Saskatchewan successfully implementing best practices

One-quarter of family physicians in Saskatchewan have volunteered to participate in a groundbreaking initiative to implement best practices in the treatment of diabetes and coronary artery disease.

After one year, the Chronic Disease Management Collaborative reports an increase in the number of patients receiving the recommended drugs, tests and services, and a decrease in the time they wait to see their family physicians. For example, the number of patients with diabetes receiving annual kidney screening jumped from 48% to 68%, and the number of patients receiving antiplatelet therapy for coronary artery disease rose from 73% to 82%.

In one family practice in Saskatoon, the wait time for an appointment dropped from 17 to 3 days and a backlog of 100 annual check-ups was cleared in 5 months.

"It is clear that these efforts are helping to turn the tide on chronic disease in Saskatchewan," said Dr. Ben Chan, CEO of the Health Quality Council, an independent agency of the provincial department of health. The council is using a collaborative approach to set benchmarks and share effective strategies among 73 family practices across Saskatchewan, involving 216 family physicians, 400 other health care professionals and more than 12 000 patients.

"There isn't a collaborative initiative across the country of the scale that we are doing in Saskatchewan, and we were purposeful about that scale because we wanted to reach the tipping point. We wanted to go big," said Bonnie Brossart, deputy CEO of the Health Quality Council.

Representatives of each family practice attend 4 workshops during the year where they "share nuggets of what works and what doesn't work, and through that sharing, we're seeing a rapid improvement in results," said Brossart.

Patient data is entered into an electronic toolkit that lists the recommended best practices for each disease and tracks implementation. This Web-based toolkit allows physicians to create flowcharts, measure progress, create reports and share information electronically with other health professionals, patients and the council.

The workshops were held in 2 stages during 2005–06 and 2006–07; data presented here are based on the first wave.

"In Saskatchewan, we have a shortage of physicians so you're always overworked and acute patients take up much of your time," says Vino Padayachee, a family physician from Estevan and chair of the Chronic Disease Management Collaborative. "We're making a concerted effort to bring chronic disease into the forefront. We will save money and time in the long run."

Padayachee says the Saskatchewan Medical Association is working with the provincial government to increase physician fees for chronic disease management.

To qualify, physicians will be required to follow best practice guidelines and document the results. — Amy Jo Ehman, Saskatoon, Sask.

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New deputy editor dedicated to knowledge transfer

CMAJ has revitalized its research focus with the appointment of a deputy editor for scientific content. Dr. Matthew Stanbrook, an assistant professor, researcher and specialist in respirology at the Toronto Western Hospital, will oversee reviews and research — including his own.

"The idea is to shape and build this core component of the journal," says Stanbrook, who is also an assistant professor of Medicine and Health Policy, Management and Evaluation at the University of Toronto. This includes encouraging publication of more randomized trials and increasing the quality of research and its relevancy to readers.

"We are very fortunate to have someone of Matthew's calibre join our team," says *CMAJ* Editor-in-Chief Dr. Paul Hébert. "He will substantially enhance the science we publish."

The move to *CMAJ* is a natural progression for Stanbrook whose longtime passion for publications began with the *University of Toronto Medical Journal*, where he was associate editor in 1992 and then editor-in-chief. "I got the bug early on," he laughs

After completing residencies in internal medicine and respirology at the University of Toronto, Stanbrook began a doctorate in clinical epidemiology. He asked respirologist Dr. Jeff Drazen, editor-in-chief at the *New England Journal of Medicine*, to take him on for a year so could look at the ways medical journals influence knowledge translation and research. For Stanbrook, Drazen created the editorial fellowship, a position that continues today.

At the time Stanbrook assumed his position at *CMAJ* on Feb. 19, he was a peer reviewer for 5 journals, an editorial board member of *Clinical and Investigative Medicine* and an associate editor of *ACP Journal Club*. He has nearly 40 publication credits to his name and has received several awards and scholarships, including the University of Toronto's respirology teaching award (2004).

His new position with *CMAJ* is an opportunity to "expand on my thesis and look at how medical journals influence patient outcomes."

Stanbrook will be looking at ways of presenting information, such as Web casts, that bolster its relevancy to Canadian and international readers.

Data show that *CMAJ* is increasingly

B. Sibbald

Respirologist and researcher, Dr. Matthew Stanbrook, will build and shape *CMAJ*'s scientific content.

used internationally, a trend that is bound to continue as it is now the world's leading open-access, general medical journal. "We are open to the world through open access and the world is coming to us," says Stanbrook. "It's absolutely vital that we remain open access."

The Internet has revolutionized how we present science, he explains, citing examples such as preprints online and online-only journals like *PLoS Medicine*. "It's a time of transition for everyone. It's like science on speed."

To stay connected to practice, Stanbrook, like Hébert, will devote about a day a week to patient care. Stanbrook, 37, is married to general internist, Dr. Nadine Abdullah. — Barbara Sibbald, *CMAJ*

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Pharmacare for children slow to gain ground in NS

Low-income families are not flocking to sign up for Nova Scotia's new Low Income Pharmacare for Children program. To date, approximately 6500 families out of a potentially eligible 35 000 have registered for the program, which was launched Oct. 1, 2006.

However, the small numbers are not necessarily a concern, says Linda Laffin, spokesperson for the Community Services department that oversees the program.

First, she notes, it's unclear exactly how many families actually qualify for the program, which requires participants to pay only $5 per prescription. This uncertainty stems from the fact that eligible families must meet 3 criteria: they must have children under 18 years of age; an annual household income below $20 921; and be in receipt of the Nova Scotia Child Benefit. However, the latter is administered by the federal government, which does not release its mailing list. It did, however, send a notice about the program to all Nova Scotia families on that list.

In addition, low-income families who are covered under a drug program through work are ineligible while those on social assistance are already covered. These numbers are also not known.

As well, "People may not apply until they need it," Laffin says, noting that the number of applicants doubled in the first 2 months of 2007.

The slow growth means additional revenue for the province. It had committed $1 million for the last 6 months of this fiscal year, but had only spent $113 000 by the end of January.

The province is now planning to send a second letter to child benefit recipients and is exploring other options, including more advertising, for getting the word out. — Donalee Moulton, Halifax

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Proposed Alberta physician agreement sets new template

Canada's wealthiest province has traditionally set the benchmark for physician fee increases across the nation as most jurisdictions believe they must match Alberta or risk having their physicians poached or persuaded to pack their bags for Wild Rose Country.

From that perspective, the Mar. 13 trilateral fiscal agreement between the Alberta Medical Association (AMA), the provincial government and the province's 9 health regions augers well for other negotiators as it proposes a 4.5% pay increase in both the current and coming fiscal year.

However, the unique deal may also set a new template for redressing threats to the viability of community practice through a multi-pronged solution that includes retention bonuses and targeted monies for overhead costs.

AMA President Dr. Gerry Kiefer says this "made-in-Alberta approach" should help the province retain its 7100 physicians and attract the estimated 1500 additional doctors needed to handle a population boom of 11% over the past 5 years.

"I'm hopeful it will make practice in Alberta attractive," says Kiefer. It should also help redress financial pressures faced by family and community practitioners, he adds.

Alberta physicians are now voting on the agreement through a mail-in ballot. Results are expected in early May.

At the core of the proposed $580-million deal lies the 4.5% hike in the fee schedule, which will increase Alberta's overall outlay to $1.7 billion this year and $2 billion in 2008.

Canapress

The proposed $580-million deal for Alberta physicians should help mitigate some of the boom-related stressors.

The agreement also sets aside $103.5 million over 2 years for initiatives to help cover skyrocketing overhead costs, including rent and salaries, associated with the province's oil and gas boom, as well as keep Alberta physicians at home by paying them an annual 2.8% retention benefit. The amount of the latter depends on how long a physician has practised in the province and the amount they bill. Doctors billing over $80 000 annually are eligible for a 100% retention payment. The majority of the province's physicians are expected to receive either $8000 (for 16–25 years of practice) or $10 000 (for 26 or more years).

The agreement also provides $56.5 million for a new clinical stabilization fund targeted at under-serviced communities, like Fort McMurray. Some $17 million of that fund will be set aside to help offset higher overhead costs associated with practice across the province.

The agreement also reserves roughly $175 million over 2 years for continuing