College updates to policies and other important information relative to practicing medicine in Saskatchewan.*

From the President

How Physician Engagement Affects Quality of Care 4



Council News

Policy Development; Truth and Reconciliation; New Electoral Boundaries for Upcoming Council Elections; Call for Nominations 5

From the Registrar

Proposed Education Session Aims to Mitigate Rise in Number of Serious Complaints 6
CPSS Welcomes New Deputy Registrar 7



Addressing Quality of Care

Your Feedback on our Quality of Care Services 8

DocTalk
Volume 5, Issue 2

ISSN 2368-0628
ISSN 2368-0636 (Online)

2018



College of Physicians and Surgeons of Saskatchewan

101-2174 Airport Drive, Saskatoon, SK S7L 6M6
(306) 244-7355 communications@cps.sk.ca

REGISTRAR: Dr. Karen Shaw

EDITORIAL ADVISORY COMMITTEE

Dr. Brian Brownbridge
Joanna Alexander
Dr. Karen Shaw
Dr. Micheal Howard-Tripp
Caro Gareau
Alyssa Van Der Woude

MAIN CONTRIBUTORS

Dr. Brian Brownbridge
Dr. Karen Shaw
Bryan Salte
Dr. Micheal Howard-Tripp
Caro Gareau
Ed Pas
Julia Bareham
Carol Bowkowsky

EDITOR

Caro Gareau

REVISION

Caro Gareau
Dr. Micheal Howard-Tripp
Dr. Brian Brownbridge
Joanna Alexander
Alyssa Van Der Woude
Sue Waddington

GRAPHIC DESIGN

Caro Gareau
Meagan Fraser

FOLLOW US

www.cps.sk.ca



FACEBOOK



TWITTER

PHOTO CREDITS

Cover: Stock photo. Inside: As indicated, CPSS photos or public domain



Legally Speaking

<i>Requirements for Residents to Prescribe Medications</i>	9
<i>Policy, Standard and Guideline Updates</i>	10
<i>College Disciplinary Actions</i>	10



Registration Times

<i>Renewing your Licence to Practice</i>	11
<i>Medical Corporation Permit Renewal</i>	11
<i>Changes to Licensing Requirements Now Official</i>	12
<i>Updated SIPPA Program Requirements</i>	12



CPSS Programs and Services

<i>Drugs of Abuse: Gabapentinoids (PRP)</i>	13
<i>The Risks Associated with the Concurrent Use of GAPABENTIN and OPIOIDS (PRP)</i>	15



Indigenous Wellness - Providing Quality Care

<i>The Meadow Chronic Pain Clinic in Regina</i>	16
<i>Eagle Moon Health Office - FN Traditional Health Advisors</i>	17
<i>Call for Submissions on the Topic of Indigenous Wellness</i>	17



Physician Update

<i>Determining Capacity: A Structured Interview - Is your patient able to manage personal financial affairs?</i>	18
<i>Collaboration, Reducing Risk and Improving Community Safety and Well-Being: Hub Tables in Saskatchewan</i>	20
<i>Prescriber Snapshots - Project for Developing Prescriber Report Cards</i>	23
<i>Project ECHO: Management of Chronic Pain and Opioid Use Disorder</i>	25
<i>#IWillReport - Workplace Violence and Agression</i>	26
<i>Is your Practice a Safe and Supportive Place for LGTBQ2+ Individuals?</i>	27



Sask Leaders in Health Care

<i>Kendel Award - Call for nominations</i>	28
<i>Senior Life Designation - Have you served 40 years in SK?</i>	29

We're Working for You 30

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

Submit your ideas & articles by **November 15, 2018** to COMMUNICATIONS@cps.sk.ca



Dr. Brian Brownbridge
President, CPSS

FROM THE PRESIDENT

How Physician Engagement Affects Quality of Care

I believe one of the biggest issues our healthcare system and profession has to grapple with is lack of physician engagement. This issue is not new and it is far from simple but in my opinion it is not getting better.

Background

In 2011 a report¹ was commissioned by the Regina Qu'Appelle Health Region authored by Amer Kaissi looking at the issue of physician engagement. We now have one provincial health region and are we any closer to addressing this very important issue?

It is generally felt that employee and physician engagement improves the overall function of the organization including productivity and quality. Physicians have worked in the healthcare system for years as independent thinkers and often feel more personal responsibility for outcomes of patients. Key characteristics of physicians are problem solvers and critical thinkers. The present push for standardization and doing things the same can come into conflict with physician autonomy and independent thinking although there is fairly strong data that suggest marked variation in care does not improve it. This standardization push by management can lead to conflict with physician providers if they are not integrally involved in the changes and decisions. Some physicians see this standardization as potentially depersonalizing and simplifying the individual patient. "Every patient is a round widget to fit in a predetermined hole".

The Situation Today

Physicians are under constant pressure by their patients and society to do more and extend life further. As the baby boomers age and as Canada becomes much more multi-cultural, their expectations may not be realistic lead-

ing to pressures to expand the scope of care to individuals who may never have been a candidate for it in the past. This leads to expanding costs which administrators and departments of health are trying to curtail. Physicians are asked to be the gate keepers but many decisions they are asked to address require a much larger consensus by administrators, government and society.

I believe the vast majority of physicians are truly concerned about the quality of care of their patients and their outcomes with care. They work long hours to assist their patients and administrators. If you want to actively disengage a physician suggest the following phrase, "We need to do more with less". Physicians are committed to quality improvement but also realize that this requires a significant investment in time and resources.

How does Physician Engagement Affect Quality of Care?

The Medical Engagement Scale (MES) developed in the U.K. provides a valid tool examining three areas that encompass physician engagement: feeling valued and empowered; having purpose and direction; and working in an open culture. Lack of physician engagement can lead to easily frustrated physicians who may lash out at colleagues and allied healthcare workers. I believe lack of engagement is a key factor in poor communication with patients which is the leading cause of complaints to regulatory bodies.

The healthcare system and the medical profession have to get physicians actively engaged. As physicians we must be-

...continued on p. 5

¹ Regina Qu'Appelle Health District: A Roadmap for Trust: Enhancing Physician Engagement.
<https://pdfs.semanticscholar.org/b9a1/9f415e24b3462537499d7a11c3b0c0226bb9.pdf>



...continued from p. 4.

gin to shed some of our skepticism and try to make a difference. We must continuously put the wellbeing and quality of care of our patients above any other goals in healthcare. We must take an active role in deciding key decisions in healthcare that affect quality of care. We must be willing to sit on committees but insist that these committees make a difference and not simply meet because that is what is expected. We must be willing to stand up when bad decisions are made for patient care. We must remember why we went into medicine - to "help patients and make a difference". Leadership must be willing to allow these things to happen and must actively support physicians in this endeavour.

Kaissi's report: *A Roadmap for Trust: Enhancing Physician Engagement* might be a useful tool for all parties involved in healthcare to improve physician engagement.

I believe enhanced physician engagement will lead to improved patient care, less complaints about physicians and likely a more fulfilled physician profession.

I believe If we have good physician engagement, the public will be safer, and this is the mandate of the College.

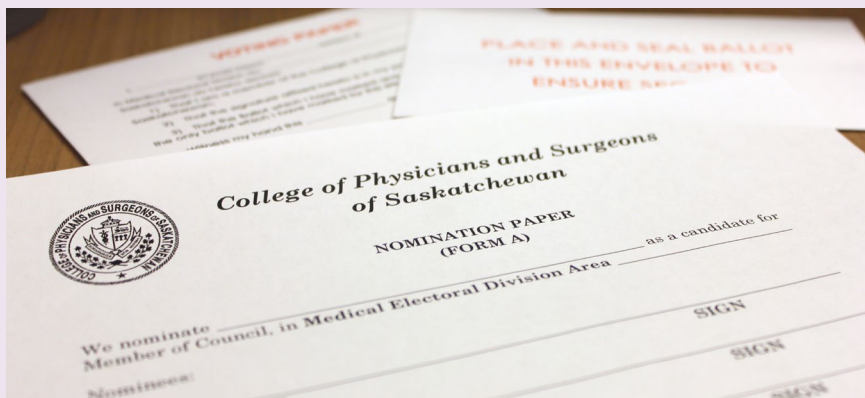
Policy Development

Council appreciates the constructive suggestions that were received on the policy of *Regulation of Office Based Procedures* that was posted on our website.

The policy on *Complementary and Alternative Therapies* was recently reviewed. Council advises members to use a great deal of discretion when offering care or services deemed outside the confines of conventional medicine. When offering new care alternatives, there should be good evidence-based medicine (EBM) to support the care.

Truth and Reconciliation

We continue to move forward on the issues from the Truth and Reconciliation Report and certainly welcome physicians who may bring a unique perspective to the Council sub-committee.



New Electoral Boundaries for Upcoming Council Election

Council has ratified in principle realignment of medical electoral districts to more closely represent the numbers of physicians as well as the large geographical areas. The elections for Council seats will be phased in over the next few years to represent this new plan.

Have you thought of running for Council?

Now is your chance!

Council strongly encourages you to put your name forward to sit on Council. Deadline for nominations is **October 23, 2018** for four positions on Council. The areas are Saskatoon, Regina, North West/ Athabasca and South East area.

Write to OfficeOfTheRegistrar@cps.sk.ca for more information.



Dr. Karen Shaw
Registrar, CEO

FROM THE REGISTRAR

Proposed Education Session Aims to Mitigate Rise in Number of Serious Complaints

Plans for the January 2019 Educational Session will focus on Physician Communication & Boundaries to examine recent trends, reinforce collegiality and improve communication between physicians.

In January 2019, the College will be hosting an educational session to explore physician communication and boundary issues that are of concern to physicians. We expect that we will be able to Webex the educational session. This will allow those physicians who are not from Saskatoon to attend with the least amount of disruption to their professional and personal lives.

The media frequently reports instances of inappropriate physician – patient boundaries. Regulatory bodies across Canada are experiencing an increase in the number of complaints of boundary violations. We have not been immune to this trend. After many years of not having any reported cases related to physician-patient boundaries, the College has revoked the licences of 6 physicians in the past 5 years. The details of these cases have been reported in Doctalk and are available on the College's website. The College is currently investigating 8 allegations of improper sexual conduct with patients. Regulators do not have a clear understanding as to why this trend is occurring despite the education physicians receive about appropriate boundaries.

We also are not immune to the “Me Too” movement that has identified inappropriate communication, harassment and boundary violations within medicine; often with our learners. We need to listen to these stories and decide what we can do to stop this. CBC's White Coat Black Art has a compelling piece on this and the transcript or video link can be accessed at <https://www.cbc.ca/radio/white-coat/metoo-in-medicine-1.4559561/metoo-in-medicine-culture-of-silence-keeps-med-students-from-reporting-abuse-by-their-mentors-1.4559570>. I encourage you to listen and think about what you could contribute to stopping this behaviour.

We are also witness to a lack of collegiality, and at times incivility within the profession, again without a clear un-

derstanding of why. Poor communication with patients, between physicians, and between physicians and our non-physician colleagues has resulted in complaints, registered by patients, families, physicians and non-physicians. What steps can we take to identify the cause and remedy it? What supports are necessary to accomplish this work together?

An article by Diane Shannon entitled *Effective Physician-to-Physician Communication: An Essential Ingredient for Care Coordination* (PEJ January February 2012), is an interesting read. She states that “without effective, timely communication between physicians, both the quality of care and the patient experience can suffer”. I think we all have examples in our practices when gaps in communication led to a series of unintended negative consequences including delay in treatment, inappropriate or inadequate treatment, an increased length of hospital stay or, worse, patient harm. The author of the paper goes on to ponder “how did we get here?” She identifies problems with the health system design – one being the existence of “disincentives” for appropriate communication that exist in the current health care system. Although she is speaking about the American system, the risk factors she identifies such as “physicians have too much activity in their daily professional lives”, strikes a chord with me. She goes on to identify other factors such as peer relationships and how they have changed; perhaps due to the fact that fewer primary care physicians admit patients to hospitals and therefore they do not know the consultants personally, and that “collegiality, that sense of being a peer, has gone away.” That sense of collegiality has changed with our use of access tools like ACAL and the loss of relationships with consultants whom we know well. We have contemplated the loss of the “surgeons lounge” and its value in the “old days” as a place to get to know your consultants, have an opportunity for an informal consultation and to develop those important peer relationships. Is there a different

... continued from p. 6

model that would allow us to relink with our colleagues? Certainly the SRMA has been trying to develop a different, more collegial connection for physicians who practice within the Saskatoon area.

The use of asynchronous communication (e-mail, text messaging, electronic medical records) is another factor Dianne Shannon identifies that may affect the number of direct conversations physicians have about specific patient care. She asks: what are we missing with this type of communication being substituted for face to face communication? It is a good question. Another concern we have seen with email communication or other social media is the problem that can arise with the impersonal nature of email, texts and blog posts and the tendency to say things differently and be less polite than if the communication was in person. This can lead to inappropriate communication and the erosion of peer relationships. So what are the benefits, risks and best practices associated with social media and health care professions?

AGM Presenters Sought

These are some of the areas we hope to explore in our educational session. We are trying to identify some expert presenters, so if you are one or you know of someone, please let me know.

Please provide me your comments; many minds working together should make this a great opportunity to explore how we can influence positive change in these fundamental aspects of physician's work.

Write to OfficeOfTheRegistrar@cps.sk.ca.

CPSS Welcomes New Deputy Registrar

Recently appointed as the new Deputy Registrar of the College, Dr. Werner Oberholzer is a South African-trained family physician and former Dr. Dennis A. Kendel Distinguished Service Award winner who provided many years of service to the community of Radville before moving to Saskatoon. He recently completed his CCFP-EM designation and has been contributing to the provision of emergency services in the Saskatoon hospital emergency departments. He comes with a strong background in the provision of high quality care and has an interest in process improvement.

Dr. Oberholzer has been working with the College in the position of Senior Medical Advisor since last Fall, assisting with the Quality of Care complaints, prescription review and assessment work of the College. He will be an additional point of contact for physicians seeking College advice on non-legal matters. He will oversee the quality of care process as well as provide medical guidance to the Prescription Review Program. He will continue to assist in scope changes and process improvements related to the integration of internationally trained physicians through the summative assessment process.

Dr. Oberholzer will replace Dr. Micheal Howard-Tripp, who is retiring at the end of September 2018.

We thank Dr. Howard-Tripp warmly for his years of service as Deputy Registrar and Medical Manager with the College and wish him well in his future endeavours.



Dr. Werner Oberholzer

Your Feedback on our Quality of Care Services

Dr. Micheal Howard-Tripp
Deputy Registrar



As I prepare to depart from my role as Deputy Registrar and Medical Manager of the Quality of Care complaints process, I thought I would look back on some of the achievements in Quality of Care over the past 4+ years. During this time I have greatly appreciated the support of an excellent staff, public and physician colleagues on the Quality of Care Advisory Committee, senior staff at the College and the members of Council. I would also like to welcome Dr. Werner Oberholzer to the position of Deputy Registrar and have the utmost confidence that, with his input, there will be sustained improvements in the Quality of Care processes.

In line with Council's strategic plan, the Quality of Care department has attempted to improve the complaints process for both complainants and respondent physicians, while maintaining a focus on the primary function of the College; patient safety.

One way of gauging our success is through the surveys sent to both complainants and respondent physicians. Many years ago the CPSS discontinued surveying physicians and complainants and a decision was made in 2017 to re-institute a survey. Over a period of approximately 10 months we mailed out 149 surveys to physicians and 142 surveys to complainants. The return on these surveys overall is 15% (19% for physicians and 11% for complainants).

The complaints process can be confusing and efforts have been made to improve the quality of letters and documents sent out as well as simplifying the language used. In response to questions relating to the clarity of information provided 56% of complainants and 100% of physicians either agreed or strongly agreed that the information provided, relating to the complaints process, was adequately explained. 75% of complainants and 100% of physicians also indicated that they strongly agreed or agreed that the outcome of the complaint was clearly communicated to them.

An initial primary focus was on reducing the timeline for resolution of a complaint. Shorter timelines to resolution have a number of benefits, not least of all reducing the stress of responding to a complaint and increasing complainant satisfaction, but also by allowing more timely intervention for concerns. Despite our attempts at shortening the timeline for resolution of complaints, we have not been able to get the average time for resolution to less than 120 days. This is, however, compatible with response times of other medical regulatory colleges in Canada. In answer to questions relating to the time to resolution of a complaint, 56% of complainants and 100% of physicians either agreed or strongly agreed that their complaint was resolved in a reasonable time frame.

Additional questions in the survey revealed that 46% of physicians contacted the CMPA for advice and 18% contacted the Physician Support Program of the Saskatchewan Medical Association.

The Quality of Care department, together with the Quality of Care Advisory Committee, attempts to provide fair and balanced decisions that reflect current practice and evidence informed medical care. In response to the question, *The final decisions made by the College were evidence based and reflected current practice*, 43% of physician respondents strongly agreed and 54% agreed with this statement. In addition, 79% of physicians stated that they had made changes to their practice as a result of the complaint. Only 50% of complainants agreed that they thought their complaint was taken seriously but, despite this, some of the comments we received included:

"I was very impressed with attention towards my complaint and actions taken. The College acted perfectly on our behalf and that is the reason we will not pursue any further. Senior Medical Advisor was at the highest professional level."

"I would like to say "thank you" for taking my concerns seriously."

Based on the feedback from complainants, we will be exploring the possibility of more personal contact with complainants, including informal facilitated resolution for the more minor concerns. This may certainly decrease the time taken to resolve some complaints and may lead to higher levels of satisfaction with the process by complainants.



Requirements for Residents to Prescribe Medications

Bryan Salte

Associate Registrar
and Legal Counsel



As a result of a recent disciplinary investigation, the College became aware that some residents and some supervising physicians are unaware of the College's requirements for residents to prescribe medications. These requirements apply to medications dispensed by pharmacists to patients in the community, not to medications that are dispensed pursuant to a hospital order.

Requirements related to all prescriptions

Regulatory bylaw 17.1 sets out the requirements that apply to all written and verbal prescriptions issued by physicians. There is an additional requirement that residents place the name of the supervising physician on the script:

- (i) Physicians in training who are enrolled on the educational register of the College of Physicians and Surgeons and who may be authorized to issue prescriptions must clearly identify on the prescription the name of the fully registered physician who is their supervisor in respect to that specific physician/patient interaction.

The College requires this so that pharmacists who receive these prescriptions will be able to contact the supervising physician with any questions or concerns related to the prescription.

Requirements related to prescription review medications

Regulatory bylaw 18.1 sets out the additional requirements that apply to prescriptions for prescription review medications. PRP medications include opioids, benzodiazepines, gabapentin, stimulants, etc. The bylaw contains a complete list of the medications that are subject to the bylaw.

In addition to the general requirements for writing such prescriptions, the bylaw imposes additional requirements if the writer is a resident:

(f) If a physician is registered on the Educational Register, the physician shall, in addition to the information in paragraph (c) [of the bylaw] above, include the following in a prescription for a drug to which the Prescription Review Program applies:

- (i) The training level of the physician writing the prescription;*
- (ii) The legibly printed name of the Most Responsible Physician (the physician to whom queries regarding the prescription should be addressed);*
- (iii) The legibly printed name of the physician writing the prescription.*

Residents and physicians who supervise residents should be aware of these requirements to avoid patients having problems obtaining prescribed medications as a result of incomplete prescriptions.



Policy, Standard and Guideline Updates

Council regularly reviews the policies, guidelines and standards which are then made available on the College's website. Since the last Newsletter, Council has adopted one new policy:

POLICY - Complementary and Alternative Therapies

This document was adapted from a similar document established by the College of Physicians and Surgeons of British Columbia.

It begins with the statement: "It is unethical to engage in or to aid and abet in treatment which has no acceptable scientific basis, may be dangerous, may deceive the patient by giving false hope, or which may cause the patient to delay in seeking proper care until his or her condition becomes irreversible".

The document establishes expectations for physicians who provide complementary or alternative therapies, including an expectation that:

- The physician should use appropriate and conventional methods to establish a diagnosis and basis for treatment;

- The physician should provide full and accurate information to the patient to allow the patient to provide informed consent before agreeing to accept a complementary or alternative therapy; and
- The physician should offer standard therapies before complementary or alternative therapies are provided.

[Click here to view full policy](#)

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

College Disciplinary Actions



The College reports discipline matters in the next issue of the Newsletter after the disciplinary action is complete. The [College website](#) also contains information on discipline matters that are completed, and matters where charges have been laid but have not yet been completed. There were three discipline matters completed since the last Newsletter report.

Dr. Josias Furstenberg

Dr. Furstenberg admitted 10 charges of unprofessional conduct. The charges included establishing sexual relationships with two patients, providing medical care to individuals with whom he was in a relationship, inappropriately accessing the health information of a person without consent and breaches of patient confidentiality.

Council revoked Dr. Furstenberg's licence and ordered him to pay costs of \$9,594.87.

Dr. Tiffany Lee

Dr. Lee was licensed to practise medicine in Ontario. She practised medicine in Saskatchewan before she was issued a Saskatchewan licence. She was ordered to take an ethics course, was reprimanded and required to pay costs of \$690.

Dr. Brian Nadler

Dr. Nadler was a resident in a residency program. The charges alleged that he made a late entry into a medical record without noting the date and time of the addition and that he used unprofessional language to refer to a colleague with whom he had a disagreement.

The charges were resolved through an alternative dispute resolution process. Dr. Nadler agreed to take courses in record-keeping and ethics and to provide an apology to the Council.



REGISTRATION TIMES

It's Renewal Season!

Renewing Your Physician Licence to Practice

Physician registration renewal time
is fast approaching!

You will soon be receiving your registration renewal notice in the mail.

Please follow the instructions in the letter to promptly renew your registration for the period of December 1, 2018 to November 30, 2019.

Medical Corporation Permit Renewal

Remember to renew your
Medical Corporation Permit too!

Physicians with medical professional corporations will also soon be receiving their corporation permit renewal letter in the mail for the period of January 1, 2019 to December 31, 2019.

All corporation renewals must now be submitted online.

Follow the instructions in your renewal notice letter to promptly renew your medical corporation!

To renew online, you will need:

- Access to a computer;
- Credit card for payment of fees (Visa or MasterCard)
- Your User ID for corporation renewal (provided in the letter from the College);
- Your personal account password for corporation renewal (provided in the letter from the College).

Mr. Ed Pas

Director, Registration Services



**All
Registration Renewals
AND
Medical Corporation
Renewals
are due no later than
November 1, 2018**

to ensure that College staff has sufficient time
to process applications for all physicians.

**Avoid interruption in your licence
and additional fees for restoration
to the register by acting promptly!**

Changes to Licensing Requirements Now Official

English Language Proficiency

- IELTS Academic is now the only test that meets CPSS requirements for English language proficiency. The minimum score is 7.0 in each component, and the test must have been completed within the previous 24 months.
- TOEFL is no longer accepted. This came into effect for licences issued after June 30, 2018.

Medical Council of Canada Exams

- The MCC Evaluating Exam (MCCEE) is being phased out, with the final session to be held in November 2018.
- Because of the elimination of this exam, the MCCEE will no longer be sufficient for licenses issued after June 30, 2019.
- For licences issued on or after July 1, 2019, the minimum MCC exam requirement for licensure will be the MCCQE1.
- Note that these dates refer to the issuance of licences regardless of application date. Because it can be time consuming to obtain some of the required documentation for licensing, please allow ample time. Registration staff cannot guarantee dates for issuance of licences.



*Be it Known to All that
Sally Smith*

has been duly Registered as a Member of the College of Physicians and Surgeons of Saskatchewan and holds Regular Licensure under Bylaw 2.3 pursuant to The Medical Profession Act, 1981 as a member in good standing on the register.

Updated SIPPA Program Requirements

The SIPPA program has revised the **minimum entry requirements** for internationally educated family physicians. Applicants who wish to be selected for the SIPPA program must demonstrate that they have:

- A pass standing on the Medical Council of Canada Qualifying Exam Part 1 (MCCQE1)

AND

- Completed the National Assessment Collaboration Objective Structures Clinical Examination (NAC OSCE) (written in 2014 or later) with a minimum score of 75;

OR

- A pass standing on the Medical Council of Canada Qualifying Exam Part 2 (MCCQE2) and have obtained the Licentiate of the Medical Council of Canada (LMCC) credential.

AND

- Have been in active, independent practice as a family physician in the last three years with a minimum of three months full-time family practice.

AND

- A pass standing on the Therapeutics Decision Making (TDM) exam. (A pass standing on the TDM Exam will be required for selection into SIPPA, but it is not required at the application stage.)

Applicants will also need to meet the non-exemptible standards for licensure as outlined in Bylaw 2.3.

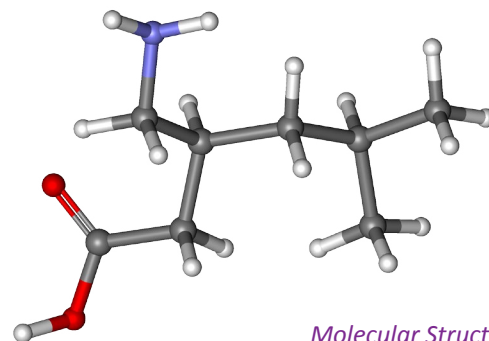
Gabapentinoids are easily misused and abused. Here are some tips on how to ensure appropriate prescribing.

Drugs of Abuse

GABAPENTINOIDS

Gabapentin (Neurontin) and Pregabalin (Lyrica)

By Diar Alazawi and Julia Bareham



Molecular Structure
of Pregabalin

Gabapentinoid Abuse

The medication class of gabapentinoids includes both gabapentin and pregabalin. These medications have historically been viewed as a relatively safe medication, not as a drug of abuse. Initially used as antiepileptics, today gabapentinoids have a wide variety of off-label uses, such as a treatment for neuropathic pain. However, it is important to be aware that gabapentinoids have the potential for misuse, abuse and diversion. In their systemic review Smith et al. reported that 40 to 65% of people with a prescription for gabapentin misuse the drug. In addition to that, 15 to 22% of people abusing opioids (with or without a gabapentin prescription) also misuse gabapentin. Substance abuse or a history of substance abuse is a risk factor for gabapentinoid abuse.

Gabapentinoid abuse is increasing, and these medications are being diverted, sold on the street, and traded for illicit drugs. Gabapentin has a reported street value varying from \$2 to \$5 per capsule/tablet. Gabapentinoids are commonly abused along with opioids or alcohol. Of note, pregabalin's higher potency, quicker absorption, and greater bioavailability may lead to an increased likelihood of abuse or misuse compared to gabapentin.

The effects experienced by gabapentinoid users are wide ranging. This class of medication can produce effects similar to alcohol, benzodiazepines, and opioids so users may be chasing the feeling of other drugs and using gabapentinoids as a substitute. Gabapentinoids have been associated with a cocaine-like high, a marijuana-like high, an amphetamine rush, disassociation, and a MDMA-like high. Euphoria is common, either by combining gabapentin with other drugs or by taking doses of 1500mg or more. Relaxation and calmness can also be experienced by gabapentin

users when combined with other drugs or when used at doses of 600mg or more. Other experiences reported with misuse of gabapentinoids include: improved sociability, disassociation, increased energy and focus, and improved sleep. Some individuals may also misuse and abuse gabapentinoids for the self-treatment of alcohol, cocaine or opioid cravings.

What Can You Do Different?

Prescribers should take care to evaluate if a gabapentinoid is appropriate for the indication for which it is being prescribed. SNRIs have similar efficacy as gabapentinoids for neuropathic pain (e.g. post-herpetic neuralgia or diabetic neuropathy). There is a lack of good evidence to support the use of a gabapentinoid for use in chronic back pain. Use gabapentinoids cautiously in patients with a history of abusing alcohol, benzodiazepines, or opioids, or in patients receiving other medications with abuse potential.

Always use the lowest effective dose. Consider targeting a dose of gabapentin 1200mg to 3600mg/day or pregabalin 300mg to 600mg/day for neuropathic pain.

Prescribers should also limit off-label use of gabapentin, and limit its co-prescription with opioids. For more information on the risk associated with the concomitant use of gabapentin and opioids, see [The Risks Associated with the Concurrent Use of GABAPENTIN and OPIOIDS](#) on page 15. Remember to caution patients that combining a gabapentinoid with an opioid may increase the risk of overdose death and document those conversations on the patient medical record.

To help minimize the opportunity for diversion, ensure you prescribe a formulation that will minimize the number of

... continued on p. 14

... continued from p. 13

capsules/tablets dispensed. For example, instead of gabapentin 300mg ii TID, prescribe gabapentin 600mg i TID. Gabapentin is available as: 100, 300, 400 capsules, and as 600 and 800mg tablets.

Watch for red flags such as early refills, multiple prescribers, multiple pharmacies, etc.

Remember to utilize random urine drug screens and random pill counts to ensure the safe and appropriate use of the medication.

If you suspect misuse, abuse or diversion, consider alternatives for neuropathic pain such as tricyclics or duloxetine, which are at least as effective as gabapentin.

Clinical Resource

Comparison of Gabapentin and Pregabalin. Pharmacist's Letter/Prescriber's Letter. August 2018.

PL Detail-Document, Drugs of Abuse. Pharmacist's Letter/Prescriber's Letter. October 2015.

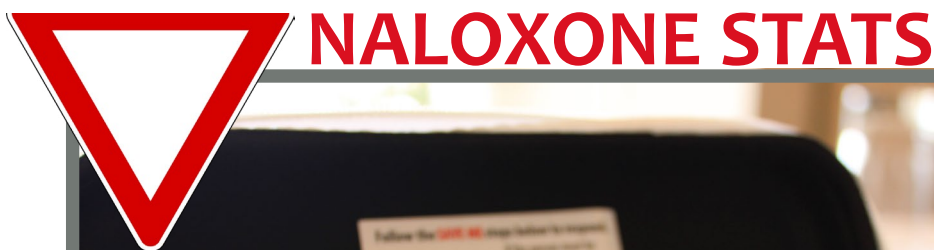
Smith RV, Havens JR, Walsh SL. Gabapentin misuse, abuse and diversion: a systematic review. *Addiction*. 2016 Jul;111(7):1160-74. doi: 10.1111/add.13324. Epub 2016 Mar 18. Review. PubMed PMID: 27265421; PubMed Central PMCID: PMC5573873.



Diar Alazawi

Pharmacy Student Completes Internship with the CPSS

Thanks to the 2018 Canada Summer Jobs program, the Prescription Review Program (PRP) applied for and received funding to employ a pharmacy student over the summer. The PRP was fortunate enough to have Diar Alazawi, a pharmacy student entering his fourth and final year this upcoming fall, join the team. During his time at the College, Diar focussed on updating the Opioid Agonist Therapy Standards and Guidelines for the Treatment of Opioid Use Disorder to reflect recent changes to the Health Canada methadone exemption process. The updated standards and guidelines will be released early this fall.



Since the beginning of the Take Home Naloxone Program in November 2015, more than 1,000 Take-Home Naloxone Kits have been distributed in Saskatchewan and more than 2,700 individuals have received training on how to recognize and respond to an overdose.

The Risks Associated with the Concurrent Use of GABAPENTIN and OPIOIDS

Physicians should keep in mind these increased risks when considering prescribing gabapentin and opioids concurrently.

By Diar Alazawi and Julia Bareham

Although gabapentin is considered a relatively safe medication, drug-induced respiratory depression has been reported when used alone, or in combination with other medications such as opioids. Both opioids and gabapentin are used to treat pain (nociceptive and neuropathic, respectively), and the concomitant prescribing of these medications is quite common in Saskatchewan.

Patients receiving gabapentin and opioids have significantly higher odds of opioid-related death compared to those taking opioids alone. Gomes et al. found that individuals taking 900mg or more of gabapentin daily are at risk for a 60% increase in the odds of opioid-related death. The study also determined that a dose of 2500mg or more of gabapentin daily was associated with a two-fold increase in the odds of death.

Why is the risk so high?

Opioids have cumulative effects when combined with gabapentin. Opioids can also increase gabapentin absorption by the body. Co-administration of gabapentin with morphine was shown to result in a 44% increase in gabapentin exposure due to lowered intestinal motility.

Risk factors that place patients at an increased risk of gabapentin-related respiratory depression include:

- Advancing age
- Renal insufficiency
- Chronic lung diseases
- Dose of gabapentin used

Pregabalin could have the same effects due to similar pharmacology to gabapentin

Use of an opioid and gabapentin together results in a **49% higher risk of opioid overdose**

What can be done to minimize the risk to patients?

- Prescribers should be very cautious when co-prescribing gabapentin with an opioid, especially for those patients with any of the risk factors listed above. This potentially deadly combination should be avoided whenever possible.
- When the combination of gabapentin and an opioid is deemed necessary, prescribers should closely monitor the patients and adjust their opioid dose accordingly. The lowest effective dose should always be used. Prescribers should discuss the risks of this combination with their patients, and document the conversation on the patient medical record.

Gomes T, Juurlink DN, Antoniou T, Mamdani MM, Paterson JM, van den Brink W (2017) Gabapentin, opioids, and the risk of opioid-related death: A population-based nested case-control study. PLoS Med 14(10): e1002396. <https://doi.org/10.1371/journal.pmed.1002396>





Indigenous Wellness - Providing Quality Care

How can you, as a physician, help provide quality care to Indigenous patients in a culturally safe and welcoming environment? This new section of DocTalk aims to give you some ideas!

A Regina Clinic serving a large Indigenous population shares its methods of providing quality care.

The Meadow Chronic Pain Clinic

By Dr. Radhika Marwah, Physician, Saskatchewan Health Authority (SHA), Regina

Background

The Saskatchewan Health Authority's (SHA) Meadow Primary Healthcare Centre is a Ministry of Health Innovation Site started in 2013 to deliver multi-disciplinary care for the population of North Central Regina.

Out of 10,000 residents in North Central Regina, 44% residents identify themselves as Indigenous compared to 10% in the rest of Regina^{1,2}. In this area, approximately 34% of the population is living below the Low Income Cut-Off, compared to 13% in the rest of the city^{1,2}.

These individuals present significant health burdens related to the social determinants of health, with multiple complex comorbidities including: chronic diseases, chronic pain, opioid dependence, mental illness, and substance use disorders. We, the team at Meadow, strive to offer culturally-sensitive and comprehensive care for this population at our Chronic Pain Clinic (CPC), and provide dedicated care of clients affected with chronic pain and opioid dependence. The objective of this **holistic program** at CPC



Photo: Courtesy Dr. Marwah

is to **optimally manage chronic pain and addictions**, mainly opioid use disorders, while minimising drug abuse and diversion.

Involving the Patient in Patient Care

Each patient goes through appropriate screening, assessing, education and counselling and **shared decisions are made** with the client for managing the treatment of opioid use. The care rendered is based on standard guidelines of *Opioid Use in Chronic Non Cancer Pain and Opioid Agonist Therapy*³⁻⁸.

We fostered partnerships with a neighborhood community physiotherapy clinic and a collegial pharmacist with an always-ready-to-help attitude. These efforts were compounded thanks to funding obtained from the College of Physicians and Surgeons of Saskatchewan. Physiotherapy and exercise therapy are essential components here as well, giving us superb results.

Important aspects on which to focus are: being **client friendly and culturally sensitive, rapport building and reducing stigma of mental illness and substance use disorders**. Our experienced Addictions and Psych Nurse provides one on one addictions counselling and naloxone training and kits to clients and their care givers. This also helps to monitor and reassess patients just inducted into the CPC. Clients are encouraged to engage in self-management, an important goal of any addictions program.

A unique part of the CPC Project is the collaboration with traditional medicine services from Eagle Moon Health Office. All patients regardless of ethnicity and background, are offered this referral⁹.



Challenges and Successes

- In our experience, it takes time for these clients to open up, given their longterm suffering and multiple medical and psycho-social concerns. So, we devote a few sessions to develop rapport and establish trust with these clients.
- Contacting some of our clientele who sometimes have no address or phone numbers poses significant problems. We seek the help of the SHA's *Connecting to Care* program, Crisis Outreach and Support Team (COAST) services and even the RCMP at times.
- Seeking out resources and connecting them with social services is a time-consuming task handled ably by both our Addictions Nurse and Navigator nurse.
- Educating about non-pharmacological methods of pain relief and rehabilitating these patients to increase functionality is key to management of chronic pain and opioid use.
- We use easy-to-understand hand-outs and also refer clients to resources such as Online Therapy User, and community resources such as *Live Well with Chronic Pain*.

The highlight is an **informal and down to earth approach** in collaborating with all the team members to enhance the quality of care of our Indigenous client group. We are a small initiative and have begun this positive journey on a long and arduous road ahead, thus contributing humbly but positively towards tackling the provincial opioid crisis.

References

1. First Nations Regional Health Survey, 2012.
2. CRG report for City of Regina, 2014 Mar-05
3. Canadian Guideline for Safe and Effective Use of Opioid for Chronic Non Cancer Pain: Practise Tool Kit. NOUGG. 2010. Available from <http://nationalpaincentre.mcmaster.ca>
4. Canadian opioid prescribing guidelines; https://www.cfpc.ca/uploadedFiles/CPD/Opioid%20poster_CFP_ENG.pdf
5. The Centre for Effective Practice updates the Opioid Manager tool to reflect the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain
6. https://www.cfpc.ca/uploadedFiles/CPD/List_of_Pain_Opioid_Initiatives_May_2_2017_final.pdf
7. OPIOID MANAGER-used to monitor patients using opioids and opioid agonist therapy in CPC Meadow. <https://www.cfpc.ca/uploadedFiles/CPD/CEP-Opioid-Manager.pdf>
8. More references <http://www.rxfiles.ca/rxfiles/uploads/documents/RxFiles-Pain-and-Opioid-Resource-Links.pdf>
9. Pain Management in First Nations, Metis, Inuit People: Through the Lens of Culture, Society and Medicine, Centre for Addictions and Mental Health, Jonathan Bertram, MD-Addictions Medicine Physician

Eagle Moon Health Office

If you would like to talk with a **First Nations Traditional Health Advisor**

They are available here
Wednesdays, 1:00 p.m.— 4:00 p.m.

An EMHO traditional Health Advisor can provide information about or help with access to:

Elders, Medicine Men, Healers, Traditional Counselling, Ceremonies (pipe, feast, sweat lodge, sun dance, smudging, etc.)

Please speak with the receptionist or call Eagle Moon Health Office at 306-766-6995
400 Broad Street, Regina, SK

Saskatchewan Health Authority

Image: Courtesy Eagle Moon Health Office

TELL US!

Patient-Physician Dialogue is Important for Quality of Care to Indigenous Patients!

We encourage First Nations Health Services, healthcare providers working with First Nations, and First Nations individuals to submit their ideas, articles, or information on services, their experience with successful programs, as well as upcoming projects that encompass Indigenous Wellness.

Write to communications@cps.sk.ca for details on how you can contribute to DocTalk.

Determining Capacity

By Dr. Allan Fong

(summarized by Dr. Laura Lee McFadden)

Competency or Capacity? Physicians are sometimes asked about a patient's ability to manage their financial affairs. How is this best evaluated?

Family physicians are sometimes asked to provide an opinion about a patient's ability to manage their financial affairs. In this context, *Competency* should be differentiated from *Capacity*. Competency is a legal construct denoting the minimum level of ability that an individual needs to make decisions or perform particular transactions. Capacity denotes a clinical status determined by a clinician. Capacity fluctuates and can change from day to day.

Medical History

Evaluation for financial decision-making capacity involves obtaining information related to the underlying condition that has put in question the capacity of the individual. One common example is dementia.

- Does the patient understand their condition and treatment?
- Does the patient understand the benefits, risks, and options for the treatment?
- Can the patient apply information to their own condition?
- Is their reasoning consistent with the facts and their values?
- Can the patient communicate their choices clearly?

Cognitive Testing

Cognitive skills relevant to financial decision-making include:

- Orientation
- Comprehension
- Reasoning
- Problem-solving
- Judgement
- Cognitive flexibility
- Impulsivity

Tools available to obtain information on the above include the Mini Mental Status Exam (MMSE) and the Montreal Cognitive Assessment (MoCA). There is debate about the correlation of these test scores with the capacity to make decisions about money. Physicians should be aware of the limitations of these tests and base a decision on more than just one test score.

... continued on p. 20



The Structured Interview

The interview focusing on financial decision-making capacity should initially begin with:

- Determining the reason for the evaluation (did a poor decision result in a bad financial outcome and cause the family, company to be concerned?)
- Discuss the reasons with the patient.
- Review any supporting documents from other care givers, family members.



The next part of the interview should focus on specific key areas around managing finances:

Financial Situational Awareness

- ☒ What are your current sources of income?
- ☒ How worried are you about having enough money to pay for things?
- ☒ Who manages your money and bills day to day?
- ☒ Do you regret financial decisions you have recently made? Are you helping anyone financially on a regular basis?
- ☒ Have you gifted or lent money to anyone in the past couple of years?

Psychological Vulnerability

- ☒ Have you recently lost someone who was a confidante?
- ☒ Do you feel downhearted about your financial situation
- ☒ Is your memory or thinking skills about finances worse than it was a year ago?
- ☒ When it comes to making financial decisions, how often are you treated with less courtesy and respect than other people?

Financial Transactions

- ☒ What major financial decisions are you intending to make?
- ☒ How will this impact you and is there a risk?
- ☒ Who will be adversely affected by this transaction? How will they react?
- ☒ Did you consult with anyone or discuss this with anyone?
- ☒ Would someone who knows you well say this decision was unusual for you?

Exploitation

- ☒ Have you ever had cheques missing from your cheque book?
- ☒ Do you have a credit or debit card that you allow someone else to use?
- ☒ Has anyone ever signed your name to a cheque? How often in the past few months has someone asked you for money?

Undue Influence

- ☒ Have you had conflicts with anyone about the way you spend money or to whom you give money?
- ☒ Has anyone asked you to change your will?
- ☒ Has anyone recently told you to stop getting financial advice from someone?
- ☒ Was this transaction your idea or did someone else suggest it?
- ☒ Did this person drive or accompany you to carry out this transaction?

Other areas to cover during the Interview

- ☒ Basic money skills (counting money, naming currency)
- ☒ Cash transactions (item grocery purchases, tipping)
- ☒ Chequebook and statement management
- ☒ Bill payment (recognize and prioritize bills)
- ☒ Knowledge of Assets and Estate

The goal of this assessment is to evaluate, as objectively as possible, an individual's abilities to manage or direct the management of his or her funds in a way that routinely meets the person's basic needs of food, shelter, and clothing. This can be a very complex and time-consuming process and may require more than one office visit. For many family physicians there is often not enough time to perform a thorough assessment in one visit. It may be prudent to begin an assessment by reviewing the reasons behind the request for capacity, outlining the medical issues and the patient's understanding of them, followed by an objective test such as the MMSE. Further detailed testing could then be done with referral to a resource in your community. This could include a social worker, an occupational therapist, a neuropsychologist, or a Geriatric Assessment Team.

Intergovernmental and interdisciplinary collaboration at special hub tables is helping identify at-risk individuals in Saskatchewan and provide effective assistance by sharing information while protecting privacy.

Collaboration, Reducing Risk and Improving Community Safety and Well-Being

Hub Tables in Saskatchewan

By Sarah Collins and Gary Nolin
Community Safety and Well-Being, Integrated Justice Services
Ministry of Justice and Attorney General
Ministry of Corrections and Policing

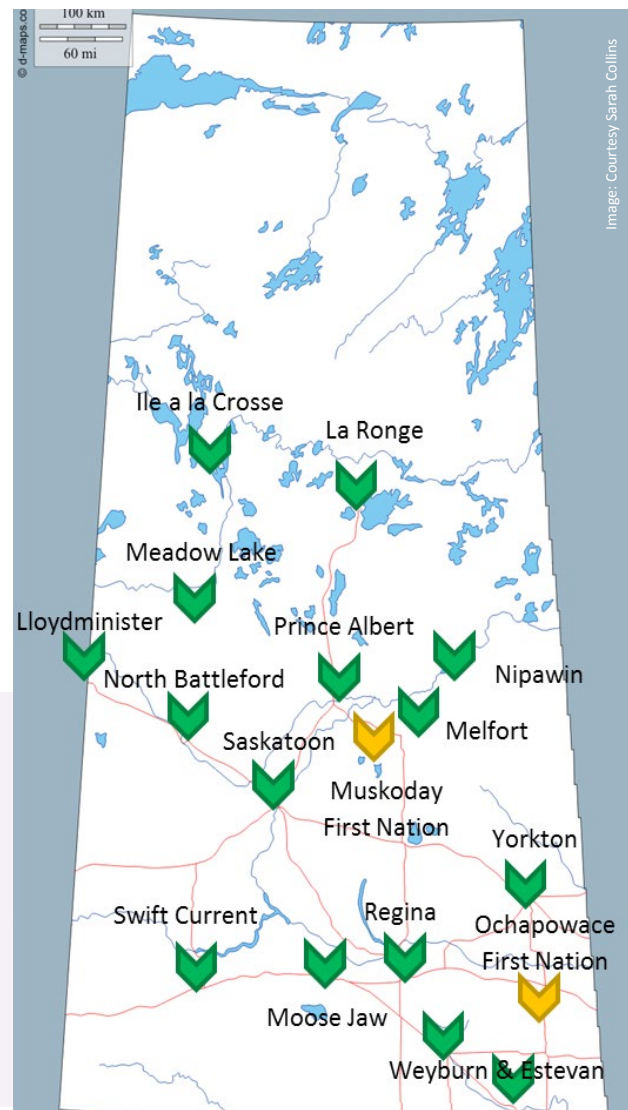
A teacher talks to a parent about a student sleeping in class; a nurse checks a patient's vitals after an overdose; an addictions worker counsels their client on the harms of alcohol; police respond to a home where neighbours hear yelling and fighting. These professionals are all committed to making our communities a better place to live and work.

What none of them know is that they share a client; her name is Jessica and Jessica has a secret.

What is a Hub Table?

Since 2011 Hub tables across Saskatchewan have met twice weekly to address the needs of thousands of citizens like Jessica. Professionals from a variety of disciplines discuss specific situations regarding citizens facing elevated risk and then develop immediate, coordinated, and integrated responses through the mobilization of resources. No one agency or service provider, be it educators, health care professionals, social workers, or police officers, have all the information, resources, or expertise to effectively respond to the increasingly complex social issues facing many individuals and families.

Hub tables do not deliver services; they are a way of mobilizing and using systems and resources already in place to address specific situations where there is a reasonable risk of harm coming to an individual or a family. Designated staff members from community and government service providers bring information about an "at risk" individual or family to the meeting. The team then establishes a plan to quickly intervene and connect the individual or family to services that already exist in the community. Recently, two First Nations communities in Saskatchewan have pioneered an adaptation of Hub tables and are



Currently there are 14 Hub tables serving 15 communities and two intervention circles serving two First Nations in Saskatchewan

working to reduce risk in their communities. Hub tables and Intervention Circles operate from a risk-driven response rather than an incident driven response.

Hub tables are part of a robust approach that focuses on community safety and well-being from a system perspective. Typically when thinking about how to respond to vulnerable people in communities, the first thoughts lean towards additional resources in emergency and incident response services. Communities look for more emergency room beds, more police officers, more detox beds and more homeless shelters. When we take a systems view of community safety and well-being, quality incident response services are still critical, in addition to working with individuals and families before harm comes to them. We intervene when risk is elevated, and focus on prevention and social development in communities.

THE HUB'S FOUR STAGE FILTER SHARING INFORMATION AND PROTECTING PRIVACY

Filter 1: The originating agency determines need for multisector involvement.

Filter 2: The identifying information is removed from the description of the situation brought to the Hub table. The Hub table reaches consensus on presence of acutely elevated risk.

Filter 3: Limited information is disclosed to determine which agencies should be involved.

Filter 4: Intervention planning is performed only by the lead and supporting agencies, who meet to share information and determine the right intervention for the situation.

Image: Courtesy Sarah Collins

How do Hub Tables work?

Shifting from reactionary incident driven responses towards social development, prevention and reducing risk requires collective action from a variety of service providers and multiple disciplines. In order for this to happen we must focus on collaboration, information sharing and measuring success.

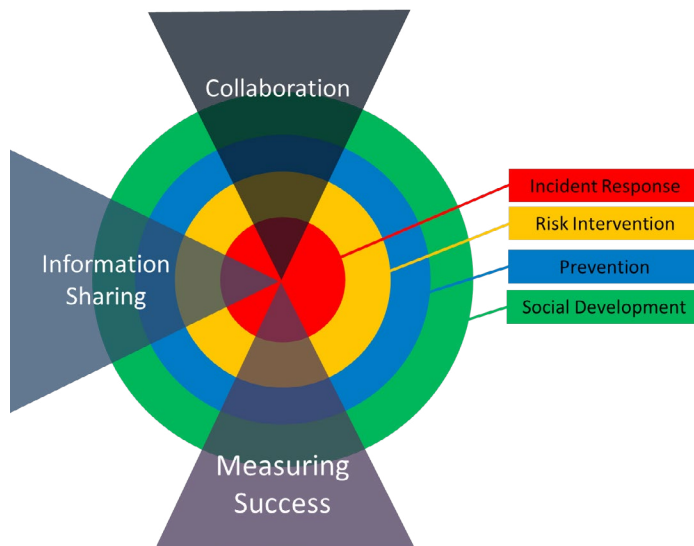


Image: Courtesy Sarah Collins

Above: Community Safety and Well-Being – Reducing our reliance on reactive, incident driven responses, shifting to social development, prevention and reducing risk

Back to Jessica... On a Tuesday morning somewhere in Saskatchewan an educator brings information about Jessica to the Hub table. In order to share information in a way that protects the privacy of Jessica there is a four stage filter process used before a plan to connect Jessica to services can be discussed. The representative from the local school division knows that Jessica was a good student up until last year, now she only attends school 50% of the time, and when she is there she falls asleep. The school has made several calls home about attendance. Jessica's mom committed to getting Jessica there, but Jessica's attendance has not improved over the last six months. Now Jessica's mom is not answering the phone.

First the educator confirms that Jessica's risk level is elevated and that Jessica likely needs supports that the school alone cannot provide.

Next the educator shares information about Jessica's risk factors at the Hub table without mentioning her name or the details of the information they know. They might share that a youth female has been missing a lot of school; her risk factors may include risk of truancy, parenting concerns, and substance use. The professionals around the table then reach a consensus on if the discussion should proceed.

...continued on p. 22

... continued from p. 21

Once agreement is reached the educator shares Jessica's name and only the details needed to identify her. This way, other professionals around the table are able to determine if they need to be involved in the information sharing. If an organization has had no contact with Jessica and will not be supporting her moving forward, they remove themselves from the discussion.

Then the appropriate service providers begin to share the information others need to know about Jessica.

A mental health and addictions representative shares that Jessica was referred to them after an overdose eight months ago, she was engaged, showed up for all of her appointments and finished up her last appointment six weeks ago. A social worker shares that they have received a call raising concerns about Jessica's well-being, with the caller mentioning that she has had three overdoses in the last year. Jessica had no previous contact with the police, but recently she has been picked up for shoplifting twice and was intoxicated and questioned at a party the police broke up.

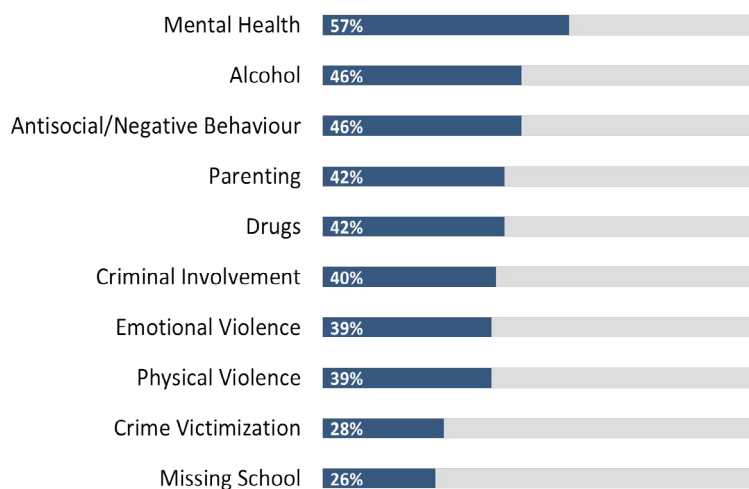
As the discussion continues, a critical discovery is made: Jessica's mom is a victim of domestic violence. Both Jessica and her mom have been keeping this secret for over a year.

With this critical information now shared, the service providers are able to mobilize to support Jessica and her mom. They knock on Jessica's door, share that they are here to help, and then make an offer to connect both Jessica and her mom to services.

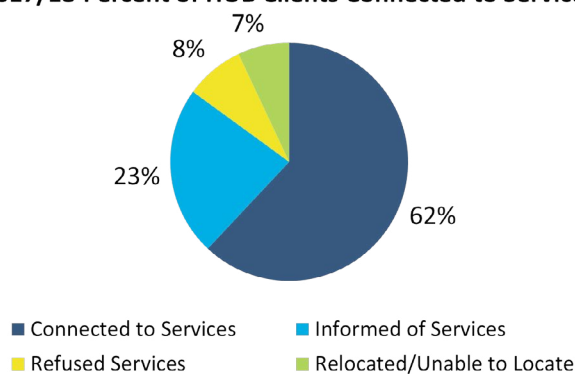
Privacy and Confidentiality

Privacy and confidentiality are important ethical considerations for all agencies involved in Hub tables across the province. In 2016, amendments were made to the Freedom of Information and Protection of Privacy Act, the Local Authority Freedom of Information and Protection of Privacy Act, the Health Information and Protection Act and the Youth Drug Detoxification and Stabilization Act, to help clarify that appropriate information sharing in multi-agency settings can be done with the support of information sharing agreements.

2017/18 Most Frequently Occurring Risk Factors at Saskatchewan Hub Tables



2017/18 Percent of HUB Clients Connected to Services



Images: Courtesy Sarah Collins

Want to know more?

If you are interested in learning more about Saskatchewan's Hub tables, information sharing agreements, or the community safety and well-being approach described in this article please contact:

Community Safety and Well Being
Government of Saskatchewan
(306) 787-0400

COMING SOON

An opportunity to review a personalized practice feedback report on your prescribing of Prescription Review Program medications will soon be available.

Prescriber Snapshots

Soon, the Prescription Review Program (PRP) will have the ability to provide Saskatchewan physicians with a personalized Prescriber Snapshot. This report will list three medication classes (opioids, benzodiazepines, stimulants), as well as gabapentin. Physicians will be able to see how many patients they prescribe these medications to, what the average dose prescribed by the physician is, how many patients fall above the recommended guidelines dosages, and many other parameters. Physicians will also see how they compare to other physicians in the province based on specialty (e.g. family practice).

This physician tool has been designed to provide feedback to encourage practice improvement, but the PRP wants to ensure that the information provided will be valuable to physicians. As such, the PRP has engaged with researchers at the University of Saskatchewan with the goal of seeking guidance from physicians to help perfect the Prescriber Snapshot tool to provide more effective feedback to physicians.

Participants will participate in a one-on-one semi-structured interview and will have the opportunity to provide feedback on the various aspects of the Prescriber Snapshot to help improve the utility of the tool. It is expected that the time commitment will be less than 1 hour.

Space is limited at this time due to limited researcher availability. Interviews are expected to take place between early October to mid-December. If you are interested in participating, do not delay in expressing your interest.

See the Sample Prescriber Report Card on the next page!

PARTICIPATION A GREAT WAY TO IMPROVE YOUR OWN PRESCRIBING PRACTICES!

How to Participate

If you would like to participate in this research project and have the opportunity to review your own Prescriber Snapshot while helping shape the tool before its implementation, contact:

Dr. Derek Jorgenson,
College of Pharmacy
and Nutrition,
University of Saskatchewan
at derek.jorgenson@usask.ca
to express your interest
and learn more about
the research project.

Sample Prescriber Report Card



College of Physicians and Surgeons of Saskatchewan Prescription Review Program Prescriber Report Card from 5/21/2017 to 11/21/2017



Prescriber Details

Name: CPSS ID: MPID:
Specialty Group: General Practice Location:

Prescribing Snapshot: Opioids

	Your Practice	Median in Specialty	Percentile in Specialty	Median in SK	Percentile in SK
Patient to whom you prescribed opioids	129	33	93.5%	13	95.8%
Average OME/day prescribed	304,301.4	4,596.8	99.6%	390.4	99.8%
Average OME/day/patient	2,358.9	136.3	98.9%	33.8	99.4%
Patients dispensed over 200 OME/day	16	Seniors to whom you prescribed opioids			38
Patients dispensed 3+ opioid ingredients	5	Patients dispensed opioids from 3+ prescribers			18

Prescribing Snapshot: Benzodiazepines (BZD)

	Your Practice	Median in Specialty	Percentile in Specialty	Median in SK	Percentile in SK
Patient to whom you prescribed BZDs	124	25	97.3%	7	98.5%
Average ODE/day prescribed	1,868.5	70.8	98.3%	6.6	99.0%
Average ODE/day/patient	15.1	2.8	96.0%	1.0	97.7%
Patients dispensed over 2 ODE/day	21	Seniors to whom you prescribed BZDs			34
Patients dispensed 2+ BZDs ingredients	13	Patients dispensed BDZs from 3+ prescribers			5

Prescribing Snapshot: Stimulants

	Your Practice	Median in Specialty	Percentile in Specialty	Median in SK	Percentile in SK
Patient to whom you prescribed stimulants	103	4	100.0%	1	99.7%
Average DDD/day prescribed	969.3	13.6	99.2%	0.5	99.4%
Average DDD/day/patient	9.4	2.6	92.3%	0.4	95.7%
Patients dispensed over 2 DDD/day	21	Seniors to whom you prescribed stimulants			0
		Patients dispensed stimulants from 3+ prescribers			3

Prescribing Snapshot: Gabapentin

	Your Practice	Median in Specialty	Percentile in Specialty	Median in SK	Percentile in SK
Patient to whom you prescribed Gabapentin	64	13	96.1%	3	98.2%
Average mg/day prescribed	976,786.5	41,982.2	98.4%	3,694.1	99.3%
Average mg/day/patient	15,262.3	2,757.5	96.2%	1,058.9	98.0%
Patients dispensed over 3600 mg/day	3	Seniors to whom you prescribed Gabapentin			20
		Patients dispensed Gabapentin from 3+ prescribers			1

Special Note: Prescriptions may come from prescribers other than you, who have also prescribed to your patients.
OME is the total "Oral Morphine Equivalent" (measured in mg of morphine) from all prescriptions dispensed to your opioid patients.
ODE is the total "Oral Diazepam Equivalent" (measured in doses of 10 mg Diazepam) from all prescriptions dispensed to your BZD patients.
DDD is the total "Defined Daily Dose" (as determined by the WHO) from all prescriptions dispensed to your stimulant patients.

The CPSS Management of Chronic Pain and Opioid Use Disorder Project ECHO®



Coming Soon!

What is Project ECHO®?

Project ECHO® (Extension for Community Healthcare Outcomes) is a collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people, right where they live. The ECHO® model™ does not actually “provide” care directly to patients. Instead, it dramatically increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions such as pain and substance use disorders. It does this by engaging clinicians in a continuous learning system and facilitating partnerships with specialist mentors at an academic medical center or hub.

Interested in participating in the CPSS Management of Chronic Pain and Opioid Use Disorder Project ECHO®???

Chronic pain, as well as substance use disorders are a prevalent problem in our province. Primary care providers manage the majority of chronic pain and addictions patients, yet receive minimal training in these conditions.

The CPSS Management of Chronic Pain and Opioid Use Disorder Project ECHO® will launch in the fall of 2018 with the mission to link primary care providers in a supportive community of practice that will enhance their skills and confidence to manage their patients safely and effectively.

The CPSS Project ECHO® will run weekly 2-hour sessions that start with a short didactic lecture followed by a de-identified patient case presented by participants. Case presenters receive recommendations from the specialist team and other community partners.

You can participate from anywhere in the province. Attendance is facilitated through Zoom Video Conferencing. All you need is an Internet connection and a computer, laptop, tablet or smart phone. It is easy to use and there is no cost to participants to join the CPSS Project ECHO®.

Accreditation will be sought for this learning activity for 1 Mainpro+ credit/CPD credit per hour (2 credits per session).

If you would like to be added to the CPSS Management of Chronic Pain and Opioid Use Disorder Project ECHO® e-mail list to stay informed of all developments related to this pilot project, e-mail echo@cps.sk.ca with your name and preferred e-mail address. NOTE: this is not just for physicians, but for all primary care providers who may be interested.

Project ECHO: A Revolution in Medical Education and Care Delivery

Project ECHO is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities. The heart of the ECHO model™ is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their own communities.



People need access to specialty care for their complex health conditions.



There aren't enough specialists to treat everyone who needs care, especially in rural and underserved communities.



ECHO trains primary care clinicians to provide specialty care services. This means more people can get the care they need.



Patients get the right care, in the right place, at the right time. This improves outcomes and reduces costs.

Ending Workplace Violence and Aggression

SASKATCHEWAN ASSOCIATION FOR
SAFE WORKPLACES
IN HEALTH

Workplace violence, whether physical or psychological, is a global issue. Once largely unreported, violence at work is now a priority concern in all workplaces in Canada. Healthcare workers in Saskatchewan sustain 14% of overall injuries resulting from violence, the highest in the province (WCB, 2016). While the Saskatchewan healthcare sector overall has made some progress to address violence, evidence of escalation remains (WCB, 2016). In particular, three healthcare areas in Saskatchewan were identified to require immediate attention; **acute care (emergency rooms), inpatient mental health facilities, and long term care facilities.**

Despite recent escalation of violence in the workplace, the lack of reporting and under reporting of incidents of such violence and acts of aggression in healthcare is attributed to the notion that care providers put the “duty of care” ahead of their own safety (CFNU, 2017). Under reporting is also associated with the normalization of violence among healthcare workers. The under reporting of violence and aggression is attributed, in part, to workers viewing such regular occurrences as “just part of the job”.

The Provincial Violence Prevention Framework includes risk assessment tools and resources to assist frontline and management to better assess the risk of the potential for violence. A significant part of the **Violence Prevention Framework and Strategy** is the need to have effective and timely reporting. To bring about the desired corrective actions, increased reporting is required and this campaign of **#IWillReport** calls for additional collaboration with system partners and frontline workers. The key issues are safety culture and effective violence prevention initiatives through a coordinated Provincial approach that included the development of this video production that elevates the awareness of the under reporting of violence and aggression occurrences.

Healthcare partners and leaders in safety must view violence and acts of aggression in our workplaces as a priority and collaborate on corrective actions that drive a change in behavior.

VIDEO LINK:
https://youtu.be/Ji_bEXUZ3SA

TARGET AUDIENCE:

- Healthcare senior leaders
- Physicians
- Regulators
- Educators
- Students in healthcare careers
- Front line care givers, managers, supervisors
- Unions
- Patients and family members

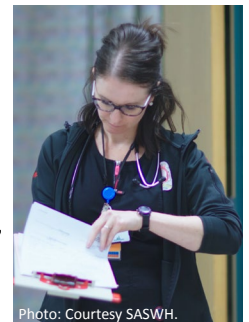


Photo: Courtesy SASWH.

SASWH acknowledges and thanks all the partners in this initiative to raise awareness that violence and aggression in healthcare workplaces should not be considered normal for any healthcare worker, patient, family member or member of the public.

By Sandra Cripps, CEO
Saskatchewan Association for Safe Workplaces in Health (SASWH)
www.saswh.ca

The Saskatchewan Association for Safe Workplaces in Health (SASWH) is a non-profit safety association committed to work in partnership with Saskatchewan’s healthcare industry to reduce the number of workplace injuries and illnesses in the health sector.

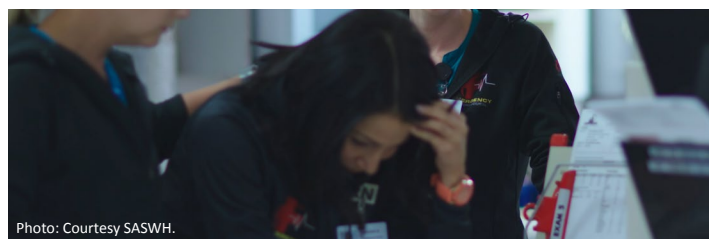


Photo: Courtesy SASWH.

References

Public Services Health and Safety Association. (2016). Workplace violence risk assessment toolkit for acute care. Retrieved from: <https://www.pshsa.ca/workplace-violence-assessment-tools-acute-or-long-term-care-work-environments/>
Saskatchewan Workers' Compensation Board. (2017). Health care statistics. Retrieved from <http://worksafesask.ca/health-care-stats/>
The Canadian Federation of Nurses Unions. (2017). Enough is enough; putting a stop to violence in the health care sector. Retrieved from http://nursesunions.ca/wp-content/uploads/2017/05/CFNU_Enough-is-Enough_June1_FINALlow.pdf

Is your Practice a Safe and Supportive Place for LGBTQ2+ Individuals?

Let them know:
Register here!

The Q List Survey: Healthcare Professionals:

<https://goo.gl/i6LctB>

Current List:

http://www.outsaskatoon.ca/medical_professionals

Resources:

http://www.outsaskatoon.ca/medical_professionals

LINK The “VIRTUAL” Physician Lounge

Child Psychiatry specialists have joined LINK!

Effective September 17, 2018, **Child Psychiatry** specialists will start providing telephone consultations to colleagues via LINK (*Leveraging Immediate Non-urgent Knowledge*).

LINK gives primary care providers and their patients rapid access to specialists to discuss less serious patient conditions.

Available 8:00 AM - 5:00 PM, Monday - Friday, excluding statutory holidays

Specialties providing the LINK service:

Adult Psychiatry

Palliative Care

Nephrology

HIV and HCV

Child Psychiatry (starting 2018/09/17)

Call: 1-844-855-LINK (5465)

For more information on LINK:

Visit the [LINK Brochure](#) or email LINK@health.gov.sk.ca



what language do
YOU speak?

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

How about sign language?

Register your language proficiencies
online with the College at:

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

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



SASK LEADERS IN HEALTH CARE



2018

Dr. Dennis A.
Kendel
Distinguished
Service Award

NOW ACCEPTING
NOMINATIONS!

Nomination Deadline: September 30, 2018

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

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

Nomination Packages are available by visiting the homepage of the [College website](#), or at

<http://www.cps.sk.ca/iMIS/Documents/Dr%20Kendel%20Service%20Award%20-%20Nomination%20Package.pdf>

or by contacting Sue Waddington at

OfficeOfTheRegistrar@cps.sk.ca

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

If you have practiced in Saskatchewan for 40 consecutive years or more, or if the only interruptions in your practice were for service in the armed forces or to take postgraduate training, and you have not yet received your Senior Life Designation, please let us know! Physicians with this designation are presented with an award at an official Council Banquet in November of each year.

You may be eligible for
**SENIOR LIFE
DESIGNATION**

CONTACT

Sue Waddington at
officeoftheregistrar@cps.sk.ca
or at 306-244-7355





INFECTION PREVENTION

News Updates

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

<https://saskpic.ipac-canada.org/picns-link-letter.php>



A core service of the Réseau Santé en français de la Saskatchewan (Saskatchewan Francophone Health Network)



HEALTH ACCOMPAGNATEUR INTERPRETATION SERVICES IN FRENCH

French-speaking newcomers | Seniors | Families

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

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

You may also come across Saskatchewan Francophone Seniors and Families:

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

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

A Health Accompagnateur may be present at your patient's point-of-care and will act as an interpreter between you and your patient.

Patients who need an interpreter are encouraged to call
1-844-437-0373 (Toll free)

🌀 This is not an emergency service 🌀



CCENDU IS ON FACEBOOK!

Stay updated on drug news in Saskatchewan
and across Canada!

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

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



Canadian Community Epidemiological Network on Drug Use • Réseau communautaire canadien d'épidémiologie des toxicomanies



We're Working for You



College of Physicians and Surgeons of Saskatchewan

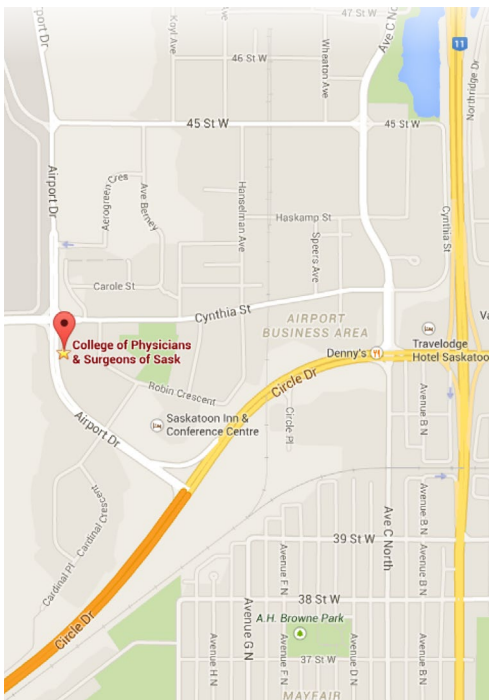
101-2174 Airport Drive
Saskatoon, SK S7L 6M6

Phone: (306) 244-7355
Fax: (306) 244-0090
E-mail: cpssinfo@cps.sk.ca
Visit us at: www.cps.sk.ca

KEEP IN TOUCH



OUR LOCATION:



Senior Staff

Dr. Karen Shaw
Dr. Micheal Howard-Tripp
Dr. Werner Oberholzer
Mr. Bryan Salte
Mr. Ed Pas

Registrar
Deputy Registrar & Medical Manager (outgoing)
Deputy Registrar (incoming)
Associate Registrar/Legal Counsel
Director, Registration Services

OUR DEPARTMENTS

Office of the Registrar

Telephone 1 (306) 244-7355
E-mail OfficeOfTheRegistrar@cps.sk.ca

HR & Finance

Telephone 1 (306) 244-7355
E-mail amy.mcdonald@cps.sk.ca

Communications

Telephone 1 (306) 667-4638
Media Inquiries communications@cps.sk.ca

Quality of Care (Complaints)

Saskatoon & area calls 1 (306) 244-7355
Toll Free 1 (800) 667-1668
Inquiries complaints@cps.sk.ca

Diagnostic Imaging & Lab Quality Assurance (Regina)

Office Address 5 Research Drive, Regina, SK S4S 0A4
Telephone 1 (306) 787-8239
E-mail cpssinfo@cps.sk.ca

Prescription Review Program (PRP) & Opioid Agonist Therapy Program (OATP)

Telephone 1 (306) 244-7355
Anonymous Tip Line 1 (800) 667-1668
E-mail prp@cps.sk.ca
oatp@cps.sk.ca

Registration Services

Telephone 1 (306) 244-7355
Assessment/Supervision cpssreg-assess@cps.sk.ca
Registration Inquiries cpssreg@cps.sk.ca
Corporate Inquiries cpssreg-corp@cps.sk.ca
Certificate of Professional
Conduct/Good Standing cpssreg-cpc@cps.sk.ca