Choosing Wisely Canada™

Choisir avec soin MC

Canadian Home Care Summit – Accountable Care

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Chair, Dept of Medicine Quality & Professional Appraisal Committee

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November 15th, 2017

Objectives

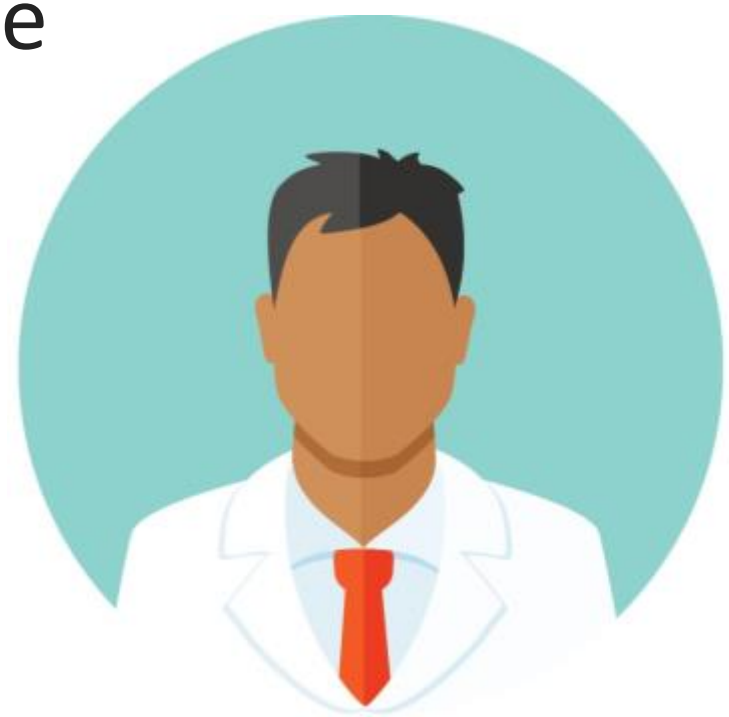
1. To introduce Choosing Wisely Canada
2. To provide practical information and tools to implement and measure Choosing Wisely Canada recommendations in practice
3. To present Choosing Wisely Canada's efforts to educate and engage patients
4. To describe other areas of focus for Choosing Wisely Canada including integration into medical education, other clinical groups, and international collaboration


I've always done this
The patient wants it
$$
New tests are good
I don't want to get sued
Better to do something than do nothing
Referring doctor wants it

Choosing Wisely Canada is a campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments and make smart and effective choices to ensure high-quality care.

Who has ever…

- Successfully ***stopped*** a treatment?
- Said ***no*** to a patient and had them leave smiling?
- ***Stopped*** themselves from ordering a low-value test or treatment?



What is unique about CWC?

- Clinician led
- Bottom up approach
- Focused on common clinical conditions
- Simple
- Remarkably rapid uptake

Campaign priorities

Clinician leadership	• Engage with clinical bodies to take a leadership role in tackling unnecessary care
Patient and public engagement	• Scale up education and social marketing efforts to shift patient attitudes and shared decision-making
Medical education	• Integrate resource stewardship into clinical training and continuing education
Implementation and improvement	• Support health care delivery organizations to redesign and retool the practice environment to reduce unnecessary care and improve appropriateness
Measurement and evaluation	• Develop and release new data and strengthen Canadian research capacity around overuse
Regional hubs	• Establish regional Choosing Wisely Canada campaigns to accelerate the pace of change through locally-relevant and -led strategies
International	• Coordinate an international community of countries who are implementing similar programs

Choosing Wisely Canada™

In partnership with the Canadian Medical Association

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Professional Societies: Association of Medical Microbiology and Infectious Disease Canada | Canadian Academy of Child and Adolescent Psychiatry | Canadian Academy of Geriatric Psychiatry | Canadian Academy of Sport and Exercise Medicine | Canadian Anesthesiologists Society | Canadian Association for the Study of the Liver | Canadian Association of Advanced Practice Nurses | Canadian Association of Critical Care Nurses | Canadian Association of Emergency Physicians | Canadian Association of General Surgeons | Canadian Association of Hospital Dentists | Canadian Association of Medical Biochemists | Canadian Association of Medical Oncologists | Canadian Association of Medical Radiation Technologists | Canadian Association of Nuclear Medicine | Canadian Association of Paediatric Surgeons | Canadian Association of Pathologists | Canadian Association of Physical Medicine & Rehabilitation | Canadian Association of Radiation Oncology | Canadian Association of Radiologists | Canadian Blood and Marrow Transplant Group | Canadian Cardiovascular Society | Canadian College of Medical Geneticists | Canadian Critical Care Society | Canadian Geriatrics Society | Canadian Headache Society | Canadian Hematology Society | Canadian IBD Network of Researchers for Healthcare Growth and Improvement | Canadian Neurological Society | Canadian Nurses Association | Canadian Orthopaedic Association | Canadian Paediatric Society | Canadian Pediatric Neurosurgery Study Group | Canadian Pharmacists Association | Canadian Psychiatric Association | Canadian Rheumatology Association | Canadian Society for Surgical Oncology | Canadian Society for Transfusion Medicine | Canadian Society for Vascular Surgery | Canadian Society of Allergy and Clinical Immunology | Canadian Society of Clinical Chemists | Canadian Society of Hospital Medicine | Canadian Society of Hospital Pharmacists | Canadian Society of Internal Medicine | Canadian Society of Nephrology | Canadian Society of Otolaryngology: Head and Neck Surgery | Canadian Society of Palliative Care Physicians | Canadian Society of Respiratory Therapists | Canadian Society of Endocrinology and Metabolism | Canadian Spine Society | Canadian Urological Association | Canadian Association of Gastroenterology | Long Term Care Medical Directors Association of Canada | Occupational Medicine Specialists of Canada | Public Health Physicians of Canada | Society of Obstetricians and Gynaecologists of Canada | Trauma Association of Canada

Medical Associations: Alberta Medical Association | Canadian Medical Association | Doctors Manitoba | Doctors Nova Scotia | New Brunswick Medical Society | Newfoundland and Labrador Medical Association | Northwest Territories Medical Association | Ontario Medical Association | Quebec Medical Association | Saskatchewan Medical Association | Yukon Medical Association

Health System Organizations: Canada Safe Imaging | Canadian Agency for Drugs & Technologies in Health | Canadian Association of Professors of Medicine | Canadian Deprescribing Network | Canadian Federation of Medical Students | Canadian Foundation for Healthcare Improvement | Canadian Institute for Health Information | Canadian Partnership Against Cancer | Canadian Patient Safety Institute | Canadian Task Force on Preventive Health Care | College of Family Physicians of Canada | Fédération des médecins résidents du Québec | Fédération médicale étudiante du Québec | Health Quality Ontario | Ontario College of Family Physicians | Ontario Medical Students Association | Resident Doctors of Canada | Royal College of Physicians and Surgeons of Canada | Touchstone Institute

Patient Organizations: Canadian Arthritis Patient Alliance | Canadian Association of Retired Teachers | Canadian Association of Social Workers | Consumer Reports Health | Crohn's and Colitis Canada | Gastrointestinal Society | National Association of Federal Retirees | Patients Canada | Patients for Patient Safety Canada | Retired Teachers of Ontario

Financial Supporters: ABIM Foundation | Bertelsmann Stiftung | Canadian Medical Association | Diagnostic Services Manitoba | Government of Alberta | Government of Canada | Government of New Brunswick | Government of Newfoundland and Labrador | Government of Northwest Territories | Government of Nova Scotia | Government of Nunavut | Government of Ontario | Government of Prince Edward Island | Government of Saskatchewan | Government of Yukon | Health Quality Ontario | Medical Society of Prince Edward Island | Medical Society of Prince Edward Island | Quebec Medical Association | Saskatchewan Medical Association | St. Michael's Hospital | The Commonwealth Fund | University of Toronto

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Primary Care Co-Lead

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Primary Care Co-Lead

Brian Wong
Medical Education Lead

Clinician Engagement

60+ SOCIETIES COMMITTED

to Choosing Wisely Canada at various stages of engagement.

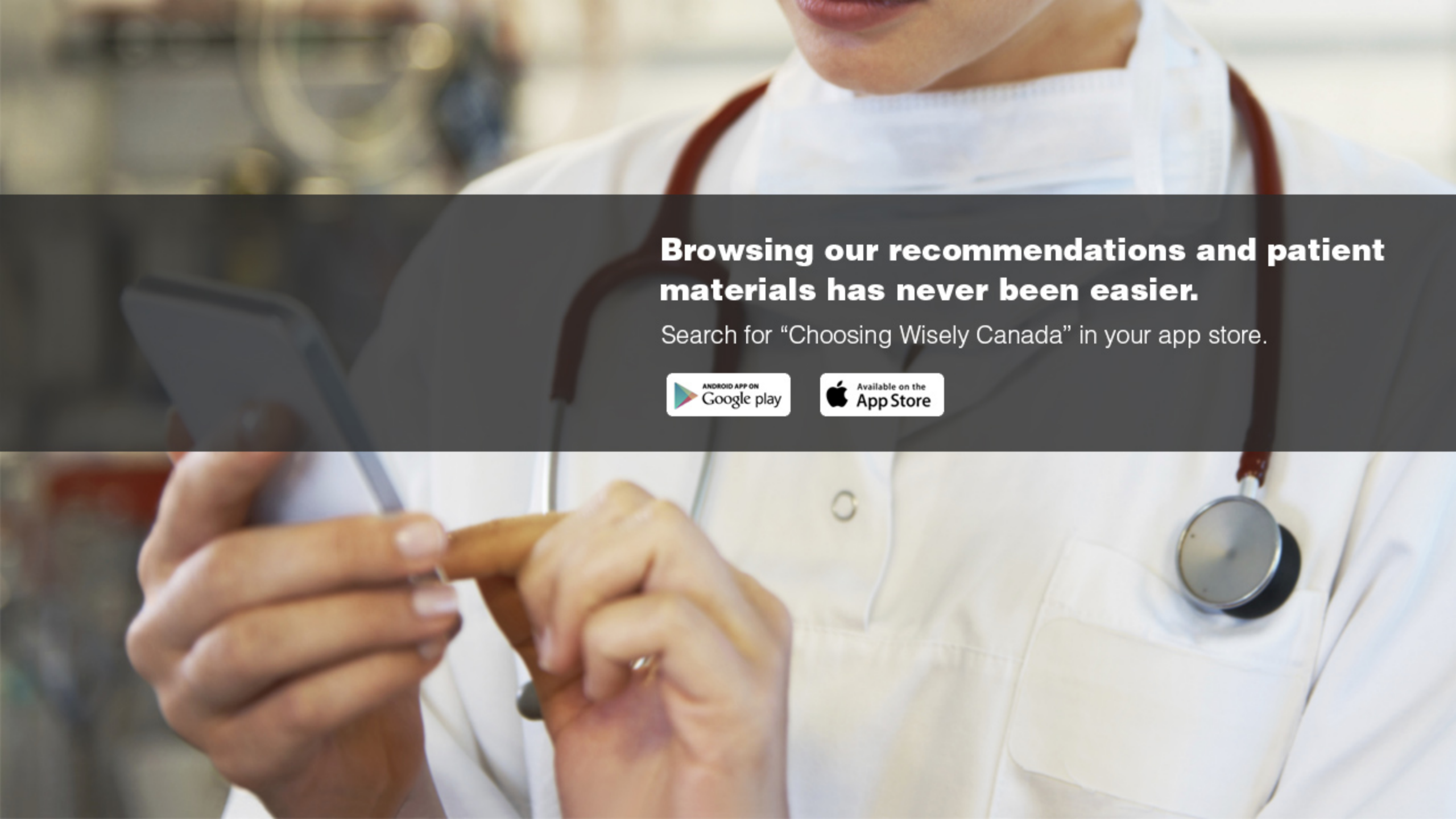
270+ RECOMMENDATIONS

published to date across 45+ specialties.

OTHER HEALTH CARE PROVIDER GROUPS ENGAGED

including nursing, pharmacy, nurse practitioner, hospital dentistry.

BEYOND THE LISTS


Browsing our recommendations and patient materials has never been easier.
Search for “Choosing Wisely Canada” in your app store.
ANDROID APP ON Google play
Available on the App Store

Confronting unnecessary care

This accredited online module reviews the issue of unnecessary care in Canada and describes the resources and clinical guidance available through Choosing Wisely Canada.

Nursing

Nine Things Nurses and Patients Should Question
by
Canadian Nurses Association
Last updated: May 2017

Choosing Wisely Canada™
In partnership with the Canadian Medical Association

1. **Don't insert an indwelling urinary catheter or leave it in place without daily assessment.**
The use of indwelling urinary catheters among hospital patients is common. Yet it can also lead to preventable harms such as urinary tract infection, sepsis and delirium. Guidelines support routine assessment of appropriate urinary catheter indications—including acute urinary obstruction, critical illness and end-of-life care—and minimizing their duration of use. Strategies consistent with CAUTI (catheter-associated urinary tract infection) guidelines regarding inappropriate urinary catheter use have been shown to reduce health care-associated infections.

2. **Don't advise routine self-monitoring of blood glucose between appointments for clients with type 2 diabetes who are not taking insulin or other medications that could increase risk for hypoglycemia.**
Many studies show that, once target control is achieved, routine self-monitoring of blood glucose (SMBG) does little to control blood sugar for most adults with type 2 diabetes who don't use insulin or other medications that could increase risk for hypoglycemia. It should be noted that SMBG may be indicated during acute illness, medication change or pregnancy; when a history or risk of hypoglycemia exists (e.g., if using a sulfonylurea), and when individuals need monitoring to maintain targets — considerations that should be part of assessment and client education.

3. **Don't add extra layers of bedding (sheets, pads) beneath patients on therapeutic surfaces.**
Additional layers of bedding can limit the pressure-dispersing capacities of therapeutic surfaces (such as therapeutic mattresses or cushions). As a result, extra sheets and pads can contribute to skin breakdown and impede the healing of existing pressure wounds.

4. **Don't use oxygen therapy to treat non-hypoxic dyspnea.**
Oxygen is frequently used to relieve shortness of breath. However, supplemental oxygen does not benefit patients who are short of breath but not hypoxic. Supplemental flow of air is as effective as oxygen for non-hypoxic dyspnea.

5. **Don't routinely use incontinence containment products (including briefs or pads) for older adults.**
Adult incontinence containment products are frequently used for continent patients (especially women) with low mobility. Yet the literature associates their use with multiple adverse outcomes including diminished self-esteem and perceived quality of life, and higher incidence rates of dermatitis, pressure wounds and urinary tract infections. Among older adults, nurses should conduct a thorough assessment to determine the risk of such outcomes before initiating or continuing the use of incontinence containment products. The development of a continence care plan should be a shared decision-making process that includes the known wishes of clients regarding care needs and the perspectives of carers and the health care team.

6. **Don't recommend tube feeding for clients with advanced dementia without ensuring a shared decision-making process that includes the known wishes of clients regarding future care needs and the perspectives of carers and the health care team.**
Tube feeding for older adults with advanced dementia offers no benefit over careful feeding assistance related to the outcomes of aspiration pneumonia and the extension of life. While food is the preferred form of obtaining nutrition, oral supplements may be beneficial if this intervention meets the person's known goals of care. Tube feeding may contribute to client discomfort and result in agitation, the use of physical and/or chemical restraint and worsening pressure wounds.

7. **Don't recommend antipsychotic medicines as the first choice to treat symptoms of dementia.**
People with dementia frequently exhibit responsive behaviors, which are often misinterpreted as aggression, resistance to care and challenging or disruptive behaviours. In such instances antipsychotic medicines are regularly prescribed. The benefit of these drugs is limited, however, and they can also cause serious harm including premature death. Their use should be limited to cases where non-pharmacologic measures have failed and where patients pose an imminent threat to themselves or others. Identifying and addressing the causes of behaviour change can render drug treatment unnecessary. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescriber.

8. **Don't recommend antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.**
Signs and symptoms suggestive of urinary tract infection (UTI) are increased frequency, urgency, pain or burning on urination, supra-pubic pain, flank pain and fever. Dark, cloudy and/or foul-smelling urine may not be suggestive of UTI but rather of inadequate fluid intake. Cohort studies have found no adverse outcomes associated with asymptomatic bacteriuria for older adults. Not only does antimicrobial treatment for such bacteriuria in older adults show no benefits, it increases adverse antimicrobial effects. Consensus criteria have been developed for the specific clinical symptoms that (when associated with bacteriuria) define UTI. Exceptions to these criteria include recommended screening for and treatment of asymptomatic bacteriuria before urologic procedures where mucosal bleeding is anticipated. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescribers.

9. **Don't routinely recommend antidepressants as a first-line treatment for mild depressive symptoms in adults.**
Antidepressant response rates are higher for moderate or severe adult depression. For mild depressive symptoms a complete assessment, ongoing support and monitoring, psychosocial interventions and lifestyle modifications should be the first lines of treatment. This approach can avoid the side-effects of medication and establish etiological factors important to future assessment and management. Antidepressants are appropriate in cases of persistent mild depression where a past history of more severe depression exists or where other interventions have failed. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescriber.

MORE IS NOT ALWAYS BETTER

www.ChoosingWisely.ca

More Is Not Always Better goals

1. Promote the message that in medicine as it is in life, “more is not always better”
2. Educate patients about when they might need a particular test or treatment, and when they don’t
3. Encourage patients to talk with their doctor about unnecessary care

FOUR QUESTIONS
TO ASK YOUR HEALTH CARE PROVIDER

1) Do I really need this test, treatment or procedure?

2) What are the downsides?

3) Are there simpler, safer options?

4) What happens if I do nothing?

Talk about what you need, and what you don't.
To learn more, visit www.choosingwisely.ca

Choosing Wisely Canada

What patients say to us?

"I don't want to challenge my doctor"

"Doctors don't make it safe to question"

"I need to understand the choices in my care"

"I want a 'Choosing wisely safe zone' sticker at my Docs office"

Antibiotics for sinusitis

When you need them and when you don’t

www.ChoosingWisely.ca

Choosing Wisely Canada™

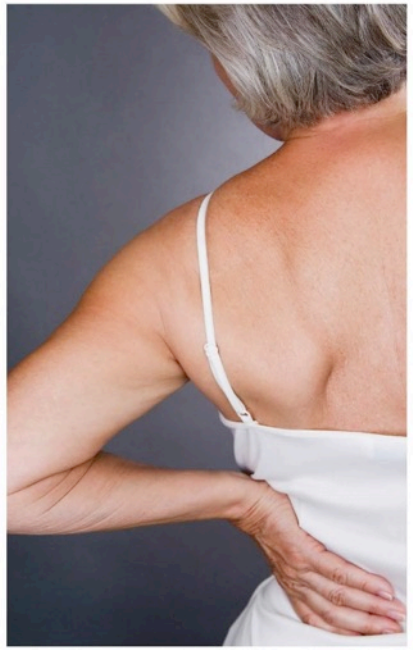
Canadian Association of Radiologists
L'Association canadienne des radiologistes
The College of Family Physicians of Canada
Le Collège des médecins de famille du Canada
Association médicale canadienne
Canadian Medical Association
Forum on General and Family Practice Issues

Choosing Wisely Canada is a campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments and make smart and effective choices to ensure high-quality care.

For more information on Choosing Wisely Canada or to see other patient materials, visit www.ChoosingWisely.ca.
Join the conversation on Twitter @ChooseWiselyCA

Imaging tests for lower back pain

When you need them—and when you don't



Back pain can be excruciating. So it seems that getting an X-ray, CT scan, or MRI to find the cause would be a good idea. But that's usually not the case, at least at first. Here's why:

They don't help you get better faster. Most people with lower back pain feel better in about a month whether they get an imaging test or not. In fact, those tests can lead to additional procedures that complicate recovery. For example, one large study of people with back pain found that those who had imaging tests soon after reporting the problem fared no better and sometimes did worse than people who took simple steps like applying heat, staying active, and taking an over-the-counter (OTC) pain reliever. Another study found that back pain sufferers who had an MRI in the first month were eight times more likely to have surgery, but didn't recover faster.

They can pose risks. X-rays and CT scans expose you to radiation, which can increase cancer risk. While back x-rays deliver less radiation, they still can give 75 times more radiation than a chest x-ray. That's especially worrisome to men and women of childbearing age, because x-rays and CT scans of the lower back can expose testicles and ovaries to radiation. Furthermore, the tests often reveal spinal abnormalities that could be completely unrelated to the pain. Those findings can cause needless worry and lead to unnecessary follow-up tests and procedures such as injections or sometimes even surgery.

When do imaging tests make sense? It can be a good idea to get an imaging test right away if you have signs of severe or worsening nerve damage, or a serious underlying problem such as cancer or a spinal infection. "Red flags" that can alert your doctor that imaging may be worthwhile include:

- A history of cancer.
- Unexplained weight loss.
- Fever.
- Recent infection.
- Loss of bowel or bladder control.
- Abnormal reflexes, or loss of muscle power or feeling in the legs.

If none of these additional symptoms is present, you probably don't need an imaging test for at least several weeks after the onset of your back pain, and only after you've tried the self-care measures described at right.

How should you treat lower back pain?

Your doctor can advise you on how best to treat your lower back pain. Most people get over back pain in a few weeks, and these simple steps might help:

Stay active. Resting in bed for more than a day or so can cause stiffness, weakness, depression, and slow recovery.

Apply heat. A heating pad, electric blanket, or warm bath or shower relaxes muscles.

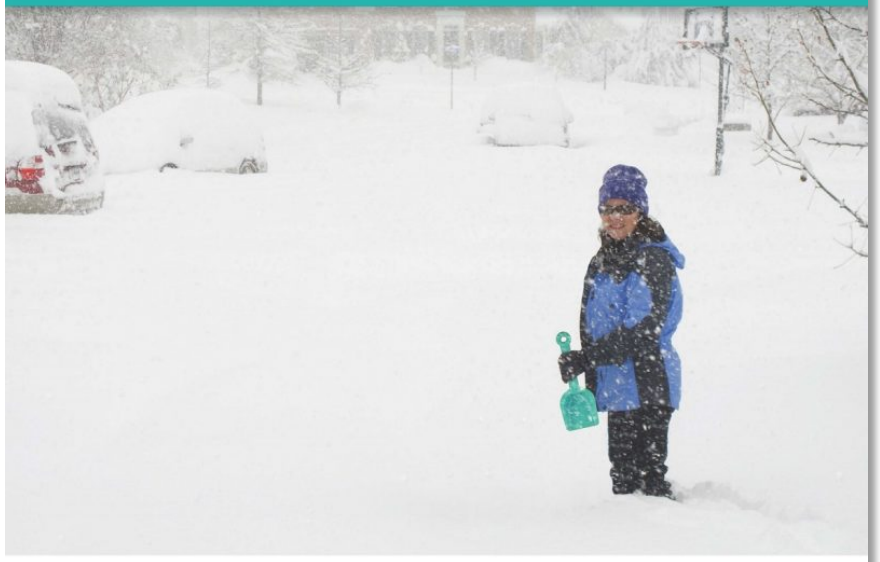
Consider over-the-counter medicines. Good options include pain relievers such as acetaminophen (Tylenol and generic) or anti-inflammatory drugs such as ibuprofen (Advil and generic) and naproxen (Aleve and generic).

Sleep comfortably. Lying on your side with a pillow between your knees or lying on your back with a few pillows beneath your knees might help.

Talk with your doctor. If symptoms don't improve after a few days, consider seeing a doctor to make sure that the problem doesn't stem from a serious underlying health problem. If the pain is severe, ask about prescription pain relievers.


IMPROVING YOUR HEALTH!
WOO HOO!
?
MORE isn't BETTER...

Choose wisely.



Antibiotics aren't always the right tool for the job.

Choosing Wisely NL | Choosing Wisely Canada

Antibiotics aren't effective in treating most coughs, colds or flus. Be #healthcareful – talk to your doctor about what you need, and what you don't. To learn more, visit **choosingwiselynl.ca**

DRAFT

Choosing Wisely Manitoba | Choosing Wisely Canada

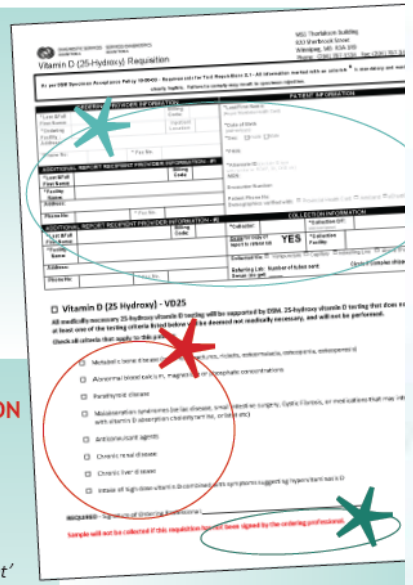
New 25(OH)D Requisition

Process Effective July 4, 2016

WRONG REQUISITION

DO NOT DRAW SAMPLE

- Advise patient that vitamin D test cannot be processed
- Offer to contact physician or provide option for patient to personally follow up
- Follow up as per patient directive



INCOMPLETE REQUISITION
- Missing Criteria -

DO NOT DRAW SAMPLE

- Fax requisition back to physician for completion
- Add standard REQC *'incomplete requisition sent'* message in Delphic

- Missing Signature-

DRAW SAMPLE

- Fax requisition back to physician for completion
- Add standard REQC *'incomplete requisition sent'* message in Delphic

REQUIREMENTS

- Complete patient demographics and physician info
- At least one medical indication checked
- Physician signature

Choosing Wisely Manitoba | Choosing Wisely Canada

Vitamin D & Me

Most of us don't have enough vitamin D in our bodies but very few of us have levels low enough to put us at risk for health concerns related to low levels of vitamin D.

Most of us can get enough vitamin D from our diets, safe sun exposure or supplements.

Who Needs to Be Tested for Vitamin D Deficiency?

Clinical evidence shows that most people do not benefit from vitamin D testing. Vitamin D testing may be medically appropriate for people with the following conditions or taking the following medications:

- Osteoporosis, calcium disorders, rickets and other metabolic bone diseases
- Celiac disease, cystic fibrosis and other malabsorption syndromes
- Renal and liver disease
- Anticonvulsant medications

Dietary Sources of Vitamin D

Foods rich in vitamin D include:

- Milk and other fortified beverages
- Fatty fish
- Egg yolks
- Fish liver oil

Supplementation

Although most of us do not need to be tested for deficiency, vitamin D supplementation could still be beneficial, particularly during Manitoba's long winter (October-April).

Health Canada recommends a daily intake of vitamin D from all sources as per the U.S. Institute of Medicine:

Infants 0-12 months	400 IU
Children & Adults 1-70 years	400-600 IU
Adults >70	400-800 IU

For more information on recommended dietary allowance of vitamin D, please visit Health Canada, or talk to your doctor.

www.hc-sc.gc.ca/fn-an/nutrition/vitamin/vita-d-eng.php#a10

Choosing Wisely Manitoba

CWM, a partnership of the Centre for Healthcare Innovation and Diagnostic Services Manitoba, is an initiative to improve the appropriate use of diagnostic testing in our province.

Centre for Healthcare Innovation

DIAGNOSTIC SERVICES MANITOBA


Elder Health
Staying Healthy
St. Michael's Academic Family health Team
IS PLEASED TO OFFER
FREE
Prenatal Classes
MONDAY EVENINGS FROM 5:00 - 7:00 PM
AT
THE HEALTH CENTRE 80 BOND,
Lower Level Classroom
St. Michael's Hospital
Academic Family Health Team
Life After Trauma
We are offering a ten week separate group for men and women ages 18 and up who are suffering from physical and/or emotional symptoms of trauma.
There are ten educational sessions on the various impacts of trauma on our lives and on developing new coping mechanisms to move forward.
MORE IS
NOT
ALWAYS
BETTER
Choosing Wisely Canada
Mid Toronto
For a limited time only!!!
Enjoy 5
FREE visits
*Includes wheelchair accessible transportation, snacks and a delicious hot meal.
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Toronto, ON
416-962-9449
Ext. 222
Wellness
Recovery
Action
Plan® for families
Family Matters Peer Support and Recovery Program
Ontario
Why smoke? Why quit?
Smoking rates within LGBT communities are two to three times higher than the general population.
It's time to clear the air.
For more information, visit clear-the-air.ca
camh
Craving Change™
A How-to Workshop for Changing Your Relationship with Food
RESEARCH PARTICIPANTS NEEDED
Flu in the family is no holiday for anyone
Is it flu?
THE SKELETAL SYSTEM
65+ SENIORS
Do you have a history of depression? Are you experiencing difficulties with your memory?
St. Michael's
camh
We believe
every person deserves the best possible health care.
We are Nurse Practitioners (NPs).
RNAO
DO YOU WANT TO QUIT SMOKING?
Smoking Cessation Treatment
... Family Health Team Patients
Our smoking cessation program offers Nicotine Replacement Therapy® (patch, gum, inhaler, lozenge) at no cost to the smoker and counselling support to Family Health Team Patients who want to quit smoking.
To find out more, please talk to your health care practitioner.
camh
St. Michael's Hospital Academic Family Health Team
"Living Well With Diabetes"
This workshop is being offered:
Location:
Health Centre at 80 Bond Street, Lower Level
Time: 9:00-11:00 a.m.
To Register: Please call (416) 864-6060 ext. 77226
Do you have difficulty affording your prescription medication?
60+ SENIORS
St. Michael's
TORONTO

Media

Winnipeg Free Press

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Opinion › Analysis

Analysis

More isn't necessarily better in health care

By: Wendy Levinson

Posted: **05/2/2016 4:00 AM** | Last Modified: 05/2/2016 5:38 PM | Updates | Comments: 1

Sections thestar.com

Life · Health & Wellness

Ontario patients taking too many medical tests

A growing body of evidence suggests that patients are being sent for too many blood tests, x-rays, CT scans and preoperative tests.

Some doctors belive that Ontarians are being sent for too many medical tests. (dreamstime)

By **SACHA BHATIA** University of Toronto

Mon., April 25, 2016

Home » Opinion

ANDRÉ PICARD

When it comes to tests, more is not always better

ANDRÉ PICARD

The Globe and Mail

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Home › Health › Do you really need that annual physical?

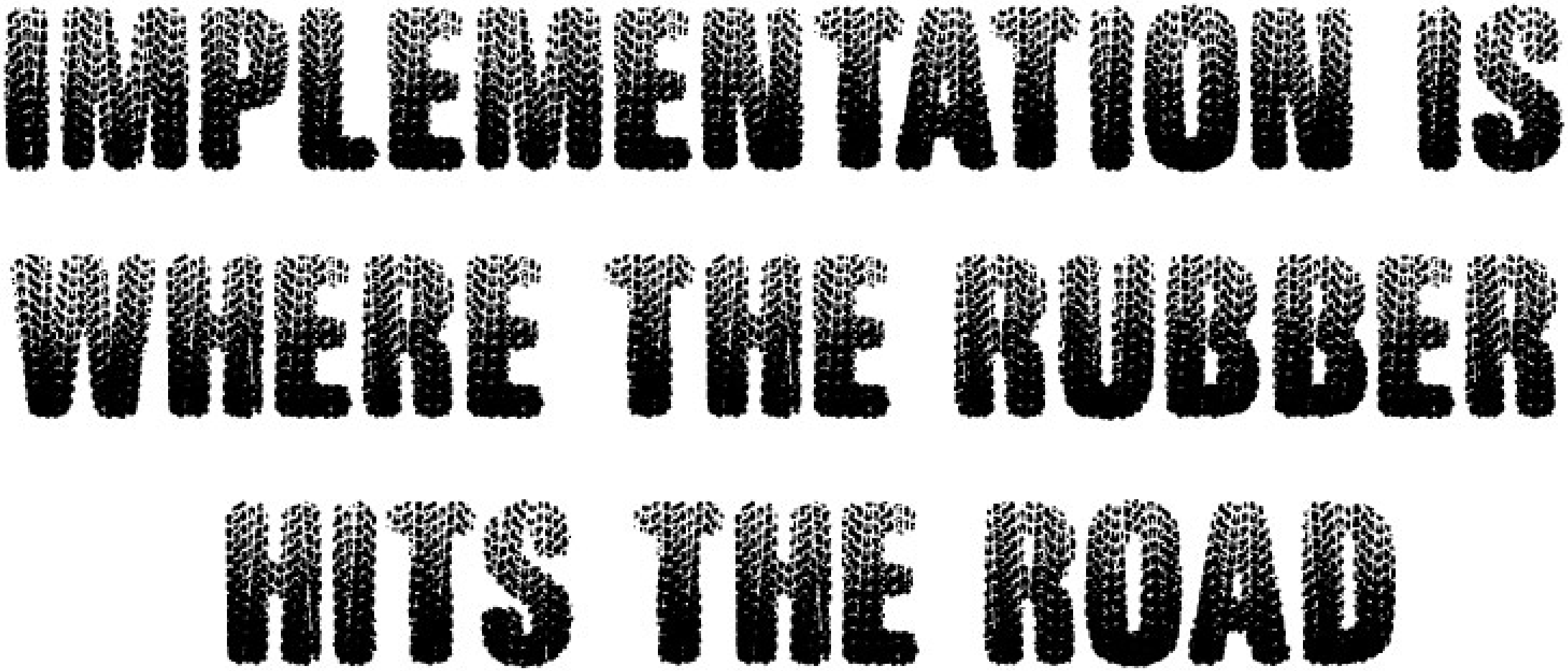
CHÂTELAINE

Health

Do you really need that annual physical?

Here's why there's little benefit to a 45-minute poke-and-prod session if you're already feeling fine.

Apr 14, 2016 Dr. Danielle Martin 0


IMPLEMENTATION IS
WHERE THE RUBBER
HITS THE ROAD

The Implementation Spectrum

Education

- Clinician education
- Patient education
- Awareness campaigns

Measurement & Improvement

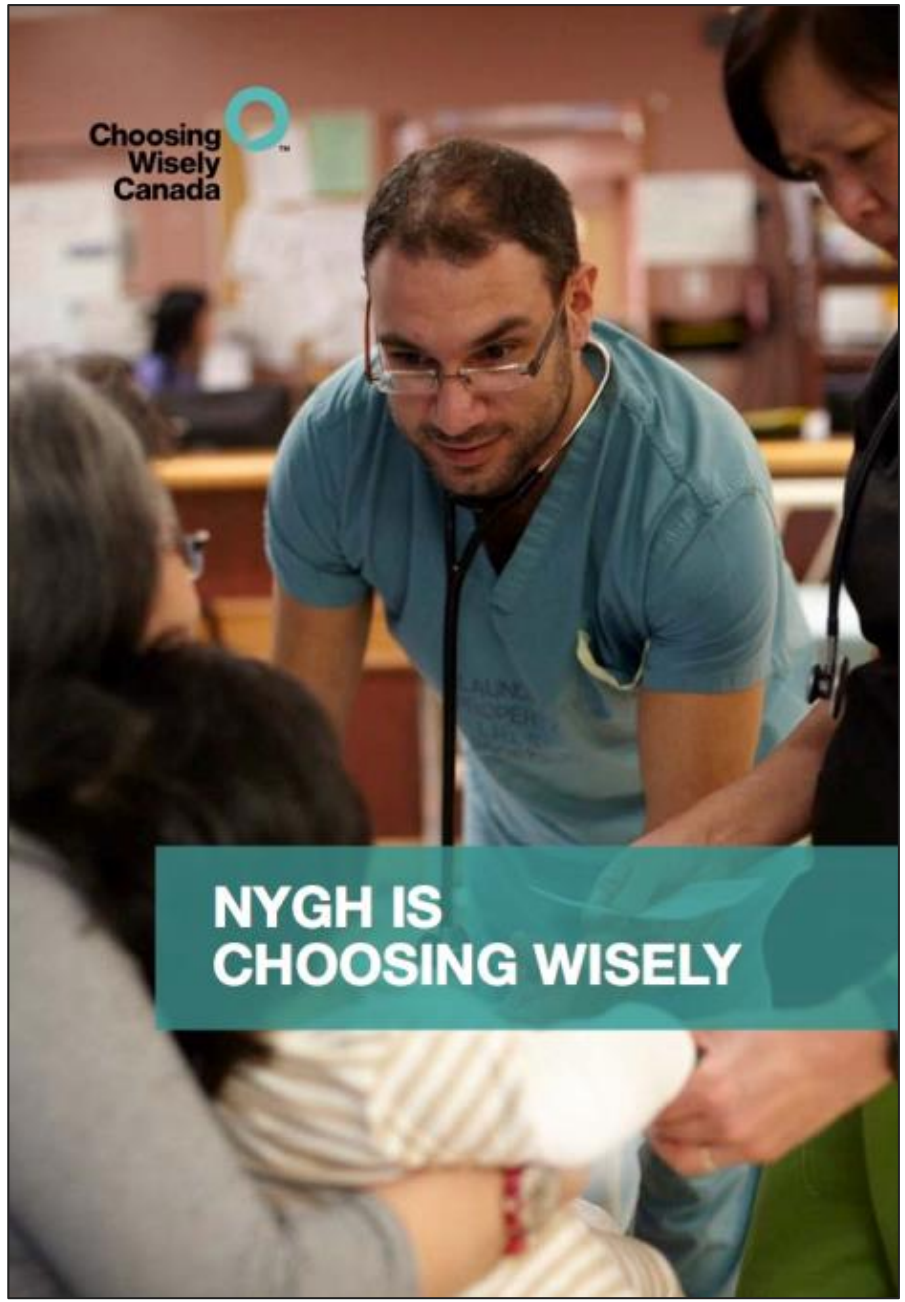
- Performance measurement
- Quality improvement projects
- Audit and feedback

Hard Coding

- Medical directives
- Order sets
- EMR/CPOE integration

Low leverage interventions ⟷ High leverage interventions


Choosing
Wisely
Canada
DIY



North York General Hospital, Toronto

- Results so far:
  - ED Lab Testing: ↓ 31%
  - Pre-Op Clinic Lab Testing: ↓ 38%
  - Inpatient Lab Testing: ↓ 12%
  - ICU Chest X-Rays: ↓ 12%

USER-GENERATED

AUTHORED BY PRACTITIONERS WITH A PROVEN TRACK RECORD

PEER-REVIEWED

SHORT, SIMPLE, PRACTICAL

LIVING DOCUMENT

This toolkit was prepared by:

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This toolkit has been peer-reviewed by:

The Canadian Society of Internal Medicine
Choosing Wisely Canada Subcommittee

Choosing Wisely Canada™

www.ChoosingWiselyCanada.org
info@ChoosingWiselyCanada.org

Sunnybrook Health Sciences Centre, Toronto

- Results: Monthly RBC usage ↓ 29%

Nova Scotia Provincial Health Authority

- Results: RBC Transfusion ↓ 16.4%

Both no negative impact

Alberta Health Services

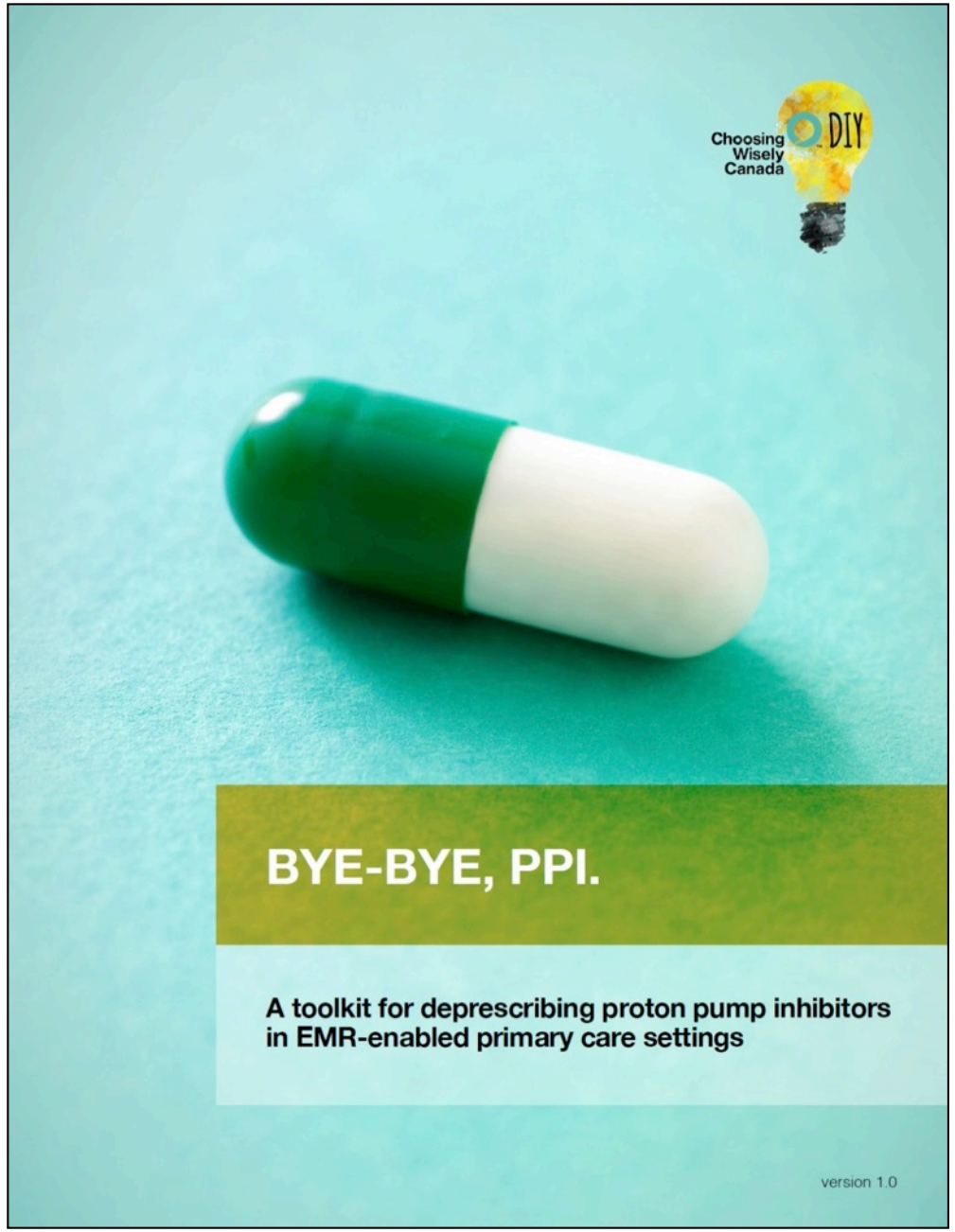
- Results:
  - Province wide LTC antipsychotic use ↓ 8%
    - 11 early adopter sites ↓ 50%;

both no negative impact

Sunnybrook Health Sciences Centre, Toronto

- Results:
  - Urinary catheter use on medical wards: ↓ 50%;

no negative impact



Toronto Western Family Health Team

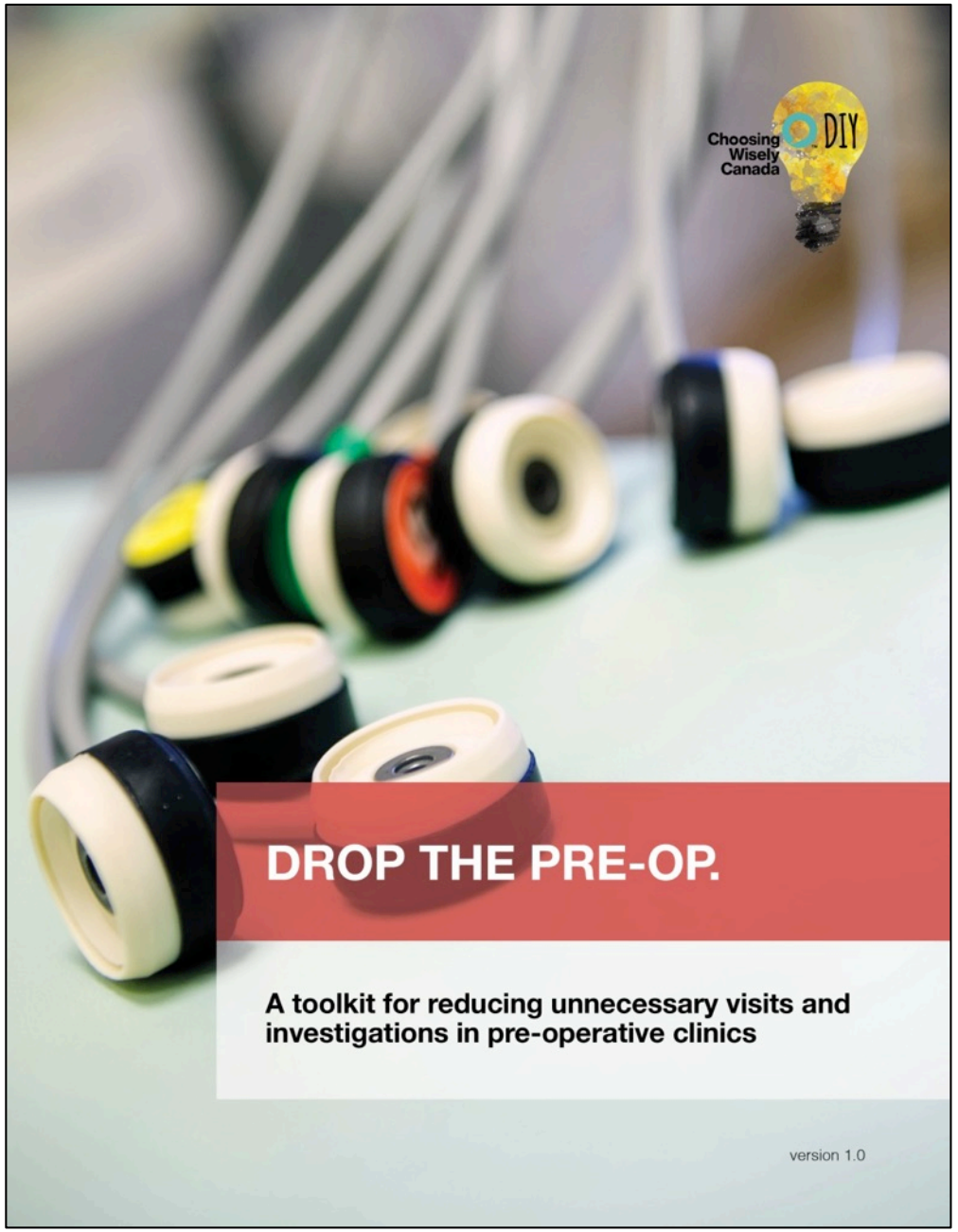
- Results:
  - Patients prescribed PPIs ↓ 26%
  - 93% of patients had their PPIs reassessed

both no negative impact

Sinai Health System

- Results:
  - Sedative-hypnotic prescriptions ↓ 40%

no negative impact



North York General Hospital

- Results:
  - Pre-op lab testing ↓ 47%;

no negative impact

What is a toolkit?

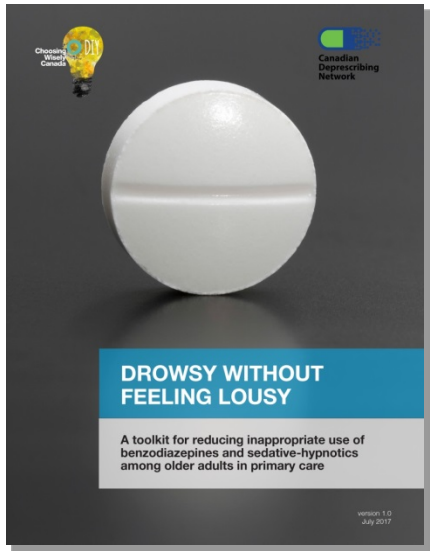
Key ingredients of intervention

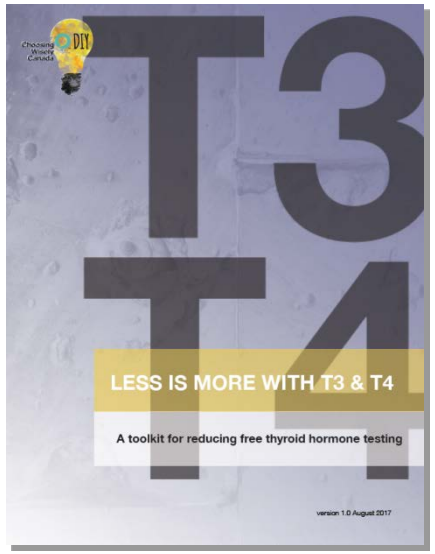
Measuring your performance

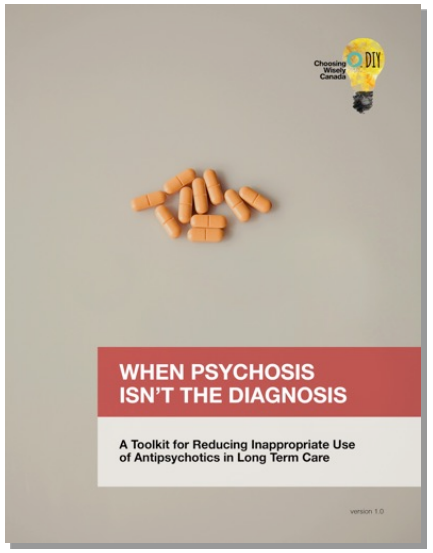
Sustaining early successes

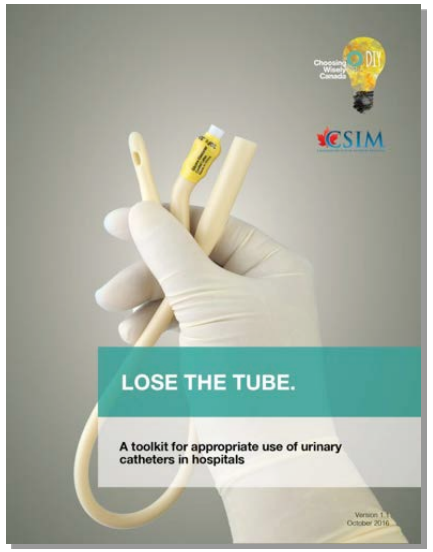
Additional resources and patient aids

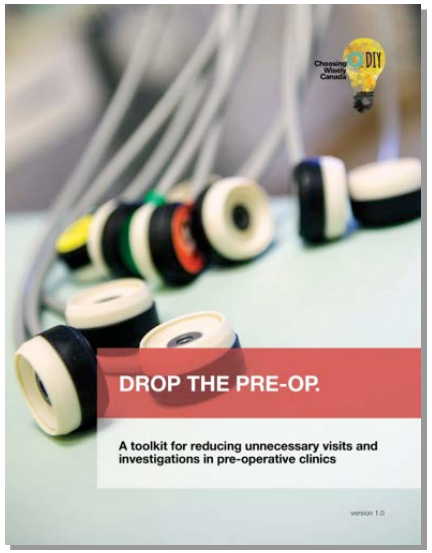
DIY Toolkits











Choosing Wisely Canada DIY

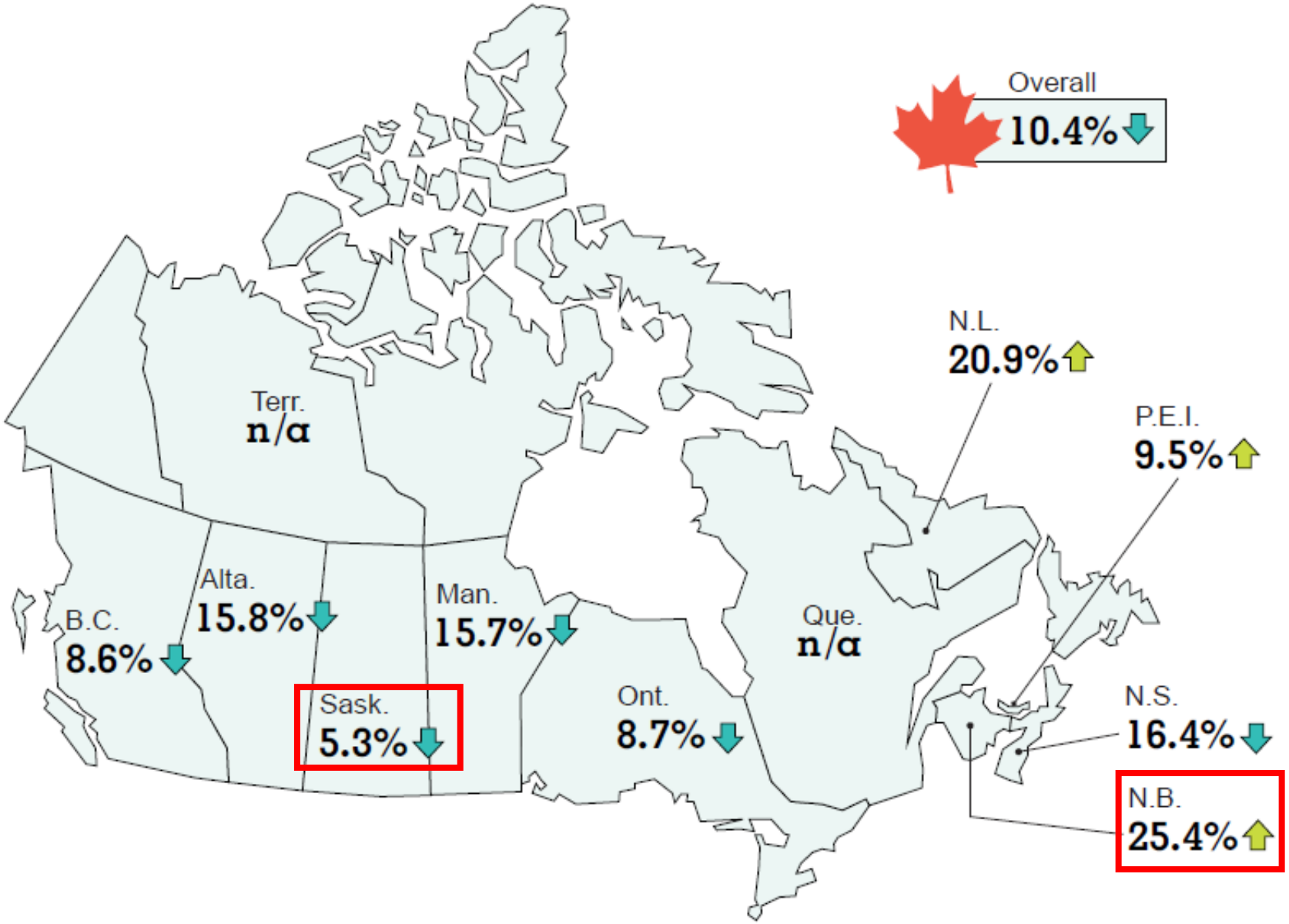
LESS SEDATIVES FOR YOUR OLDER RELATIVES.

A toolkit for reducing inappropriate use of benzodiazepines and sedative-hypnotics among older adults in hospitals

Don’t use benzos or other sedatives as the first choice for insomnia, agitation or delirium.

- 1/10 Canadian seniors regularly use benzos/sedatives
- Women chronically use benzos 5% more than men in Canada (likely due to insomnia)

Rate of Chronic Benzodiazepine use Among Seniors



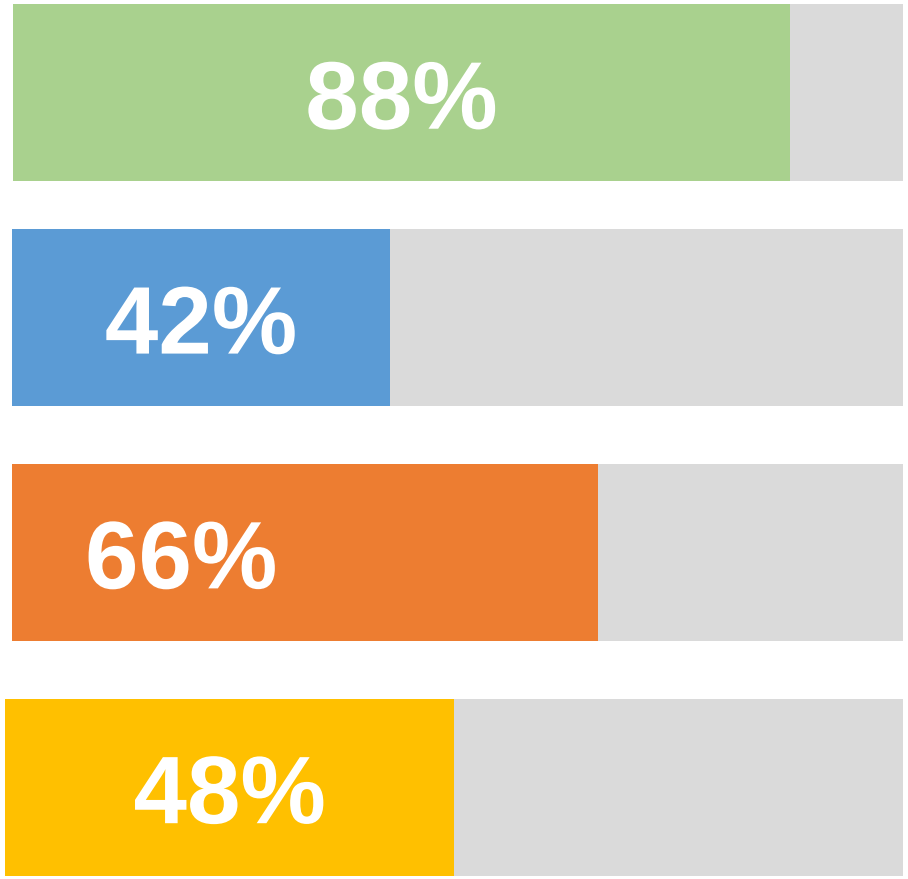
2014-2015


Introducing
Choosing Wisely
Talks
PRESENTED BY
ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION
First Thursday of every month
12PM ET

Measurement framework

- Provider attitudes and awareness
- Patient attitudes and awareness
- Provider behaviours related to overuse of low value services

Physician Attitudes



Aware of CWC

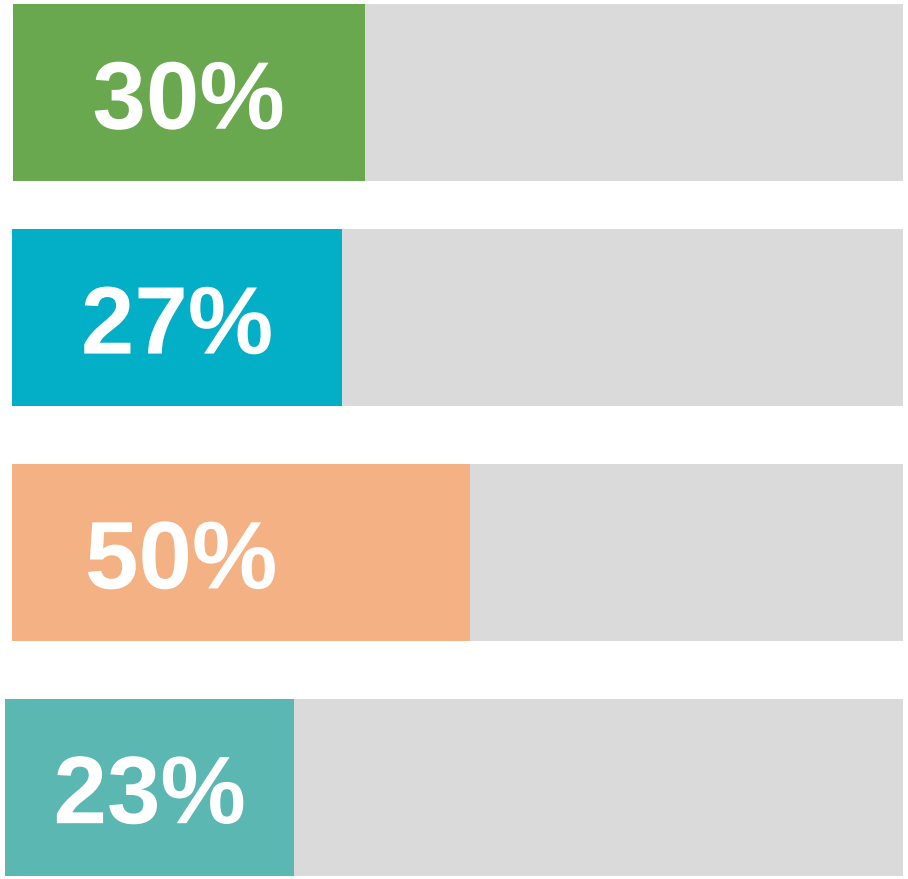
Use lists in daily practice

Patients need tools to make informed decisions

MDs require more tools to help make decisions

CMA e-Panel Disseminated November 2016

Patient Attitudes



of patients said aa doctor had recommended a test/treatment they did not feel was necessary

Took test without discussing with MD

Asked MD why the test/treatment was necessary

Ignored MD's advice

Ipsos Reid (2017). Awareness and Attitudes towards Choosing Wisely Campaign.

Unnecessary care in Canada

Wastes health system resources

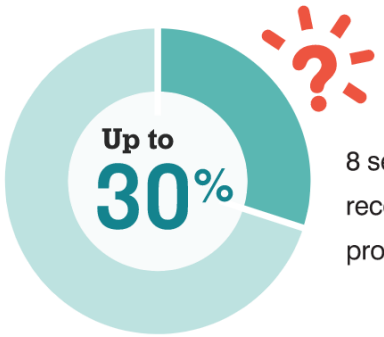
Increases wait times for patients

Can lead to patient harm

Canadians have

1 million+

potentially unnecessary medical tests and treatments each year.



of patients indicated in the 8 selected Choosing Wisely Canada recommendations had tests, treatments and procedures that **are potentially unnecessary**.

There is room to reduce unnecessary care.

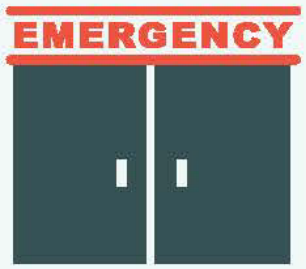
Substantial variation exists among regions and facilities in terms of the number of unnecessary tests and procedures performed — **this points to an opportunity to improve.**

Choosing Wisely Canada is a campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments, and make smart choices.

Unnecessary Care in Canada explores 8 out of 200+ Choosing Wisely Canada recommendations across sectors of the health system: primary care, specialist care, emergency care and hospital care.

cihi.ca

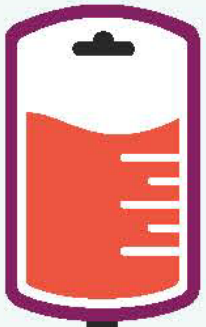
Choosing Wisely Canada™ CIHI



30% of emergency department patients in Ontario and Alberta with low-risk minor head trauma **received a CT head scan.**

22% of Canadian women age 40 to 49 **received a screening mammogram,** despite being of average risk.

In Ontario, **23%** of inpatients with delirium **had a potentially unnecessary head CT scan.**



Red blood cell transfusions for elective hip (12%) and knee (8%) replacements **have decreased but continue to be done across Canada,** even though blood is a precious resource.

CANADIAN PARTNERSHIP AGAINST CANCER | PARTENARIAT CANADIEN CONTRE LE CANCER

SYSTEM PERFORMANCE REPORTS

EMBARGOED UNTIL ITS PUBLIC RELEASE ON MARCH 31, 2016

Quality and Sustainability in Cancer Control

A SYSTEM PERFORMANCE SPOTLIGHT REPORT

MARCH 2016

740,000

screening tests for breast and cervical cancer were performed outside recommended age groups

17,000

cancer patients received treatment that may be of low value

9,000

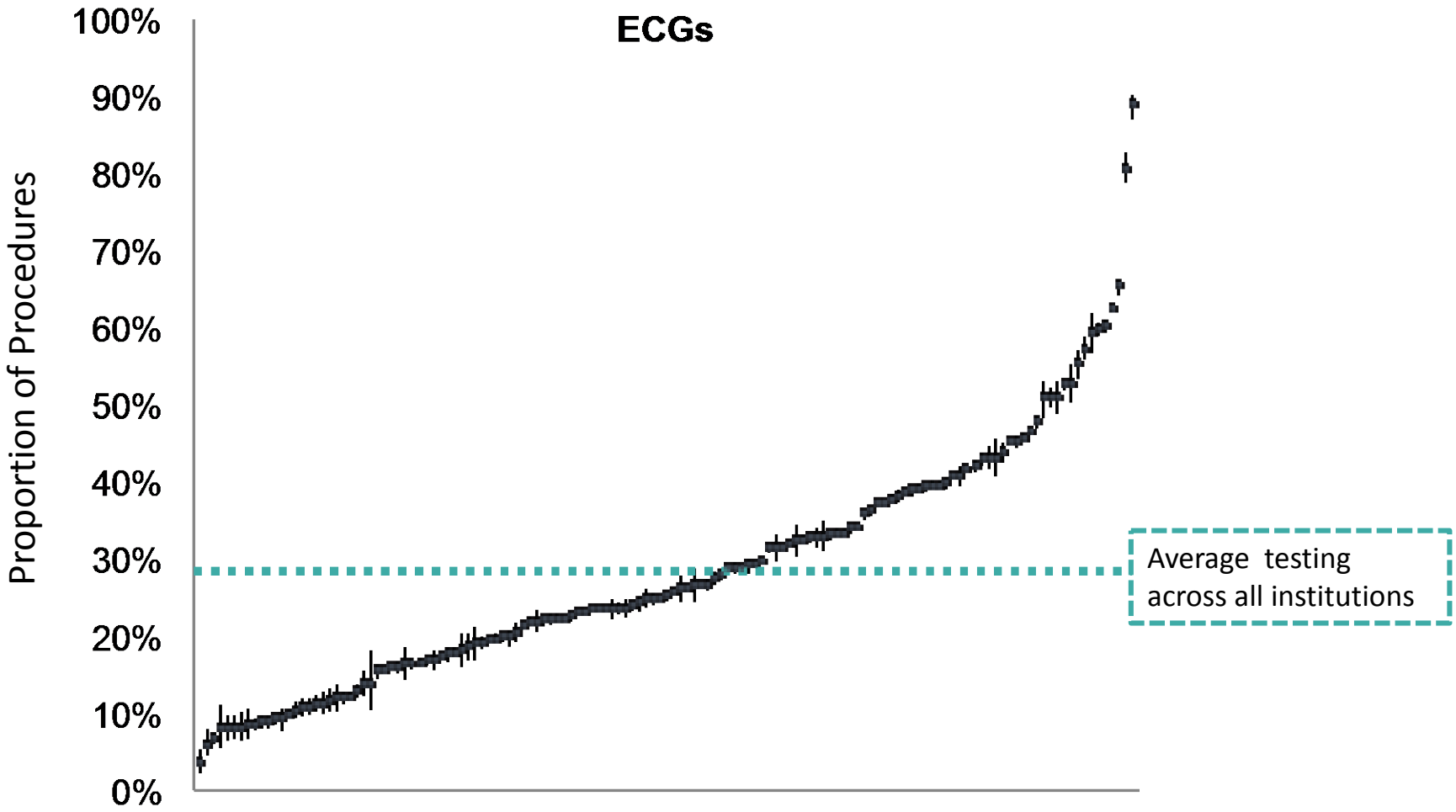
cancer patients near end of life received care in an ICU

5,000

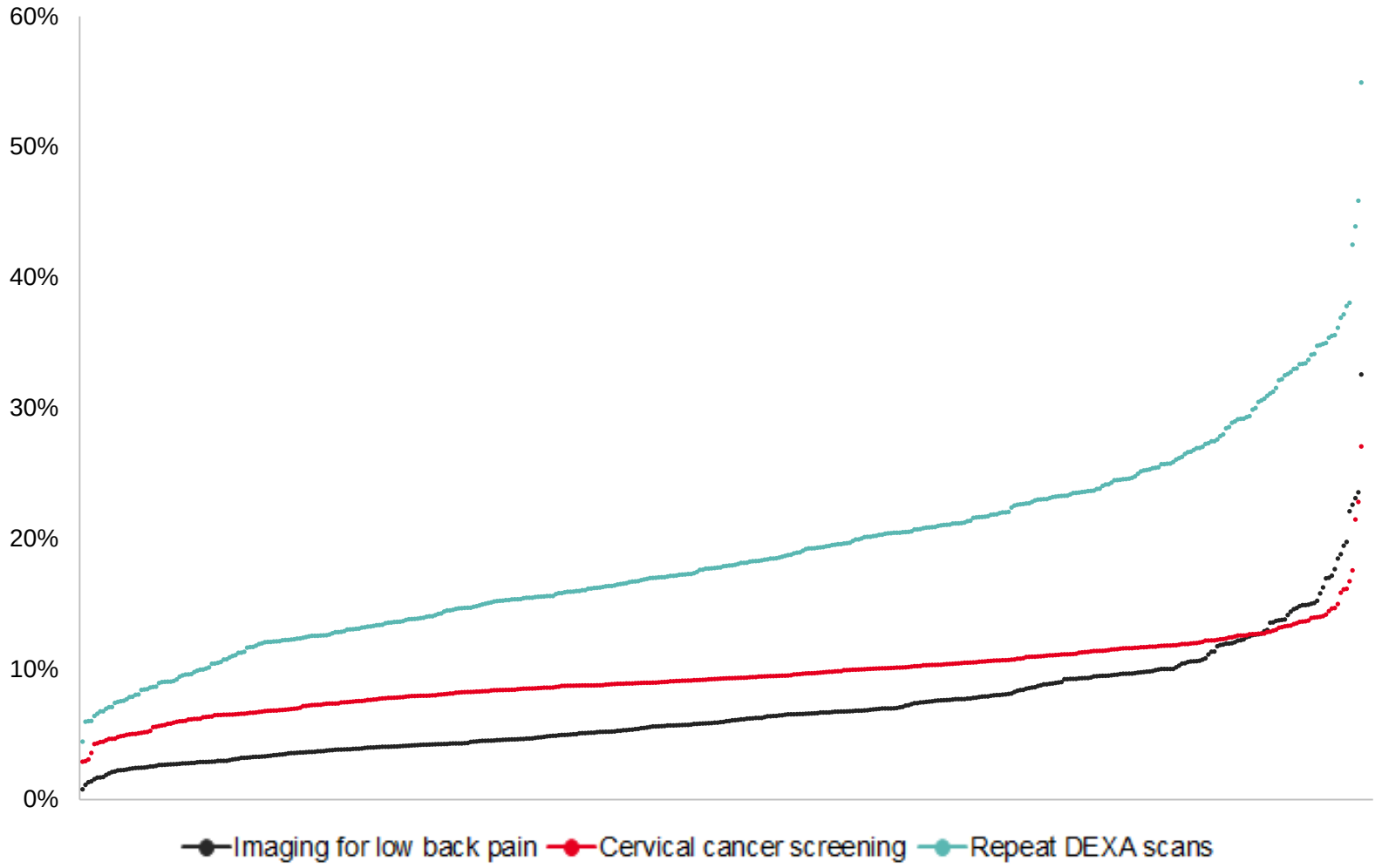
mastectomies were performed in an inpatient setting

systemperformance.ca

Preoperative testing in Ontario: ECGs



Variation across practices in Ontario



Noteworthy publications

- Preoperative testing before low-risk surgical procedures. *CMAJ*. 2015 Aug 11.
- Preoperative laboratory investigations: rates and variability prior to low-risk surgical procedures. *Anesthesiology*. 2016 Jan 28.
- Frequency and variation of Choosing Wisely recommendations ordered in primary care (submitted to *JGIM*).

Regional Choosing Wisely campaigns

Choosing Wisely Canada

STARS

Students & Trainees Advocating for Resource Stewardship

www.ChoosingWiselyCanada.org / medical-education

Medical Education: Students

Six Things Medical Students and Trainees Should Question
by
Canadian Federation of Medical Students
Fédération médicale étudiante du Québec
Last updated: November 2015

Choosing Wisely Canada
In partnership with the Canadian Medical Association

1. **Don't suggest ordering the most invasive test or treatment before considering other less invasive options.**
There are often diagnostic approaches and treatment options that result in the same clinical outcome but are less invasive. Examples include the use of ultrasound instead of computed tomography (CT) scanning to diagnose acute appendicitis in children, or the use of an oral antibiotic that has similar oral bioavailability as its intravenous counterpart. Taking time to consider the diagnostic sensitivity and specificity of less invasive tests or the therapeutic effectiveness of less invasive treatments can minimize unnecessary patient exposure to harmful side effects of more invasive tests or treatments.

2. **Don't suggest a test, treatment, or procedure that will not change the patient's clinical course.**
When ordering tests, it is important to always consider the diagnostic characteristics such as sensitivity, specificity and predictive value in light of the patient's pre-test probability. Patients who are at very low baseline risk often do not require an additional test to rule out the diagnosis. Furthermore, evidence suggests that in such low-risk patients, diagnostic tests do not reassure patients, decrease their anxiety, or resolve their symptoms. Examples include the use of computed tomography (CT) scanning in low-risk patients to rule out pulmonary embolism, or pre-operative cardiac testing for patients prior to low risk surgery. Evaluation of baseline risk and the use of decision tools wherever possible, along with a 'how will this change my management' approach, can help to avoid unnecessary 'rule out' testing in patients.

3. **Don't miss the opportunity to initiate conversations with patients about whether a test, treatment or procedure is necessary.**
Patient requests sometimes drive overuse. For example, a parent might request antibiotics for his or her child who likely has viral sinusitis, or a patient might request magnetic resonance imaging (MRI) for low-back pain. Often patients are unaware of the benefits, side-effects and risks of tests and treatments. Taking time to explore a patient's concerns, and counseling them about the relative benefits and risks of tests or treatments represents a patient-centered approach to ensuring the appropriate use of resources.

4. **Don't hesitate to ask for clarification on tests, treatments, or procedures that you believe are unnecessary.**
Unfortunately, in some learning environments, a hierarchy exists between supervisors and students that makes it difficult for students to feel comfortable speaking up. As a result, students might observe unnecessary care, but avoid saying anything for fear of potential consequences. Supervisors need to encourage students to feel free to question whether tests or treatments are truly necessary without fear of repercussion. The clinical training environment should be one where students feel safe to ask questions.

5. **Don't suggest ordering tests or performing procedures for the sole purpose of gaining personal clinical experience.**
The clinical training years in medical school represent an important opportunity for students to translate what was learned in the classroom to the bedside. This can be a challenging time of great uncertainty for students. Students may order tests excessively due to a lack of clinical experience, or recommend investigations in order to build upon their personal experience.

6. **Don't suggest ordering tests or treatments pre-emptively for the sole purpose of anticipating what your supervisor would want.**
A "hidden curriculum" pervasive in the academic environment encourages medical students to search for zebras through extensive (and often unnecessary) diagnostic workups. Because restraint is often discouraged, students adopt the belief that faculty expect an exhaustive diagnostic approach, and feel that they need to demonstrate their knowledge, thoroughness and curiosity through test ordering. Students can overcome this practice by articulating why they chose not to order a specific test. This, combined with a shift towards 'celebrating restraint' by faculty can help to combat this pervasive practice in medical training.

Medical Education: Residents

Five Things Residents and Patients Should Question
by
Resident Doctors of Canada
Last updated: July 2017

Choosing Wisely Canada
In partnership with the Canadian Medical Association

1. **Don't order investigations that will not change your patient's management plan.**
Investigations may not change your patient's management plan for several reasons. In some cases, the patient's pre-test probability for a condition is low, and further testing is not necessary (e.g., screening for breast cancer in younger women with low risk of breast cancer). Another example is unnecessary preoperative testing before a low-risk surgical procedure where the risk of complications is low. On the other hand, high-risk patients may warrant treatment irrespective of the test result; thus, testing in these patients would not influence the ultimate decision to treat (e.g., thrombophilia testing in patients with an unprovoked pulmonary embolism at high risk for recurrence is not helpful, since these patients should receive indefinite anticoagulation). Where possible, residents can refer to evidence-based clinical decision rules to guide appropriate testing or treatment – examples include the Well's criteria or pulmonary embolism rule-out criteria (PERC) for pulmonary embolism, the Canadian CT Head Rule for CT scan of the head in a trauma patient, or the Centor criteria for likelihood of bacterial infection in adult patients with a sore throat.

2. **Don't order repeat laboratory investigations on inpatients who are clinically stable.**
Daily laboratory investigations can persist despite clinical stability for a variety of reasons (e.g., daily order without a stop date, not reassessing whether investigations are still needed). Observational studies suggest that resident physicians order routine daily CBC (complete blood count) and electrolyte panels more frequently than attending physicians. Daily phlebotomy contributes to patient discomfort and iatrogenic anemia. Studies support the safe reduction of repetitive laboratory investigations when patients are clinically stable without a negative impact on patient outcomes, including readmission rates, critical care utilization, adverse events, or mortality. Laboratory investigations should be ordered with a specific purpose which directly links to a specific management plan for patients.

3. **Don't order intravenous (IV) when an oral (PO) option is appropriate and tolerated.**
Patients are often ordered intravenous (IV) medications when oral (PO) options are available, appropriate, and equally bioavailable. Common examples include antibiotics that are highly orally bioavailable (e.g., fluoroquinolones), oral potassium replacement (which is more effective than IV replacement), proton pump inhibitors (PPI) including in the setting of many cases of acute gastrointestinal bleeding, and oral vitamin B12 replacement (as opposed to intramuscular injections, including in the context of pernicious anemia). Peripheral catheters increase the risk of complications, including extravasation, infections, and thrombophlebitis. Furthermore, IV medication administration is often significantly costlier, decreases patient mobility, and increases length of hospital stay and pharmacist and nursing workload.

4. **Don't order non-urgent investigations or procedures that will delay discharge of hospital inpatients.**
Discharges are commonly delayed for investigations that will not change acute management. Examples include biopsies, imaging to further investigate incidental findings, assessment by a specialist that is non-urgent, waiting for bloodwork results as part of a non-urgent diagnostic work-up, or echocardiography for patients with mild heart failure. Delayed discharges contribute to hospital over-crowding and negatively impact care efficiency. Crucially, longer lengths of stay is a risk factor for nosocomial infections, venous thromboembolism, pressures injuries, immobility, malnutrition, and deconditioning. Consider outpatient investigations when possible, if good follow-up can be assured.

5. **Don't order invasive studies if less invasive options are available and as effective.**
When considering diagnosis or screening investigations, consider all available tests. It is prudent to consider the least invasive option that will have similar sensitivity and specificity to guide clinical decision making to minimize the potential for harm to the patient. For example, when diagnosing acute appendicitis in children, ultrasound should be considered before computed tomography (CT) scanning. Not only is ultrasound radiation- and contrast-free, but it has been shown to be equivalent to CT scanning in the diagnosis and management of acute appendicitis across several clinically-relevant endpoints, including time to antibiotic delivery, time to appendectomy, negative appendectomy rate, perforation rate, or length of stay. Another example is conducting a non-invasive urea breath test rather than invasive endoscopy to prove H. pylori eradication. The sensitivity and specificity of the urea breath test are superior compared to other diagnostic tests and the risk of patient harm is minimal compared to endoscopy.


theatrum anato
waag society
International Roundtable on Choosing Wisely
Date: Thursday 12th of June 2014
Time: 09.00 – 17.00 hrs
Location: Theatrum Anatomicum, 2nd Floor

The Norwegian Medical Association
DEN NORSKE LEGEFORENING

Choosing Wisely Australia
An initiative of NPS MedicineWise

CHoosing wisely

Choosing Wisely®
An initiative of the ABIM Foundation

CHOOSE WISELY

医療における
“賢明な選択”を
目指して

CHOOSING WISELY JAPAN

Slow Medicine
Sobria
Rispettosa
Giusta

CHOOSING WISELY WALES
DEWIS DOETH CYMRU

Verstandig Kiezen


ORDEM E PROGRESSO

Who cares about low value care?

Right Care Alliance

Too Much Medicine

Conclusions

- Choosing Wisely Canada:
  - Encourages smart, thoughtful decision making, not rationing of healthcare
  - Is evidence based
  - Has gained widespread support in the physician community
  - Promotes patient communication as a key component of reducing unnecessary tests and treatments
- There are opportunities to implement some of these recommendations into your individual practice or your institution