A NEWSLETTER FOR PRIMARY CARE PROVIDERS

THE QUARTERLY

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ENGAGING INDIGENOUS PEOPLES WITH TRUTH & RECONCILIATION >

When it comes to the Health Status of Indigenous Peoples in Canada the statistics are undeniably abysmal and the news reports evoke a wealth of emotions. From decreased life expectancy to increased diabetes, depression and suicide, substance abuse, poverty, food insecurity, lack of potable water and deplorable, overcrowded living conditions are but a few of social determinants impacting your Indigenous patients. You likely muse, "I want to help, but it seems so overwhelming! What can one physician do?"

Dr. Jason J. Pennington , MD, MSc, FRCSC
Regional Aboriginal Cancer Lead, Central East RCP
Member of the Huron-Wendat First Nation

By all accounts the health status of the millions of people inhabiting Turtle Island (North America) at the time of "Discovery" was excellent. The Indigenous peoples were inviting and generous, providing food, shelter and medicine to help the newcomers through their first winters. Initial treaties, like the Two Row & Dish with One Spoon Wampum Belts, talked of sharing resources peaceably and sustainably in friendship. If, and when, disagreements arose the parties could come together to negotiate a mutually acceptable resolution. This sounds like a very firm foundation on which to start an equitable, mutually beneficial relationship.

Slowly over time, without a war and, often, without the ceding of territory, the equality of these agreements eroded. Paternalism, as much a part of medicine as any other aspect of Western society, became the prime way of dealing with the "Indian problem" in fledgling Canada. The Indian Act, residential Schools and the Sixties Scoop all attest to that mission. These, among other acts and programs, were assimilatory in nature. Aimed at "removing the Indian from the child" by disallowing and demonizing Indigenous language, culture, medicine and ceremony. These processes, which can be given many different names, have led to the personal and intergenerational trauma that underlies all other Social Determinants of Aboriginal Health and the current Health Inequities that exist. That is the TRUTH. The first step in Reconciliation is to face the Truth. That goes for ALL of us, non-Indigenous, Indigenous and mixed individuals alike. Every person, family and community in Canada has been, and continues to be, impacted by this history. That is why one of the "Calls to Action" of the Truth and Reconciliation Commission (TRC) was to recommend that this history be included in the curriculum of every medical school. Physicians with this knowledge may better recognize how it may affect the health of Indigenous patients and complicate therapeutic encounters. This history impacts both the patient and the provider.

PLEASE JOIN ME. YOU MAY ARRIVE AT THE TRUTH ALONE, BUT RECONCILIATION, REQUIRES US TO WALK TOGETHER

Only upon acknowledging the Truth, and becoming conscious of its impact, can we begin Reconciliation. For healthcare professionals, the TRC calls upon us to get Cultural Safety training. Cultural Safety is an Indigenous concept, first published by a Maori nurse, who demonstrated culture to be an independent risk factor in health outcomes. I like to acknowledge the origin because it demonstrates that Indigenous Peoples, including Traditional Healers and Knowledge Holders, can contribute to the healthcare of all. Culturally safe practices are not only applicable to Indigenous patients, but can be use with any number of factors that may be different from your own. These include, but are not limited to: race, religion, orientation, ability and socio-economic status. Becoming Culturally Safe is an ongoing process by which the healthcare practitioner uses self-reflection to mediate the impact of their biases on a clinical encounter. There are a number of Cultural Safety workshops and on-line courses. Cancer Care Ontario has a free, Main-Pro accredited course that can be found at: www.elearning.cancercare.on.ca. I, myself, have participated in several workshops and courses and continue to learn something new with each experience. Taking a course or workshop does not make one culturally safe. Having Indigenous leads, navigators or an assigned office does not make an institution culturally safe. However, when, implemented with self-reflection and without paternalism they are a good start.

If these things are done in a "good" way then we are actually recognizing and honouring the spirit of the original Wampum Treaties. This will help heal and build relationships, both therapeutic and more broadly. For good relationships are essential to help us along the difficult path to reconciliation and wellness.

AROUND THE REGION >

ENGAGING OUR UNDER AND NEVER SCREENED POPULATIONS

As part of our ongoing strategy to educate and support under/never screened communities, the CRCP partnered with York West Active Living Centre and Humber River Hospital to coordinate a visit to the HRH Breast Health Centre for 15 Italian-speaking members on March 29th, 2017. This included a tour of the breast imaging unit, educational talks covering screening guidelines for all 3 programs, as well as a presentation from Osteoporosis Canada and the family and patient resource services available at Humber River Hospital. The collaboration was a great success, with plans for future tours.

FIT TEST - COMING SOON!

In the interim, please continue your current practice screening your patients using FOBT

SENIOR CAREGIVER SUPPORTS AVAILABLE

There are resources available to senior caregivers in the community. ENRICHES offers support services by providing workshops and training, social programs and various classes, and linking caregivers to services in the community. Health Care Professionals can also participate in workshops that help identify areas to provide support to caregivers. Find more information here: https://www.nych.ca/senior-caregivers

SUPPORT FOR YOUR PATIENTS RETURNING TO WORK

Through funding by the Canadian Partnership Against Cancer and in partnership with de Souza Institute there is a website available to patients currently undergoing cancer treatment and survivors to assist in the processing of returning to work after treatment or continuing to work during treatment. There are tools available to help assess your current work abilities, a framework that assists with the planning to return to work process, as well a comprehensive section that outlines the impact cancer has on individuals and strategies to manage these symptoms.
https://www.cancerandwork.ca/survivors/

LET'S GET REAL ABOUT CANCER SCREENING

On March 22nd the Central Region Cancer Program partnered with Toronto Central and the Central East Regional Cancer programs to host a Primary Care Provider event focused on engaging hard to reach populations.. Set at the beautiful Aga Khan, Ismaili Centre, the event was a success with over 80 PCP's in attendance. Feedback was positive and many appreciated the review of screening guidelines, the panel discussion and Dr. J. Pennington's talk on FNIM care. FIT implementation and High Risk Lung Cancer Screening were also presented. Pictured right: Dr. Onye Nomron, Regional Primary Care Lead, Central East Region

COLPOSCOPY GUIDELINES Q & A WITH DR. ERICA MANTAY

REGIONAL COLPOSCOPY LEAD, CENTRAL REGIONAL CANCER PROGRAM

Dr. Erica Mantay, MD, FRCSC

WHEN TO RECOMMEND HPV TESTING?

In primary care, the High risk HPV test should be offered only for women 30 and older who have ASCUS on their pap test. Use of HR HPV testing in women less than thirty is not recommended because of the high prevalence of the virus in that demographic.

WHY DO SOME WOMEN HAVE HIGH RISK HPV TESTING DURING THEIR COLPOSCOPY VISIT?

Identifying the presence or absence of high risk HPV DNA allows the stratification of risk. A negative HPV test has a very high negative predictive value as women who do not carry a high risk strain of HPV have minimal risk of cervical cancer. The best practice algorithms have been designed using HPV testing as a risk stratification marker, and as a 'test of cure' after a diagnostic excision procedure before return to primary care. Currently, high risk HPV testing is not an OHIP insured benefit although some hospital based colposcopy clinics do cover the cost of the test. Given that not all women choose to pay for the test, a second set of algorithms was designed to account for those not using HPV testing. In this algorithm, an extra round of colposcopy is required to achieve the same predictive certainty.

WHY ARE UNTREATED WOMEN WHO HAVE ASCUS OR LSIL BEING RETURNED TO PRIMARY CARE FOR SCREENING INSTEAD OF REMAINING IN THE CARE OF A COLPOSCOPY PROVIDER?

The recommendations for continuing colposcopy, screening annually, or routine triennial screening are based on evaluation of a woman's risk of developing a high grade lesion within 3 -5 years. Women who have had a high risk HPV test that is negative have a very low 5 year risk of high grade dysplasia, less that that of the general population. They are eligible for "population based" screening every three years. Women with LSIL or ASCUS who have not had high risk HPV testing, but who have had adequate normal colposcopy are at slightly higher risk of CIN 3 within 5 years but many of these mild abnormalities will clear spontaneously. They are thus referred back for "surveillance", ie. repeat pap in one year. Follow up after that pap will depend on results.

HOW OFTEN SHOULD A WOMAN FOLLOW UP AFTER AN ABNORMAL PAP RESULT?

This will depend on the post procedure colposcopy findings, cytology and whether or not a patient has had a follow up high risk HPV test. Women who have had a negative HR HPV test can be screened routinely every three years. Women who have had no HPV test and have had three normal colposcopies and paps since the treatment can be screened every three years.
Women who have had a positive post procedure HPV test or women who have had normal post procedure colposcopy and paps that are low grade abnormality (ASCUS or LSIL) should be under annual pap surveillance

WHAT IS THE COLPOSCOPY CLINICAL GUIDANCE DOCUMENT?

Published in June 2016, the Clinical Guidance Recommends Best Practices for Delivery of Colposcopy Services in Ontario, is a summary of evidence-informed recommendations for intake, flow and discharge from colposcopy care for numerous indications. It is intended to be adopted and used by colposcopy providers and their clinical support team.
The recommendations in the document were formulated by a review of current evidence and jurisdictional scan by the Clinical Expert Advisory Group, a multidisciplinary team convened by CCO.

IMPROVE THE LIVES OF COUNTLESS CANADIANS >

UTOPIAN is a University of Toronto initiative that pairs PCP's with academic researchers creating a 'living laboratory'. Utopian represents about 1400 family physicians and includes approximately 1 million patients. There are many quality initiatives that UTOPIAN data can be utilized for if you opt to donate your EMR data.

If interested, please contact dfcm.utopian@utoronto.ca
You will receive reports on your own practice and you can claim Mainpro+ credits for reviewing the reports.

LISA RHODENIZER, COORDINATION ADVISOR, HEALTH PROMOTION

I am excited to start my new role as Health Promotion Coordination Advisor with the Prevention and Screening team. I look forward to making new connections in the community and enhancing existing partnerships to educate the community on cancer screening and prevention guidelines. In my previous role as Health Promoter with the North Bay Parry Sound District Health Unit, my portfolio focused in the area of falls prevention. I gained great experience in community development, coalition building, as well as chronic disease and injury prevention. I hold a Bachelor's Degree in Public Health and a Post-graduate Certificate in Workplace Wellness and Health Promotion.

Why did you choose healthcare? I am passionate and proud of the universal model of the Canadian Healthcare system. With health promotion I see an opportunity to enhance our healthcare system by reducing the burden of disease through public education.

What are the most rewarding aspects of your job?

Almost everyone knows someone who has been affected by cancer, and being in this line of work motivates you to do the best possible job you can do. It is rewarding because you know the affects cancer can have on a person and their family, and you can see the impact you are having in the community.

What have you learned about cancer prevention and screening that others may not know?

I have learned that Ontario has one of the highest rates of colon cancer in the world. I have also discovered that some of the screening guidelines have changed, and wonder if the public is aware of the updates.

CANCER CARE ONTARIO E-LEARNING

FREE ONLINE MAINPRO CREDITS AVAILABLE

Accedited Cancer Screening Courses (Mainpro-M1)
Aboriginal Relationship and Cultural Competency-Enhances your knowledge of First Nations, Inuit and Metis history, culture and health landscape to improve health outcomes and person centred care.
Visit: www.cancercare.on.ca/pcresources

Central
Regional Cancer Program
in partnership with Cancer Care Ontario

QUESTIONS? CONCERNS? NEWSLETTER IDEAS, DISTRIBUTION INFORMATION, TOPICS YOU'D LIKE TO SEE COVERED? CONTACT US:
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